

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board
Occupational Therapy Section Meeting
September 10, 2020
9:00 AM Roll Call
Call 1-614-721-2972; 133 677 561#

Occupational Therapy Section 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.

1. Administrative Matters

1.1 Agenda Review

1.2 Approval of Minutes

Action Required

1.3 Executive Director's Report

1.4 Executive Session

1.4.1 To discuss pending and imminent court action (*ORC 121.22 (G)(3)*)

1.4.2 To discuss personnel matters related to:

- Appointment; Employment; Dismissal; Discipline; Promotion; Demotion; Compensation (*ORC 121.22 (G)(1)*)

Investigation of charges/complaints against a public employee, licensee, or regulated individual in lieu of a public hearing (*ORC 121.22 (G)(1)*)

1.4.3 To discuss matters required to be kept confidential by federal law, federal rules, or state statutes (*ORC 121.22 (G)(5)*)

1.5 Special Orders

1.5.1 Election of Officers

1.5.1.1 Election of Chair

Action Required

1.5.1.2 Election of Secretary

Action Required

1.5.2 Liaison Appointments

1.5.2.1 Enforcement Division Liaison

1.5.2.2 Licensure Liaison

1.5.2.3 Continuing Education Liaison

1.5.2.4 Correspondence Liaisons

1.5.2.5 Rules Liaison

1.5.3 Authorize the Executive Director or Agency Designee to accept or reject consent agreements on the Section's behalf for the period beginning September 10, 2020 and ending September 30, 2021.

Action Required

1.5.4 Authorize the use of signature stamps or electronic signatures by the Section Chairperson, Section Secretary, Executive Director or Agency Designee for the period beginning September 10, 2020 and ending September 30, 2021.

Action Required

1.5.5 Authorize the Executive Director or Agency Designee to make editorial changes to motions for the period beginning September 10, 2020 and ending September 30, 2021.

Action Required

1.5.6 Authorize the use of hearing officers for the period beginning September 10, 2020 and ending September 30, 2021.

Action Required

1.5.7 Authorize the staff to issue licenses to applicants with completed applications and that the Section ratify all licenses issued by the staff at the Section meeting following the issuance of the license for the period beginning September 10, 2020 and ending September 30, 2021.

Action Required

1.6 Discussion of Law and Rule Changes

1.6.1 Military licensure changes

1.6.2 Continuing Education rule

1.6.3 Laws and rules document has been updated

1.6.4 Law changes in budget submission

1.7 Board newsletter topics

1.8 Budget submission

2. Licensure Applications

2.1 Application Review Liaison Report

Action Required

2.2 Releases from Limited License Agreement(s)

2.3 License Application Waiver Requests

2.4 Occupational Therapist/Occupational Therapy Assistant Examination Applications

Action Required

2.5 Occupational Therapist/Occupational Therapy Assistant Endorsement Applications

Action Required

2.6 Occupational Therapist/Occupational Therapy Assistant Reinstatement Applications

Action Required

2.7 Occupational Therapist/Occupational Therapy Assistant Restoration Applications

Action Required

2.8 CE Request(s) for Approval

Action Required

2.8.1 CE Denial Appeal

Action Required

- 2.9 Application withdrawals
- 3. Enforcement Division**
 - 3.1 Assistant Attorney General Report (*5 Minutes*)
 - 3.2 Case Review Liaison Report (*10 Minutes*)
 - 3.3 Releases from Consent Agreement(s)
 - 3.4 Notice(s) of Opportunity for Hearing
 - 3.5 Consent Agreement(s)
 - 3.6 Affidavit Consideration(s)
 - 3.7 Hearing Officer Report(s)
 - 3.8 Summary Suspension(s)
 - 3.9 To discuss proposed disciplinary action against a licensee pursuant to ORC 121.22 (G)(1) and pursuant to 121.22 (G)(5) that involve matters required to be kept confidential under ORC sections 149.43 (A)(2) and 4755.02 (E)(1)
- 4. Correspondence**
 - Joint Correspondence**
- 5. OOTA Report**
- 6. Open Forum**
- 7. Old Business**
- 8. New Business**
- 9. Retreat Agenda**
 - 9.1 AOTA Code of Ethics review
 - 9.2 Telehealth standard response
 - 9.3 Treatment via online technology in skilled nursing
 - 9.4 OOTA presentation
 - 9.5 Ethics presentations in general
 - 9.6 OT Compact
 - 9.7 Additional jurisprudence questions (topics/question suggestions on recent rule changes)
- 10. Next Meeting Preparation**
 - 10.1 Agenda Items
 - 10.2 Executive Director Assignments
- 11. Adjournment**



**Ohio Occupational Therapy, Physical Therapy,
and Athletic Trainers Board**

*Occupational Therapy Section
July 23, 2020
9:00 AM*

Virtual Meeting via Microsoft Teams

Members Present

Beth Ann Ball, OTR/L
Joanne Estes, PhD, OTR/L
Mary Beth Lavey, COTA/L, Chair
Anissa Siefert, MOT, OTR/L
Melissa Van Allen, OTR/L, Secretary

Legal Counsel

Emily Pelphey, AAG

Staff

Missy Anthony, Executive Director
Jeffery Duvall, Enforcement Division Supervisor
Jaklyn Shucofsky, Paralegal
Debbie Fulk, Licensure
Jan Hills, Executive Assistant

Guests

Jackie Chamberlain

Call to Order

Mary Beth Lavey, Chair, called the meeting to order at 9:03 AM.

The Section began 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

Joanne Estes moved that the minutes from the May 15, 2020 meeting be approved as amended. Beth Ann Ball seconded the motion. Motion carried.

Executive Director's Report

- Licensure statistics- OT licenses lag due to continuous testing
- eLicense- several tickets pending
 - Duty to report
 - Minimum age requirement
 - Wall certificate printing delay
- Personnel, Budget and Office
 - Hiring freeze
 - Finishing AT & PTA audit
 - OT audit in fall
 - Revenue down in March and April
 - OTAs down by 1600 due to deadline extension of December 1 from June 30

- Board member training
 - Ethics
 - Domestic violence
 - Disability awareness

Discussion of Law and Rule Changes

- Minimum age of licensure - final filed with effective date
- Five year review- final filed with effective date
- Military Licensure changes- filed with CSI
- Continuing Education Rule- topic will be on retreat agenda
- Concussion Rules- no changes
- ODE Education of Students with Special Needs- fundamental misunderstanding of OTA/OT services and ORC 4755.

Melissa Van Allen moved that the executive director submit comments on the Department of Education’s rules regarding students with special needs. Second by Joanne Estes. Motion passed.

Licensure Applications

Joanne Estes recommended that the Section grant a limited license for **LR-003768839** to allow for supervised practice in order to complete a limited license agreement. Moved by Beth Ann Ball, seconded by Mary Beth Lavey. Motion passed.

Joanne Estes informed the section that **OT004073** has passed her NBCOT exam and fulfilled the terms of her out of practice agreement.

Joanne Estes recommended that the Section approve the amended limited license agreement for **OT004526LTD** and deem it complete and grant a full license. Motion made by Mary Beth Lavey, seconded by Beth Ann Ball. Motion passed.

Joanne Estes recommended that the Section allow limited license **OT-001898LTD** to complete the Texas OT Reentry program in lieu of completing the supervision hours in her limited license agreement. Moved by Melissa Van Allen, seconded by Beth Ann Ball. Motion passed.

Occupational Therapist/Occupational Therapist Assistant Examination Applications

Joanne Estes made a motion that the Occupational Therapy Section ratify, as submitted, the occupational therapist and the occupational therapy assistant licenses issued by examination, endorsement, reinstatement, and restoration by the Ohio Occupational Therapy, Physical Therapy and Athletic Trainers Board from May 16, 2020 to July 23, 2020, taking into account those licenses subject to discipline, surrender, or non-renewal. Anissa Siefert seconded the motion. Motion passed. * denotes abstention by Joann Estes

Occupational Therapist by Examination- 65

Natalie Rae Anderson
Emily Marie Aviles
Victoria Nicole Baker
Caroline Amanda Bard
Rachel Elizabeth Bea
Madison Olivia Blair
Abby Marie Bowers
Hannah Alise Boy
Jessica Danielle Brown
Krysten Rene Chadwick
Colleen Marie Clement
Lauren Kathryn Conine
Katelyn Connelly
Veronica Lynn Cope
Ann Margaret Coyne
Kelsi A Doerr
Mary Catherine Drockton
Meghan Anne Esarove
Andrea Evanoff
Christopher Edward Fox
Amy Elizabeth Fox
Jennifer Lynn Gerspacher

Lily Maria Ingeborg Grebe
Alexis Grothouse
Alli Danielle Hall
Samantha Elyse Hammock
Blair Harmon
Haven Elizabeth Helmstetter
Mary Elizabeth Herman
Ashley Hughes
Samantha Jensen
Eric Mark Johnson
Manvir Kaur
Allison Florence Kienzle
Claudia Konstand
Hannah Kreider-Letterman
Rose Elaine Lintelman
Taylor Nicole MacWhade
Tori Madaris
Portia Lynn Maravich
Emily Markland
Ralph Walter Meckstroth
Katlyn Patricia Meyers
Sarah Anne Monvillers

Brooke Michele Moran
Alexander Orkwis
Jamison Elizabeth Pence
Alexandra Plaster
Darshani Ram
Samuel David Reeder
Mary Kate Riffle
Marla Ann Schroeder
Leah Schwinn
Anna Seastone
Jene R Shaw
Denielle Lynn Simich
Ellen Stakely
Brianna Starr
Sydney Reese Stewart
Kelsi Nicole Thompson
Savanah Wagner
Brooke Ashley White
Aerika Marie Wieser
Molly Ann Wilson
Kristin Marie Zink

Occupational Therapist by Endorsement-23

Kendra Adams
Gina Marie Buonpane
Bridget Rebecca Coakley
Allyson Elaine Frost
Rebecca Gilchrist
Allyson Green
Evelyn Grace Hart
Jason Charles Hinson

Abbi Danielle Huggins
Claire Isaia
Julie Ann Jones
Kristen Kowalski
Wanda Lunden
Taylor Mangas*
Karen Elizabeth Michel
Rachel Allison Murphy

Valerie Rapp O'Brien
Rachel Orelowitz
Madeline Runyen
Samantha Cari Schnur
David Simpson
Leah Elizabeth Storch
Alexandra Bess Young

Occupational Therapist Assistant by Examination-18

Bailey Lynn Brobst
Brooke Elizabeth Burdette
Jennifer Catalano
Lindsey Fitch
Nichole Michelle Forrer
Bailey Funkhouser

Amy Elizabeth Groves
Nikayla Vernell Hamilton
McKenzie Rose Huff
Ashley Nichole Jordan
Ashley Lynn Martin
Mandy Sue Massie

Kylie Anne Neer
Michelle Pechinko
Joseph Patrick Sengstock
Emily Rose St. John
Denise Renae' Swigart
Holly L Waters-Williams

Occupational Therapist Assistant by Endorsement- 4

Stephanie Corin Ayers
Dawn Sue Colville

Kaylee Christine Peterson
Alexandria Nichole Wilson

Withdrawals

Joanne Estes recommended that the section grant the application withdrawal requests for OT/OTA examination, endorsement, and reinstatement applications on file with the Board on July 23, 2020 based on the documentation provided. Motion made by Beth Ann Ball, second by Anissa Siefert. Motion carried.

Andrew Lash	APP-000064978
Jennifer Connor	APP-000373228
Alexander Orkwis	APP-000364676
Joseph Sengstock	APP-000366318
Ashley Bolitho	APP-000369174
Alexandra Young	APP-000334077
Natalie Anderson	APP-000364394
Allison Kienzle	OT-011063
Emily St. John	APP-000362776
Lindsey Fitch	APP-000361049

CE Requests

Beth Ann Ball moved that the section approve 22 applications for contact hour approval, deny 3 applications and send 1 back for further information. Joanne Estes seconded. Motion passed.

Licensure Renewal Report

Executive Director Missy Anthony will be sending out reminder notifications to all

CE Waiver requests

Beth Ann Ball recommended that the requests for additional time to complete CEs for June 30 deadline for OTAs be granted per applicants' individual requests. Joanne Estes made a motion, second by Mary Beth Lavey. Motion passed.

Angela Herbert	OTA006040	(2X)
Lauren Powers	OTA002824	
Jack Griner	OTA004438	
Margaret Griner	OTA004528	
Allison Dietz	OTA004036	

Enforcement Division

Statistics

"New" cases opened since the last meeting: 8
Cases "closed" since the last meeting: 3
Cases "currently open": 33
Active consent agreements: 9
Adjudication orders being monitored: 1

Releases from Consent Agreement

Anissa Siefert informed the Board that **Emily Yearly, OTA**, has complied with all terms and conditions and will be released from her consent agreement.

Anissa Siefert informed the Board that **Katherine Gibson, OT**, has complied with all terms and conditions and will be released from her consent agreement.

Anissa Siefert informed the Board that **Tara Clark, OTA**, has complied with all terms and conditions and will be released from her consent agreement

Notice of Opportunity of Hearing

Anissa Siefert recommended a motion be made to issue a notice of opportunity for hearing for **case # OT-20-088**, for respondent for CE Deficiency, Motion made by Joanne Estes, second by Beth Ann Ball. Anissa Siefert abstained. Motion passed.

Anissa Siefert recommended a motion be made to issue a notice of opportunity for hearing for **case # OT-20-105** for CE Deficiency. Beth Ann Ball made the motion, second by Joanne Estes. Anissa Siefert abstained. Motion passed.

Anissa Siefert recommended a motion be made to issue a notice of opportunity for hearing for **case # OT-20-129** for CE Deficiency. Beth Ann Ball made the motion, second by Joanne Estes. Anissa Siefert abstained. Motion passed.

Proposed Consent Agreements

Anissa Siefert recommended that a motion be made accepting the consent agreement for **case # OT-20-098** in lieu of going to hearing. Melissa Van Allen made the motion, second by Joanne Estes. Anissa Siefert abstained. Motion passed. The Board has accepted the consent agreement for **Marlo Harvey, OTA**.

Anissa Siefert recommended that a motion be made accepting the consent agreement for **case # OT-20-103** in lieu of going to hearing. Beth Ann Ball made the motion, second by Joanne Estes. Anissa Siefert abstained. Motion passed. The Board has accepted the consent agreement for **Karen Grattan, OTA**.

Anissa Siefert recommended that a motion be made accepting the consent agreement for **case # OT-20-177** in lieu of going to hearing. Melissa Van Allen made the motion, second by Beth Ann Ball. Anissa Siefert abstained. Motion passed. The Board has accepted the consent agreement for **Mary Allen, OTA**.

Notice of Hearing -Rescind

Anissa Siefert recommended that a motion be made to rescind the notice of opportunity for hearing issued for **case # OT-20-103** as this individual entered into a consent agreement in lieu of going to hearing. Joanne Estes made a motion, second by Beth Ann Ball. Anissa Siefert abstained. Motion passed.

Goldman Hearings

Mary Beth Lavey, Chairperson of the Occupational Therapy Section of the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board called the proceedings to order at 10:32 AM on July 23, 2020, in an online board meeting held on Microsoft Teams.

Executive Director Missy Anthony called the roll:

Beth Ann Ball
Joanne Estes
Mary Beth Lavey
Anissa Siefert
Melissa Van Allen

It is noted for the record that a majority of the members of the Board are present for the eight adjudication proceedings. The proceedings are in the matters of **Barbara Scott**, case number **OT-20-101**, **Julia Litschel**, case number **OT-20-108**, **Peter Maurer**, case number **OT-20-110**, **Lisa Wyatt**, case number **OT-20-111**, **Kinda Martin**, case number **OT-20-112**, **Amanda Beach**, case number **OT-20-118**, **Dana Ochmanski**, case number **OT-20-119**, and **Jaclyn Holt**, case number **OT-20-120**.

These proceedings shall be affidavit-based adjudications relative to the Notice of Opportunity for Hearing mailed to the respondent in the aforementioned cases and believed to have been properly served according to the Administrative Procedures Act (Chapter 119. of the Ohio Revised Code).

As the respondents declined to have a hearing in the case, these proceedings will be held before the Board pursuant to Goldman v. State Medical Board of Ohio. The individuals named do not have the ability to present written or oral testimony today but may be present to hear the proceeding and outcome.

You have already received a sworn affidavit from the Board's Enforcement Division Paralegal, and the accompanying exhibits for the Goldman Proceedings in your Board packet. The affidavit contains the evidence and testimony upon which you will deliberate. Please take a few moments to review the evidence and testimony.

In lieu of a stenographic record being made, let the minutes reflect that the original sworn affidavit and exhibits shall be kept as the official record of the proceeding in the aforementioned matters in the Board office.

Assistant Attorney General, Emily Pelphey provided a synopsis of the cases. With all cases being similar Jaklyn Shucofsky, Board paralegal, provided an affidavit on each case. These hearings are the result of the Occupational Therapist Assistant continuing education audit, and each case is either deficient in continuing education hours or chose not to respond to the OTA CE audit.

Mary Beth Lavey recommended a motion be made to admit the facts and exhibits outlined in the sworn affidavits in the aforementioned cases into evidence. Beth Ann Ball made a motion, seconded by Melissa Van Allen.

With no further evidence to come before the Board the proceedings were closed at 10:43 AM. The procedural and jurisdictional matters having been satisfied, we will now continue with the proceedings by deliberation on the sworn affidavit and exhibits. Joanne Estes made a motion to recess the meeting in order to go into private session for the purpose of quasi-judicial deliberation on **Barbara Scott**, case number **OT-20-101**, **Julia Litschel**, case number **OT-20-108**, **Peter Maurer**, case number **OT-20-110**, **Lisa Wyatt**, case number **OT-20-111**, **Kinda Martin**, case number **OT-20-112**, **Amanda Beach**, case number **OT-20-118**, **Dana Ochmanski**, case number **OT-20-119**, and **Jaclyn Holt**, case number **OT-20-120** and to reconvene the meeting after deliberations are complete. Second made by Melissa Van Allen.

Executive Director called the roll:

Beth Ann Ball
Joanne Estes,
Mary Beth Lavey,
Anissa Siefert,
Melissa Van Allen

Anissa Siefert abstained from attending the executive session.

Mary Beth Lavey requested the Executive Director and AAG participate in the executive session phone call.

The Section came out of executive session at 11:30 am.

Beth Ann Ball made a motion to have a member of the section read the Section's decisions regarding findings of fact, conclusions of law, and order of the Section. Joanne Estes seconded the motion. Motion passed.

Amanda Beach, case number OT-20-118

Based on a thorough review of the evidence, the Board found that the following Findings of Fact were proved by a preponderance of the evidence:

1. The Board had jurisdiction to conduct a hearing in this matter pursuant to Goldman v. State Medical Board of Ohio, 110 Ohio App. 3d 124; 673 N.E.2d 677 (1996).
2. **Beach** was selected for continuing education audit.
3. **Beach** was notified of continuing education audit selection.
4. **Beach** failed to respond to the continuing education notices.
5. **Beach** did not request a hearing on the aforementioned charge.

Based on thorough review of the evidence, the Board made the following Conclusions of Law based upon a preponderance of evidence:

1. **Beach** was properly served with the Notice of Opportunity for a Hearing pursuant to R.C. 119.07.
2. R.C. 119.07 required **Beach** to request a hearing within thirty (30) days of the mailing of the Notice.
3. **Beach** violated Ohio Administrative Code Rule 4755-9-01 and 4755-7-08.

Based upon a preponderance of the evidence and the Findings of Fact and Conclusions of Law stated above, it is the conclusion of the Board that the occupational therapy assistant license of **Beach** should be revoked.

Thereafter, the Board voted to enter upon its Journal the following Order:

The occupational therapy assistant license of Amanda Beach is hereby REVOKED.

Barbara Scott, case number OT-20-101

Based on a thorough review of the evidence, the Board found that the following Findings of Fact were proved by a preponderance of the evidence:

1. The Board had jurisdiction to conduct a hearing in this matter pursuant to Goldman v. State Medical Board of Ohio, 110 Ohio App. 3d 124; 673 N.E.2d 677 (1996).
2. **Scott** was selected for continuing education audit.
3. **Scott** was notified of continuing education audit selection.
4. **Scott** failed to respond to the continuing education notices.
5. **Scott** did not request a hearing on the aforementioned charge.

Based on thorough review of the evidence, the Board made the following Conclusions of Law based upon a preponderance of evidence:

1. **Scott** was properly served with the Notice of Opportunity for a Hearing pursuant to R.C. 119.07.
2. R.C. 119.07 required **Scott** to request a hearing within thirty (30) days of the mailing of the Notice.
3. **Scott** violated Ohio Administrative Code Rule 4755-9-01 and 4755-7-08.

Based upon a preponderance of the evidence and the Findings of Fact and Conclusions of Law stated above, it is the conclusion of the Board that the occupational therapy assistant license of **Scott** should be revoked.

Thereafter, the Board voted to enter upon its Journal the following Order:

The occupational therapy assistant license of Barbara Scott is hereby REVOKED.

Julia Litschel, case number OT-20-108

Based on a thorough review of the evidence, the Board found that the following Findings of Fact were proved by a preponderance of the evidence:

1. The Board had jurisdiction to conduct a hearing in this matter pursuant to Goldman v. State Medical Board of Ohio, 110 Ohio App. 3d 124; 673 N.E.2d 677 (1996).
2. **Litschel** was selected for continuing education audit.
3. **Litschel** was notified of continuing education audit selection.
4. **Litschel** failed to respond to the continuing education notices.
5. **Litschel** did not request a hearing on the aforementioned charge.

Based on thorough review of the evidence, the Board made the following Conclusions of Law based upon a preponderance of evidence:

1. **Litschel** was properly served with the Notice of Opportunity for a Hearing pursuant to R.C. 119.07.
2. R.C. 119.07 required **Litschel** to request a hearing within thirty (30) days of the mailing of the Notice.
3. **Litschel** violated Ohio Administrative Code Rule 4755-9-01 and 4755-7-08.

Based upon a preponderance of the evidence and the Findings of Fact and Conclusions of Law stated above, it is the conclusion of the Board that the occupational therapy assistant license of **Litschel** should be revoked.

Thereafter, the Board voted to enter upon its Journal the following Order:

The occupational therapy assistant license of Julia Litschel is hereby REVOKED.

Peter Maurer, case number OT-20-110

Based on a thorough review of the evidence, the Board found that the following Findings of Fact were proved by a preponderance of the evidence:

1. The Board had jurisdiction to conduct a hearing in this matter pursuant to Goldman v. State Medical Board of Ohio, 110 Ohio App. 3d 124; 673 N.E.2d 677 (1996).
2. **Maurer** was selected for continuing education audit.
3. **Maurer** was notified of continuing education audit selection.
4. **Maurer** failed to respond to the continuing education notices.
5. **Maurer** did not request a hearing on the aforementioned charge.

Based on thorough review of the evidence, the Board made the following Conclusions of Law based upon a preponderance of evidence:

1. **Maurer** was properly served with the Notice of Opportunity for a Hearing pursuant to R.C. 119.07.
2. R.C. 119.07 required **Maurer** to request a hearing within thirty (30) days of the mailing of the Notice.

3. **Maurer** violated Ohio Administrative Code Rule 4755-9-01 and 4755-7-08.

Based upon a preponderance of the evidence and the Findings of Fact and Conclusions of Law stated above, it is the conclusion of the Board that the occupational therapy assistant license of **Maurer** should be revoked.

Thereafter, the Board voted to enter upon its Journal the following Order:

The occupational therapy assistant license of Peter Maurer is hereby REVOKED.

Dana Ochmanski, case number OT-20-119

Based on a thorough review of the evidence, the Board found that the following Findings of Fact were proved by a preponderance of the evidence:

1. The Board had jurisdiction to conduct a hearing in this matter pursuant to Goldman v. State Medical Board of Ohio, 110 Ohio App. 3d 124; 673 N.E.2d 677 (1996).
2. **Ochmanski** was selected for continuing education audit.
3. **Ochmanski** was notified of continuing education audit selection.
4. **Ochmanski** failed to respond to the continuing education notices.
5. **Ochmanski** did not request a hearing on the aforementioned charge.

Based on thorough review of the evidence, the Board made the following Conclusions of Law based upon a preponderance of evidence:

1. **Ochmanski** was properly served with the Notice of Opportunity for a Hearing pursuant to R.C. 119.07.
2. R.C. 119.07 required **Ochmanski** to request a hearing within thirty (30) days of the mailing of the Notice.
3. **Ochmanski** violated Ohio Administrative Code Rule 4755-9-01 and 4755-7-08.

Based upon a preponderance of the evidence and the Findings of Fact and Conclusions of Law stated above, it is the conclusion of the Board that the occupational therapy assistant license of **Ochmanski** should be revoked.

Thereafter, the Board voted to enter upon its Journal the following Order:

The occupational therapy assistant license of Dana Ochmanski is hereby REVOKED.

Jaclyn Holt, case number OT-20-120

Based on a thorough review of the evidence, the Board found that the following Findings of Fact were proved by a preponderance of the evidence:

1. The Board had jurisdiction to conduct a hearing in this matter pursuant to Goldman v. State Medical Board of Ohio, 110 Ohio App. 3d 124; 673 N.E.2d 677 (1996).
2. **Holt** was selected for continuing education audit.
3. **Holt** was notified of continuing education audit selection.
4. **Holt** failed to respond to the continuing education notices.
5. **Holt** did not request a hearing on the aforementioned charge.

Based on thorough review of the evidence, the Board made the following Conclusions of Law based upon a preponderance of evidence:

1. **Holt** was properly served with the Notice of Opportunity for a Hearing pursuant to R.C. 119.07.
2. R.C. 119.07 required **Holt** to request a hearing within thirty (30) days of the mailing of the Notice.
3. **Holt** violated Ohio Administrative Code Rule 4755-9-01 and 4755-7-08.

Based upon a preponderance of the evidence and the Findings of Fact and Conclusions of Law stated above, it is the conclusion of the Board that the occupational therapy assistant license of **Holt** should be revoked.

Thereafter, the Board voted to enter upon its Journal the following Order:

The occupational therapy assistant license of Jaclyn Holt is hereby REVOKED.

Lisa Wyatt, case number **OT-20-111**

Based on a thorough review of the evidence, the Board found that the following Findings of Fact were proved by a preponderance of the evidence:

1. The Board had jurisdiction to conduct a hearing in this matter pursuant to Goldman v. State Medical Board of Ohio, 110 Ohio App. 3d 124; 673 N.E.2d 677 (1996).
2. **Wyatt** was selected for continuing education audit.
3. **Wyatt** was notified of continuing education audit selection.
4. **Wyatt** failed to respond to the continuing education notices.
5. **Wyatt** did not request a hearing on the aforementioned charge.

Based on thorough review of the evidence, the Board made the following Conclusions of Law based upon a preponderance of evidence:

1. **Wyatt** was properly served with the Notice of Opportunity for a Hearing pursuant to R.C. 119.07.
2. R.C. 119.07 required **Wyatt** to request a hearing within thirty (30) days of the mailing of the Notice.
3. **Wyatt** violated Ohio Administrative Code Rule 4755-9-01 and 4755-7-08.

Based upon a preponderance of the evidence and the Findings of Fact and Conclusions of Law stated above, it is the conclusion of the Board that the occupational therapy assistant license of **Wyatt** should be revoked.

Thereafter, the Board voted to enter upon its Journal the following Order:

The occupational therapy assistant license of Lisa Wyatt is hereby REVOKED.

Kinda Martin, case number **OT-20-112**

Based on a thorough review of the evidence, the Board found that the following Findings of Fact were proved by a preponderance of the evidence:

1. The Board had jurisdiction to conduct a hearing in this matter pursuant to Goldman v. State Medical Board of Ohio, 110 Ohio App. 3d 124; 673 N.E.2d 677 (1996).
2. **Martin** was selected for continuing education audit.
3. **Martin** was notified of continuing education audit selection.
4. **Martin** failed to respond to the continuing education notices.
5. **Martin** did not request a hearing on the aforementioned charge.

Based on thorough review of the evidence, the Board made the following Conclusions of Law based upon a preponderance of evidence:

1. **Martin** was properly served with the Notice of Opportunity for a Hearing pursuant to R.C. 119.07.
2. R.C. 119.07 required **Martin** to request a hearing within thirty (30) days of the mailing of the Notice.
3. **Martin** violated Ohio Administrative Code Rule 4755-9-01 and 4755-7-08.

Based upon a preponderance of the evidence and the Findings of Fact and Conclusions of Law stated above, it is the conclusion of the Board that the occupational therapy assistant license of **Martin** should be revoked.

Thereafter, the Board voted to enter upon its Journal the following Order:

The occupational therapy assistant license of Kinda Martin is hereby REVOKED.

The Executive Director is hereby instructed to prepare an adjudication order to carry out the mandates of this Board and serve the order on **Barbara Scott, case number OT-20-101, Julia Litschel, case number OT-20-108, Peter Maurer, case number OT-20-110, Lisa Wyatt, case number OT-20-111, Kinda Martin, case number OT-20-112, Amanda Beach, case number OT-20-118, Dana Ochmanski, case number OT-20-119, and Jaclyn Holt, case number OT-20-120** in the manner prescribed by law.

This concludes the matters of **Barbara Scott, case number OT-20-101, Julia Litschel, case number OT-20-108, Peter Maurer, case number OT-20-110, Lisa Wyatt, case number OT-20-111, Kinda Martin, case number OT-20-112, Amanda Beach, case number OT-20-118, Dana Ochmanski, case number OT-20-119, and Jaclyn Holt, case number OT-20-120.**

Correspondence

Correspondence was reviewed by board.

Joint Correspondence was reviewed by board.

OOTA Report was given.

Open Forum

Old Business

OT Compact and pathway to obtain licensure in Ohio as a compact privilege.

New Business

Minimum age requirement notification will be sent out to all program directors in the state.

Retreat was rescheduled for September 10 at 9:00 AM.

Items for agenda:

- Telehealth- standard response
- Telehealth/equipment assistance
- CE rule
- OOTA presentation
- Adding questions on jurisprudence exam

Adjournment

There being no further business and no objections, the meeting was adjourned at 12:25 PM.

Respectfully submitted,

Jan Hills

Mary Beth Lavey, COTA/L, Chair
Ohio Occupational Therapy, Physical Therapy,
And Athletic Trainers Board, OT Section

Melissa Van Allen, OTR/L, Secretary
Ohio Occupational Therapy, Physical Therapy,
And Athletic Trainers Board, OT Section

Missy Anthony, Executive Director
Ohio Occupational Therapy, Physical Therapy,
And Athletic Trainers Board

4755-9-01

Continuing education.

(A) Pursuant to division (C) of section 4755.06 of the Revised Code, no person shall qualify for licensure renewal as an occupational therapist or occupational therapy assistant unless the license holder has shown to the satisfaction of the occupational therapy section that the license holder has completed twenty contact hours of continuing education activities within the two year renewal cycle.

~~(1) If the license was valid for a period of twelve months or less, the license holder shall complete ten contact hours of continuing education within the renewal cycle, including one contact hour of ethics, jurisprudence, or cultural competence pursuant to paragraph (A)(5) of this rule. The category limits contained in paragraph (B) of this rule do not apply if the license was valid for twelve months or less.~~

~~(2)~~(1) ~~License~~ License holders are not required to obtain any continuing education units for the first renewal.

~~(2) In the case of a license reinstatement, if the license was valid for a period of twelve months or less, the license holder shall complete ten contact hours of continuing education within the renewal cycle, including one contact hour of ethics, jurisprudence, or cultural competence pursuant to paragraph (A)(5) of this rule. The category limits contained in paragraph (B) of this rule do not apply if the license was valid for twelve months or less.~~

(3) A "contact hour" is one hour spent in a continuing education activity meeting the requirements of this rule. Contact hours exclude refreshment breaks, receptions, social gatherings, and meals that do not include an acceptable activity.

(4) All continuing education activities shall be earned in the two year period immediately preceding the thirtieth day of June of the year in which licensure renewal is required. Contact hours may not be carried over from one renewal period to the next.

(5) ~~License~~ License holders shall complete at least one contact hour of ethics, jurisprudence, or cultural competence education per renewal cycle. The one hour ethics, jurisprudence, or cultural competence requirement may be fulfilled by completing an acceptable activity outlined in paragraph (B) of this rule that contains at least one hour addressing professional ethics, jurisprudence, or cultural competence. In addition, any presentation by the occupational therapy section meets the ethics, jurisprudence, or cultural competence requirement.

(B) Acceptable continuing education activities may include:

- (1) Activities sponsored or approved by the occupational therapy section, the American occupational therapy association (AOTA), the Ohio occupational therapy association (OOTA), the national board for certification in occupational therapy, or offered by an AOTA approved provider.
- (2) Attending professional workshops, seminars, and/or conferences. There is no limit of contact hours in this category.
 - (a) Credit is obtained by attending presentations that have either been sponsored or approved by the occupational therapy section, AOTA, OOTA, offered by an AOTA approved provider, or which meets the following criteria:
 - (i) It contributes directly to professional competency;
 - (ii) It relates directly to the clinical practice, management, or education of occupational therapy practitioners; and
 - (iii) It is conducted by people who have demonstrated expertise in the subject matter of the program.
 - (b) Prior approval from the section is not required if paragraphs (B)(2)(a)(i) to (B)(2)(a)(iii) of this rule have been met.
 - (c) Proof of content shall be demonstrated by the original workshop or conference brochure, agenda, notes, or materials given to participants during the presentations.
 - (d) Copies of continuing education unit certificates or other original documents indicating credits awarded may also be used as verification of participation. If no other form of verification is available, license holders may obtain from the board verification of participation forms, which are to be signed by each presenter at the conclusion of each presentation. If a presentation is made by a panel of people, only one signature is required.
- (3) Presentations of occupational therapy programs, workshops, or seminars. The presentation shall be to health or education professionals and/or students, be at least one contact hour in length and relate to the clinical practice, management, or education of occupational therapy practitioners. Two contact hours will be awarded for each hour of presentation. A maximum of eight

contact hours may be earned in this category. Proof of presentation is the workshop, conference, or seminar contract, or the brochure, agenda, or other printed materials describing content and audience. Continuing education credit will not be awarded for subsequent presentations of the same material.

- (4) Preparation to teach a clinical course in occupational therapy. The course shall be taught in an occupational therapy program accredited by the accreditation council for occupational therapy education (ACOTE). Credit will only be awarded for preparation for a new course or substantive changes to an existing course. One contact hour will be awarded for each hour of preparation. A maximum of eight contact hours may be earned in this category. Proof of presentation is the course syllabus or other printed materials describing the content and goals of the course.
- (5) Publications of books, articles, or films related to clinical practice, management, or education of occupational therapy. A maximum of five contact hours for each published article, ten contact hours for a published book, five contact hours for a chapter in a book, and ten contact hours for a film may be earned in these categories. Co-authorship is acceptable. The item shall be published within the current renewal cycle. Proof of completion is the published article, title page of the book, or film. There is no limit of contact hours in this category.
- (6) Undergraduate or graduate courses. A maximum of ten contact hours may be earned per completed course. Courses shall be related to the management, practice, or education of occupational therapy. Proof of completion is an unofficial college or university transcript. An official college or university transcript may be requested at the discretion of the occupational therapy section. Proof of content is the catalog description. There is no limit of contact hours in this category.
- (7) Supervision of fieldwork.
 - (a) Continuing education credit can be earned by supervising level I students. One contact hour may be earned for each student supervised, with a maximum of six contact hours per renewal cycle.
 - (b) Continuing education credit can be earned by supervising level II students. Six contact hours may be earned per student for eight weeks of supervision. Eight contact hours may be earned per student for twelve weeks of supervision. ~~There is no limit of contact hours for level II supervision.~~

- (i) A maximum of twelve hours may be earned per renewal period for level II supervision of a student occupational therapy assistant.
 - (ii) A maximum of sixteen hours may be earned per renewal period for level II supervision of a student occupational therapist.
 - (iii) The total earned through level II supervision per renewal period must not exceed sixteen.
- (c) A license holder shall be a signing rater on the American occupational therapy association fieldwork performance evaluation (FWPE) to be eligible for continuing education credit. If more than one license holder is a signing rater on the FWPE, the contact hours earned shall be divided between the signing raters.
- (d) Proof of student supervision is a certificate of supervision from the student's school.
- (8) Self-study. Formal study packages, such as printed text, multi-media, or internet based activities, related to the clinical practice, management, or education of occupational therapy are acceptable. There is no limit of contact hours in this category. Proof of completion is the certificate of completion and/or a copy of the post test results.
- (9) Distance learning. Credit for distance learning requires that there be opportunity for interaction with the program presenter and that the content is related to the clinical practice, management, or education of occupational therapy. The agenda and certificate of participation are required to verify completion. There is no limit of contact hours in this category.
- (10) Apprenticeships. Supervised clinical experience aimed at developing specialized skills in occupational therapy is acceptable. Five contact hours shall be credited for each forty hour week. There is no limit to the amount of contact hours that can be earned under this category. Proof of completion is a signed letter from the clinical supervisor describing length and type of education experiences and an evaluation of the occupational therapist's or occupational therapy assistant's performance.
- Apprenticeships shall be served under the supervision of a licensed occupational therapist whose license is in good standing and who has demonstrated expertise in the practice of occupational therapy or other people who have demonstrated expertise in specialized techniques as approved by the occupational therapy section.

- (11) Research projects. A maximum of ten contact hours may be earned in this category. The hours will be granted only for completed, published or unpublished research projects related to the theory, clinical practice, management, or education of occupational therapy. Proof of completion is the published article or unpublished manuscript.
- (12) Informal independent study. One contact hour will be given for reading an evidence based book chapter or research journal article relating to the clinical practice, management, or education of occupational therapy practitioners and identifying how the information presented can be applied to one's own practice, management, or education situation. Proof of completion is a copy of the article's title page and the first page, and a written report summarizing the information and outlining how it can be applied by the license holder. One hour will be awarded for each chapter/article. A maximum of four contact hours may be earned in this category per renewal cycle.
- (13) Jurisprudence examination. One contact hour may be earned for completing and passing the Ohio occupational therapy jurisprudence examination. This contact hour may be utilized only once per renewal cycle for continuing education credit. Proof of completion is the graded examination. This contact hour may be used to fulfill the ethics, jurisprudence, or cultural competence requirement established in paragraph (A)(5) of this rule.

~~(14) Mentorship. Continuing education credit can be earned by mentoring a student completing a graduate level research/capstone project at an ACOTE accredited entry level or a post professional occupational therapist education program. One contact hour may be earned for every eighty hours of mentorship completed, with a maximum of four contact hours per renewal cycle. Proof of mentorship will be a certificate from the student's school and a time log documenting the mentor's activities and the time spent completing those activities. Faculty members mentoring students enrolled in the faculty member's own program are not eligible for continuing education credit for mentorship.~~

(14) Mentorship. A maximum of four hours per renewal cycle can be earned by any of the following:

- (a) Continuing education credit can be earned by mentoring a student completing a graduate level research/capstone project at an ACOTE accredited entry-level or a post-professional occupational therapist education program. One contact hour may be earned for every eighty hours of mentorship completed, with a maximum of seven contact hours per renewal cycle. Proof of mentorship will be a certificate from the student's school and a time log documenting the mentor's activities

and the time spent completing those activities. Faculty members mentoring students enrolled in the faculty member's own program are not eligible for continuing education credit for mentorship.

(b) Continuing education credit can be earned by mentoring a practitioner in the first year of practice or any practitioner entering a practice area or attempting to achieve certification in a practice area in which the mentee has no prior experience. One contact hour may be earned for every eighty hours of mentorship completed, with a maximum of four contact hours per renewal cycle. Proof of mentorship will be a written contract which includes the signatures of the mentor and the practitioner who has agreed to be mentored. The contract must also include a time log documenting the mentor's activities and the time spent completing those activities.

(c) Continuing education credit can be earned by mentoring a practitioner of an AOTA Fellowship Program. The mentor must spend a minimum of 350 hours with the fellow while the fellow delivers occupational therapy services in the identified practice area. Four contact hours may be earned for each AOTA Fellowship Program mentorship with only one mentorship eligible for contact hours per renewal cycle. Proof of mentorship will be the written contract developed by the AOTA Fellowship Program and documentation of successful completion by this program.

(15) Volunteer services to indigent and uninsured persons pursuant to section 4745.04 of the Revised Code. To qualify under this rule, volunteer services shall:

(a) Be provided at a free clinic or other non-profit organization that offers health care services based on eligibility screenings identifying the client as an "indigent and uninsured person" as that term is defined in division (A)(7) of section 2305.234 of the Revised Code.

(b) Be documented in writing in the form of a certificate or a written statement on letterhead from an administrative official at the organization where services were rendered, specifying at a minimum the license holder's name, license number, date(s) of qualifying volunteer services, number of hours of services, and describing the services that were rendered.

(c) Not be credited for license holders in a paid position at the organization at which the services are rendered.

- (d) Be occupational therapy or occupational therapy assistant services provided in compliance with the Revised Code and Administrative Code.
 - (e) Be credited as one hour of CE for each sixty minutes spent providing services as a volunteer, not to exceed four hours of the total biennial CE requirement.
 - (f) Not count toward the one contact hour of ethics, jurisprudence, or cultural competence education per renewal cycle as required by paragraph (A)(5) of this rule.
- (16) Competency assessment or knowledge/skills assessment activities. Credit for completion of competency assessment or knowledge/skill assessment activities, or both, completed either online or in person. A certificate of completion or similar document that includes the participant's name, activity, date, contact hours awarded, and sponsoring organization shall be submitted as proof of completion.
- [\(17\) Journal article review. - NEEDS DISCUSSION](#)
- (C) Continuing education credit will not be granted to standard employer required annual competency training, such as CPR, blood-borne pathogens, or HIPAA.
 - (D) The occupational therapy section shall conduct an audit of the continuing education records of not less than five per cent of the license holders each renewal year.
 - (1) License holders chosen for audit shall submit to the board by the date specified by the board copies of all records and documentation of the continuing education activities used to meet the requirements of paragraph (A) of this rule.
 - (2) Failure to provide proof of the required number of continuing education hours, in the appropriate categories, for the specified time period will result in the commencement of disciplinary action.
 - (3) Failure to respond to or acknowledge receipt of an audit notice will result in the commencement of disciplinary action.
 - (E) An occupational therapist or occupational therapy assistant license shall not be renewed unless the license holder certifies that the person completed the required

number of continuing education hours specified in paragraph (A) of this rule.

A license holder who falsifies a renewal application may be disciplined by the occupational therapy section for violating section 4755.11 of the Revised Code.

Potential 4755 Law Changes for Budget Proposal

1. Eliminate references to OT limited permit
2. OPP Investigative confidentiality
3. OPP bootstrap language
4. OPP discipline – licensee is responsible for hearing costs (4755.031)
5. OPP alternative pathway to licensure (if not resolved prior-to)
6. Eliminate photo submission requirement
7. Mechanism for permanent revocation
8. PT Foreign trained is not based on the date of license, but on the date of graduation (align with FSBPT)
9. 4755.47 (A)(25) – sexual contact and conduct – definition of contact is too specific (look at other sections too)
10. Add intervention in lieu of conviction as something that must be reported to the Board
11. Board member term appointments don't expire until filled by the Governor
12. Broaden the PT faculty to include PTAs who teach in PTA programs (4755.482)
13. Make Franklin County the jurisdiction for appeals of Board rulings, rather than the court of residency of the licensee

Occupational Therapist by Examination- 55

Kylee Ahlgrim	Katherine Claire Kiss	Danielle M Snyder
Nancy Alsheyab	Catherine Kohl	Rachel Sperry
Markia Ashe	Victoria Rae Krenn	Danielle Stelbasky
Alexandria Nikole Bastin	Kimberly Nicole Lawrence	Kelli Anne Stratman
Caitlin Brown	Brianna Noel Libertore	Alyssa Marie Synek
Valerie Ann Czyzewski	Sarah Elizabeth Lyman	Logan Taylor
Ashlynn Alyce Daley	Stefani Manchick	McKenzie Trentman
Julia Davis	Katrina Latriece Matthews	ZOKIRJON UMAROV
Desiree Marie Dick	Lindsay McIlwain	Alexa Nicole Vantrease
Brittany Leigh DiFiore	Jodie Michelle Meyer	Brianna Marie Wagner
Kayla Marie Frederick	Collin Nissen	Mallory Washburn
Sydney Michelle Gately	Molly Ellen O'Reilly	Kelsie Claire Whalen
Talia Renee Gibson	Alysia Michelle Paesano	Shannon R. Whitacre
Kylee Nicole Grady	Amy Judith Piekosz	Megan Witwer
Emily Hazen	Janelle Marie Pitts	Sarah Woolever
Kylee Danielle Hooper	Danielle Reddington	Sydney Yulo
Rachel Horn	Allison Schneider	Lauren Marie Zastrow
Rebecca A Hughes	Christina Schriefer	
Marlene Keith	Anna Kristine Silvestri	

Occupational Therapy Assistant by Exam- 20

Sara Jean Balsmeyer	Emma Grace Ford	Michelle Marie Rush
Angela Battiatto	Ashley Elizabeth Goodell	Amanda Marie Savage
Taylor Makenzie Beasley	KRISTINE A HARMON	Jada Vandagriff
McKayla Ashlynn Bilyeu	Katelyn Merzke	Julie Kay Watson
Madison Rae Bryant	Kristine Kate Minnick	Erika Amber Weigand
Danielle Erin Downs	Hannah Northington	Jenna Zuppe
Laura Ann Egnacheski	Ginger Kay Pierce	

Occupational Therapist by Endorsement- 17

Mary Grace Antalovich	Kristin Garncarz	Rachel Rose Sanford
Jacqueline Hilda Bennett	MEGAN K HANSON	Lindsey Schelfo
Seth Michael Bidlack	Hannah Lillard	Tre Scott
Serafina Cain	Tara Lookabaugh	Jordyn Kathryn Thiery
Bethany DeMario	Jennifer Mandato	Sara Beth Tubergen
joseph c gagliardo	Melissa Gwen Piper	

Occupational Therapist Assistant by Endorsement- 3

Samantha Carolin Jarrett	REBECCA K LUCAS	Alina Frances Moloney
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Occupational Therapy Section
Withdrawals
September 10, 2020

Occupational Therapy Withdrawals

Sean Smith - APP-000065212

Virginia Sullivan - APP-000378917

Julie Watson - APP-000372101

Nehaben Patel - APP-000365768

Kristine Minnick - APP-000337472

Seth Bidlack - APP-000312455

Sara Balsmeyer - APP-000387684

Allison Schneider - APP-000389876

ENFORCEMENT STATISTICS FOR OCCUPATIONAL THERAPY SECTION MEETING

Date: 09/10/2020

Statistics:

“New” cases opened since the last meeting: 03

Cases “closed” since the last meeting: 02

Cases “currently open”: 32

Active consent agreements: 06

Adjudication orders being monitored: 01

***Statistics as of 09/02/2020**

From: [Kristen Neville](#)
To: [Kristen Neville](#)
Subject: Survey for the AOTA Occupational Therapy Code of Ethics
Date: Monday, July 27, 2020 2:22:12 PM

Dear Occupational Therapy Licensing Entity Administrators and Staff:

As part of the standard 5-year review process, the Ethics Commission (EC) is seeking member and staff input on the draft Occupational Therapy Code of Ethics (2020).

Background

The Principles of Occupational Therapy Ethics was adopted in 1978, revised in 1988 as the Occupational Therapy Code of Ethics (2nd edition), and again in 1994 (3rd edition), 2000 (4th addition), 2005 (5th edition), 2010 (6th edition), and 2015 (7th addition). The Occupational Therapy Code of Ethics (the Code) is intended for occupational therapy practitioners and students, other health care professionals, educators, researchers, payers, and consumers.

The EC is seeking feedback on the draft of the 8th edition of the Code (2020).

Your Input is Critical

The Code is widely used in education and practice. It is one of AOTA's most important documents, frequently requested by both OT practitioners and external groups. Therefore, feedback from all areas of practice is essential to guide the revisions and thus the content of this document. This is an opportunity for members to provide input and review proposed changes before a final draft is voted on by the Representative Assembly. The EC is encouraging discussion among members of AOTA's volunteer groups; on CommunOT; and, on state and local levels.

To facilitate completing this review, you can access a survey about the draft Occupational Therapy Code of Ethics through the following link: <https://surveys.aota.org/s3/AOTA-Membership-SRB-Stakeholders-Survey-for-2020-Code-Revision-copy>

The draft of the 2020 Code of Ethics can be found here:

<https://www.aota.org/~media/Corporate/Files/Practice/Ethics/Code-of-Ethics-Draft.pdf>

Survey must be completed by Thursday, August 27, 2020.

The AOTA EC thanks you for your interest and time in providing comments on this document under review.

You may also send feedback to the ethics commission at ethics@aota.org.

Kristen Neville
Manager, State Affairs
American Occupational Therapy Association
6116 Executive Boulevard, Suite 200
North Bethesda, MD 20852-4929

240-800-5981 (direct)
Twitter: @KNevilleAOTA

AOTA Virtual Conference Series



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The AOTA Occupational Therapy Code of Ethics (2020)

Part 1. Preamble

The *Occupational Therapy Code of Ethics* (2020) (the Code) of the American Occupational Therapy Association (AOTA) is designed to reflect the dynamic nature of the occupational therapy profession, the evolving health care environment, and emerging technologies that can present potential ethical concerns in research, education, and practice. AOTA members are committed to promoting inclusion, participation, safety, and well-being for all recipients in various stages of life, health, and illness and to empowering all beneficiaries of service to meet their occupational needs. Recipients of services may be individuals, groups, families, organizations, communities, or populations (AOTA, 2020).

The Code is an AOTA Official Document and a public statement tailored to address the most prevalent ethical concerns of the occupational therapy profession. It outlines Standards of Conduct the public can expect from those in the profession. It should be applied to all occupational therapy personnel in all areas of occupational therapy and shared with relevant stakeholders to promote ethical conduct.

The Code serves two purposes:

1. It provides aspirational Core Values that guide members toward ethical courses of action in professional and volunteer roles, and
2. It delineates enforceable Principles and Standards of Conduct that apply to AOTA members.

Whereas the Code helps guide and define decision-making parameters, ethical action goes beyond rote compliance with these Principles and is a manifestation of moral character and mindful reflection. It is a commitment to benefit others, to the virtuous practice of artistry and science, to genuinely good behaviors, and to noble acts of courage. Recognizing and resolving ethical issues is a systematic process that includes analysis of the complex dynamics of situations, applying moral theories and weighing alternatives, making reasoned decisions, taking action, and reflecting on outcomes. Occupational therapy personnel are expected to abide by the Principles and Standards of Conduct within this Code. **The term “personnel” in this document is intended to include the roles of occupational therapist and occupational therapy assistant professionals and practitioners (e.g., direct service, consultation, administration); educators; students in occupational therapy and occupational therapy assistant professional programs; researchers; entrepreneurs; business owners; and those in elected, appointed, or other professional volunteer service.**

The process for addressing ethics violations by AOTA members (and associate members, where applicable) is outlined in the Code’s Enforcement Procedures (AOTA, 2019).

While many State Regulatory Boards adopt the Code or similar language regarding ethical behavior, the Code is meant to be a free-standing document, guiding ethical dimensions of professional behavior, responsibility, practice, and decision making. This Code is not exhaustive; that is, the Principles and Standards of Conduct cannot address every possible situation.

Therefore, before making complex ethical decisions that require further expertise, occupational therapy personnel should seek out resources to assist with resolving conflicts and ethical issues not addressed in this document. Resources can include, but are not limited to, ethics committees, organizational ethics officers or consultants, and the AOTA Ethics Commission. For a full list of AOTA ethics resources, please refer to the AOTA website at <https://www.aota.org>.

Please refer to Appendix A for a summary of the revision process for the Code in 2020. Please refer to Appendix B for a history of the AOTA Occupational Therapy Code of Ethics.

Part 2. Core Values

The occupational therapy profession is grounded in seven long-standing Core Values: *Altruism, Equality, Freedom, Justice, Dignity, Veracity, and Prudence*. The seven Core Values provide a foundation to guide occupational therapy personnel in their interactions with others. The Core Values should be considered when determining the most ethical course of action.

- *Altruism* involves demonstrating concern for the welfare of others.
- *Equality* refers to treating all people impartially and free of bias.
- *Freedom* and personal choice are paramount in a profession in which the values and desires of the client guide our interventions.
- *Justice* describes the promotion of a society in which diverse communities are structured such that all members experience equity and inclusion, so that they can function, flourish, and live a satisfactory life.
- *Dignity* indicates the promotion and preservation of the individuality of the client, by treating them with respect in all interactions. Dignity encompasses cultural sensitivity, cultural humility, and the need to be inclusive of all people.
- *Veracity* indicates that occupational therapy personnel in all situations should be truthful and provide accurate information in oral, written, and electronic forms.
- *Prudence* indicates that occupational therapy personnel should exercise sound judgment and reflection in their clinical and ethical reasoning skills to make decisions in professional and volunteer roles.

Part 3. AOTA Code of Ethics Principles

The Principles guide ethical decision making and inspire occupational therapy personnel to act in accordance with the highest ideals. These concepts are not hierarchically organized. At times, conflicts between competing principles may need to be carefully balanced according to individual and cultural beliefs, and organizational policies.

Principle 1. Beneficence. Occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services.

Beneficence includes all forms of action intended to benefit other persons. The term *beneficence* connotes acts of mercy, kindness, and charity (Beauchamp & Childress, 2019). Beneficence requires taking action by helping others; in other words, by promoting good, by preventing harm, and by removing harm. Examples of beneficence include protecting and

defending the rights of others, preventing harm from occurring to others, removing conditions that will cause harm to others, helping persons with disabilities, and rescuing persons in danger (Beauchamp & Childress, 2019).

Principle 2. Nonmaleficence. Occupational therapy personnel shall refrain from actions that cause harm.

Nonmaleficence indicates that occupational therapy personnel will refrain from causing harm to recipients of service (Beauchamp & Childress, 2019). The Principle of *Nonmaleficence* also includes an obligation to not impose risks of harm even if the potential risk is without malicious or harmful intent. This Principle often is examined under the context of due care. The standard of *due care* requires that the benefits of care outweigh and justify the risks undertaken to achieve the goals of care (Beauchamp & Childress, 2019). For example, in occupational therapy practice, this standard applies to situations in which the client might feel pain from a treatment intervention; however, the acute pain is justified by potential longitudinal, evidence-based benefits of the treatment.

Principle 3. Autonomy. Occupational therapy personnel shall respect the right of the individual to self-determination, privacy, confidentiality, and consent.

The Principle of *Autonomy* expresses the concept that occupational therapy personnel have a duty to treat the client according to the client's desires, within the bounds of accepted standards of care, and to protect the client's confidential information. Often, respect for Autonomy is referred to as the *self-determination principle*. Respecting a person's autonomy acknowledges the agency of the client, including their right to their own views and opinions and the right to make choices in regard to their own care and based on one's own values and beliefs. (Beauchamp & Childress, 2019). Individuals have the right to make a determination regarding care decisions that directly affect their lives. In the event that a person lacks decision-making capacity, their autonomy should be respected through the involvement of an authorized agent or surrogate decision-maker.

Principle 4. Justice. Occupational therapy personnel shall promote fairness, equity, inclusion, and objectivity in the provision of occupational therapy services.

The Principle of *Justice* relates to the fair, equitable, and appropriate treatment of persons (Beauchamp & Childress, 2019). Occupational therapy personnel should relate in a respectful, fair, and impartial manner to individuals and groups with whom they interact. They should also respect the applicable laws and standards related to their area of practice. Justice requires the impartial consideration and consistent following of rules to generate unbiased decisions and promote fairness. Occupational therapy personnel work to uphold a society in which all individuals have an equitable opportunity to achieve occupational engagement as an essential component of their life.

Principle 5. Veracity. Occupational therapy personnel shall provide comprehensive, accurate, and objective information when representing the profession.

The Principle of *Veracity* refers to comprehensive, accurate, and objective transmission of information and includes fostering understanding of such information. Veracity is based on the virtues of truthfulness, candor, and honesty, and respect owed to others (Beauchamp & Childress, 2019). In communicating with others, occupational therapy personnel implicitly promise to be truthful and not deceptive. When entering into a therapeutic or research relationship, the recipient of service or research participant has a right to accurate information. In addition, transmission of information is incomplete without also ensuring that the recipient or participant understands the information provided.

Principle 6. Fidelity. Occupational therapy personnel shall treat clients, colleagues, and other professionals with respect, fairness, discretion, and integrity.

Fidelity refers to the duty one has to keep a commitment once it is made (Veatch et al., 2015). This commitment refers to promises made between a provider and a client; as well as maintenance of respectful collegial and organizational relationships (Doherty & Purtilo, 2016). Professional relationships are greatly influenced by the complexity of the environment in which occupational therapy personnel work. Practitioners, educators, and researchers alike should consistently balance their duties to service recipients, students, research participants, and other professionals as well as to organizations that may influence decision making and professional practice.

Part 4. Categories and Standards of Ethical Behavior

The AOTA Ethics Commission enforces these Standards under the Enforcement Procedures for the Occupational Therapy Code of Ethics (AOTA, 2019)

Categories	Standards of Ethical Behavior: Occupational Therapy Personnel Shall:
<p>1. Professional Integrity, Responsibility, and Accountability: OT personnel maintain awareness and comply with AOTA policies and official documents, current laws and regulations that apply to the profession of occupational therapy, and</p>	<p>1A. Comply with current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy. (Principle: Justice; Keywords: policy, procedures, rules, law, roles, scope of practice)</p> <p>1B. Abide by policies, procedures, and protocols when serving or acting on behalf of a professional organization or employer to fully and accurately represent the organization's official and authorized positions. (Principle: Fidelity; Keywords: policy, procedures, rules, law, roles, scope of practice)</p> <p>1C. Inform employers, employees, colleagues, students, and researchers of applicable policies, laws, and Official Documents. (Principle: Justice; Keywords: policy, procedures, rules, law, roles, scope of practice)</p> <p>1D. Comply with relevant laws and promote transparency when participating in a business arrangement as owner,</p>

<p>employer policies and procedures.</p>	<p>stockholder, partner, or employee. (Principle: Justice; Keywords: policy, procedures, rules, law, roles, scope of practice)</p> <p>1E. Respect the practices, competencies, roles, and responsibilities of one's own and other professions to promote a collaborative environment reflective of interprofessional teams. (Principle: Fidelity; Keywords: policy, procedures, rules, law, roles, scope of practice, collaboration, service delivery)</p> <p>1F. Refrain from engaging in illegal actions, whether directly or indirectly harming stakeholders in OT practice. (Principle: Justice; Keywords: illegal, unethical practice)</p> <p>1G. Refrain from actions that reduce the public's trust in occupational therapy. (Principle: Fidelity; Keywords: illegal, unethical practice)</p> <p>1H. Report potential or known unethical or illegal actions in practice, education, or research to appropriate authorities (Principle: Justice; Keywords: illegal, unethical practice)</p> <p>1I. Report impaired practice to the appropriate authorities. (Principle: Nonmaleficence; Keywords: illegal, unethical practice)</p> <p>1J. Refrain from exploiting human, financial, and material resources of their employers for personal gain. (Principle: Fidelity; Keywords: Exploitation, employee)</p> <p>1K. Avoid exploiting any relationship established as an occupational therapy practitioner, educator, or researcher to further one's own physical, emotional, financial, political, or business interests. (Principle: Nonmaleficence; Keywords: Exploitation, academic, research)</p> <p>1L. Avoid conflicts of interest or conflicts of commitment in employment, volunteer roles, or research. (Principle: Fidelity; Keywords: Conflict of interest)</p> <p>1M. Avoid using one's position (e.g., employee, consultant, or volunteer) or knowledge gained from that position in such a manner as to give rise to real or perceived conflict of interest among the person, the employer, other AOTA</p>
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	<p>members, or other organizations. (Principle: Fidelity; Keywords: Conflict of interest)</p> <p>1N. Avoid bartering for services when there is the potential for exploitation and conflict of interest. (Principle: Nonmaleficence; Keywords: Conflict of interest)</p> <p>IO. Conduct and disseminate research in accordance with currently accepted ethical guidelines and standards for the protection of research participants, including informed consent and disclosure of potential risks and benefits. (Principle: Beneficence; Keywords: Research)</p>
<p>2. Therapeutic Relationships: Occupational therapy personnel develop therapeutic relationships to promote occupational well-being in individuals, groups, organizations, and society.</p>	<p>2A. Respect and honor the expressed wishes of recipients of service. (Principle: Autonomy; Keywords: Relationships, clients)</p> <p>2B. Avoid inflicting harm or injury to recipients of occupational therapy services, students, research participants, or employees. (Principle: Nonmaleficence; Keywords: Relationships, clients, students, research, employer, employee)</p> <p>2C. Refrain from threatening, manipulating, coercing, or deceiving clients to promote compliance with occupational therapy recommendations. (Principle: Autonomy; Keywords: relationships, clients)</p> <p>2D. Avoid engaging in sexual activity with a recipient of service, including the client's family or significant other, while a professional relationship exists. (Principle: Nonmaleficence; Keywords: Relationships, clients, sex)</p> <p>2E. Refrain from accepting gifts that would unduly influence the therapeutic relationship or have the potential to blur professional boundaries; and adhere to employer policies when offered gifts. (Principle: Justice; Keywords: Relationships, gifts, employer)</p> <p>2F. Establish a collaborative relationship with recipients of service and relevant stakeholders, to promote shared decision making. (Principle: Autonomy; Keywords: Relationships, clients, collaboration)</p>

	<p>2G. Avoid abandoning the service recipient by facilitating appropriate transitions when unable to provide services for any reason. (Principle: Nonmaleficence; Keywords: Relationships, client, abandonment)</p> <p>2H. Adhere to organizational policies when requesting an exemption from service to an individual or group due to self-identified conflict with personal, cultural, or religious values. (Principle: Fidelity; Keywords: Relationships, client, conflict, cultural, religious, values)</p> <p>2I. Avoid dual relationships and situations in which an occupational therapy professional or student is unable to maintain clear professional boundaries or objectivity. (Principle: Nonmaleficence; Keywords: Relationships, clients, colleagues, professional boundaries, objectivity)</p> <p>2J. Proactively address workplace conflict that is or can potentially affect professional relationships and the provision of services. (Principle: Fidelity; Keywords: Relationships, conflict, clients, colleagues)</p> <p>2K. Avoid any undue influences that may impair practice and compromise the ability to safely and competently provide occupational therapy services, education, or research. (Principle: Nonmaleficence; Keywords: Relationships, colleagues, impair, safety, competence, client, education, research)</p> <p>2L. Recognize and take appropriate action to remedy personal problems and limitations that might cause harm to recipients of service. (Principle: Nonmaleficence; Keywords: Relationships, clients, personal, safety)</p> <p>2M. Refrain from actions or inactions that jeopardize the safety or well-being of others or team effectiveness. (Principle: Fidelity; Keywords: Relationships, clients, colleagues, safety, law, unethical, impaired, competence)</p>
<p>3. Documentation, Reimbursement, & Financial Matters: Occupational therapy personnel</p>	<p>3A. Bill and collect fees justly and legally in a manner that is fair, reasonable, and commensurate with services delivered. (Principle: Justice; Keywords: Billing, fees)</p> <p>3B. Ensure that documentation for reimbursement purposes is done in accordance with applicable laws, guidelines,</p>

<p>maintain complete, accurate, and timely records of all client encounters.</p>	<p>and regulations. (Principle: Justice; Keywords: Documentation, reimbursement, law)</p> <p>3C. Record and report in an accurate and timely manner and in accordance with applicable regulations all information related to professional or academic documentation and activities. (Principle: Veracity; Keywords: Documentation, timely, accurate, law, fraud)</p> <p>3D. Avoid compromising rights or well-being of others based on arbitrary directives (e.g., unrealistic productivity expectations, fabrication, falsification, or plagiarism of documentation, inaccurate coding) by exercising professional judgment and critical analysis. (Principle: Nonmaleficence; Keywords: Productivity, documentation, coding, fraud)</p>
<p>4. Service Delivery: Occupational therapy personnel strive to deliver quality services that are occupation-based, client-centered, safe, interactive, culturally sensitive, evidence-based, and consistent with occupational therapy's values and philosophies.</p>	<p>4A. Respond to requests for occupational therapy services (e.g., a referral) in a timely manner as determined by law, regulation, or policy. (Principle: Justice; Keywords: OT process, referral, law)</p> <p>4B. Provide appropriate evaluation and a plan of intervention for recipients of occupational therapy services specific to their needs. (Principle: Beneficence; Keywords: OT process, evaluation, intervention)</p> <p>4C. Use, to the extent possible, evaluation, planning, intervention techniques, assessments, and therapeutic equipment that are evidence based, current, and within the recognized scope of occupational therapy practice. (Principle: Beneficence; Keywords: OT Process, evaluation, intervention, evidence, scope of practice)</p> <p>4D. Obtain informed consent (written, verbal, or implied) after disclosing appropriate information and answering any questions posed by the recipient of service or qualified family member/caregiver or research participant to ensure voluntary participation. (Principle: Autonomy; Keywords: OT process, informed consent)</p> <p>4E. Fully disclose the benefits, risks, and potential outcomes of any intervention; the occupational therapy personnel who will be providing the intervention; and any reasonable alternatives to the proposed intervention.</p>

	<p>(Principle: Autonomy; Keywords: OT process, intervention, communication, disclose, informed consent)</p> <p>4F. Describe the type and duration of occupational therapy services accurately in professional contracts, including the duties and responsibilities of all involved parties. (Principle: Veracity; Keywords: OT process, intervention, communication, disclose, informed consent, contracts)</p> <p>4G. Respect the client's right to refuse occupational therapy services temporarily or permanently, even when that refusal has potential to result in poor outcomes. (Principle: Autonomy; Keywords: OT process, refusal, intervention)</p> <p>4H. Provide occupational therapy services, including education and training, that are within each practitioner's level of competence and scope of practice. (Principle: Beneficence; Keywords: OT process, services, competence, scope of practice)</p> <p>4I. Re-evaluate and reassess recipients of service in a timely manner to determine whether goals are being achieved and whether intervention plans should be revised. (Principle: Beneficence; Keywords: OT process, re-evaluation, reassess, intervention)</p> <p>4J. Terminate occupational therapy services in collaboration with the service recipient or responsible party when the services are no longer beneficial. (Principle: Beneficence; Keywords: OT process, termination, collaboration)</p> <p>4K. Refer to other providers when indicated by the needs of the client. (Principle: Beneficence; Keywords: OT process, referral)</p> <p>4L. Assist those in need of occupational therapy services to secure access through available means. (Principle: Justice; Keywords: Beneficence, advocate, access)</p> <p>4M. Report systems and policies that are discriminatory or unfairly limit or prevent access to occupational therapy. (Principle: Justice; Keywords: discrimination, unfair, access)</p> <p>4N. Provide professional services within the scope of OT practice during community-wide public health</p>
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	<p>emergencies as directed by federal, state, and local agencies. (Principle: Beneficence; Keywords: Disasters, emergency)</p>
<p>5. Professional Competence, Education, Supervision, & Training: Credentials, degrees, licenses and other certifications demonstrate the commitment to develop and maintain competent, evidence-based practice.</p>	<p>5A. Hold requisite credentials for the occupational therapy services one provides in academic, research, physical, or virtual work settings. (Principle: Justice; Keywords: Credentials, competence)</p> <p>5B. Represent credentials, qualifications, education, experience, training, roles, duties, competence, contributions, and findings accurately in all forms of communication. (Principle: Veracity; Keywords: Credentials, competence)</p> <p>5C. Take steps (e.g., continuing education, research, supervision, training) to ensure proficiency, use careful judgment, and weigh potential for harm when generally recognized standards do not exist in emerging technology or areas of practice. (Principle: Beneficence; Keywords: Credentials, competence)</p> <p>5D. Maintain competency by ongoing participation in education relevant to one's practice area. (Principle: Beneficence; Keywords: Credentials, competence)</p> <p>5E. Address incompetent, disruptive, unethical, illegal, or impaired practice in self or others (Principle: Fidelity; Keywords: Competence, law)</p> <p>5F. Ensure that all duties delegated to other occupational therapy personnel are congruent with credentials, qualifications, experience, competency, and scope of practice with respect to service delivery, supervision, fieldwork education, and research. (Principle: Beneficence; Keywords: Supervisor, fieldwork, supervision)</p> <p>5G. Provide appropriate supervision in accordance with AOTA Official Documents and relevant laws, regulations, policies, procedures, standards, and guidelines. (Principle: Justice; Keywords: Supervisor, fieldwork, supervision)</p> <p>5H. Be honest, fair, accurate, respectful, and timely in gathering and reporting fact-based information regarding employee job performance and student performance.</p>

	<p>(Principle: Veracity; Keywords: Supervisor, supervision, fieldwork, performance)</p> <p>5I. Refrain from participating in any action resulting in unauthorized access to educational content or exams, screening and assessment tools, websites, and other copyrighted information, including but not limited to plagiarism, violation of copyright laws, and illegal sharing of resources in any form. (Principle: Justice; Keywords: Plagiarize, student, copyright, cheating)</p> <p>5J. Provide students with access to accurate information regarding educational requirements and academic policies and procedures relative to the occupational therapy program or educational institution. (Principle: Veracity; Keywords: Education, student)</p>
<p>6. Communication: Whether written, verbal, electronic or virtual communication, occupational therapy personnel uphold the highest standards of confidentiality, informed consent, autonomy, accuracy, timeliness, and record management.</p>	<p>6A. Maintain the confidentiality of all verbal, written, electronic, augmentative, and nonverbal communications, in compliance with applicable laws, including all aspects of privacy laws and exceptions thereto (e.g., Health Insurance Portability and Accountability Act, Family Educational Rights and Privacy Act). (Principle: Autonomy; Keywords: Law, autonomy, confidentiality, communication)</p> <p>6B. Maintain privacy and truthfulness when utilizing telecommunication in delivery of occupational therapy services. (Principle: Veracity; Keywords: telecommunication, telehealth, confidentiality, autonomy)</p> <p>6C. Preserve, respect, and safeguard private information about employees, colleagues, and students unless otherwise mandated or permitted by relevant laws. (Principle: Fidelity; Keywords: Communication, confidentiality, autonomy)</p> <p>6D. Display responsible conduct, respect, and discretion when engaging in digital media and social networking, including but not limited to refraining from posting protected health information. (Principle: Autonomy; Keywords: Communication, confidentiality, autonomy, social media)</p> <p>6E. Facilitate comprehension and address barriers to communication (e.g., aphasia; differences in language,</p>

	<p>literacy, health literacy, or culture) with the recipient of service (or responsible party), student, or research participant. (Principle: Autonomy; Keywords: Communication, barriers)</p> <p>6F. Refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, misleading, or unfair statements or claims. (Principle: Veracity; Keywords: Fraud, communication)</p> <p>6G. Identify and fully disclose to all appropriate persons any errors or adverse events that compromise the safety of service recipients. (Principle: Veracity; Keywords: Truthfulness, communication, safety, clients)</p> <p>6H. Ensure that all marketing and advertising are truthful, accurate, and carefully presented to avoid misleading recipients of service, research participants, or the public. (Principle: Veracity; Keywords: Truthfulness, communication)</p> <p>6I. Give credit and recognition when using the ideas and work of others in written, oral, or electronic media (i.e., do not plagiarize). (Principle: Veracity; Keywords: Truthfulness, communication, plagiarism, students)</p> <p>6J. Refrain from verbal, physical, emotional, or sexual harassment of any individual or group. (Principle: Fidelity; Keywords: Inappropriate communication, harassment, professional civility)</p> <p>6K. Refrain from communication that is derogatory, biased, intimidating, or disrespectful and that unduly discourages others from participating in professional dialogue. (Principle: Fidelity; Keywords: Inappropriate communication, professionalism, professional civility)</p> <p>6L. Promote collaborative actions and communication as a member of interprofessional teams to facilitate quality care and safety for clients. (Principle: Fidelity; Keywords: Communication, collaboration, interprofessional, professional civility)</p>
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<p>7. Professional Civility: Professional civility “entails honoring one’s personal values, while simultaneously listening to disparate points of view” (Kaslow & Watson, 2016). These values include cultural sensitivity and humility. Occupational Therapy personnel conduct themselves in a civil manner during all discourse.</p>	<p>7A. Treat all stakeholders professionally and equitably through constructive engagement or dialogue that is inclusive, collaborative and represents a diversity of thought. (Principle: Justice; Keywords: Civility, diversity, inclusivity, equitability, respect)</p> <p>7B. Demonstrate courtesy, civility, value and respect to individuals, groups, organizations, and populations when engaging in personal, professional, or electronic communications, including all forms of social media or networking, especially when that discourse involves disagreement of opinion, disparate points of view, or differing values. (Principle: Fidelity; Keywords: values, respect, opinion, points of view, social media, civility)</p> <p>7C. Demonstrate a level of cultural humility and cultural sensitivity within professional practice that promotes inclusivity and refrains from harmful actions or inactions with individuals, groups, organizations, and populations from diverse backgrounds. (Principle: Fidelity; Keywords: Civility, cultural competence, diversity; cultural humility; cultural sensitivity)</p> <p>7D. Advocate for environments or organizational cultures free of incivility, intimidating behaviors (bullying), and workplace violence. (Principle: Fidelity; Keywords: Civility, intimidation, hate, violence, bullying)</p> <p>7E. Conduct professional and personal communication with colleagues, including electronic communication and social media/ networking, in a manner that is free from personal attacks, threats, and/or attempts to defame character and credibility directed toward an individual, group, organization, or population without basis or through manipulation of information, in order to create a healthy and safe work or professional environment (Principle: Fidelity; Keywords: Civility, culture, communication, social media, social networking, respect)</p>
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Appendix A. 2020 Revisions to the Code

In the Fall of 2019, the AOTA Ethics Commission (EC) began the process of reviewing the AOTA Code of Ethics (the Code), as part of the AOTA Representative Assembly's five-year review cycle. While ethical principles are timeless, the issues to which they apply and the manner of application are constantly evolving, as are the healthcare and community environments in which occupational therapy personnel apply them. Therefore, the Code must change to remain applicable to the environments in which occupational therapy personnel work. The following paragraphs outline the changes to the 2015 Code with rationale.

From August to November 2019, EC members reviewed codes of ethics from several healthcare professions and found that the organization of codes of ethics documents and online platforms had evolved. Professions had organized their codes not by bioethical principles, but by their relationship to areas of practice and professionalism. Moreover, professions had organized online platforms for greater interactive agility. The EC decided that a major revision of the Code's organization was in order, while the majority of the content remained unchanged.

EC members divided into two work groups to reorganize the Code followed by the Enforcement Procedures. The group working on the Code began its revisions by dividing the current code into the following parts: 1) Preamble, 2) Ethical Principles, 3) Behaviors and Standards of Conduct, 4) tracking document and 5) History of the Code. Later, the Preamble was divided into Preamble and Core Values, to create six parts.

In Part 3, EC work group members shifted Standards from the 2015 Code into behavioral categories. The work group reviewed and discussed the placement of the Standards until consensus was reached. The work group then presented the reorganization of the Standards to the full EC for discussion on 2/25/2020. The EC continued to review and reorganize the standards until 6/9/2020. The EC added a section on Professional Civility in response to a charge from the Representative Assembly. Once completed and reviewed on 6/9/2020, the EC then sent the revised Code draft to content experts for further review and edits.

Content experts completed a survey for responding to changes in the Code. Experts responded to both Likert-type scales and open-ended responses. The EC then reviewed feedback from content experts on July 14, 2020 and incorporated revisions to create a final draft of the Code for membership review.

In July-August 2020, the EC sent a survey to all AOTA members to garner feedback on the revised Code.

(Note: Appendix A will be completed once the Code revision process is completed.)

Appendix B. History of the AOTA Code of Ethics

As society evolves, so must our understanding of, and implementation of, ethical practices as occupational therapy personnel. The American Occupational Therapy Association (AOTA) Code of Ethics (the Code) continues to be a critical tool in the AOTA Ethics Commission's quest to guide ethical conduct and elevate public trust in the profession. The Code must be a dynamic, "living" document that grows and develops to complement changes in occupational therapy delivery models, technology, and society.

The first official AOTA ethical code was established in 1975. Work to create this document, entitled "Principles of Ethics," began in 1973. Carolyn Baum, Carlotta Welles, Larry Peak, Lou Arents, and Carole Hayes authored this document. At this time, many professional associations began creating Codes of Ethics in response to the ethical issues being raised at the time due to the Tuskegee Institute Study. In this study, researchers studied the effects of syphilis on African American males who were not given informed consent and were told that they were being treated for the disease. The outcry after the public became aware of this violation, even after standards were in place following World War II and the Nuremberg Code of 1947, led to many professions establishing ethics rules.

In April 1977, the Representative Assembly (RA) approved the Principles of Ethics, and AOTA distributed them in the AJOT Newspaper in November 1977. This first publicly circulated rendition of the Code of Ethics consisted of twelve principles, all starting with the words, "Related to," such as "Related to the Recipient of Service."

The Code of Ethics underwent revisions in 1988, 1994, 2000, 2005, 2010, 2015, and 2020, with input from AOTA membership. The 1988 revision began to look like the modern Code, with headings called "Principles" and subheadings called "Standards." In 1994, the members of the AOTA Ethics Commission (EC) added a focus on bioethical principles rather than on professional behaviors, as the previous two editions had contained. These principles included beneficence; autonomy, privacy, and confidentiality; duty; justice; and fidelity and veracity. The principle of nonmaleficence was added in 2000, and social justice was added in 2010, then combined with the principle of justice in 2015. There were originally 30 standards in 2000; this number increased to 38 in 2005, to 77 in 2010, and decreased to 69 in 2015. These standards, categorized under the various principles, were expanded to defend ethical practice in a variety of areas, including the use of technology for telehealth, social media, internet use, and health records. With the 2020 Code revision, the EC has grouped the revised 73 Standards by behaviors rather than under the Principles, in order to return to the original concept of relating standards to desired professional behaviors, so that they are more easily accessible to the membership when utilizing the Code. As charged by the Representative Assembly, the Ethics Commission added a section to the Code on Professional Civility in 2020.

The Representative Assembly mandates that the Code, as an official AOTA policy document, undergoes review every five years. This continual review is especially important when considering that some states use the AOTA Code as part of their licensure acts. Additionally, some states require ethics continuing education in order to maintain licensure. In

updating the Code to meet needs of members and society, the occupational therapy profession continues to reflect and lead change in health care.

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Ethics Commission Members, 2019-2020 and 2020-2021

Brenda S. Howard, DHSc, OTR, Ethics Chairperson, 2019-2023

Rebecca E. Argabrite Grove, MS, OTR/L, FAOTA, AOTA Ethics Program Manager

Leslie Bennett, OTD, OTR/L, Member-At-Large, 2019-2022

Brenda Kennell, MA, OTR/L, FAOTA, Education Representative, 2015-2021

Kimberly S. Erler, PhD, OTR/L, Practice Representative, 2014-2020

Barbara Elleman, MHS, OTD, OTR/L, Practice Representative, 2020-2023

Jan Keith, BA, COTA/L, OTA Representative, 2017-2020

Marita Hensley, COTA/L, OTA Representative, 2020-2023

Donna Ewy, MD, FAAFP, MTS, Public Member 2019-2022

Roger A. Ritvo, PhD, Public Member 2018-2021

Mark Franco, Esq., Legal Counsel



Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

77 South High Street, 16th Floor
Columbus, Ohio 43215-6108

Governor
Mike DeWine
Executive Director
Missy Anthony

What does the OTPTAT Board say about telehealth?

Telehealth is permitted under all practice acts for occupational therapy, physical therapy, athletic trainers, orthotics, prosthetics, and pedorthics. Additionally, the professional sections offer the following advice:

- Occupational Therapy

It is the position of the Ohio Occupational Therapy Section that an occupational therapy practitioner is required to hold a valid, current license in the State of Ohio to serve any clients residing in Ohio. Therefore, out of state occupational therapy personnel must hold a valid Ohio license to treat clients in Ohio via telehealth.

The Section recommends that you contact the occupational therapy board in any state where the client resides to explore the requirements for practicing via telehealth in that state. In addition, the Section recommends that you review the American Occupational Therapy Association's *Position Paper: Telerehabilitation* (AOTA, 2018) for additional guidance on occupational therapy practice via telehealth.

- Physical Therapy

It is the position of the Physical Therapy section that the physical therapist or physical therapist assistant must be licensed in the state in which the patient is located at the time of the physical therapy evaluation and treatment for the provision of telehealth services. In addition, as with all practice settings, a physical therapy evaluation and the establishment of a physical therapy plan of care is required, including when the physical therapy service is provided via telehealth.

A client's appropriateness to be treated via telehealth should be determined on a case-by-case basis, with selections based on physical therapist judgment, client preference, technology availability, risks and benefits, and professional standards of care. A PT is responsible for all aspects of physical therapy care provided to a client and should determine and document the technology used in the provision of physical therapy. Additionally, the PT is responsible for ensuring the technological proficiency of those involved in the client's care.

Given that in the telehealth clinical setting the client and therapist are not in the same location and may not have established a prior in-person relationship, it is critical, at least initially, that the identities of the physical therapy providers and client be verified, as well as informed consent be obtained.

- Athletic Training

It is the position of the Ohio Athletic Trainers Section that an athletic trainer is required to hold a valid, current license in the State of Ohio to serve any person residing in Ohio. Therefore, out of state athletic training personnel must hold a valid Ohio license to treat clients in Ohio via telehealth.

The Section recommends that you contact the appropriate licensing board in any state where the client resides to explore the requirements for practicing athletic training via telehealth in that state. The Section also recommends that any athletic trainer who is providing telehealth services follow all established laws and rules related to non-telehealth athletic training such as consent, scope of practice, standard operating procedures, ethics, documentation, standard of care and referrals.

- Orthotics, Prosthetics, and Pedorthics

<https://www.abcop.org/individual-certification/Documents/Statement%20on%20Telehealth%20in%20Orthotics%20and%20Prosthetics.pdf>

The American Occupational Therapy Association Advisory Opinion for the Ethics Commission

Telehealth

Advances in technology have intersected with the health care sector to produce innovative practice and delivery venues known under the umbrella term of *telehealth*, which is “the use of electronic information and telecommunications technologies to support and promote long distance clinical health care, patient and professional health-related education, public health, and health administration” (Health Resources and Services Administration, n.d., para. 3). *Telerehabilitation*, a rapidly growing branch of telehealth, “is the application of telecommunication and information technologies for the delivery of rehabilitation services” (American Occupational Therapy Association [AOTA], 2013, p. S69).

In telehealth, various types of services can be delivered and typically include client evaluation, treatment intervention and monitoring, consultation, education, and training (Russell, 2009). Synchronous videoconferencing is a common form of service delivery and can be provided using a variety of forms of technology (e.g., voice over the Internet protocol, or VoIP; mobile videoconferencing; consumer HDTV videoconferencing; plain old telephone service, or POTS; and telehealth network with commercial videoconferencing system; Cason, 2011). Other modes of delivery include text-based (e.g., e-mail, cell phone text messaging), audio-based (e.g., teleconferencing), virtual reality (e.g., video games), Web-based (e.g., real-time chat rooms), and wireless (e.g., personal digital assistants, or PDAs) technologies (Pramuka & van Roosmalen, 2009).

Occupational therapy practitioners are among the rehabilitation health care providers who may use telehealth technologies for service delivery. Potential uses include consultation, client evaluation, client monitoring, supervision, and intervention (AOTA, 2013). Reports in the literature describe interventions such as wheeled mobility and seating assessments (Schein, Schmeler, Holm, Saptono, & Brienza, 2010); poststroke arm rehabilitation delivered over the Internet (Hermann et

al., 2010); evaluation of rural clients (Dreyer, Dreyer, Shaw, & Wittman, 2001); and polytrauma rehabilitation (Bendixen et al., 2008).

AOTA (2013) has examined current issues important to telehealth practice in its *Telehealth* position paper. Some practice and ethical considerations outlined in this document include informed consent/consent to treat, privacy/confidentiality, effectiveness of this service delivery model, competency, compliance with licensure laws and regulations, and ensuring compliance with current standards of practice.

General Considerations for Occupational Therapy Practice

To practice ethically, occupational therapists and occupational therapy assistants must consider the unique features of service delivery using telecommunication methods. These issues can relate to the client or client extenders receiving services or to the technology used to provide services. A major advantage of telehealth is that it can provide access to services for those clients who live in rural areas and who have difficulty traveling. Without the use of telehealth delivery methods, some may not receive services at all.

Client Comfort and Competence

Several issues could arise because the site of service is physically distant from the client (AOTA, 2013), and extenders (e.g., family members, support staff) may need to be present during the session. Presence of a third party may affect client comfort or be problematic due to privacy and confidentiality issues, especially if the same third party would not necessarily be present during in-person treatment sessions. For example, an occupational therapist may need to discuss issues of bathing or toileting during a videoconference, possibly creating a sense of discomfort or feelings of intrusiveness for the client.

In addition, clients or extenders must be comfortable with and competent in using the technology (Torsney, 2003). For clients, technology competence often can be problematic due to sequela of the condition for which they require rehabilitation services. Sensory loss due to normal aging (e.g., diminished hearing and vision) or cognitive, motor, language, or vocal impairments can impede clients' ability to operate the technology or benefit from services delivered from a distance (Brennan et al., 2010).

Provider Competence

Occupational therapy practitioners must be competent in the use of the technology to ensure effective service delivery, and the equipment or technology must be of sufficient quality and in dependable working order. Lapses in sound or picture transmission can impede the therapeutic encounter (Denton, 2003; Grosch, Gottlieb, & Cullum, 2011). To avoid disruption of services, facilities and private practitioners should have a sound plan of action in the event of equipment malfunction (Denton, 2003).

Ethical Considerations for Occupational Therapy Practice

Occupational therapists and occupational therapy assistants who provide services via telehealth technology face unique ethical considerations. The Occupational Therapy Code of Ethics (2015) (referred to as the “Code”; AOTA, 2015), in conjunction with other AOTA official documents, offers guidance for these considerations. Specific issues that may arise relate to attaining consent to treat, protecting clients’ privacy and confidentiality, and adhering to professional standards to ensure the highest level of quality care or best alternative when delivering services using a telehealth model.

Consent to Treat

As guided by Principle 3 (Autonomy) and Principle 4 (Justice) of the Code, occupational therapy practitioners must fully disclose information about the specific occupational therapy services (e.g., benefits, risks, potential outcomes, providers of services, reasonable alternatives; AOTA, 2015) and about the implications of the use of technology during intervention. Clients should be informed of the risks and benefits, their rights (including the right to refuse treatment) and responsibilities, and organizational policies for the retention and storage of audio and video recordings and electronic medical records (Grosch et al., 2011).

Some risks related to providing services via telecommunication include the potential for loss of client privacy or confidentiality, lack of knowledge and skills of the care recipient or extender when needed for equipment use, the possibility for equipment malfunction, high costs, potential for client feelings of less-personalized care, or modifications to assessment administration and scoring procedures (Bauer, 2001; Grosch et al., 2011; van Wynsberghe & Gastmans, 2009). Practitioners should consider all these risks as well as benefits when determining whether to provide occupation therapy services via telehealth technology.

Practitioners should document the consent-to-treat process and content, and some professions recommend that clients sign a consent-to-treat document (Hyler & Gangure, 2004). Initially and throughout the duration of intervention, clients should be given opportunities to ask questions to ensure ongoing affirmative consent. Finally, in accordance with Principle 3E, practitioners must respect clients' right to refuse service provision using telecommunication methods.

Privacy and Confidentiality

As stipulated in Principle 3H of the Code, occupational therapy practitioners must “maintain the confidentiality of all verbal, written, electronic, augmentative, and non-verbal communications, in compliance with applicable laws, including all aspects of privacy laws and exceptions thereto” (AOTA, 2015, p. 4). Providers should ensure that clear policies related to service provision; documentation; and transmission, retention, and storage of audio, video, and electronic recordings and records are in place and are in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104–191) privacy rule to protect the privacy and confidentiality of clients' protected health information. Strategies include ensuring that equipment and connections are secure (Hyler & Gangure, 2004) and taking steps to make certain unauthorized third parties do not accidentally enter the room during a videoconferencing session (Grosch et al., 2011). Practitioners should inform clients of the possibility of third-party presence (e.g., technology assistant) and obtain client permission for the same (Grosch et al., 2011).

Clients have the right to know that, despite efforts to protect their privacy and confidentiality, breaches may occur. In these instances, practitioners should understand and adhere to appropriate procedures addressing the compromise of the client's privacy and confidentiality of protected health information (AOTA, 2013). To maximize privacy and confidentiality, organizations and practitioners should use authentication or encryption technology (Brennan et al., 2010). Authentication technology ensures that people accessing the technology are whom they claim to be, and encryption ensures that no one can copy information transported via the Internet (Chadwick et al., 2000).

Quality Care and Adherence to Standards

Occupational therapy practitioners delivering services using a telehealth model must consider the impact of the technology on the services delivered to ensure they provide the best care possible and adhere to all professional and legal standards. Determination for appropriateness of occupational

therapy intervention using telehealth technology should be made on a case-by-case basis according to sound clinical reasoning and should be consistent with published professional standards (Brennan et al., 2010). That is, a decision to implement telehealth service delivery should be client-centered and based on advocating for recipients to attain needed services (Principle 4B of the Code) rather than on factors related to convenience or administrative directives.

In addition, when using telehealth, practitioners must be aware of the potential impact of technology on the communication process (e.g., distorted or delayed audio or video transmission) and take steps to facilitate meaningful communication and comprehension (Principle 3J) and promote open and collaborative dialogue (Principles 3D and 3J; AOTA, 2015). Finally, practitioners should be knowledgeable as to how technology could affect the reliability of assessments when performing client evaluations using telehealth delivery methods. Consistent with Principle 1C, practitioners should remain abreast of the current evidence related to conducting evaluations using telehealth technology (AOTA, 2013).

Telehealth delivery opens the door to the provision of service with clients from a variety of diverse backgrounds. According to Principle 4D, occupational therapy personnel shall “advocate for changes to systems and policies that are discriminatory or unfairly limit or prevent access to occupational therapy services.” (AOTA, 2015, p. 5). Practitioners should recognize and consider issues related to their own cultural competence, especially if language and ethnicity issues could affect the delivery or effectiveness of services (AOTA, 2015).

Practitioners also must meet their ethical responsibilities to “maintain awareness of current laws and AOTA policies and official documents that apply to the profession of occupational therapy” as stipulated in Principle 4 (Justice) (AOTA, 2015, p. 5). Principle 5E states that therapists should “hold the appropriate national, state, or other requisite credentials for the occupational therapy services they provide in academic, research, physical, or virtual work settings” (AOTA, 2015, p. 5). As mentioned previously, practitioners must be aware of state licensure laws (of each state where involved parties reside) and of each state’s regulations related to telehealth practice. At this time, a practitioner who delivers occupational therapy services via telehealth technology to a client who lives in a different state from the one in which the practitioner is licensed must adhere to the licensure regulations of his or her home state as well as the state where the client receives services, including possibly obtaining additional licensure in the state where the client resides (AOTA, 2013).

Knowledge of and adherence to billing and reimbursement regulations are also important considerations when providing occupational therapy services via telehealth technology (AOTA, 2013). As of the writing of this paper, Medicare does not provide reimbursement for occupational therapy services provided using telehealth technology, and Medicaid reimbursement practices vary on a state-by-state basis (AOTA, 2013). Private insurance, school systems, state early intervention systems, workers' compensation programs, and other payers may have rules that guide or restrict interventions provided using a telehealth service delivery model. Principles 4 (Justice) and 5 (Veracity) of the Code direct practitioners to collect fees legally (Principle 4M) and ensure that documentation for reimbursement meets laws, guidelines, and regulations (Principle 5C). Thus, practitioners should be transparent in describing services delivered via technology when documenting telehealth encounters and ensure that the documentation meets professional (or practice) standards.

As stated in the Code, occupational therapists and occupational therapy assistants are obligated to provide services within their level of competence and scope of practice (Principle 1E) and to take responsibility for maintaining high standards and continuing competence in practice (Principle 1G). Principle 1F specifically refers to situations in which “generally recognized standards do not exist in emerging technology” and directs therapists to take steps to ensure their own competence and weigh benefits of service provision with the potential for client harm (AOTA, 2015, p. 3).

Practitioners providing services via telehealth technology must develop and maintain competency in several areas. Beyond competency in administering typical occupational therapy assessments and interventions, practitioners must be knowledgeable about the implications of providing these services using technology as opposed to in person, as modifications in materials, techniques, or instructions may be required (Brennan et al., 2010). Similarly, they must keep informed of and apply current evidence (Principle 1C) related to telehealth service delivery into their practice (AOTA, 2015). Practitioners also must gain and maintain competency in the use of all relevant technology to provide safe and effective services (Brennan et al., 2010).

Case Scenarios

Case 1. Client With Cerebral Palsy

Carrie is an occupational therapist who is licensed in West Virginia and Ohio and employed by a children's hospital in Ohio; she specializes in adapted seating and positioning systems for

individuals with cerebral palsy (CP). Carrie is considered an expert in this area and has earned a reputation for providing high-quality services by designing innovative seating systems for children with multiple and complex impairments.

Carrie recently gave a presentation at AOTA's Annual Conference & Expo about her experiences in providing consultation to clients using real-time videoconferencing. Because she is naturally drawn to and adept with technology, Carrie is excited to expand her telehealth practice.

Sam, an occupational therapist who practices in rural West Virginia, attended Carrie's presentation. After the presentation, Sam approached Carrie and asked her to serve as a consultant with one of his clients, Becky, a 13-year-old girl with CP. Becky has multiple impairments, and a recent growth spurt has rendered her seating system obsolete. Sam tried everything he could think of but was unable to develop an effective seating system for Becky.

Carrie agreed to consult with Becky using a HIPAA-compliant, real-time videoconferencing Internet program, as she was licensed to practice occupational therapy in both Ohio and West Virginia.

Sam explained to Becky and her mother how the teleconferencing session with Carrie would work. He told them that during the session Carrie would ask Sam and Becky questions and instruct Sam to do specific physical assessments so that Carrie can determine the best seating options for Becky. Becky and her mom enthusiastically agreed to participate because, traveling to Ohio would have been very difficult and costly for them, and they were anxious for a seating system that would improve Becky's ease of functioning.

The session proceeded as planned. However, after her standard, initial questions were answered, Carrie felt that she still didn't have a good "feel" for what Becky needed. Carrie wanted more information about Becky's pelvic mobility, and if the session were in person, Carrie would be able to use light touch to maneuver Becky's pelvis to attain this information. Carrie asked Sam to pull down Becky's pants and lift her shirt so that she could better observe Becky's mobility. Upon hearing this, Becky started to cry, so Sam decided to end the session (C. Morress, personal communication, January 23, 2012).

In this scenario, a well-intentioned situation turned out poorly. Becky was in need of specialized occupational therapy services that were geographically inaccessible to her. In arranging for Becky to receive services via live videoconferencing, Sam was meeting his ethical

responsibility to advocate for Becky to receive these services in the only available way according to Principle 4B (Justice) of the Code (AOTA, 2015). After being fully informed about procedures, Becky and her mother readily consented to the videoconferencing session, in accordance with Principle 3C (Autonomy), as this potentially resolved two issues for them (i.e., they did not have to travel for services, and Becky could receive the treatment she needed).

However, when Becky heard that Sam would need to pull down her pants and lift her shirt, she became upset by the thought of having her body parts exposed via video communication. By ending the session at this point, Sam avoided exploiting Becky physically or emotionally and was thus in adherence with Principle 2I (Nonmaleficence).

Carrie and Sam might have avoided the problem all together. According to Principle 3B (Autonomy) of the Code (AOTA, 2015), they should have more fully informed Becky about what to expect during and about potential risk of her removal of clothing and being touched by Sam.

Case 2. Supervision

Abby is a certified and licensed occupational therapy assistant who has 10 years of experience working at a Brookhaven, a rural skilled nursing facility (SNF). Her supervisor is Scott, a licensed and registered occupational therapist who works at 2 SNFs about 60 miles from Brookhaven.

To meet professional and state supervisory standards and regulations, Scott travels to Brookhaven every other week to spend the day with Abby. During these meetings, Scott typically discusses client initial evaluations, intervention plans, and outcome measures with Abby. He also cosigns her documentation and provides instruction in new treatment techniques as needed or cotreats with Abby when necessary. In between visits, Abby and Scott communicate as needed via telephone conversation or electronic mail.

While their supervisory routine is effective and meets state licensure requirements for occupational therapy assistant supervision, Scott is concerned about the amount of time supervision is detracting from his availability for other responsibilities, including his own client caseload. To address this issue, Scott applies his technology knowledge and skills to establish a routine of weekly videoconferencing sessions with Abby using technology that comply with HIPAA standards. He also checks with the state licensure board to ensure that regulations permit tele-supervision, and he reviews Medicare, Medicaid, and other payer requirements for supervision to be sure he is following them.

While Scott still travels to Brookhaven twice per month, using videoconferencing technology decreases the amount of time he spends there. Abby also appreciates having weekly face-to-face time with him, as it enables more regular and effective discussions about client needs. Furthermore, Scott and Abby plan to expand their use of video teleconferencing to include his observation of Abby treating clients, Scott's provision of instruction as Abby implements treatments in real-time, and Abby's participation in staff continuing education activities conducted at Scott's worksites (e.g., journal club, case discussions).

Both models of Scott and Abby's supervisory process were appropriate and effective. In ensuring that both met state licensure regulations, they have complied with the Code (AOTA, 2015). Specifically, Principle 5H directs that occupational therapists provide appropriate supervision "in accordance with AOTA official documents and relevant laws, regulations, policies, procedures, standards, and guidelines" (AOTA, 2015, p. 5). Furthermore, these processes met standards and guidelines delineated in the *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2014) in that the frequency, methods, and content were appropriate to ensure safe and effective delivery of services and also supported Abby's current and advancing competency.

Using videoconferencing to supplement in-person, telephone, and e-mail supervisory communication does offer advantages to Scott, Abby, and the clients they serve. Using videoconferencing technology to meet some supervisory responsibilities via real-time interactions could be a more efficient and effective process for Scott. It could free up time to enable him to better meet other responsibilities and provide opportunities to observe Abby providing interventions or instruct her in providing new or complex interventions in real time. Similarly, Abby could benefit from the provision of real-time and face-to-face instruction as well as the opportunity to participate in continuing education opportunities otherwise not available to her. Ultimately, their clients will benefit by adding videoconferencing to their repertoire of supervisory methods.

At the same time, Scott and Abby must ensure they conduct their videoconferencing sessions in accordance with legal and ethical standards. As mentioned previously, they must make sure they are knowledgeable about and competent in using the technology. They should attain fully informed written consent from clients before including them in a videoconference and implement strategies to protect clients' privacy and confidentiality by using secure connections and minimizing

opportunities for others to overhear their conversations. Scott and Abby also are responsible for ensuring that providing supervision using videoconferencing is appropriate to situations for which it is used, is the best way to meet their needs, and is not used as a convenient replacement for situations that call for an in-person meeting.

Conclusion

Occupational therapists and occupational therapy assistants are using technological advances to provide interventions and services to people who may not otherwise have access to them in innovative ways. Although the benefits and advantages of using telehealth are important, therapists should be aware of ethical considerations that accompany the use of emerging technology in practice. Practitioners should fully disclose to clients (and ensure that they comprehend) the risks, benefits, and nature of service delivery using technology. In addition, the client, his or her family, or service extenders may need to develop knowledge and skills in operating technology. The technology used must be of sufficient quality to provide dependable services and include protective measures to meet HIPAA privacy standards.

Practitioners using telehealth must be cognizant of and practice according to ethical standards outlined in the *Occupational Therapy Code of Ethics* (AOTA, 2015). In addition to attaining consent to treat and to treat in this manner, practitioners may need to take extra measures to protect clients' privacy and confidentiality. Practitioners also should take several measures to ensure they provide optimal interventions. Such measures relate to the responsibility to ensure competency in delivery of services and adherence to local, state, and federal standards and regulations. Practitioners must understand how to operate the technology and how the use of technology can affect the communication, intervention, and assessment processes and to make adjustments as needed.

Practitioners also must exercise clinical judgment and reasoning when deciding whether providing services via telehealth technology is an appropriate option. When using distance technology to provide services to a client in another state, practitioners should be aware of the potential to treat clients from unfamiliar diverse backgrounds and how this could affect the interventions. Comparable to traditional service provision, practitioners should provide interventions that are based on current, best evidence.

Because telehealth as a mode of service delivery is nontraditional and evolving, practitioners must be knowledgeable about how local, state, and national standards and regulations affect their practice. Federal reimbursement regulations (e.g., Medicare) and policy (e.g., HIPAA privacy standards) and state reimbursement regulations (e.g., Medicaid regulations) and policy (e.g., practice licensure) can influence service delivery.

In addition, practicing according to standards and guidelines published in several AOTA official documents can promote the safe and effective delivery of occupational therapy services via telehealth technology. By adhering to the highest level of ethical standards, occupational therapists and occupational therapy assistants can join other health care providers in using technological advances to better serve their clients.

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Author

Joanne Estes, MS, OTR/L

Education Representative, Ethics Commission (2009–2012, 2012–2015)

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AOTA Position Paper

Telehealth in Occupational Therapy

This paper provides the current position of the American Occupational Therapy Association (AOTA) regarding the use of telehealth by occupational therapy practitioners.¹ This document describes the use of telehealth within occupational therapy practice areas, as discussed in the existing research. In addition, occupational therapy practitioner qualifications, ethics, and regulatory issues related to the use of telehealth as a service delivery model within occupational therapy are outlined. Occupational therapy practitioners are the intended audience for this document, although others involved in supervising, planning, delivering, regulating, and paying for occupational therapy services also may find it helpful.

Definitions

Telecommunication and information technologies have prompted the development of an emerging model of health care delivery called *telehealth*, which encompasses health care services, health information, and health education. AOTA defines *telehealth* as the application of evaluative, consultative, preventative, and therapeutic services delivered through *information and communication technology* (ICT; see Appendix A).

Telerehabilitation falls within the larger realm of telehealth and is the application of ICT specifically for the delivery of rehabilitation and habilitation services (Richmond et al., 2017). However, the term *telehealth* best represents the scope of occupational therapy services (Cason, 2012a) and is the prevailing term used in state and federal policy. For these reasons, telehealth is the recommended term for all occupational therapy services provided through ICT.

Use of Telehealth in Occupational Therapy

The overarching goal of occupational therapy is to support people in participation in life through engagement in occupation for “habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non-disability-related needs” (AOTA, 2014b, p. S1). This goal is achieved through the occupational therapy process: evaluation, intervention, and promotion or maintenance of health and participation outcomes for individuals, groups, and populations.

Occupational therapy services provided by means of telehealth can be *synchronous*, that is, delivered through interactive technologies in real time, or *asynchronous*, using store-and-forward technologies. Occupational therapy practitioners can use telehealth as a mechanism to provide services at a location that is physically distant from the client, thereby allowing for services to occur where the client lives, works, learns, and plays, if that is needed or desired.

Occupational therapy practitioners use telehealth as a service delivery model to, for example,

- Help clients develop skills;
- Incorporate assistive technology (AT) and adaptive techniques;

¹When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2015b). *Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).

- Modify work, home, or school environments; and
- Create health-promoting habits and routines.

Some benefits of a telehealth service delivery model include increased access to services, especially for clients who live in remote or underserved areas; improved access to specific providers and specialists otherwise unavailable to clients; prevention of unnecessary delays in receiving care; and sharing of expertise between practitioners through remote consultation (Cason, 2012a, 2012b).

Telehealth may ameliorate the impact of personnel shortages, overcome transportation challenges, and be beneficial in situations where service to clients may be best served during nontraditional work hours of some traditional care models. By removing barriers to accessing care, including social stigma, travel, and socioeconomic and language barriers, the use of telehealth as a service delivery model within occupational therapy leads to improved access to care (Gardner, Bundy, & Dew, 2016; Hinton, Sheffield, Sanders, & Sofronoff, 2017; Levy et al., 2018).

Occupational therapy outcomes achievable through telehealth include the facilitation of occupational performance, participation in activities of daily living (ADLs) and instrumental activities of daily living (IADLs), health and wellness, role competence, well-being, quality of life, and occupational justice (AOTA, 2014b). Telehealth has potential as a service delivery model in every major practice area within occupational therapy. Given the variability of client factors, activity demands, performance skills, performance patterns, and contexts and environments, the candidacy and appropriateness of a telehealth service delivery model should be determined on a case-by-case basis using clinical judgment. See Appendix B for case examples supporting the use of telehealth within occupational therapy practice areas.

Evaluation Using ICT: Tele-Evaluation

ICT has broadened the possibilities for conducting evaluations. Studies have described the use of telehealth in areas that are of concern to occupational therapy, such as evaluation and consultative services for cognitive screening (Abdolahi et al., 2014; Stillerova, Liddle, Gustafsson, Lamont, & Silburn, 2016), orthopedic (hand) assessment (Worboys, Brassington, Ward, & Cornwell, 2017), lymphedema assessment (Galiano-Castillo et al., 2013), wheelchair prescription (Schein, Schmeler, Holm, Saptono, & Brienza, 2010; Schein et al., 2011), home assessment (Hoffman & Russell, 2008; Nix & Comans, 2017), adaptive equipment prescription and home modification (Sanford et al., 2009), and ergonomic assessment (Baker & Jacobs, 2012).

Clinical reasoning guides the selection and application of appropriate ICT necessary to evaluate clients' occupations, client factors, performance skills and patterns, contexts and environments. Occupational therapists should consider the reliability and validity of specific assessment tools when administered remotely.

Researchers have investigated the reliability of assessments used by occupational therapy practitioners and found the following assessments to be reliable when administered remotely through telehealth:

- The Montreal Cognitive Assessment (Abdolahi et al., 2014; Stillerova et al., 2016)
- The Mini-Mental State Exam (Ciernins, Holloway, Coon, McClosky-Armstrong, & Min, 2009; McEachern, Kirk, Morgan, Crossley & Henry, 2014)
- The Functional Reach Test and European Stroke Scale (Palsbo, Dawson, Savard, Goldstein, & Heuser, 2007)
- The Kohlman Evaluation of Living Skills and the Canadian Occupational Performance Measure (Dreyer, Dreyer, Shaw, & Wiltman, 2001)
- The Timed Up and Go Test (Hwang et al., 2016)
- The FIM, Jamar Dynamometer, Preston Pinch Gauge, Nine-Hole Peg Test, and Unified Parkinson's Disease Rating Scale (Hoffmann, Russell, Thompson, Vincent, & Nelson, 2008)
- The Ergonomic Assessment Tool for Arthritis (Backman, Village, & Lacaille, 2008).

In some cases, an in-person assistant, such as a caregiver or other health professional, may be used to relay assessment tool measurements or other measures (e.g., environmental, wheelchair and seating) to the remote therapist during the evaluation process.

When using a telehealth model for conducting an evaluation, occupational therapists must consider the client's health care needs, client's preference, access to technology, and ability to measure outcomes. Practitioners should adhere to all copyright laws and requirements when administering assessments (AOTA, 2015a). If assessment materials or the administration protocol requires modification when used via telehealth, this should be documented and factored into the scoring and interpretation of the assessment.

While AOTA supports state regulation of the profession and supports the role of state regulatory boards (SRBs) in regulating the practice of occupational therapy, certain requirements imposed by individual state regulations such as that a practitioner be physically located in the same state as the client to use telehealth technologies denies access to services and specialists unavailable to the client. Similarly, a requirement that a client must first be seen in person by the practitioner before receiving services via telehealth is not appropriate and should be determined by the practitioner based on clinical reasoning and ethical judgment (Cason, 2014). This requirement denies access to services and specialists unavailable to the client and negates the benefits of a telehealth service delivery model.

When telehealth is used on the basis of sound clinical reasoning and ethical judgment, evidence demonstrates that clients can be effectively treated without the need to first be seen in person by the remote practitioner (Baker & Jacobs, 2012; Hwang et al., 2016; Worboys et al., 2017). The occupational therapist may determine that an in-person evaluation or a hybrid evaluation approach (i.e., some aspects of the evaluation are administered through telehealth and other aspects in person) is required for some clients. Because of the evolving knowledge and technology related to telehealth, occupational therapists should review the latest research to remain current on the appropriate use of ICT for conducting evaluations.

Intervention Using ICT: Teleintervention

A telehealth model of service delivery may be used for providing interventions that are preventative, habilitative, or rehabilitative in nature. Factors to consider when planning and providing interventions delivered with ICT include

- Technology availability and options for the occupational therapy practitioner and the client;
- The safety, effectiveness, and quality of interventions provided exclusively through telehealth or a hybrid model;
- The client's choice about receiving interventions by means of telehealth;
- The client's desired outcomes, including their perception of services provided;
- Reimbursement; and
- Compliance with federal and state laws, regulation, and policy, including licensure requirements (AOTA, 2017a; Richmond et al., 2017).

Consultation Using ICT: Teleconsultation

Teleconsultation is a virtual consultation that includes the

- Remote provider and client, with caregiver as appropriate;
- Remote provider and local provider (e.g., therapist, durable medical equipment vendor, prosthetist, physician) with the client and caregiver, as appropriate; or
- Remote provider and local provider without the client present.

Teleconsultation uses ICT to obtain health and medical information or advice. Teleconsultation has been used to overcome the shortage of various rehabilitation professionals across the United States. For example, an occupational therapist can remotely evaluate and recommend adjustments to a client's prosthetic device using computer software with videoconferencing capability and remote access to a local clinician's computer screen despite the physical distance between the expert clinician and client (Whelan & Wagner, 2011). Similarly, Schein, Schmeler, Brienza, Saptono, and Parmanto (2008) demonstrated positive outcomes associated with teleconsultation between a remote seating specialist and a local therapist for evaluating wheelchair prescriptions.

In addition, teleconsultation may be used to conduct home safety and home modification evaluations (Romero, Lee, Simic, Levy, & Sanford, 2017), prevention and wellness services (Parmanto, Pramana, Yu, Fairman, & Dicianno, 2015), ergonomic consultation (Baker & Jacobs, 2012), preadmission consultation for patients undergoing total hip and total knee replacement (Hoffman & Russell, 2008), and to facilitate support groups for people with chronic conditions (Lauckner & Hutchinson, 2016). In the area of pediatrics, teleconsultation has been used to treat children with complex pediatric feeding disorders (Clawson et al., 2008), facilitate coordination and motor control in children with cerebral palsy (Reifenberg et al., 2017), support school-based services for children with complex medical needs (Cormack et al., 2016), and provide occupation-based coaching for caregivers of young children with autism (Little, Pope, Wallisch, & Dunn, 2018).

Monitoring Using ICT: Telemonitoring

Telemonitoring, or *remote patient monitoring (RPM)*, is commonly used in the medical model for chronic disease management and involves the transmission of a client's vital signs (e.g., blood pressure, heart rate, oxygen levels) and other health data (e.g., blood sugar levels, weight, ADL performance, fall events) for review by a clinician to assure more timely monitoring. This type of monitoring can prevent health crises, emergency department use, and hospitalization and can promote health and wellness.

Occupational therapy practitioners may work on interprofessional teams using telemonitoring for chronic disease management, for instance. Practitioners may use ICT to monitor a client's

- Adherence to an intervention program (Paneroni et al., 2014),
- ADLs (Gokalp & Clarke, 2013),
- Cognitive changes (Stillerova et al., 2016), and
- Fall risk (Horton, 2008; Naditz, 2009).

Wearable and home-based sensor monitoring systems are being examined for efficacy with older adults to aid recovery of the ability to effectively and safely perform ADLs following hip fracture (Pol et al., 2017). Telemonitoring can be a tool to enable occupational therapy practitioners to assist clients in achieving desired outcomes. Further, telemonitoring can give occupational therapy practitioners insights and information about issues and concerns with performance in clients' natural environments.

Considerations for Occupational Therapy in Telehealth

Practitioner Qualifications and Ethical Considerations

It is the professional and ethical responsibility of occupational therapy practitioners to provide services only within each practitioner's level of competence and scope of practice. The *Occupational Therapy Code of Ethics* (AOTA, 2015a) establishes principles that guide safe and competent occupational therapy practice and that must be applied when providing occupational therapy services through a telehealth service delivery model. Practitioners should refer to the relevant principles from the Code and comply with state and federal regulatory requirements.

Principle 1A of the Code states that “occupational therapy personnel shall provide appropriate evaluation and a plan of intervention for recipients of occupational therapy services specific to their needs” (AOTA, 2015a, p. 2). This requirement reinforces the importance of careful consideration about whether evaluation or intervention through a telehealth service delivery model will best meet the client’s needs and is the most appropriate method of providing services given the client’s situation.

Clinical and ethical reasoning guides the selection and application of appropriate telehealth technology necessary to evaluate and meet client needs. Occupational therapy practitioners should consider whether the use of technology and service provision through telehealth will ensure the safe, effective, and appropriate delivery of services. Due to the intimate nature of some occupational therapy services (e.g., interventions related to dressing, bathing, toileting), special consideration should be made to avoid exposure of the client on camera in an undressed or otherwise compromised state. Targeting client factors and performance skills in a different context, viewing the client engaged in the occupation while wearing tight-fitting clothing or a bathing suit, and relying on caregiver report may be viable options to address the area of concern while upholding ethical principles and standards of conduct (AOTA, 2015a, 2017a).

In addition, the American Telemedicine Association’s “Principles in Delivering Telerehabilitation Services” outlines important administrative, clinical, technical, and ethical principles associated with the use of telehealth (Richmond et al., 2017). Occupational therapy practitioners may use various educational approaches to gain competency in using ICT to deliver occupational therapy services. They may gain experience with telehealth and ICT as a part of entry-level education (Standard B.4.15; Accreditation Council for Occupational Therapy Education, 2018) or may participate in continuing education opportunities as clinicians to acquire knowledge of this service delivery model. Examples of ethical considerations related to telehealth are outlined in Appendix C.

Practitioners should have a working knowledge of the hardware, software, and other elements of the technology they are using and have technical support personnel available should problems arise (Richmond et al., 2017). They should use evidence, mentoring, and continuing education to maintain and enhance their competency related to the use of telehealth within occupational therapy.

Supervision Using Telehealth Technologies

State licensure laws, institution-specific guidelines regarding supervision of occupational therapy students and personnel, the *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2014a), and the *Occupational Therapy Code of Ethics* (AOTA, 2015a) must be followed, regardless of the method of supervision. Telehealth may be used while adhering to those guidelines to support students and practitioners working in isolated or rural areas (Bernard & Goodman, 2013; Miller, Miller, Burton, Sprang, & Adams, 2003; Nicholson, Bassham, Chapman, & Fricker, 2014; Rousmaniere & Renfro-Michel, 2016). Factors that may affect the model of supervision and frequency of supervision include the complexity of client needs, number and diversity of clients, skills of the occupational therapist and the occupational therapy assistant, type of practice setting, requirements of the practice setting, and other regulatory requirements (AOTA, 2014a).

Legal and Regulatory Considerations

Occupational therapy practitioners are to abide by state licensure laws and related occupational therapy regulations regarding the use of a telehealth service delivery model within occupational therapy (AOTA, 2015a, 2017a). AOTA supports state regulation of the profession and supports the role of SRBs in regulating the practice of occupational therapy.

Given the inconsistent adoption and non-uniformity of language regarding the use of telehealth within occupational therapy (AOTA, 2017b), it is incumbent upon the practitioner to check a state’s statutes, regulations, and policies before beginning to practice using a telehealth service delivery model (Cason, 2014). Typically, information may be found on SRBs’ websites, which often include links to relevant statutes, regulations, and policy statements. SRBs should be contacted directly in the absence of written guidance to

determine the appropriateness of using telehealth for the delivery of occupational therapy services within their jurisdictions. In addition, the policies and guidelines of payers should be consulted.

Practitioners engaging in interstate practice should consult the occupational therapy licensure board in their state as well as in the state where the client is located for further clarification on policies related to telehealth before rendering services. While a formal license portability mechanism (i.e., licensure compact) is not yet in place, some states have exemptions in licensure laws for temporary practice and for consultation. There is a mechanism for licensure portability through a federal rule (U.S. Department of Veterans Affairs, 2018) for practitioners providing services to veterans.

Occupational therapy practitioners are to abide by Health Insurance Portability and Accountability Act (HIPAA, 1996; Pub. L. 104–191) regulations to maintain security, privacy, and confidentiality of all records and interactions. Additional safeguards inherent in the use of technology to deliver occupational therapy services must be considered to ensure privacy and security of confidential information (Peterson & Watzlaf, 2015; Watzlaf, Zhou, Dealmeida, & Hartman, 2017). Occupational therapy practitioners are to consult with their practice setting's or facility's privacy officer or legal counsel or to consult with independent legal counsel if they are in independent practice or other employment or contracting situation to ensure that the services they provide through telehealth are consistent with protocol and HIPAA regulations.

Funding and Reimbursement

It is the position of AOTA that occupational therapy services provided through telehealth should be valued, recognized, and reimbursed the same as occupational therapy services provided in person. At this writing, Medicare does not list occupational therapy practitioners as eligible providers of services delivered through telehealth (Centers for Medicare and Medicaid Services, 2016). However, AOTA supports the inclusion of occupational therapy practitioners on Medicare's approved list of telehealth providers. The U.S. Department of Defense and Veteran's Health Administration uses telehealth to provide occupational therapy services as well as other telehealth programming (U.S. Department of Veterans Affairs, n.d.).

Opportunities for reimbursement exist through some state Medicaid programs; insurance companies; school districts; and private pay with individuals, agencies, and organizations. It is recommended that occupational therapy practitioners contact their state Medicaid agency or other third-party payers to determine the guidelines for reimbursement of services provided through telehealth.

When billing occupational therapy services provided by means of telehealth, practitioners may be required to distinguish the service delivery model, sometimes designated with a modifier (Cason & Brannon, 2011; Richmond et al., 2017). However, regardless of whether the services are reimbursed or the practitioner is responsible for completing documentation related to billing, the nature of the service delivery as being performed through telehealth should be documented.

Summary

Telehealth is a service delivery model that uses information and communication technology to deliver health-related services when the client is at a distance from the practitioner. AOTA asserts that occupational therapy practitioners may use synchronous and asynchronous ICT to provide evaluative, consultative, preventative, and therapeutic services to clients who are physically distant from the practitioner. Occupational therapy practitioners using telehealth as a service delivery model must adhere to all standards and requirements for practice, including the *Occupational Therapy Code of Ethics* (AOTA, 2015a), maintain the *Standards of Practice for Occupational Therapy* (AOTA, 2015b), and comply with federal and state regulations to ensure their competencies as practitioners and the well-being of their clients.

Occupational therapy practitioners must give careful consideration as to whether evaluation or intervention via telehealth will best meet the client's needs and provide the most appropriate method of providing services given the client's situation and the capacity and competence of the practitioner. Clinical and ethical reasoning guides the selection and application of appropriate use of telehealth to evaluate and meet client needs.

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Authors

Jana Cason, DHS, OTR/L, FAOTA
Kim Hartmann, PhD, OTR/L, FAOTA
Karen Jacobs, EdD, CPE, OTR/L, FAOTA
Tammy Richmond, MS, OTR/L, FAOTA

for

The Commission on Practice:

Julie Dorsey, OTD, OTR/L, CEAS, *Chairperson*

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Appendix A. Overview of Telehealth Technologies

Synchronous Technologies: Videoconferencing

Synchronous technologies enable the exchange of health information in real time (i.e., live) by interactive audio and video between the patient or client and a health care provider located at a distant site. Several options for HIPAA-compliant videoconferencing software are available. Software features commonly used with telehealth include screen sharing, onscreen annotation, and text chat. Additional features may include remote control of the client's camera to allow the occupational therapy practitioner to change the camera angle or to "zoom in" as needed (see Table A.1 for an overview of ICT used in telehealth).

Advantages of synchronous ICT include service provision within the context where occupations naturally occur (e.g., home, work, community), minimal infrastructure requirements, and lower costs for equipment and connectivity (e.g., residential service plan, data plan). Disadvantages may include privacy, security, and confidentiality risks; lack of infrastructure (e.g., limited access to high-speed Internet/broadband; inadequate bandwidth for connectivity); recurring expense (e.g., residential service plan, data plan); diminished sound or image quality; and technological challenges associated with end-user experience and expertise with videoconferencing technology (Cason, 2011; see Table A.1).

Asynchronous Technologies

Telehealth applications that are asynchronous, commonly referred to as *store-and-forward data transmission*, may include video clips, digital images, virtual technologies, and other forms of electronic communications. With asynchronous technologies, the provider and client are not connected at the same time. Potential applications within occupational therapy include home assessments and recommendations for home modifications that are based on recorded data of the home environment; recommendations for inclusion of ergonomic principles and workstation modifications that are based on recorded data of the work environment; and secure viewing of video and digital images for evaluation and intervention purposes.

Technologies That May Be Synchronous or Asynchronous

Telemonitoring Technologies

Occupational therapy practitioners providing services through telehealth technologies can take advantage of digital or *mhealth* (mobile health) devices. These include wearable devices (e.g., Apple Watch, Fitbit) and home devices (e.g., AMC Healthcare Console) that enable occupational therapy practitioners to monitor and subsequently provide services within varied environments. These technologies provide information that allows offsite occupational therapy practitioners to assess performance and modify services and the environment.

Telemonitoring technologies also enable occupational therapy practitioners to understand the real-life occupations and performance challenges of the client and to plan appropriate interventions. As a result, practitioners can tailor environmental accommodations for clients with physical limitations or can develop individualized technology-based cueing systems for clients with cognitive disabilities so that they can live more independently.

Sensor Technologies

Sensor technologies detect and respond to input or stimuli from an individual or the physical environment. Sensor technologies include some digital or mhealth devices (e.g., wearable devices), gaming systems, virtual reality (VR), augmented reality, the Internet of things, and sensor driven environmental and personal assistant technologies (e.g., Alexa through Amazon's Echo and Echo Dot, Google's Home and Home Mini).

Although typical use of sensor technologies does not constitute a telehealth service delivery model, live data (synchronous) streamed to a remote occupational therapy practitioner or recorded data (asynchronous) used

by an occupational therapy practitioner to monitor and adjust a client's course of treatment would constitute the use of sensor technologies within a telehealth service delivery model. Practitioners can use sensor technologies within a telehealth service delivery model when providing interventions, home exercise programs, or consulting in setting up a "smart home" to increase independence and performance within various contexts.

VR typically refers to the use of interactive simulations created with computer hardware and software to present users with opportunities to engage in environments that appear and feel similar to real-world objects and events. Occupational therapy practitioners can use a telehealth service delivery model with VR technologies when conducting evaluations and providing interventions. Telehealth combined with VR has been used in stroke rehabilitation (Corbetta, Imeri, & Gatti, 2015; DeLuca et al., 2017; Laver et al., 2017; Vanbellingen, Filius, Nyffeler, & Van Wegen, 2017), assessment for client's with traumatic brain injury using virtual environments (Lamargue-Hamel et al., 2015; Wright et al., 2016), training of users of power wheelchairs (Nunnerley, Gupta, Snell, & King, 2017; Sugita et al., 2012), and for rehabilitation for clients with Parkinson's disease (Albiol-Pérez et al., 2018) and hand injuries (Huang, Naghdy, Naghdy, Du, & Todd, 2018; Yeh et al., 2017).

Low-cost video capture gaming systems (e.g., Nintendo Switch, Sony PlayStation MOVE and PlayStation Virtual Reality Platform) were not developed specifically for rehabilitation, but they offer an easy-to-set-up, fun, and less-expensive alternative to the expensive VR systems. Although typical use of gaming systems does not constitute telehealth, live data (synchronous) streamed to a remote occupational therapy practitioner or recorded data (asynchronous) used by a practitioner to monitor and adjust a client's course of treatment would constitute a telehealth application of the devices.

Table A.1. Telehealth Technologies

Technology Type	Examples	Considerations
Synchronous	<ul style="list-style-type: none"> • Videoconferencing software for health care (e.g., Vsee, Zoom, Doxy.Me) • Consumer high-definition television videoconferencing • Telephone/POTS • Telehealth network with commercial videoconferencing system • Sensor technologies (with live-streaming data to remote practitioner) 	<ul style="list-style-type: none"> • Confidentiality (security, privacy) • Integrity (information protected from changes by unauthorized users) • Availability (information, services) • Cost-benefit ratio • Socioeconomic considerations • Leveraging existing infrastructure (equipment and personnel) • Technology connection requirements (e.g., broadband, T1 line) • Sound and image quality • Equipment accessibility
Asynchronous	<ul style="list-style-type: none"> • Mobile messaging • Data from wearables or remote patient-monitoring devices • Digital images, videos, or files • Sensor technologies (with store-and-forward data to remote practitioner) 	
Synchronous (interactive) or asynchronous (store-and-forward data)	Telemonitoring technologies <ul style="list-style-type: none"> – Home monitoring systems/devices – Sensor/wearable technologies Sensor technologies <ul style="list-style-type: none"> – Remote use of gaming and VR systems/devices 	

Source. From "Telerehabilitation: An Adjunct Service Delivery Model for Early Intervention Services," by J. Cason, 2011, *International Journal of Telerehabilitation*, 3(1), p. 24. <https://doi.org/10.5195/ijt.2011.6071> Copyright © 2011 by Jana Cason. Adapted with permission.

Note. POTS = plain old telephone service; VR = virtual reality.

Appendix B. Telehealth Case Examples

While not explicitly stated in each case example, occupational therapy practitioners should complete the following steps prior to implementing telehealth:

- Examine state telehealth laws and regulations that may affect the delivery of services using ICT
- Explore the state occupational therapy practice act and state occupational therapy board's website for additional guidance on the use of telehealth to deliver occupational therapy services within the state
- Inquire from the payer source about telehealth reimbursement and coding requirements
- Confirm with malpractice insurance carrier that malpractice policy provides same coverage for services provided through ICT.

In addition, practitioners engaging in interstate practice should examine state laws and regulations related to telehealth in the state where the client is located. Practitioners should also consult the occupational therapy licensure board in their state as well as in the state where the client is located for further clarification on policies related to telehealth before rendering services.

Case Description	Application of Telehealth in the Occupational Therapy Process	Intervention and Outcome
<p>Mathew is an OT employed by a home health company. He provides services in multiple counties within a rural portion of the state where he lives. The company recently employed 2 OTAs to provide services in the same counties and has asked Mathew to provide the requisite supervision. Due to the large geographical area and limited days spent in each county, Mathew would like to incorporate telehealth as a means for supervision.</p>	<p>First, Mathew examines the practice act in the state where he is licensed to determine if there are any regulations or policies that may affect his ability to use telehealth to supervise OTAs. On investigation, Mathew learns that he is permitted to provide a portion of the required supervision hours using ICT/telehealth. Mathew also works with administrators within the home health company to identify reimbursement requirements of the third-party payers.</p> <p>Next, Mathew identifies ICT, including HIPAA-compliant videoconferencing software, to be used for remote supervision. A protocol for supervision using ICT and documentation (including process for countersignatures) is established in adherence with supervision requirements set forth in the state's practice act.</p>	<p>Use of ICT enables the OTAs to carry out the plan of care; Mathew will provide effective supervision and clinical support to 2 OTAs serving a large geographical area within the state. In adherence with his state's occupational therapy practice act, including supervision requirements, the use of telehealth enables Mathew and the OTAs to provide client-centered occupational therapy services in a home health setting.</p>
<p>Lisa, age 70 years, has difficulty performing her daily occupations because of a stroke resulting in right-sided weakness. Although she had learned compensatory techniques for completing ADLs, IADLs, and work, she wants to increase the function of her right hand, particularly for tasks related to managing her farm. Lisa learned of a program in a nearby community using new technology that might be beneficial for people with hemiparesis; however, the clinic is 2 hours from her home.</p>	<p>Lisa meets with her OT in a clinic for the initial evaluation. During the evaluation, Lisa learns additional strategies for incorporating her right hand to perform her farm work. She is fitted for a functional electrical stimulation orthosis that she can use at home once it is programmed in the clinic. Twice each week, Lisa meets with her OT by computer, using a Web camera and online video software. As Lisa continues to make progress, the OT instructs her in how to more effectively use her right hand for completion of ADLs and IADLs, including farm chores.</p>	<p>Lisa makes functional gains in using her right hand for everyday occupations. She reports that she is able to rely less on compensatory strategies and use her right hand more easily, especially while completing ADLs. Lisa achieved these outcomes with only 2 trips to the clinic and without therapist travel.</p>

(Continued)

Case Description	Application of Telehealth in the Occupational Therapy Process	Intervention and Outcome
<p>José, age 35 years, is administrative assistant working at an urban university. He has been employed in this position for 5 years. Recently, he began experiencing discomfort in his neck, shoulder, and back areas. He reported this discomfort, which he associated with computer work, to his immediate supervisor.</p>	<p>José scheduled an appointment with an OT who had expertise in ergonomic workstation evaluation. During his initial contact with the OT, he requested that because of his busy schedule, he would prefer to have his evaluation conducted through telehealth.</p> <p>The OT asked José to have photographs taken of him while working at his office computer workstation. The OT requested that the photographs be from multiple angles and then emailed to a secure platform, where the OT would be able to review them. In addition, José was asked to keep a time log for a week into which he would input information on his activities along with when he experienced discomfort.</p> <p>A consultation via videoconference was arranged, during which the OT reviewed findings from the photographs along with the time log. José reported on the time log that he sat at his computer workstation 100% of the time during the work day. During this time, he multitasked by using a hand-held telephone while keying. It was observed from the photographs that José was using a notebook computer, which placed him in an awkward posture for computing.</p>	<p>Explicit workstation modification recommendations were provided by the OT by means of a videoconference consultation with José. The recommendations included raising the notebook computer so that his head was not positioned in flexion or extension and that the monitor was about arm's length away (closed fist) and using a keyboard and mouse as input devices. An adjustable keyboard tray was recommended for the keyboard and mouse. On the basis of data from the time log, the OT encouraged José to change his work behaviors by taking regular stretch breaks every 20 minutes.</p> <p>A second videoconference consultation occurred within 2 weeks. José reported that his supervisor ordered the external notebook computer accessories and that this new workstation arrangement had reduced his discomfort.</p>
<p>Angela, age 10 years, has a complicated medical history that includes spina bifida. She is significantly limited in her ability to be mobile in the home and community. Although she uses a basic power wheelchair to drive around town and attend her family activities, it is in poor condition and too small for her. Angela cannot adequately reposition herself or properly perform a weight shift because of decreased UE strength and ROM.</p>	<p>Angela has trouble traveling and sitting for long distances. She and her mother meet with an OT in person at a nearby clinic. Concurrently, an OT who has expertise in wheeled mobility at another location participates in the occupational therapy session remotely using HIPAA-compliant videoconferencing software. The remote OT provides consultation to the local OT, Angela, and her mother about seating system frames, bases, and accessories; policy implications and funding mechanisms; and wheeled mobility and seating options.</p>	<p>After interviewing Angela and her mother and observing Angela navigate in her current chair, the remote OT recommends the appropriate power wheelchair and seating features. On approval from the insurance company, the remote OT uses the HIPAA-compliant videoconferencing software to monitor the delivery, evaluate the fitting, and provide feedback and advice to Angela about use of the wheelchair within the community and home.</p> <p>Angela benefited from services without the need to travel a long distance. The local OT gained additional knowledge about wheeled mobility and seating options.</p>

(Continued)

Case Description	Application of Telehealth in the Occupational Therapy Process	Intervention and Outcome
<p>Ethan, age 55 years, is a self-employed entrepreneur who has severe depression, anxiety, and isolation after head and neck cancer resection surgery. The surgery left one side of his face disfigured. He plans to have reconstructive surgery in the future.</p> <p>Ethan has difficulties with eating, fatigue, facial-body image, depression, and pain. He lives alone and over 50 minutes away from the hospital/outpatient therapy clinic.</p> <p>Ethan was seen by an OT in the hospital and prescribed outpatient occupational therapy for his physical and mental health needs. Due to travel distance to the outpatient therapy clinic and anxiety associated with being seen in public, Ethan is interested in the option to continue his therapy at home through ICT.</p>	<p>Ethan completed a telehealth participation screening and initial occupational therapy evaluation during his hospital stay. It was determined that he would continue with occupational therapy 2X/week via telehealth using secure videoconferencing software and a web camera within his home environment. During the biweekly occupational therapy sessions delivered via telehealth, focus is on establishing a therapeutic wellness plan and implementing compensatory eating techniques, pain management and relaxation techniques, stress management, and engagement in progressive physical activities.</p> <p>Ethan completes a home program and a daily journal sent to him by his OT through ICT.</p>	<p>Ethan is able to manage his physical and mental health needs and is able to leave his house to purchase groceries and complete other errands in his community. His pain is tolerable, and breathing and stamina have improved to allow 20–30 minutes of physical activity after 6 weeks of occupational therapy delivered through telehealth.</p> <p>Ethan continues his daily journaling. The OT will follow up with Ethan via telehealth weekly until reconstruction surgery and again after surgery to make sure Ethan continues his wellness plan.</p>
<p>Alex, age 7 years, is an elementary school student with a diagnosis of spastic diplegic cerebral palsy. Alex currently receives 45 minutes per week of direct school-based occupational therapy as a related service on an IEP to support academic performance.</p> <p>Alex typically attends classes in a general education classroom in a brick-and-mortar school but currently is receiving short-term homebound academic services due to a recent surgery. While recovering from the surgical procedure, Alex will be out of the classroom for 7–8 weeks and will receive academic tutoring services during this time.</p>	<p>To provide seamless delivery of school-based occupational therapy services, which Alex is entitled to under the IEP, the educational team proposes that Alex receive occupational therapy services via telehealth during the 7–8 weeks he is at home. The school-based OT is familiar with the use of telehealth, and the school district has previously explored software and hardware capabilities, as well as privacy, security, ethical, and other logistical considerations regarding the use of telehealth. The occupational therapy intervention, delivered via telehealth, consists of weekly direct services and ongoing collaborative consultation among parent, student, and OT. Each weekly virtual session lasts for 45 minutes. The student's parent is present throughout the live therapy sessions. The OT ensures that each telehealth session involves at least a 5-minute period of collaborative consultation, including a discussion of student progress and instructions for the implementation of a home program between sessions.</p>	<p>The use of a telehealth service delivery model enables Alex to continue to receive direct school-based occupational therapy services via ICT while on homebound services. The OT sees Alex at the same day and time as he was previously scheduled while in attendance in the school building, preventing any disruption to schedules. Parent satisfaction is high, and Alex's parent is actively involved in therapeutic sessions and facilitates the use of therapeutic strategies throughout the week.</p> <p>Alex continues to demonstrate functional improvements in performance in the areas of tool usage (e.g., scissors, glue stick, pencil), handwriting, literacy, and school-related self-care (e.g., donning/doffing coat) while on home services. He re-enters the brick-and-mortar school after 8 weeks with no regression in skills.</p>

(Continued)

Case Description	Application of Telehealth in the Occupational Therapy Process	Intervention and Outcome
<p>Jane, age 22 years, is an undergraduate student with a history of depression and anxiety. She has been unable to attend classes because her medications are making her drowsy, and she has become socially isolated from classmates. She is unable to get to classes on time or complete assignments in a timely manner. As a result of Jane's difficulty keeping medical appointments due to fatigue and anxiety, telehealth was selected as the preferred delivery method for occupational therapy services.</p>	<p>Jane worked with her OT using videoconferencing technology to identify and implement strategies to improve her occupational performance and participation in ADLs and IADLs. The OT requested that Jane complete a 1-week activity time log. Jane and the OT reviewed the log virtually where areas of challenges with attending classes, completing assignments and going to medical appointments were identified. They discussed strategies for reaching out the school's Disability Services to apply for reasonable accommodations such as a self-paced academic workload and flexible due dates for assignments. The OT suggested energy conservation strategies such as simplifying activities and setting realistic goals; spacing out activities throughout the day; and stress management strategies to address Jane's anxiety. For time management, the OT recommended CST and specific apps that Jane agreed to use. Jane and the OT agreed to meet weekly using a virtual platform.</p>	<p>Occupational therapy services through telehealth enabled Jane to identify and implement effective therapeutic strategies. As a result, she was able to complete the semester's courses with passing grades.</p>
<p>Rick, age 56 years, is a real estate agent who enjoys biking on the weekends in a bike club. He recently fell off his bike and fractured his collarbone on his right side. Treatment consisted of immobilization for 2 weeks with an UE sling. Rick received a referral for occupational therapy services. His physician has cleared Rick to remove the sling and return to full-time work with modifications and begin UE AAROM/ROM and progressive strengthening over the next 4 weeks. Rick prefers to receive occupational therapy services via telehealth because of his work schedule and difficulty traveling for appointments.</p>	<p>Rick was evaluated initially at the clinic to establish short- and long-term goals. During the initial visit, Rick completed a telehealth screening tool that demonstrated that he had adequate hardware and bandwidth at his home and work, technology skills, and appropriate impairment to receive occupational therapy services via telehealth. The OT had Rick sign a telehealth informed consent and establish an account to access the company's HIPAA-compliant videoconferencing software. Rick logs into the company's web portal 2 times per week for 4 weeks for occupational therapy services. The OT provides progressive ROM, stretching, and therapeutic exercises; functional activities to improve use of his right UE, including the shoulder, neck, and upper back; and home and work modification recommendations to reduce unnecessary stress on the fracture site.</p>	<p>Rick completed all scheduled online occupational therapy sessions and his home exercise and stretching program. He continued to work full-time while receiving therapy and returned to biking after 8 weeks of therapy. All materials related to patient education, home program, and home and work modification recommendations were archived in Rick's account on the company's web portal. Rick downloaded and printed materials provided by his OT after each session.</p>

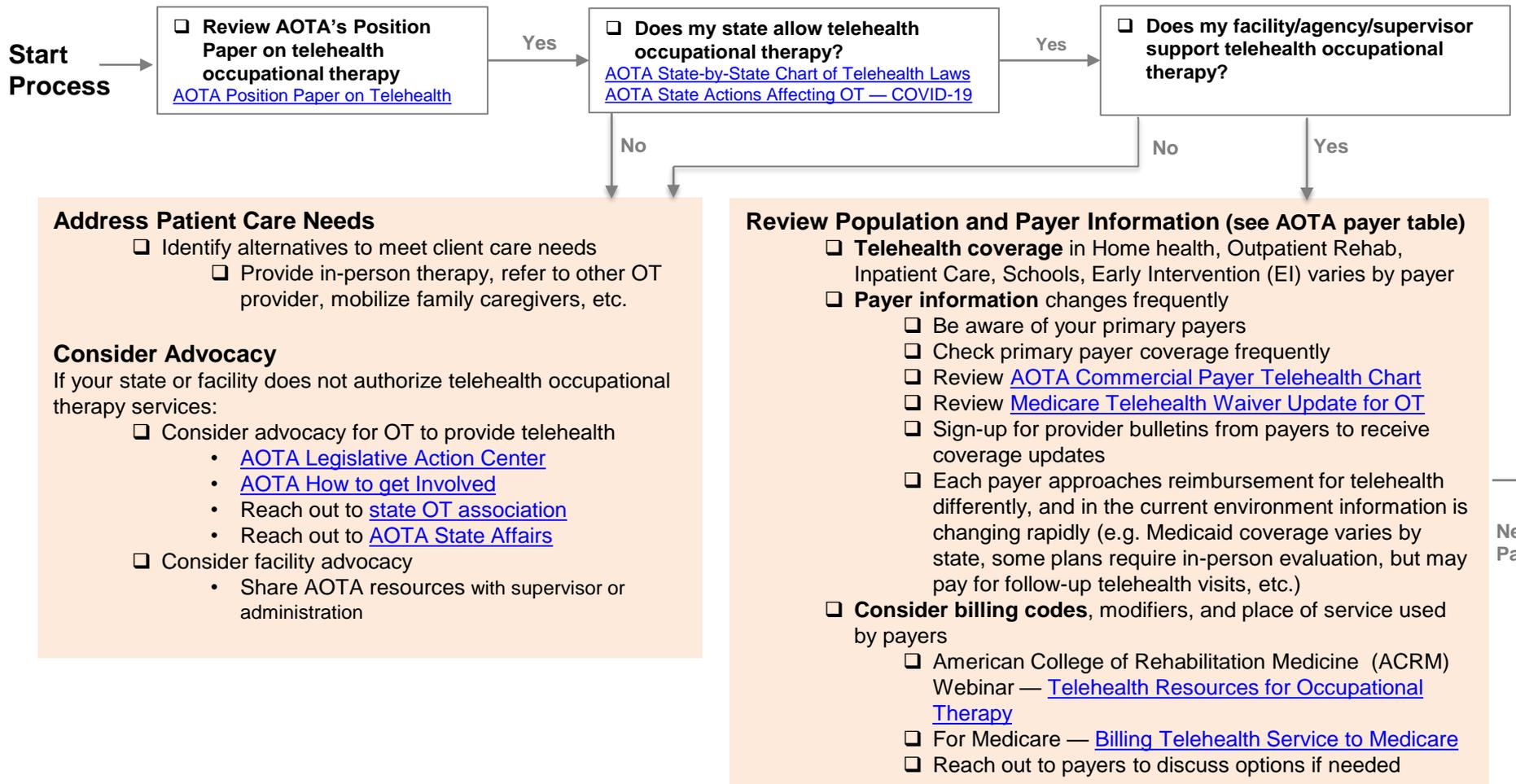
Note. AAROM = active assisted range of motion; ADLs = activities of daily living; CST = cognitive support technology; HIPAA = Health Insurance Portability and Accountability Act; IADLs = instrumental activities of daily living; ICT = information and communication technology; IEP = individualized education program; OT = occupational therapist; OTA = occupational therapy assistant; ROM = range of motion; UE = upper extremity

Appendix C. Ethical Considerations and Strategies for Practice Using Telehealth

Ethical Considerations	Strategies for Ethical Practice
Fully inform the client regarding the implications of a telehealth service delivery model vs. an in-person service delivery model.	Occupational therapy personnel shall . . . <ul style="list-style-type: none"> • “Fully disclose the benefits, risks, and potential outcomes of any intervention; the personnel who will be providing the intervention and any reasonable alternative to the proposed intervention” (Principle 3B) • “Establish a collaborative relationship with recipients of service and relevant stakeholders to promote shared decision making” (Principle 3D) • “Obtain consent after disclosing appropriate information and answering any questions posed by the recipient of service or research participant to ensure voluntariness” (Principle 3C)
Abide by laws and scope of practice related to licensure and provision of occupational therapy services using telehealth.	Occupational therapy personnel shall . . . <ul style="list-style-type: none"> • “Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy” (Principle 4E)
Adhere to professional standards.	Occupational therapy personnel shall . . . <ul style="list-style-type: none"> • “Provide occupational therapy services, including education and training, that are within each practitioner’s level of competence and scope of practice” (Principle 1E) • “Take steps (e.g., continuing education, research, supervision, training) to ensure proficiency, use careful judgment, and weigh potential for harm when generally recognized standards do not exist in emerging technology or areas of practice” (Principle 1F) • “Maintain competency by ongoing participation in education relevant to one’s practice area” (Principle 1G) • “Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy” (Principle 4E)
Understand and abide by approaches that ensure that privacy, security, and confidentiality are not compromised as a result of using telehealth.	Occupational therapy personnel shall . . . <ul style="list-style-type: none"> • “Maintain the confidentiality of all verbal, written, electronic, augmentative, and non-verbal communications, in compliance with applicable laws, including all aspects of privacy laws and exceptions thereto (e.g. Health Insurance Portability and Accountability Act [Pub. L. 104-191], Family Educational Rights and Privacy Act [Pub. L. 93-380])” (Principle 3H)
Understand and adhere to procedures if there is any compromise of security related to health information.	Occupational therapy personnel shall . . . <ul style="list-style-type: none"> • “Maintain the confidentiality of all verbal, written, electronic, augmentative, and nonverbal communications, in compliance with applicable laws, including all aspects of privacy laws and exceptions thereto (e.g., Health Insurance Portability and Accountability Act [Pub. L. 104–191], Family Educational Rights and Privacy Act [Pub. L. 93–380]).” (Principle 3H) • “Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy.” (Principle 4E)
Assess the effectiveness of interventions provided through telehealth by consulting current research and conducting ongoing monitoring of client response.	Occupational therapy personnel shall . . . <ul style="list-style-type: none"> • “Refer to other providers when indicated by the needs of the client” (Principle 1I) • “Reevaluate and reassess recipients of service in a timely manner to determine if goals are being achieved and whether intervention plans should be revised.” (Principle 1B) • “Use, to the extent possible, evaluation, planning, intervention techniques, assessments, and therapeutic equipment that are evidence-based, current, and within the recognized scope of occupational therapy practice” (Principle 1C)
Recognize the need to be culturally competent in the provision of services via telehealth, including language, ethnicity, and socioeconomic and educational background that could affect the quality and outcomes of services provided.	Occupational therapy personnel shall . . . <ul style="list-style-type: none"> • “Facilitate comprehension and address barriers to communication (e.g. aphasia; differences in language, literacy, culture) with the recipient of service (or responsible party), student, or research participant” (Principle 3J) • “Assist those in need of occupational therapy services in securing access through available means” (Principle 4B) • “Address barriers in access to occupational therapy services by offering or referring clients to financial aid, charity care, or pro bono services within the parameters of organizational policies” (Principle 4C)

Note. AOTA = American Occupational Therapy Association. Ethical principles are from AOTA’s (2015a) *Occupational Therapy Code of Ethics* (2015).

Occupational Therapy Telehealth Decision Guide



Occupational Therapy Telehealth Decision Guide

Implementing Telehealth

Regulatory Considerations

- [Consent requirements](#), which may vary by state and payer
- HIPAA Compliance [during COVID-19 Pandemic](#) and [enforcement discretion](#)
- [Business Associate Agreements](#)
- Facility HIPAA Privacy Statement
- [FERPA](#) Compliance (for educational environments)
- State Licensure
 - Location of both practitioner and client affects telehealth regulation
 - OTA ability to provide telehealth varies by state and payer
- Confirm coverage for telehealth with professional liability carrier

Technical Considerations

- Equipment/Modality, including Video Cameras
- Hardware and Software
 - [HHS HIPAA Compliant Platforms](#)
- Internet Bandwidth
- Technical Support
 - [Health IT Playbook — Learn More About Telehealth](#)
 - [National Telehealth Technology Assessment Resource Center](#)

Clinical Decision Making

- Risk/Benefit Analysis
 - Specific patient ability to benefit from telehealth
- Treatment Must be Client Centered
 - Continue to rely on the [AOTA OT Practice Framework](#) and the [Occupational Therapy Code of Ethics](#)
- Timing Considerations—benefits of synchronous vs. asynchronous sessions
- Ethical Considerations
 - Practitioner competency with telehealth- consider competency checklist
 - [AOTA Advisory Opinion for the Ethics Commission](#)
- Documentation of Services per [AOTA Guidelines](#)
 - Consider telehealth specific documentation requirements with [AHIMA Telemedicine Toolkit](#)
- Track Outcomes
- Patient Satisfaction Survey—Continue to Gather Feedback

Additional Telehealth Resources

- [AHRQ Sample Telehealth Consent Form](#)
- [AOTA Telehealth Resources](#)
- [AOTA Webinar: From Onsite to Online: Addressing Students' Needs Through a Telehealth Service Delivery Model](#)
- [American Telemedicine Organization](#)
- [FERPA and Virtual Learning](#)
- [gpTRAC Checklist for Initiating Telehealth Services](#)
- [HHS Telehealth Information](#)
- [National Consortium of Telehealth Resource Centers](#)
 - [COVID-19 Telehealth Toolkit](#)
- [Telehealth Etiquette](#)
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Occupational Therapy and Telehealth

State Statutes, Regulations and Regulatory Board Statements

Note: **Grayed out text** reflects an update to the COVID-19 telehealth information since this chart was last posted on May 7. Click on any of the links below to view the full chart of state COVID-19 updates related to licensure, telehealth, and insurance.

State	Citation and Provisions ¹	Notes
Alabama		<p>No statutes, regulations, or statements specific to OT and telehealth. The State Medical Board is reviewing telehealth. After the review process, the OT Practice Board will review the OT Practice Act and make changes accordingly. Currently, no laws or regulation prohibit the practice of telehealth.</p> <p>COVID-19 update: Medicaid extended temporary telemedicine coverage for speech and occupational therapy providers. OT Board states that telehealth is not authorized in the state practice act, but its use is not limited either. The same ethical and practice standards apply to the provision of services via telehealth as for a face-to-face visit.</p>
Alaska	<p>Regulation: 12 AAC 54.825 STANDARDS FOR PRACTICE OF TELEREHABILITATION BY OCCUPATIONAL THERAPIST.</p> <p>(a) The purpose of this section is to establish standards for the practice of telerehabilitation by means of an interactive telecommunication system by an occupational therapist licensed under AS 08.84 and this</p>	<p>Board reports that it has not endorsed the AOTA position paper on telehealth, but directs licensees with telehealth questions to read it.</p>

¹ Disclaimer: *This chart is provided for informational and educational purposes only and is not a substitute for legal advice or the professional judgement of health care professionals in evaluating and treating patients.* AOTA State Affairs staff reviewed state occupational therapy statutes, regulations and position statements adopted by state occupational therapy regulatory boards as well as broader telehealth statutes and regulations. Staff also contacted state occupational therapy regulatory boards and agency staff with oversight over occupational therapy licensure to ask if the board/agency has a position on the provision of occupational therapy via telehealth. AOTA encourages practitioners to check their state OT regulatory board/agency for the latest information about regulatory requirements regarding the provision of occupational therapy via telehealth.

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	<p>chapter in order to provide occupational therapy to patients who are located at distant sites in the state which are not in close proximity of an occupational therapist.</p> <p>(b) An occupational therapist licensed under AS 08.84 and this chapter conducting telerehabilitation by means of an interactive telecommunication system</p> <ul style="list-style-type: none"> (1) (repealed) (2) must interact with the patient maintaining the same ethical conduct and integrity required under 12 AAC 54.800; (3) must comply with the requirements of 12 AAC 54.810 for any licensed occupational therapist assistant providing services under this section; (4) may conduct one-on-one consultations, including initial evaluation, under this section; and (5) must provide and ensure appropriate client confidentiality and HIPAA compliance, establish secure connections, activate firewalls, and encrypt confidential information. <p>Regulation: 12 AAC 54.990 DEFINITIONS In this chapter and in AS 08.84:</p> <ul style="list-style-type: none"> (5) "HIPAA compliance" means compliance with 42 U.S.C. 300gg (Health Insurance Portability and Accountability Act of 1996); (6) "interactive telecommunication system" <ul style="list-style-type: none"> (A) means audio and video equipment that permits a two-way, real time communication between a therapist licensed under AS 08.84 and this chapter and a patient who is located at a distant site in the state which is not in close proximity of the therapist; (B) does not include <ul style="list-style-type: none"> (i) electronic mail; (ii) facsimile machine; or (iii) telephone; (7) "telerehabilitation" means the practice of therapy by a person licensed as a therapist under AS 08.84 and this chapter using an interactive telecommunication system. <p>Board Statement: Important Notice Regarding Telemedicine Following SB74, businesses engaged in the practice of telemedicine are required to register for placement on the Telemedicine Business Registry (TBR) through the Professional Licensing Section. Please click HERE to access the application and additional information regarding the registry. Please note that the application is for businesses rather than individual licensees to register; if you have any questions regarding scope of practice requirements or limitations regarding telemedicine, please contact the Board or program's Occupational Licensing Examiner.</p>	<p>COVID-19 update: Department of Health and Human Services updated Temporary Expansion of Medicaid Telehealth Coverage (3/30) which authorizes physical, occupational, and speech therapy services via live interactive modes of delivery.</p>
Arizona		<p>No statutes, regulations, or statements specific to OT and telehealth.</p> <p>COVID-19 update: Governor's Executive Order authorizes OTs and</p>

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		OTAs to provide services via telehealth and requires all state-regulated health insurance plans and all Medicaid plans to cover all health care services that are provided through telemedicine if the health care service was covered were it provided in person.
Arkansas	<p>Statute: Arkansas Code §17-80-402. Definitions.</p> <p>(1) "Distant site" means the location of the healthcare professional delivering services through telemedicine at the time the services are provided;</p> <p>(2) "Healthcare professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession;</p> <p>(3) "Originating site" means a site at which a patient is located at the time healthcare services are provided to him or her by means of telemedicine;</p> <p>(4) (A) "Professional relationship" means at minimum a relationship established between a healthcare professional and a patient when:</p> <ul style="list-style-type: none"> (i) The healthcare professional has previously conducted an in-person examination and is available to provide appropriate follow-up care, when necessary, at medically necessary intervals; (ii) The healthcare professional personally knows the patient and the patient's relevant health status through an ongoing personal or professional relationship and is available to provide appropriate follow-up care, when necessary, at medically necessary intervals; (iii) The treatment is provided by a healthcare professional in consultation with, or upon referral by, another healthcare professional who has an ongoing relationship with the patient and who has agreed to supervise the patient's treatment, including follow-up care; (iv) An on-call or cross-coverage arrangement exists with the patient's regular treating healthcare professional or another healthcare professional who has established a professional relationship with the patient; (v) A relationship exists in other circumstances as defined by rule of the Arkansas State Medical Board for healthcare professionals under its jurisdiction and their patients; or (vi) A relationship exists in other circumstances as defined by rule of a licensing or certification board for other healthcare professionals under the jurisdiction of the appropriate board and their patients if the rules are no less restrictive than the rules of the Arkansas State Medical Board; <p>(5) "Remote patient monitoring" means the use of synchronous or 18 asynchronous electronic</p>	<p>COVID-19 update: Arkansas Medicaid suspended the prohibition on use of telemedicine technology for limited occupational, physical or speech therapy services provided to established patients during the COVID-19 outbreak and the declaration of public health emergency. On June 18, the Governor extended for another 60 days the suspension of the requirement for an in-person encounter or a face-to-face examination using real-time audio and visual means to establish a professional relationship.</p>

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	<p>information and communication technology to collect personal health information and medical data from a patient at an originating site that is transmitted to a healthcare professional at a distant site for use in the treatment and management of medical conditions that require frequent monitoring;</p> <p>(6) "Store-and-forward technology" means the asynchronous transmission of a patient's medical information from a healthcare professional at an originating site to a healthcare professional at a distant site; and</p> <p>(7) (A) "Telemedicine" means the use of electronic information and communication technology to deliver healthcare services, including 29 without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient.</p> <p>(B) "Telemedicine" includes store-and-forward technology and remote patient monitoring.</p> <p>Regulation: Arkansas State Medical Board Regulation 2.8</p> <p>8. Requiring minimum standards for establishing Patient/Provider relationships. Provider is defined as a person licensed by the Arkansas State Medical Board. A Provider exhibits gross negligence if he provides and/or recommends any form of treatment, including prescribing legend drugs, without first establishing a proper Patient/Provider relationship.</p> <p>A. For purposes of this regulation, a proper Patient/Provider relationship, at a minimum requires that:</p> <ol style="list-style-type: none"> 1. A. The Provider performs a history and an "in person" physical examination of the patient adequate to establish a diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided, OR B The Provider performs a face to face examination using real time audio and visual telemedicine technology that provides information at least equal to such information as would have been obtained by an in-person examination; OR C The Provider personally knows the patient and the patient's general health status through an "ongoing" personal or professional relationship; <p>2. Appropriate follow-up be provided or arranged, when necessary, at medically necessary intervals.</p> <p>B. For the purposes of this regulation, a proper Patient/Provider relationship is deemed to exist in the following situations:</p> <ol style="list-style-type: none"> 1. When treatment is provided in consultation with, or upon referral by, another Provider who has an ongoing relationship with the patient, and who has agreed to supervise the patient's treatment, including follow up care and the use of any prescribed medications. 2. On-call or cross-coverage situations arranged by the patient's treating Provider. <p>C. Exceptions – Recognizing a Provider's duty to adhere to the applicable standard of care, the following situations are hereby excluded from the requirement of this regulation:</p> <ol style="list-style-type: none"> 1. Emergency situations where the life or health of the patient is in danger or imminent danger. 2. Simply providing information of a generic nature not meant to be specific to an individual patient. 	

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	<p>3. This Regulation does not apply to prescriptions written or medications issued for use in expedited heterosexual partner therapy for the sexually transmitted diseases of gonorrhea and/or chlamydia.</p> <p>4. This Regulation does not apply to the administration of vaccines containing tetanus toxoid (e.g., DTaP, DTP, DT, Tdap, Td, or TT) or inactive influenza vaccines</p> <p><u>Regulation: Arkansas State Medical Board Regulation 38</u> Requirement for all services provided by Providers using telemedicine:</p> <ol style="list-style-type: none"> 1. A Patient/Provider relationship must be established in accordance with Regulation 2.8 before the delivery of services via telemedicine. Provider is defined as a person licensed by the Arkansas State Medical Board. A patient completing a medical history online and forwarding it to a Provider is not sufficient to establish the relationship, nor does it qualify as store-and-forward technology. 2. The following requirements apply to all services provided by Providers using telemedicine: <ol style="list-style-type: none"> A. The practice of medicine via telemedicine shall be held to the same standards of care as traditional in-person encounters. B. The Provider must obtain a detailed explanation of the patient's complaint from the patient or the patient's treating Provider. C. If a decision is made to provide treatment, the Provider must agree to accept responsibility for the care of the patient. D. If follow-up care is indicated, the Provider must agree to provide or arrange for such follow-up care. E. A Provider using telemedicine may NOT issue a prescription for any controlled substances defined as any scheduled medication under schedules II through V unless the Provider has seen the patient for an in-person exam or unless a relationship exists through consultation or referral; on-call or cross-coverage situations; or through an ongoing personal or professional relationship. F. The Provider must keep a documented medical record, including medical history. G. At the patient's request, the Provider must make available to the patient an electronic or hardcopy version of the patient's medical record documenting the encounter. Additionally, unless the patient declines to consent, the Provider must forward a copy of the record of the encounter to the patient's regular treating Provider if that Provider is not the same one delivering the service via telemedicine. H. Services must be delivered in a transparent manner, including providing access to information identifying the Provider in advance of the encounter, with licensure and board certifications, as well as patient financial responsibilities. I. If the patient, at the recommendation of the Provider, needs to be seen in person for their current medical issue, the Provider must arrange to see the patient in person or direct the patient to their regular treating Provider or other appropriate provider if the patient does not have a treating Provider. Such recommendation shall be documented in the patient's medical record. 	

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	<p>J. Providers who deliver services through telemedicine must establish protocols for referrals for emergency services.</p> <p>K. All Providers providing care via telemedicine to a patient located within the State of Arkansas shall be licensed to practice medicine in the State of Arkansas.</p> <p>L. A physician shall not issue a written medical marijuana certification to a patient based on an assessment performed through telemedicine.</p>	
California	<p>Regulation: California Code of Regulations Title 16, Division 39, Article 8, Section 4172</p> <p>(a) In order to provide occupational therapy services via telehealth as defined in Section 2290.5 of the Code, an occupational therapist or occupational therapy assistant providing services to a patient or client in this State must have a valid and current license issued by the Board.</p> <p>(b) An occupational therapist shall inform the patient or client about occupational therapy services via telehealth and obtain consent prior to delivering those services, consistent with Section 2290.5 of the Code.</p> <p>(c) An occupational therapist shall determine whether an in-person evaluation or in-person interventions are necessary considering: the complexity of the patient's/client's condition; his or her own knowledge, skills, and abilities; the nature and complexity of the intervention; the requirements of the practice setting; and the patient's/client's context and environment.</p> <p>(d) An occupational therapist or occupational therapy assistant providing occupational therapy services via telehealth must:</p> <ol style="list-style-type: none"> (1) Exercise the same standard of care when providing occupational therapy services via telehealth as with any other mode of delivery of occupational therapy services; (2) Provide services consistent with section 2570.2(k) of the Code; and (3) Comply with all other provisions of the Occupational Therapy Practice Act and its attending regulations, including the ethical standards of practice set forth in section 4170, as well as any other applicable provisions of law. <p>(e) Failure to comply with these regulations shall be considered unprofessional conduct as set forth in the Occupational Therapy Practice Act.</p>	<p>COVID-19 update: Department of Consumer Affairs issued various waivers of OT licensing requirements. On April 3, the Governor issued an Executive Order relating to verbal or written consent and requiring that a covered health care provider ensure that the delivery of telehealth services is consistent with notification from the U.S. Office of Civil Rights that implemented enforcement discretion of HIPAA requirements.</p>
Colorado	<p>Statute: Colorado Revised Statutes §12-40.5-103. Definitions.</p> <p>(9) "Occupational therapy" means the therapeutic use of everyday life activities with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. The practice of occupational therapy includes:</p> <p>(c) Interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation, including:</p> <p>(XIV) The use of telehealth pursuant to rules as may be adopted by the director.</p>	<p>No regulations have been promulgated as of the date this chart has been updated.</p> <p>COVID-19 update: According to DORA, OTs and OTAs may provide services via telehealth during the state of emergency, Medicaid will cover OT services provided via telehealth during the state of emergency; Governor signed SB 212 requiring health insurance carriers, including Medicaid, to cover telehealth, prohibiting carriers from imposing specific requirements or</p>

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		<p>limitations on HIPAA-compliant technologies, and prohibiting carriers from requiring an established patient-provider relationship, or imposing additional certification, location, or training requirements as a condition of reimbursement.</p>
Connecticut	<p>Statute: Title 19a, Section 906 Telehealth services. (a) As used in this section: (1) "Asynchronous" means any transmission to another site for review at a later time that uses a camera or other technology to capture images or data to be recorded. (2) "Facility fee" has the same meaning as in section 19a-508c. (3) "Health record" means the record of individual, health-related information that may include, but need not be limited to, continuity of care documents, discharge summaries and other information or data relating to a patient's demographics, medical history, medication, allergies, immunizations, laboratory test results, radiology or other diagnostic images, vital signs and statistics. (4) "Medical history" means information, including, but not limited to, a patient's past illnesses, medications, hospitalizations, family history of illness if known, the name and address of the patient's primary care provider if known and other matters relating to the health condition of the patient at the time of a telehealth interaction. (5) "Medication-assisted treatment" means the use of medications approved by the federal Food and Drug Administration, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. (6) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. (7) "Peripheral devices" means the instruments a telehealth provider uses to perform a patient exam, including, but not limited to, stethoscope, otoscope, ophthalmoscope, sphygmomanometer, thermometer, tongue depressor and reflex hammer. (8) "Remote patient monitoring" means the personal health and medical data collection from a patient in one location via electronic communication technologies that is then transmitted to a telehealth provider located at a distant site for the purpose of health care monitoring to assist the effective management of the patient's treatment, care and related support. (9) "Store and forward transfer" means the asynchronous transmission of a patient's medical information from an originating site to the telehealth provider at a distant site. (10) "Synchronous" means real-time interactive technology. (11) "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and</p>	<p>No OT specific statute or regulation, but statute does use a definition of telehealth provider that includes occupational therapists.</p> <p>COVID-19 update: Executive Orders expand telehealth to allow services to be provided telephonically by Medicaid-enrolled providers to Medicaid recipients who are current patients and by in-network providers for services covered under private insurance to current patients; also allows for providers to provide and be reimbursed for services via telehealth to individuals who are not Medicaid recipients or are not covered by private insurance.</p>

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	<p>(B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail.</p> <p>(12) "Telehealth provider" means any physician licensed under chapter 370, physical therapist licensed under chapter 376, chiropractor licensed under chapter 372, naturopath licensed under chapter 373, podiatrist licensed under chapter 375, occupational therapist licensed under chapter 376a, optometrist licensed under chapter 380, registered nurse or advanced practice registered nurse licensed under chapter 378, physician assistant licensed under chapter 370, psychologist licensed under chapter 383, marital and family therapist licensed under chapter 383a, clinical social worker or master social worker licensed under chapter 383b, alcohol and drug counselor licensed under chapter 376b, professional counselor licensed under chapter 383c, dietitian-nutritionist certified under chapter 384b, speech and language pathologist licensed under chapter 399, respiratory care practitioner licensed under chapter 381a, audiologist licensed under chapter 397a or pharmacist licensed under chapter 400j, who is providing health care or other health services through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to the profession.</p> <p>(b) (1) A telehealth provider shall only provide telehealth services to a patient when the telehealth provider:</p> <ul style="list-style-type: none"> (A) Is communicating through real-time, interactive, two-way communication technology or store and forward technologies; (B) has access to, or knowledge of, the patient's medical history, as provided by the patient, and the patient's health record, including the name and address of the patient's primary care provider, if any; (C) conforms to the standard of care applicable to the telehealth provider's profession and expected for in-person care as appropriate to the patient's age and presenting condition, except when the standard of care requires the use of diagnostic testing and performance of a physical examination, such testing or examination may be carried out through the use of peripheral devices appropriate to the patient's condition; and (D) provides the patient with the telehealth's provider license number and contact information. <p>(2) At the time of the telehealth provider's first telehealth interaction with a patient, the telehealth provider shall inform the patient concerning the treatment methods and limitations of treatment using a telehealth platform and, after providing the patient with such information, obtain the patient's consent to provide telehealth services. The telehealth provider shall document such notice and consent in the patient's health record. If a patient later revokes such consent, the telehealth provider shall document the revocation in the patient's health record.</p> <p>(c) Notwithstanding the provisions of this section or title 20, no telehealth provider shall prescribe any schedule I, II or III controlled substance through the use of telehealth, except a schedule II or III controlled substance other than an opioid drug, as defined in section 20-14o, in a manner fully consistent with the Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time,</p>	

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	<p>for the treatment of a person with a psychiatric disability or substance use disorder, as defined in section 17a-458, including, but not limited to, medication-assisted treatment. A telehealth provider using telehealth to prescribe a schedule II or III controlled substance pursuant to this subsection shall electronically submit the prescription pursuant to section 21a-249.</p> <p>(d) Each telehealth provider shall, at the time of the initial telehealth interaction, ask the patient whether the patient consents to the telehealth provider's disclosure of records concerning the telehealth interaction to the patient's primary care provider. If the patient consents to such disclosure, the telehealth provider shall provide records of all telehealth interactions to the patient's primary care provider, in a timely manner, in accordance with the provisions of sections 20-7b to 20-7e, inclusive.</p> <p>(e) Any consent required under this section shall be obtained from the patient, or the patient's legal guardian, conservator or other authorized representative, as applicable.</p> <p>(f) The provision of telehealth services and health records maintained and disclosed as part of a telehealth interaction shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 P.L. 104-191, as amended from time to time.</p> <p>(g) Nothing in this section shall prohibit:</p> <ol style="list-style-type: none"> (1) A health care provider from providing on-call coverage pursuant to an agreement with another health care provider or such health care provider's professional entity or employer; (2) a health care provider from consulting with another health care provider concerning a patient's care; (3) orders of health care providers for hospital outpatients or inpatients; or (4) the use of telehealth for a hospital inpatient, including for the purpose of ordering any medication or treatment for such patient in accordance with Ryan Haight Online Pharmacy Consumer Protection Act, 21 USC 829(e), as amended from time to time. For purposes of this subsection, "health care provider" means a person or entity licensed or certified pursuant to chapter 370, 372, 373, 375, 376 to 376b, inclusive, 378, 379, 380, 381a, 383 to 383c, inclusive, 384b, 397a, 399 or 400j, or licensed or certified pursuant to chapter 368d or 384d. <p>(h) No telehealth provider shall charge a facility fee for telehealth services.</p>	
Delaware	<p>Statute: Title 24, Chapter 20, Subchapter 1, §2002 Definitions.</p> <p>As used in this chapter:</p> <p>(3) "Distant site" means a site at which a health-care provider legally allowed to practice in this State is located while providing health-care services by means of telemedicine or telehealth.</p> <p>(9) a. "Occupational therapy services" includes any of the following:</p> <ol style="list-style-type: none"> 1. The assessment, treatment, and education of or consultation with an individual, family, or other persons. 2. Interventions directed toward developing, improving, or restoring daily living skills, work readiness or work performance, play skills, or leisure capacities, or enhancing educational performance skills. 3. Providing for the development, improvement, or restoration of sensorimotor, oral-motor, perceptual or neuromuscular functioning, or emotional, motivational, cognitive, or psychosocial components of performance. 	<p>COVID-19 update: Department of Insurance issued guidance allowing licensed out-of-state health care providers to provide services via telehealth without obtaining a DE license.</p>

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	<p>b. "Occupational therapy services" or "practice of occupational therapy" may require assessment of the need for use of interventions such as the design, development, adaptation, application, or training in the use of assistive technology devices; the design, fabrication, or application of rehabilitative technology such as selected orthotic devices; training in the use of assistive technology, orthotic or prosthetic devices; the application of thermal agent modalities, including paraffin, hot and cold packs, and fluído therapy, as an adjunct to, or in preparation for, purposeful activity; the use of ergonomic principles; the adaptation of environments and processes to enhance functional performance; or the promotion of health and wellness.</p> <p>c. "Occupational therapy services" or "practice of occupational therapy" may be provided through the use of telemedicine in a manner deemed appropriate by regulation and may include participation in telehealth as further defined in regulation.</p> <p>(10) "Originating site" means a site in Delaware at which a patient is located at the time health-care services are provided to the patient by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.</p> <p>(13) "Store and forward transfer" means the transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present or that the transmission be in real time.</p> <p>(16) "Telehealth" means the use of information and communications technologies consisting of telephones, remote patient monitoring devices, or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulation.</p> <p>(17) "Telemedicine" means a form of telehealth which is the delivery of clinical health-care services by means of real time 2-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a licensee practicing within the licensee's scope of practice as would be practiced in-person with a patient and with other restrictions as defined in regulation.</p> <p>Regulation: Delaware Administrative Code Title 24, Regulation 2000, 4.0 Telehealth</p> <p>4.1 Telehealth is the use of electronic communications to provide and deliver a host of health-related information and health-care services including occupational therapy services as defined in 24 Del.C. §2002.</p> <p>4.2 The Occupational Therapist and Occupational Therapist Assistant (referred to as "licensee" for the purpose of this regulation) who provides treatment through telehealth shall meet the following requirements:</p> <p>4.2.1 Location of patient during treatment through telehealth</p>	

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	<p>4.2.1.1 An occupational therapy practitioner is required to be licensed in Delaware if the practitioner provides occupational therapy services to a client who is in Delaware.</p> <p>4.2.2 Informed consent</p> <p>4.2.2.1 Before services are provided through telehealth, the licensee shall obtain written, informed consent from the patient, or other appropriate person with authority to make health care treatment decisions for the patient.</p> <p>4.2.2.1.1 The use of electronic communications in the provision of care;</p> <p>4.2.2.1.2 The potential breach of confidentiality, or inadvertent access, of protected health information using electronic communication in the provision of care; and</p> <p>4.2.3 Confidentiality: The licensee shall ensure that the electronic communication is secure to maintain confidentiality of the patient's medical information as required by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable Federal and State laws. Confidentiality shall be maintained through appropriate processes, practices and technology, including disposal of electronic equipment and data.</p> <p>4.2.4 Competence and scope of practice</p> <p>4.2.4.1 The licensee shall be responsible for determining and documenting that telehealth is an appropriate level of care for the patient.</p> <p>4.2.4.2 The licensee shall comply with the Board's law and rules and regulations and all current standards of care requirements applicable to onsite care.</p> <p>4.2.4.3 The licensee shall limit the practice of telehealth to the area of competence in which proficiency has been gained through education, training and experience.</p> <p>4.2.4.4 The occupational therapist who screens, evaluates, writes or implements the plan of care is responsible for determining the need for the physical presence of an occupational therapy practitioner during any interactions with clients.</p> <p>4.2.4.5 Subject to the supervision requirements of Board subsection 1.2, the occupational therapist will determine the amount and level of supervision needed during telehealth.</p> <p>4.2.4.6 The licensee shall document in the file or record which services were provided by telehealth.</p>	
District of Columbia		<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Guidance issued by the mayor states that health care providers may use telehealth to treat patients located in DC, provided telehealth services are delivered in a manner consistent with standards of care. Licensed out-of-state health care providers must obtain a DC license to provide telehealth services to a client</p>

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		located in DC; time limited Medicaid state plan amendment in effect during the Public Health Emergency allowing therapeutic services to be provided through electronic modalities or the telephone, among other flexibilities
Florida	<p>Statute: Florida Statutes 456.47 Use of telehealth to provide services.</p> <p>(1) DEFINITIONS.—As used in this section, the term:</p> <p>(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.</p> <p>(b) "Telehealth provider" means any individual who provides health care and related services using telehealth and who is licensed or certified under s. 393.17; part III of chapter 401; chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; part II or part III of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; who is licensed under a multi-state health care licensure compact of which Florida is a member state; or who is registered under and complies with subsection (4).</p> <p>(2) PRACTICE STANDARDS.—</p> <p>(a) A telehealth provider has the duty to practice in a manner consistent with his or her scope of practice and the prevailing professional standard of practice for a health care professional who provides in-person health care services to patients in this state.</p> <p>(b) A telehealth provider may use telehealth to perform a patient evaluation. If a telehealth provider conducts a patient evaluation sufficient to diagnose and treat the patient, the telehealth provider is not required to research a patient's medical history or conduct a physical examination of the patient before using telehealth to provide health care services to the patient.</p> <p>(c) A telehealth provider may not use telehealth to prescribe a controlled substance unless the controlled substance is prescribed for the following:</p> <ol style="list-style-type: none"> 1. The treatment of a psychiatric disorder; 2. Inpatient treatment at a hospital licensed under chapter 395; 3. The treatment of a patient receiving hospice services as defined in s. 400.601; or 4. The treatment of a resident of a nursing home facility as defined in s. 400.021. <p>(d) A telehealth provider and a patient may be in separate locations when telehealth is used to provide health care services to a patient.</p> <p>(e) A nonphysician telehealth provider using telehealth and acting within his or her relevant scope of practice, as established by Florida law or rule, is not in violation of s. 458.327(1)(a) or s. 459.013(1)(a).</p>	<p>No OT specific statute or regulation regarding telehealth, but statute does use a definition of telehealth provider that includes occupational therapists. Board reports that licensees in the state with a question about telehealth should contact the Board.</p> <p>COVID-19 update: Department of Health issued order authorizing licensed out-of-state health care providers, including OTs and OTAs, to provide services to Florida residents via telehealth; Medicaid has expanded telehealth services to include therapy services and Early Intervention services.</p>

State	Citation and Provisions ¹	Notes
	<p>(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standard as used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing such services, are confidential pursuant to ss. 395.3025(4) and 100 456.057.</p> <p>(4) REGISTRATION OF OUT-OF-STATE TELEHEALTH PROVIDERS.—</p> <p>(a) A health care professional not licensed in this state may provide health care services to a patient located in this state using telehealth if the health care professional registers with the applicable board, or the department if there is a board, and provides health care services within the applicable scope of practice established by Florida law or rule.</p> <p>(b) The board, or the department if there is no board, shall register a health care professional not licensed in this state as a telehealth provider if the health care professional:</p> <ol style="list-style-type: none"> 1. Completes an application in the format prescribed by the department; 2. Is licensed with an active, unencumbered license that is issued by another state, the District of Columbia, or a possession or territory of the United States and that is substantially similar to a license issued to a Florida-licensed provider specified in paragraph (1)(b); 3. Has not been the subject of disciplinary action relating to his or her license during the 5-year period immediately prior to the submission of the application; 4. Designates a duly appointed registered agent for service of process in this state on a form prescribed by the department; and 5. Demonstrates to the board, or the department if there is no board, that he or she is in compliance with paragraph (e). The department shall use the National Practitioner Data Bank to verify the information submitted under this paragraph, as applicable. <p>(c) The website of a telehealth provider registered under paragraph (b) must prominently display a hyperlink to the department's website containing information required under paragraph (h).</p> <p>(d) A health care professional may not register under this subsection if his or her license to provide health care services is subject to a pending disciplinary investigation or action, or has been revoked in any state or jurisdiction. A health care professional registered under this subsection must notify the appropriate board, or the department if there is no board, of restrictions placed on his or her license to practice, or any disciplinary action taken or pending against him or her, in any state or jurisdiction. The notification must be provided within 5 business days after the restriction is placed or disciplinary action is initiated or taken.</p> <p>(e) A provider registered under this subsection shall maintain professional liability coverage or financial responsibility, that includes coverage or financial responsibility for telehealth services provided to patients not located in the provider's home state, in an amount equal to or greater than the requirements for a licensed practitioner under s. 456.048, s. 458.320, or s. 459.0085, as applicable.</p> <p>(f) A health care professional registered under this subsection may not open an office in this state and may not provide in-person health care services to patients located in this state.</p>	

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	<p>(g) A pharmacist registered under this subsection may only use a pharmacy permitted under chapter 465, a nonresident pharmacy registered under s. 465.0156, or a nonresident pharmacy or outsourcing facility holding an active permit pursuant to s. 465.0158 to dispense medicinal drugs to patients located in this state.</p> <p>(h) The department shall publish on its website a list of all registrants and include, to the extent applicable, each registrant's:</p> <ol style="list-style-type: none"> 1. Name. 2. Health care occupation. 3. Completed health care training and education, including completion dates and any certificates or degrees obtained. 4. Out-of-state health care license with the license number. 5. Florida telehealth provider registration number. 6. Specialty. 7. Board certification. 8. Five-year disciplinary history, including sanctions and board actions. 9. Medical malpractice insurance provider and policy limits, including whether the policy covers claims that arise in this state. 10. The name and address of the registered agent designated for service of process in this state. <p>(i) The board, or the department if there is no board, may take disciplinary action against an out-of-state telehealth provider registered under this subsection if the registrant:</p> <ol style="list-style-type: none"> 1. Fails to notify the applicable board, or the department if there is no board, of any adverse actions taken against his or her license as required under paragraph (d). 2. Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction. 3. Violates any of the requirements of this section. 4. Commits any act that constitutes grounds for disciplinary action under s. 456.072(1) or the applicable practice act for Florida-licensed providers. Disciplinary action taken by a board, or the department if there is no board, under this paragraph may include suspension or revocation of the provider's registration or the issuance of a reprimand or letter of concern. A suspension may be accompanied by a corrective action plan as determined by the board, or the department if there is no board, the completion of which may lead to the suspended registration being reinstated according to rules adopted by the board, or the department if there is no board. <p>(5) VENUE.—For the purposes of this section, any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed or in the patient's county of residence. Venue for a civil or administrative action initiated by the department, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider may be located in the patient's county of residence or in Leon County.</p>	

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	<p>(6) EXEMPTIONS.—A health care professional who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another state or jurisdiction, and who provides health care services using telehealth to a patient located in this state, is not subject to the registration requirement under this section if the services are provided:</p> <p style="padding-left: 40px;">(a) In response to an emergency medical condition as defined in s. 395.002; or</p> <p style="padding-left: 40px;">(b) In consultation with a health care professional licensed in this state who has ultimate authority over the diagnosis and care of the patient.</p> <p>(7) RULEMAKING.—The applicable board, or the department if there is no board, may adopt rules to administer this section.</p> <p>Board statement: The use of telehealth technology by Florida licensed healthcare practitioners for the purpose of providing patient care within the state of Florida is not precluded by Florida law. Telehealth technologies may be employed for patient care as long as such technologies are used in a manner that is consistent with the standard of care. (published July 18, 2017)</p>	
Georgia	<p>Statute: Georgia Statutes §43-28-3, Definitions As used in this chapter, the term:</p> <p>(13) "Telehealth" means the application of evaluative, consultative, preventative, and therapeutic services delivered through telecommunication and information technologies by licensed occupational therapy practitioners. This may include, but shall not be limited to, telemedicine, tele practice, telecare, telerehabilitation, and e-health services.</p>	<p>COVID-19 update: Medicaid issued guidance stating that OTs are qualified providers permitted to furnish Medicaid-reimbursed telehealth services during the declared public health emergency.</p>
Hawaii		<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: OT services may be provided via telephonic means and billed to Medicaid; OTs may bill Medicaid for services provided via telehealth.</p>
Idaho	<p>Statute: Idaho Statutes Title 54, Chapter 57 Idaho Telehealth Access Act 54-5703. DEFINITIONS. As used in this chapter:</p> <p>(1) "Asynchronous store and forward transfer" means the transmission of a patient's health care information from an originating site to a provider at a distant site over a secure connection that complies with state and federal security and privacy laws.</p> <p>(2) "Distant site" means the site at which a provider delivering telehealth services is located at the time the service is provided.</p> <p>(3) "Originating site" means the location of a patient at the time telehealth services are provided.</p> <p>(4) "Provider" means a person who is licensed, required to be licensed, or, if located outside of Idaho, would be required to be licensed if located in Idaho, pursuant to title 54, Idaho Code, to deliver health care consistent with his or her license.</p>	<p>No OT specific statute or regulation regarding telehealth, but statute uses a definition of provider that includes occupational therapists.</p> <p>COVID-19 update: Medicaid allows for OTs and OTAs to provide and bill for services provided via telehealth; Governor's Executive Order requiring all temporary waivers of statutes and regulations made during the</p>

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	<p>(5) "Synchronous interaction" means real-time communication through interactive technology that enables a provider and a patient at two (2) locations separated by distance to interact simultaneously through two-way video and audio or audio transmission.</p> <p>(6) "Telehealth services" means health care services provided by a provider to a person through the use of electronic communications, information technology, asynchronous store and forward transfer or synchronous interaction between a provider at a distant site and a patient at an originating site. Such services include, but are not limited to, clinical care, health education, home health and facilitation of self-managed care and caregiver support.</p> <p>54-5704. SCOPE OF PRACTICE. A provider offering telehealth services must at all times act within the scope of the provider's license and according to all applicable laws and rules, including, but not limited to, this chapter and the community standard of care.</p> <p>54-5705. PROVIDER-PATIENT RELATIONSHIP. (1) If a provider offering telehealth services in his or her practice does not have an established provider-patient relationship with a person seeking such services, the provider shall take appropriate steps to establish a provider-patient relationship by use of two-way audio and visual interaction; provided however, that the applicable Idaho community standard of care must be satisfied. Nothing in this section shall prohibit electronic communications:</p> <ul style="list-style-type: none"> (a) Between a provider and a patient with a preexisting provider-patient relationship; (b) Between a provider and another provider concerning a patient with whom the other provider has a provider-patient relationship; (c) Between a provider and a patient where the provider is taking call on behalf of another provider in the same community who has a provider-patient relationship with the patient; or (d) In an emergency. <p>(2) As used in this section, "emergency" means a situation in which there is an occurrence that poses an imminent threat of a life-threatening condition or severe bodily harm.</p> <p><u>Regulation:</u> Idaho Administrative Code 24.06.01, Rule .042 STANDARDS OF PRACTICE FOR TELEHEALTH</p> <p>01. In making the determination whether an in-person evaluation or intervention are necessary, an occupational therapist shall consider at a minimum:</p> <ul style="list-style-type: none"> a. The complexity of the client's condition; b. His or her own knowledge, skills and abilities; c. The client's context and environment; d. The nature and complexity of the intervention; e. The pragmatic requirements of the practice setting; and f. The capacity and quality of the technological interface. <p>02. Supervision of Occupational Therapy Assistant under 24.06.01.011 for routine and general supervision,</p>	<p>emergency, including any telehealth waivers, to be made permanent.</p>

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	<p>can be done through telehealth, but cannot be done when direct or direct line-of-sight is determined by the supervising occupational therapist. The same considerations in (1)(a) through (f) must be considered in determining whether telehealth should be used.</p>	
Illinois	<p>Statute: 225 ILCS 75/2, Sec. 2 Definitions. In this Act: (6) "Occupational therapy" means the therapeutic use of purposeful and meaningful occupations or goal-directed activities to evaluate and provide interventions for individuals, groups, and populations who have a disease or disorder, an impairment, an activity limitation, or a participation restriction that interferes with their ability to function independently in their daily life roles, including activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Occupational therapy services are provided for the purpose of habilitation, rehabilitation, and to promote health and wellness. Occupational therapy may be provided via technology or telecommunication methods, also known as telehealth, however the standard of care shall be the same whether a patient is seen in person, through telehealth, or other method of electronically enabled health care. Occupational therapy practice may include any of the following: (a) remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes; (b) modification or adaptation of task, process, or the environment or the teaching of compensatory techniques in order to enhance performance; (c) disability prevention methods and techniques that facilitate the development or safe application of performance skills; and (d) health and wellness promotion strategies, including self-management strategies, and practices that enhance performance abilities.</p> <p>The licensed occupational therapist or licensed occupational therapy assistant may assume a variety of roles in his or her career including, but not limited to, practitioner, supervisor of professional students and volunteers, researcher, scholar, consultant, administrator, faculty, clinical instructor, fieldwork educator, and educator of consumers, peers, and family.</p>	<p>COVID-19 update: Governor's Executive Order requires insurance issuers regulated by the Dept. of Insurance to cover all telehealth services rendered by in-network providers, including OTs and OTAs; Governor extended this Order until July 26.</p>
Indiana		<p>Board reports there is no statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Governor's Executive Order authorizes OTs, not OTAs, to practice via telemedicine.</p>
Iowa	<p>Regulation: Iowa Administrative Code Title 645, Chapter 208, Section 3 Telehealth visits. A licensee may provide occupational therapy services to a patient utilizing a telehealth visit if the occupational therapy services are provided in accordance with all requirements of this chapter.</p> <p>208.3(1) "Telehealth visit" means the provision of occupational therapy services by a licensee to a patient using technology where the licensee and the patient are not at the same physical location for the occupational therapy session.</p>	<p>COVID-19 update: Governor's Executive Orders temporarily suspending regulatory requirements to the extent that they exclude from the definition of telehealth the provision of services through audio-only telephone transmission and requiring the</p>

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	<p>208.3(2) A licensee engaged in a telehealth visit shall utilize technology that is secure and HIPAA-compliant and that includes, at a minimum, audio and video equipment that allows two-way real-time interactive communication between the licensee and the patient. A licensee may use non-real-time technologies to prepare for an occupational therapy session or to communicate with a patient between occupational therapy sessions.</p> <p>208.3(3) A licensee engaged in a telehealth visit shall be held to the same standard of care as a licensee who provides in-person occupational therapy. A licensee shall not utilize a telehealth visit if the standard of care for the particular occupational therapy services cannot be met using technology.</p> <p>208.3(4) Any occupational therapist or occupational therapist assistant who provides an occupational therapy telehealth visit to a patient located in Iowa shall be licensed in Iowa.</p> <p>208.3(5) Prior to the first telehealth visit, a licensee shall obtain informed consent from the patient specific to the occupational therapy services that will be provided in a telehealth visit. At a minimum, the informed consent shall specifically inform the patient of the following:</p> <ul style="list-style-type: none"> a. The risks and limitations of the use of technology to provide occupational therapy services; b. The potential for unauthorized access to protected health information; and c. The potential for disruption of technology during a telehealth visit. <p>208.3(6) A licensee shall only provide occupational therapy services using a telehealth visit in the areas of competence wherein proficiency in providing the particular service using technology has been gained through education, training, and experience.</p> <p>208.3(7) A licensee shall identify in the clinical record when occupational therapy services are provided utilizing a telehealth visit.</p>	<p>Insurance Commissioner to ensure that health carriers reimburse a health care provider for medically necessary, clinically appropriate telehealth services provided to a covered person on the same basis and at the same rate as if the services were rendered in person and temporarily suspending regulatory provisions to the extent that they require an out-of-state licensed OT or OTA to be licensed in Iowa to provide services by telephone or other electronic means to individuals in Iowa. OTs may bill Medicaid for telehealth services.</p>
Kansas	<p>Statute: Kansas Statutes Chapter 40, Article 2, Insurance General Provisions 40-2,211</p> <p>(a) For purposes of Kansas telemedicine act:</p> <ul style="list-style-type: none"> (1) "Distant site" means a site at which a healthcare provider is located while providing healthcare services by means of telemedicine. (2) "Healthcare provider" means a physician, licensed physician assistant, licensed advanced practice registered nurse or person licensed, registered, certified or otherwise authorized to practice by the behavioral sciences regulatory board. (3) "Originating site" means a site at which a patient is located at the time healthcare services are provided by means of telemedicine. (4) "Physician" means a person licensed to practice medicine and surgery by the state board of healing arts. 	<p>No regulations specific to OT and telehealth. Board reports that it permits the remote delivery of healthcare services, but must follow same practice as when providing in-person OT services.</p> <p>COVID-19 update: Department of Insurance advises providers to verify with individual insurers that services delivered via telehealth are covered.</p>

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	<p>(5) "Telemedicine," including "telehealth," means the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. Telemedicine shall be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a patient's healthcare. "Telemedicine" does not include communication between:</p> <ul style="list-style-type: none"> (A) Healthcare providers that consist solely of a telephone voice-only conversation, email or facsimile transmission; or (B) a physician and a patient that consists solely of an email or facsimile transmission. <p>40-2,212</p> <p>(a) The same requirements for patient privacy and confidentiality under the health insurance portability and accountability act of 1996 and 42 C.F.R. § 2.13, as applicable, that apply to healthcare services delivered via in-person contact shall also apply to healthcare services delivered via telemedicine. Nothing in this section shall supersede the provisions of any state law relating to the confidentiality, privacy, security or privileged status of protected health information.</p> <p>(b) Telemedicine may be used to establish a valid provider-patient relationship.</p> <p>(c) The same standards of practice and conduct that apply to healthcare services delivered via in-person contact shall also apply to healthcare services delivered via telemedicine.</p> <p>(d) (1) A person authorized by law to provide and who provides telemedicine services to a patient shall provide the patient with guidance on appropriate follow-up care.</p> <p>(2) (A) Except when otherwise prohibited by any other provision of law, when the patient consents and the patient has a primary care or other treating physician, the person providing telemedicine services shall send within three business days a report to such primary care or other treating physician of the treatment and services rendered to the patient in the telemedicine encounter.</p> <p>(B) A person licensed, registered, certified or otherwise authorized to practice by the behavioral sciences regulatory board shall not be required to comply with the provisions of subparagraph (A).</p> <p>40-2,213</p> <p>(a) The provisions of this section shall apply to any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides coverage for accident and health services and that is delivered, issued for delivery, amended or renewed on or after January 1, 2019. The provisions of this section shall also apply to the Kansas medical assistance program.</p> <p>(b) No individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society, health maintenance organization or the Kansas medical assistance program shall exclude an otherwise covered</p>	

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	<p>healthcare service from coverage solely because such service is provided through telemedicine, rather than in-person contact, or based upon the lack of a commercial office for the practice of medicine, when such service is delivered by a healthcare provider.</p> <p>(c) The insured's medical record shall serve to satisfy all documentation for the reimbursement of all telemedicine healthcare services, and no additional documentation outside of the medical record shall be required.</p> <p>(d) Payment or reimbursement of covered healthcare services delivered through telemedicine may be established by an insurance company, nonprofit health service corporation, nonprofit medical and hospital service corporation or health maintenance organization in the same manner as payment or reimbursement for covered services that are delivered via in-person contact are [is] established.</p> <p>(e) Nothing in this section shall be construed to:</p> <ol style="list-style-type: none"> (1) Prohibit an individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides coverage for telemedicine or the Kansas medical assistance program from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered individual's health benefits plan; (2) mandate coverage for a healthcare service delivered via telemedicine if such healthcare service is not already a covered healthcare service, when delivered by a healthcare provider subject to the terms and conditions of the covered individual's health benefits plan; or (3) allow an individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization that provides coverage for telemedicine or the Kansas medical assistance program to require a covered individual to use telemedicine or in lieu of receiving an in-person healthcare service or consultation from an in-network provider. <p>(f) The provisions of K.S.A. 40-2248 and 40-2249a, and amendments thereto, shall not apply to this section.</p> <p>40-2,215 Nothing in the Kansas telemedicine act shall be construed to authorize the delivery of any abortion procedure via telemedicine.</p> <p>40-2,216 If any provision of the Kansas telemedicine act, or the application thereof to any person or circumstance, is held invalid or unconstitutional by court order, then the remainder of the Kansas telemedicine act and the application of such provision to other persons or circumstances shall not be affected thereby and it shall be conclusively presumed that the legislature would have enacted the remainder of the Kansas telemedicine act without such invalid or unconstitutional provision, except that the provisions of K.S.A. 2018 Supp. 40-2,215, and amendments thereto, are expressly declared to be nonseverable.</p>	

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	<p>Regulation: Kansas Administrative Rules Title 100, Article 77 K.A.R. 100-77-2. Telemedicine deemed rendered at location of patient. For the purposes of this article of the board's regulations, the delivery of healthcare services shall be deemed to occur at the originating site.</p> <p>K.A.R. 100-77-3. Prescribing drugs by means of telemedicine. The same laws and regulations that apply to a healthcare provider prescribing drugs, including controlled substances, by means of in-person contact with a patient shall apply to prescribing drugs, including controlled substances, by means of telemedicine.</p>	
Kentucky	<p>Statute: Kentucky Revised Statutes 319A.300, Duty of treating occupational therapist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth".</p> <p>(1) A treating occupational therapist who provides or facilitates the use of telehealth shall ensure:</p> <ul style="list-style-type: none"> (a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and (b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law. <p>(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:</p> <ul style="list-style-type: none"> (a) Prevent abuse and fraud through the use of telehealth services; (b) Prevent fee-splitting through the use of telehealth services; and (c) Utilize telehealth in the provision of occupational therapy services and in the provision of continuing education. <p>(3) For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.</p> <p>Regulation: Kentucky Administrative Regulations 201 KAR 28:235 Section 1. Definitions.</p> <ul style="list-style-type: none"> (1) "Client" means the person receiving the services of the occupational therapist. (2) "Telehealth is defined by KRS 319A.300(3). (3) "Telehealth occupational therapy" means the practice of occupational therapy as defined by KRS 319A.010(2), between the occupational therapist or occupational therapist assistant and the patient that is provided using: <ul style="list-style-type: none"> (a) An electronic communication technology; or (b) Two (2) way, interactive, simultaneous audio and video. <p>Section 2. Client Requirements. A credential holder using telehealth to deliver occupational therapy</p>	<p>COVID-19 update: Licensing board has issued guidance authorizing the use of telehealth by OTs and OTAs and regarding SB 150 which allows for a licensed out-of-state health care provider to register with the appropriate Kentucky board to provide services remotely to a patient with whom the health care provider has established a patient-provider relationship. Medicaid will cover telehealth OT services under certain circumstances. Department of Insurance bulletin prohibits a private insurer from requiring a health care provider to have an existing patient-provider relationship before providing services with telehealth.</p>

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	<p>services shall, upon initial contact with the client:</p> <ol style="list-style-type: none"> (1) Make attempts to verify the identity of the client; (2) Obtain alternative means of contacting the client other than electronically such as by the use of a telephone number or mailing address; (3) Provide to the client alternative means of contacting the credential holder other than electronically such as by the use of a telephone number or mailing address; (4) Provide contact methods of alternative communication the credential holder shall use for emergency purposes such as an emergency on call telephone number; (5) Document if the client has the necessary knowledge and skills to benefit from the type of telehealth provided by the credential holder; (6) Use secure communications with clients, including encrypted text messages via e-mail or secure Web sites, and not use personal identifying information in non-secure communications and; (7) Inform the client in writing about: <ol style="list-style-type: none"> (a) The limitations of using technology in the provision of telehealth occupational therapy services; (b) Potential risks to confidentiality of information, or inadvertent access of protected health information, due to technology in the provision of telehealth occupational therapy services; (c) Potential risks of disruption in the use of telehealth occupational therapy services; (d) When and how the credential holder will respond to routine electronic messages; (e) In what circumstances the credential holder will use alternative communications for emergency purposes; (f) Who else may have access to client communications with the credential holder; (g) How communications can be directed to a specific credential holder; (h) How the credential holder stores electronic communications from the client; and (i) How the credential holder may elect to discontinue the provision of services through telehealth. <p>Section 3. Competence, Limits on Practice, Maintenance, and Retention of Records. A credential holder using telehealth to deliver occupational therapy services or who practices telehealth occupational therapy shall:</p> <ol style="list-style-type: none"> (1) Limit the practice of telehealth occupational therapy to the area of competence in which proficiency has been gained through education, training, and experience; (2) Maintain current competency in the practice of telehealth occupational therapy through continuing education, consultation, or other procedures, in conformance with current standards of scientific and professional knowledge; (3) Document the client's presenting problem, purpose, or diagnosis; (4) Follow the record-keeping requirements of 201 KAR 28:140; and (5) Ensure that confidential communications obtained and stored electronically shall not be recovered and accessed by unauthorized persons when the credential holder disposes of electronic equipment and data. 	

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	<p>Section 4. Compliance with Federal, State, and Local Law. A credential holder using telehealth to deliver occupational therapy services or who practices telehealth occupational therapy shall comply with:</p> <ul style="list-style-type: none"> (1) State law where the credential holder is credentialed and be licensed to practice occupational therapy where the client is domiciled or adhere to standards set forth in 201 KAR 28:030; and (2) Section 508 of the Rehabilitation Act, 29 U.S.C. 794(d), to make technology accessible to a client with disabilities. <p>Section 5. Representation of Services and Code of Conduct.</p> <ul style="list-style-type: none"> (1) A credential holder using telehealth to deliver occupational therapy services or who practices telehealth occupational therapy shall: <ul style="list-style-type: none"> (a) Not by or on behalf of the credential holder engage in false, misleading, or deceptive advertising of telehealth occupational therapy; (b) Comply with 201 KAR 28:140; and (c) Not allow fee-splitting through the use of telehealth occupational therapy services. (2) Occupational therapy continuing competence educational processes established in 201 KAR 28:200, Section 3(1), (2), (3), (5), (8), and (11), may occur through telehealth services. 	
Louisiana	<p>Statute: Title 40, Chapter 5-D Subchapter D, Part VII, §122 Louisiana Telehealth Access Act §1223.3. Definitions</p> <ul style="list-style-type: none"> (1) "Asynchronous store and forward transfer" means the transmission of a patient's medical information from an originating site to the provider at the distant site without the patient being present. (2) "Distant site" means the site at which the healthcare provider delivering the service is located at the time the service is provided via a telecommunications system. (3) "Healthcare provider" means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide healthcare or professional services as a physician assistant, hospital, nursing home, dentist, registered nurse, advanced practice registered nurse, licensed dietitian or nutritionist, licensed practical nurse, certified nurse assistant, offshore health service provider, ambulance service, licensed midwife, pharmacist, speech-language pathologist, audiologist, optometrist, podiatrist, chiropractor, physical therapist, occupational therapist, certified or licensed athletic trainer, psychologist, medical psychologist, social worker, licensed professional counselor, licensed perfusionist, licensed respiratory therapist, licensed radiologic technologist, or licensed clinical laboratory scientist. (4) "Originating site" means the location of the patient at the time the service is furnished via a telecommunications system or when the asynchronous store and forward transfer occurs. (5) "Synchronous interaction" means communication through interactive technology that enables a healthcare provider and a patient at two locations separated by distance to interact via two-way video and audio transmissions simultaneously. The healthcare provider may utilize interactive audio without the requirement of video if, after access and review of the patient's medical records, the provider determines that he is able to meet the same standard of care as if the healthcare services were provided in person. 	<p>No OT specific statute or regulation regarding telehealth, but a telehealth specific statute uses a definition of healthcare provider that includes occupational therapists. AOTA staff has reached out to the Board for clarification on potential updates to statutes, regulations, or policy statements.</p> <p>COVID-19 update: Board of Medical Examiners has authorized OTs and OTAs to provide services via telehealth. Medicaid encourages the use of telehealth and issued an emergency rule authorizing temporary coverage of services provided via interactive telecommunications system without video if such is determined to be necessary to ensure services meet the needs of the client. Emergency rule requires private insurers to waive requirements for existing patient-</p>

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	<p>(6) "Telehealth" means a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from healthcare providers. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.</p> <p>§1223.4. Telehealth; rulemaking required</p> <p>A. Each state agency or professional or occupational licensing board or commission that regulates the practice of a healthcare provider, as defined in this Part, may promulgate, in accordance with the Administrative Procedure Act, any rules necessary to provide for, promote, and regulate the use of telehealth in the delivery of healthcare services within the scope of practice regulated by the licensing entity. However, any rules and regulations shall be consistent with and no more restrictive than the provisions contained in this Section.</p> <p>B. The rules shall, at a minimum, provide for all of the following:</p> <ol style="list-style-type: none"> (1) Application of all laws regarding the confidentiality of healthcare information and the patient's rights to the patient's medical information created during telehealth interactions. (2) Application of the same standard of care by a healthcare provider as if the healthcare services were provided in person. (3) <ol style="list-style-type: none"> (a) Licensing or registration of out-of-state healthcare providers who seek to furnish healthcare services via telehealth to persons at originating sites in Louisiana. The rules shall ensure that any such healthcare provider possesses, at a minimum, an unrestricted and unencumbered license in good standing to perform the healthcare service in the state in which the healthcare provider is located, and that the license is comparable to its corresponding license in Louisiana as determined by the respective Louisiana licensing agency, board, or commission. (b) Each state agency and professional or occupational licensing board or commission is authorized to provide by rule for a reasonable fee for the license or registration provided for in this Subsection. (4) Exemption from the telehealth license or registration required by this Subsection for the consultation of a healthcare professional licensed by this state with an out-of-state peer professional. <p>C. Nothing in this Part shall be construed to authorize a state agency or professional or occupational licensing board or commission to expand, diminish, or alter the scope of practice of any healthcare provider.</p>	<p>practitioner relationships and restrictions on audio-only and personal devices, and requires telehealth to be covered on the same basis as in-person. Governor's Executive Order authorizing licensing boards to promulgate emergency rules to allow for the provision of services via telehealth extended until July 24.</p>
Maine		<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Governor's Executive Order allows OTs and OTAs</p>

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		to provide services using all modes of telehealth; MaineCare providers are encouraged to use telehealth where medically appropriate; private insurers are required to reimburse telehealth services at the same rate as in-person services.
Maryland	<p>Board Statement: POSITION STATEMENT -- TELEHEALTH OT AND OTA AUTHORITY TO USE As defined by the American Occupational Therapy Association (AOTA), Telehealth Position Paper (Revised 2013): AOTA defines telehealth as the application of evaluative, consultative, preventative, and therapeutic services delivered through telecommunication and information technologies. Telehealth services can be synchronous, delivered through interactive technologies in real time, asynchronous, using store-and-forward technologies. Occupational therapy practitioners can use telehealth as a mechanism to provide services at a location that is physically distant from the client, thus allowing for services to occur where the client lives, works, and plays, if that is needed or desired (AOTA 2010a).</p> <p>Occupational therapy practitioners are using telehealth as a service delivery model to assist clients to develop skills, incorporate assistive technology and adaptive techniques, modify work, home, or school environments, and create health-promoting habits and routines. Potential benefits of telehealth as a service delivery model within occupational therapy include increased accessibility of services to clients who live in remote or underserved areas, improved access to providers and specialists otherwise unavailable to clients, prevention of unnecessary delays in receiving care and decreased isolation for practitioners through distance learning, consultation and research among others.</p> <p>In general, the use of telehealth technologies to conduct evaluations depends on real-time two-way or multipoint observation, communication, and interaction between the practitioner and the client.</p> <p>Clinical reasoning guides the selection and application of appropriate telehealth technologies necessary to evaluate client needs and environmental factors. Reliability of telehealth technologies for providing safe and effective occupational therapy services is one important factor when deciding to use a telehealth service delivery model for assessing the client's ability to engage in specific occupations and activities and for administering specific assessments. In addition, occupational therapy practitioners should consider reliability of the particular assessment when considering using it to conduct an evaluation remotely using telehealth technologies.</p> <p>The Maryland Board of Occupational Therapy has experienced an increase in the number of questions from practitioners on whether the Maryland Board of Occupational Therapy Practice permits the use of telehealth.</p>	<p>Board cites AOTA position paper.</p> <p>COVID-19 update: Governor signed HB 1663/SB1080 which authorizes the Governor for the duration of the COVID-19 State of Emergency to establish or waive telehealth protocols, including authorizing health care professionals licensed out-of-state to provide telehealth to patients in Maryland and to order the Department of Health to reimburse synchronous and asynchronous telehealth services provided to a patient without regard to whether the patient is at a clinical site under certain circumstances.</p>

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	<p>The intent of this position statement is to acknowledge the “intra-State” use of telehealth by Maryland licensees practicing occupational therapy within the State of Maryland and to clarify that:</p> <p>(1) Occupational therapy personnel must hold a valid Maryland license prior to providing occupational therapy services via telehealth to clients physically located in Maryland; and,</p> <p>(2) The practice of occupational therapy, via telehealth or otherwise, in the State of Maryland must be in accordance with the Annotated Code of Maryland, Health Occupations Article, Title 10, and The Code of Maryland Regulations (COMAR), 10.46.01 – 10.46.07.</p>	
Massachusetts		<p>No statute or regulations specific to OT and telehealth. AOTA staff has reached out to the Board for clarification on potential updates to statutes, regulations, or policy statements.</p> <p>COVID-19 update: Governor’s Executive Order requires private insurers to cover clinically appropriate, medically necessary services delivered via telehealth by in-network providers; MassHealth issued a bulletin stating that medically necessary, MassHealth covered services delivered by enrolled providers to enrollees will be covered.</p>
Michigan	<p>Statute: Michigan Compiled Laws, Public Health Code Sections 333.16283 – 16288 333.16283 Definitions. As used in this section and sections 16284 to 16288:</p> <p>(a) "Health professional" means an individual who is engaging in the practice of a health profession.</p> <p>(b) "Prescriber" means that term as defined in section 17708.</p> <p>(c) "Telehealth" means the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration. Telehealth may include, but is not limited to, telemedicine. As used in this subdivision, "telemedicine" means that term as defined in section 3476 of the insurance code of 1956, 1956 PA 218, MCL 500.3476.</p> <p>(d) "Telehealth service" means a health care service that is provided through telehealth.</p>	<p>No statute or regulations specific to OT and telehealth, but statute uses a definition that include occupational therapy practitioners.</p> <p>COVID-19 update: Governor signed legislation codifying several telehealth provisions into law.</p>

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	<p>333.16284 Telehealth service; consent required; exception. Except as otherwise provided in this section, a health professional shall not provide a telehealth service without directly or indirectly obtaining consent for treatment. This section does not apply to a health professional who is providing a telehealth service to an inmate who is under the jurisdiction of the department of corrections and is housed in a correctional facility.</p> <p>333.16285 Telehealth service; prescribing patient with drug; conditions; requirements. (1) A health professional who is providing a telehealth service to a patient may prescribe the patient a drug if both of the following are met: (a) The health professional is a prescriber who is acting within the scope of his or her practice in prescribing the drug. (b) If the health professional is prescribing a drug that is a controlled substance, the health professional meets the requirements of this act applicable to that health professional for prescribing a controlled substance.</p> <p>(2) A health professional who prescribes a drug under subsection (1) shall comply with both of the following: (a) If the health professional considers it medically necessary, he or she shall provide the patient with a referral for other health care services that are geographically accessible to the patient, including, but not limited to, emergency services. (b) After providing a telehealth service, the health professional, or a health professional who is acting under the delegation of the delegating health professional, shall make himself or herself available to provide follow-up health care services to the patient or refer the patient to another health professional for follow-up health care services.</p> <p>333.16286 Telehealth service; restrictions or conditions; findings by disciplinary subcommittee. In a manner consistent with this part and in addition to the provisions set forth in this part, a disciplinary subcommittee may place restrictions or conditions on a health professional's ability to provide a telehealth service if the disciplinary subcommittee finds that the health professional has violated section 16284 or 16285.</p> <p>333.16287 Rules. The department, in consultation with a board, shall promulgate rules to implement sections 16284 and 16285.</p> <p>333.16288 MCL 333.16284 to 333.16287; limitations. Sections 16284 to 16287 do not do any of the following: (a) Require new or additional third party reimbursement for health care services rendered by a health professional through telehealth. (b) Limit the provision of a health care service otherwise allowed by law. (c) Authorize a health care service otherwise prohibited by law.</p>	

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Minnesota	<p>Statute: Minnesota Statutes, Chapter 62A, section 67, Telemedicine Coverage 62A.671 DEFINITIONS.</p> <p>Subd. 2.Distant site. "Distant site" means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine.</p> <p>Subd. 6.Licensed health care provider. "Licensed health care provider" means a health care provider who is:</p> <ul style="list-style-type: none"> (1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; or vendor of medical care defined in section 256B.02, subdivision 7; and (2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision. <p>Subd. 7.Originating site. "Originating site" means a site including, but not limited to, a health care facility at which a patient is located at the time health care services are provided to the patient by means of telemedicine.</p> <p>Subd. 8.Store-and-forward technology. "Store-and-forward technology" means the transmission of a patient's medical information from an originating site to a health care provider at a distant site without the patient being present, or the delivery of telemedicine that does not occur in real time via synchronous transmissions.</p> <p>Subd. 9.Telemedicine. "Telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.</p> <p>62A.672 COVERAGE OF TELEMEDICINE SERVICES.</p> <p>Subdivision 1. Coverage of telemedicine. (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.</p> <p>(b) Nothing in this section shall be construed to:</p> <ul style="list-style-type: none"> (1) require a health carrier to provide coverage for services that are not medically necessary; 	<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Bill signed by the Governor prohibits, until February 2021, health insurers from failing to cover services delivered via telehealth because the services are delivered to a resident's home; time-limited Medicaid State Plan Amendment relaxes certain restrictions on telehealth.</p>

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	<p>(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or</p> <p>(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.</p> <p>Subd. 2. Parity between telemedicine and in-person services. A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.</p> <p>Subd. 3. Reimbursement for telemedicine services. (a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider. (b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.</p> <p>Statute: Minnesota Statutes 256B.0625 MEDICAL ASSISTANCE FOR NEEDY PERSONS - COVERED SERVICES Subd. 3b. Telemedicine services. (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week. Telemedicine services shall be paid at the full allowable rate. (b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:</p> <ol style="list-style-type: none"> (1) has identified the categories or types of services the health care provider will provide via telemedicine; (2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated; (3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered; (4) has established protocols addressing how and when to discontinue telemedicine services; and (5) has an established quality assurance process related to telemedicine services. 	

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	<p>(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:</p> <ol style="list-style-type: none"> (1) the type of service provided by telemedicine; (2) the time the service began and the time the service ended, including an a.m. and p.m. designation; (3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee; (4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized; (5) the location of the originating site and the distant site; (6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and (7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b). <p>(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers, or a licensed health care provider and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.</p> <p>(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, and a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7</p> <p><u>Board statement: Telehealth and OTA Supervision (posted March 17, 2020)</u> The Board has received several inquiries related to supervision of Occupational Therapy Assistants and telemedicine in Minnesota.</p> <p>See the following statute for relevant information:</p> <ul style="list-style-type: none"> • Supervision of Occupational Therapy Assistants MN Statute 148.6432 Subd. 3 • Covered Services (Telemedicine) MN Statute 256B.0625 Subd. 3b (see above) 	

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Mississippi	<ul style="list-style-type: none"> • Coverage of Telemedicine Services MN Statute 62A.672 (see above) <p>Statute: Mississippi Code §41-127-1. Licensed health care practitioners authorized to provide health care services via electronic means; standards of practice</p> <p>Subject to the limitations of the license under which the individual is practicing, a health care practitioner licensed in this state may prescribe, dispense, or administer drugs or medical supplies, or otherwise provide treatment recommendations to a patient after having performed an appropriate examination of the patient either in person or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically. Treatment recommendations made via electronic means, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional provider-patient settings.</p>	<p>No statute or regulations specific to OT and telehealth. The Board reports that an individual must be licensed in the state before providing services via telehealth to a resident of the state.</p> <p>COVID-19 update: OT Licensure Committee has authorized OTs in the state to provide services via telehealth; Medicaid has temporarily expanded reimbursement for OT services provided via telehealth; private insurers are encouraged to relax limits on use of telehealth including limits on audio-only conversations, in-network requirements, and covering telehealth on the same basis as in-person services. Medicaid finalized a rule on telehealth, effective August 1, that permanently codifies a number of telehealth flexibilities, but does not permanently include OTs as a telehealth provider to established patients.</p>
Missouri		<p>No statute or regulations specific to OT and telehealth. The Board reports if an individual is practicing in the state then a Missouri license is required.</p> <p>COVID-19 update: Missouri HealthNet will cover services delivered via telehealth by enrolled providers; private insurance carriers are required to cover telehealth services on the same basis as in-person services. The Governor issued an Executive extending telehealth flexibilities until December 30, 2020.</p>

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Montana		<p>No statute or regulations specific to OT and telehealth. Board reports that telehealth is not permitted without statutory authority</p> <p>COVID-19 update: Governor's directive authorizes OTs and OTAs to deliver services via telehealth for the duration of the directive; Medicaid will cover services provided via telehealth if they are medically necessary and clinically appropriate for telehealth, are consistent with the appropriate provider manual, and are not required by the appropriate provider manual to be delivered face-to-face. In May, the OT licensing board adopted a statement allowing licensees to provide services via telehealth.</p>
Nebraska	<p>Statute: Nebraska Revised Statute Chapter 71, Section 8503, Terms, defined. For purposes of the Nebraska Telehealth Act:</p> <ul style="list-style-type: none"> (1) Department means the Department of Health and Human Services; (2) Health care practitioner means a Nebraska Medicaid-enrolled provider who is licensed, registered, or certified to practice in this state by the department; (3) Telehealth means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care practitioner in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient's home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care practitioner at another site for medical evaluation, and telemonitoring; (4) Telehealth consultation means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of such patient through telehealth; and (5) Telemonitoring means the remote monitoring of a patient's vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a health care practitioner for analysis and storage. 	<p>No statute or regulations specific to OT and telehealth. AOTA staff has reached out to the Board for clarification on potential updates to statutes, regulations, or policy statements.</p> <p>COVID-19 update: Medicaid has temporarily expanded billable telehealth services to include OT services provided via telehealth.</p>
Nevada	<p>Statute: Nevada Revised Statutes §629.515 Valid license or certificate required; exception; restrictions; jurisdiction over and applicability of laws. 1. Except as otherwise provided in this subsection, before a provider of health care who is located at a distant site may use telehealth to direct or manage the care or render a diagnosis of a patient who is located at an originating site in this State or write a treatment order or prescription for such a patient, the</p>	<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Licensing board authorizes OTs and OTAs to provide</p>

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	<p>provider must hold a valid license or certificate to practice his or her profession in this State, including, without limitation, a special purpose license issued pursuant to NRS 630.261. The requirements of this subsection do not apply to a provider of health care who is providing services within the scope of his or her employment by or pursuant to a contract entered into with an urban Indian organization, as defined in 25 U.S.C. § 1603.</p> <p>2. The provisions of this section must not be interpreted or construed to:</p> <ul style="list-style-type: none"> (a) Modify, expand or alter the scope of practice of a provider of health care; or (b) Authorize a provider of health care to provide services in a setting that is not authorized by law or in a manner that violates the standard of care required of the provider of health care. <p>3. A provider of health care who is located at a distant site and uses telehealth to direct or manage the care or render a diagnosis of a patient who is located at an originating site in this State or write a treatment order or prescription for such a patient:</p> <ul style="list-style-type: none"> (a) Is subject to the laws and jurisdiction of the State of Nevada, including, without limitation, any regulations adopted by an occupational licensing board in this State, regardless of the location from which the provider of health care provides services through telehealth. (b) Shall comply with all federal and state laws that would apply if the provider were located at a distant site in this State. <p>4. As used in this section:</p> <ul style="list-style-type: none"> (a) "Distant site" means the location of the site where a telehealth provider of health care is providing telehealth services to a patient located at an originating site. (b) "Originating site" means the location of the site where a patient is receiving telehealth services from a provider of health care located at a distant site. (c) "Telehealth" means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail. 	<p>services via telehealth; Medicaid has authorized OT services to be delivered via telehealth.</p>
New Hampshire		<p>No statute or regulations specific to OT and telehealth, but Board reports that telehealth can be provided with a valid state license.</p> <p>COVID-19 update: Private insurers and Medicaid must allow in-network providers to deliver appropriate, medically necessary covered services to members via telehealth.</p>
New Jersey	<p>Statute: New Jersey Revised Statutes Title 45, Chapter 1 45:1-61 Definitions relative to telemedicine and telehealth.</p>	<p>No statute or regulations specific to OT and telehealth, but statute uses a definition of healthcare provider that includes occupational therapists. Board reports that licensees in the</p>

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	<p>"Asynchronous store-and-forward" means the acquisition and transmission of images, diagnostics, data, and medical information either to, or from, an originating site or to, or from, the health care provider at a distant site, which allows for the patient to be evaluated without being physically present.</p> <p>"Cross-coverage service provider" means a health care provider, acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes, who engages in a remote medical evaluation of a patient, without in-person contact, at the request of another health care provider who has established a proper provider-patient relationship with the patient.</p> <p>"Distant site" means a site at which a health care provider, acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes, is located while providing health care services by means of telemedicine or telehealth.</p> <p>"Health care provider" means an individual who provides a health care service to a patient, and includes, but is not limited to, a licensed physician, nurse, nurse practitioner, psychologist, psychiatrist, psychoanalyst, clinical social worker, physician assistant, professional counselor, respiratory therapist, speech pathologist, audiologist, optometrist, or any other health care professional acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes.</p> <p>"On-call provider" means a licensed or certified health care provider who is available, where necessary, to physically attend to the urgent and follow-up needs of a patient for whom the provider has temporarily assumed responsibility, as designated by the patient's primary care provider or other health care provider of record.</p> <p>"Originating site" means a site at which a patient is located at the time that health care services are provided to the patient by means of telemedicine or telehealth.</p> <p>"Telehealth" means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L.2017, c.117 (C.45:1-61 et al.).</p> <p>"Telemedicine" means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider, and in accordance with the provisions of P.L.2017, c.117 (C.45:1-61 et al.). "Telemedicine" does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.</p>	<p>state with a question about telehealth should contact the Board.</p> <p>As of July, 2019, the Advisory Council is drafting regulations related to OT and telehealth.</p> <p>COVID-19 update: Governor signed law that authorizes any health care provider in the state to use telehealth for the duration of the state of emergency and requires the Commissioner of Health and Dept. of Consumer Affairs to waive requirements in law or regulation to facilitate the use of telehealth. Department of Consumer Affairs subsequently waived requirements related to establishing the patient-practitioner relationship, to specific technical requirements of the telehealth technology to be used, and to requiring a patient to be physically present at a specific address to receive services via telehealth. Insurance bulletin requires carriers to follow specific requirements.</p>

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	<p>"Telemedicine or telehealth organization" means a corporation, sole proprietorship, partnership, or limited liability company that is organized for the primary purpose of administering services in the furtherance of telemedicine or telehealth.</p> <p>45:1-62 Provision of health care through use of telemedicine, telehealth; requirements for provider.</p> <p>2.</p> <p>a. Unless specifically prohibited or limited by federal or State law, a health care provider who establishes a proper provider-patient relationship with a patient may remotely provide health care services to a patient through the use of telemedicine. A health care provider may also engage in telehealth as may be necessary to support and facilitate the provision of health care services to patients.</p> <p>b. Any health care provider who uses telemedicine or engages in telehealth while providing health care services to a patient, shall:</p> <p>(1) be validly licensed, certified, or registered, pursuant to Title 45 of the Revised Statutes, to provide such services in the State of New Jersey;</p> <p>(2) remain subject to regulation by the appropriate New Jersey State licensing board or other New Jersey State professional regulatory entity;</p> <p>(3) act in compliance with existing requirements regarding the maintenance of liability insurance; and</p> <p>(4) remain subject to New Jersey jurisdiction if either the patient or the provider is located in New Jersey at the time services are provided.</p> <p>c.</p> <p>(1) Telemedicine services shall be provided using interactive, real-time, two-way communication technologies.</p> <p>(2) A health care provider engaging in telemedicine or telehealth may use asynchronous store-and-forward technology to allow for the electronic transmission of images, diagnostics, data, and medical information; except that the health care provider may use interactive, real-time, two-way audio in combination with asynchronous store-and-forward technology, without video capabilities, if, after accessing and reviewing the patient's medical records, the provider determines that the provider is able to meet the same standard of care as if the health care services were being provided in person.</p> <p>(3) The identity, professional credentials, and contact information of a health care provider providing telemedicine or telehealth services shall be made available to the patient during and after the provision of services. The contact information shall enable the patient to contact the health care provider, or a substitute health care provider authorized to act on behalf of the provider who provided services, for at least 72 hours following the provision of services.</p> <p>(4) A health care provider engaging in telemedicine or telehealth shall review the medical history and any medical records provided by the patient. For an initial</p>	

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	<p>encounter with the patient, the provider shall review the patient's medical history and medical records prior to initiating contact with the patient, as required pursuant to paragraph (3) of subsection a. of section 3 of P.L.2017, c.117 (C.45:1-63). In the case of a subsequent telemedicine or telehealth encounter conducted pursuant to an ongoing provider-patient relationship, the provider may review the information prior to initiating contact with the patient or contemporaneously with the telemedicine or telehealth encounter.</p> <p>(5) Following the provision of services using telemedicine or telehealth, the patient's medical information shall be made available to the patient upon the patient's request, and, with the patient's affirmative consent, forwarded directly to the patient's primary care provider or health care provider of record, or, upon request by the patient, to other health care providers. For patients without a primary care provider or other health care provider of record, the health care provider engaging in telemedicine or telehealth may advise the patient to contact a primary care provider, and, upon request by the patient, assist the patient with locating a primary care provider or other in-person medical assistance that, to the extent possible, is located within reasonable proximity to the patient. The health care provider engaging in telemedicine or telehealth shall also refer the patient to appropriate follow up care where necessary, including making appropriate referrals for emergency or complimentary care, if needed. Consent may be oral, written, or digital in nature, provided that the chosen method of consent is deemed appropriate under the standard of care.</p> <p>d.</p> <p>(1) Any health care provider providing health care services using telemedicine or telehealth shall be subject to the same standard of care or practice standards as are applicable to in-person settings. If telemedicine or telehealth services would not be consistent with this standard of care, the health care provider shall direct the patient to seek in-person care.</p> <p>(2) Diagnosis, treatment, and consultation recommendations, including discussions regarding the risk and benefits of the patient's treatment options, which are made through the use of telemedicine or telehealth, including the issuance of a prescription based on a telemedicine or telehealth encounter, shall be held to the same standard of care or practice standards as are applicable to in-person settings. Unless the provider has established a proper provider-patient relationship with the patient, a provider shall not issue a prescription to a patient based solely on the responses provided in an online questionnaire.</p> <p>e. The prescription of Schedule II controlled dangerous substances through the use of telemedicine or telehealth shall be authorized only after an initial in-person examination of the patient, as provided by regulation, and a subsequent in-person visit with the patient shall be required every three months for the duration of time that the patient is being</p>	

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	<p>prescribed the Schedule II controlled dangerous substance. However, the provisions of this subsection shall not apply, and the in-person examination or review of a patient shall not be required, when a health care provider is prescribing a stimulant which is a Schedule II controlled dangerous substance for use by a minor patient under the age of 18, provided that the health care provider is using interactive, real-time, two-way audio and video technologies when treating the patient and the health care provider has first obtained written consent for the waiver of these in-person examination requirements from the minor patient's parent or guardian.</p> <p>f. A mental health screener, screening service, or screening psychiatrist subject to the provisions of P.L.1987, c.116 (C.30:4- 27.1 et seq.):</p> <ul style="list-style-type: none"> (1) shall not be required to obtain a separate authorization in order to engage in telemedicine or telehealth for mental health screening purposes; and (2) shall not be required to request and obtain a waiver from existing regulations, prior to engaging in telemedicine or telehealth. <p>g. A health care provider who engages in telemedicine or telehealth, as authorized by P.L.2017, c.117 (C.45:1-61 et al.), shall maintain a complete record of the patient's care, and shall comply with all applicable State and federal statutes and regulations for recordkeeping, confidentiality, and disclosure of the patient's medical record.</p> <p>h. A health care provider shall not be subject to any professional disciplinary action under Title 45 of the Revised Statutes solely on the basis that the provider engaged in telemedicine or telehealth pursuant to P.L.2017, c.117 (C.45:1-61 et al.).</p> <p>i.</p> <p>(1) In accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), the State boards or other entities that, pursuant to Title 45 of the Revised Statutes, are responsible for the licensure, certification, or registration of health care providers in the State, shall each adopt rules and regulations that are applicable to the health care providers under their respective jurisdictions, as may be necessary to implement the provisions of this section and facilitate the provision of telemedicine and telehealth services. Such rules and regulations shall, at a minimum:</p> <ul style="list-style-type: none"> (a) include best practices for the professional engagement in telemedicine and telehealth; (b) ensure that the services patients receive using telemedicine or telehealth are appropriate, medically necessary, and meet current quality of care standards; (c) include measures to prevent fraud and abuse in connection with the use of telemedicine and telehealth, including requirements concerning the filing of claims and maintaining appropriate records of services provided; and (d) provide substantially similar metrics for evaluating quality of care and patient outcomes in connection with services provided using telemedicine and telehealth as currently apply to services provided in person. 	

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	<p>(2) In no case shall the rules and regulations adopted pursuant to paragraph (1) of this subsection require a provider to conduct an initial in-person visit with the patient as a condition of providing services using telemedicine or telehealth.</p> <p>(3) The failure of any licensing board to adopt rules and regulations pursuant to this subsection shall not have the effect of delaying the implementation of this act, and shall not prevent health care providers from engaging in telemedicine or telehealth in accordance with the provisions of this act and the practice act applicable to the provider's professional licensure, certification, or registration.</p> <p>45:1-63 Establishment of proper provider-patient relationship; exceptions.</p> <p>3. a. Any health care provider who engages in telemedicine or telehealth shall ensure that a proper provider-patient relationship is established. The establishment of a proper provider-patient relationship shall include, but shall not be limited to:</p> <ul style="list-style-type: none"> (1) properly identifying the patient using, at a minimum, the patient's name, date of birth, phone number, and address. When properly identifying the patient, the provider may additionally use the patient's assigned identification number, social security number, photo, health insurance policy number, or other appropriate patient identifier associated directly with the patient; (2) disclosing and validating the provider's identity and credentials, such as the provider's license, title, and, if applicable, specialty and board certifications; (3) prior to initiating contact with a patient in an initial encounter for the purpose of providing services to the patient using telemedicine or telehealth, reviewing the patient's medical history and any available medical records; and (4) prior to initiating contact with a patient for the purpose of providing services to the patient using telemedicine or telehealth, determining whether the provider will be able to provide the same standard of care using telemedicine or telehealth as would be provided if the services were provided in person. The provider shall make this determination prior to each unique patient encounter. <p>b. Telemedicine or telehealth may be practiced without a proper provider-patient relationship, as defined in subsection a. of this section, in the following circumstances:</p> <ul style="list-style-type: none"> (1) during informal consultations performed by a health care provider outside the context of a contractual relationship, or on an irregular or infrequent basis, without the expectation or exchange of direct or indirect compensation; (2) during episodic consultations by a medical specialist located in another jurisdiction who provides consultation services, upon request, to a properly licensed or certified health care provider in this State; (3) when a health care provider furnishes medical assistance in response to an emergency or disaster, provided that there is no charge for the medical assistance; or (4) when a substitute health care provider, who is acting on behalf of an absent health care provider in the same specialty, provides health care services on an on-call or cross-coverage basis, 	

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	provided that the absent health care provider has designated the substitute provider as an on-call provider or cross-coverage service provider.	
New Mexico	<p>Statute: New Mexico Statutes, Chapter 24, Article 25, New Mexico Telehealth Act 24-25-3. Definitions. As used in the New Mexico Telehealth Act: A. "health care provider" means a person licensed to provide health care to patients in New Mexico, including:</p> <ol style="list-style-type: none"> (1) an optometrist; (2) a chiropractic physician; (3) a dentist; (4) a physician; (5) a podiatrist; (6) an osteopathic physician; (7) a physician assistant; (8) a certified nurse practitioner; (9) a physical therapist; (10) an occupational therapist; (11) a speech-language pathologist; (12) a doctor of oriental medicine; (13) a nutritionist; (14) a psychologist; (15) a certified nurse-midwife; (16) a clinical nurse specialist; (17) a registered nurse; (18) a dental hygienist; (19) a pharmacist; (20) a licensed independent social worker; (21) a licensed counselor; (22) a community health representative; or (23) a licensed athletic trainer; <p>B. "originating site" means a place where a patient may receive health care via telehealth. An originating site may include:</p> <ol style="list-style-type: none"> (1) a licensed inpatient center; (2) an ambulatory surgical or treatment center; (3) a skilled nursing center; (4) a residential treatment center; (5) a home health agency; (6) a diagnostic laboratory or imaging center; (7) an assisted living center; (8) a school-based health program; 	<p>No OT specific statute or regulations regarding telehealth, but statute uses a definition of healthcare provider that includes occupational therapist.</p> <p>COVID-19 update: OT licensing board issued guidance approving the use of telehealth by licensees, including using Internet, email, texting, and telephonic means, and reminds OTs that supervision requirements still apply; Medicaid and private insurers are required to reimburse for telehealth services at the same rate as in-person services.</p>

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	<p>(9) a mobile clinic; (10) a mental health clinic; (11) a rehabilitation or other therapeutic health setting; (12) the patient's residence; (13) a federally qualified health center; or (14) a community health center; and</p> <p>C. "telehealth" means the use of electronic information, imaging and communication technologies, including interactive audio, video, data communications as well as store-and-forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education.</p> <p>24-25-4. Telehealth authorized; procedure. The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in New Mexico. No health care provider or operator of an originating site shall be disciplined for or discouraged from participating in telehealth pursuant to the New Mexico Telehealth Act. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines and shall follow established federal and state rules regarding security, confidentiality and privacy protections for health care information.</p> <p>24-25-5. Scope of act. A. The New Mexico Telehealth Act does not alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. B. Because the use of telehealth improves access to quality health care and will generally benefit the citizens of New Mexico, health insurers, health maintenance organizations, managed care organizations and third-party payors offering services to the citizens of New Mexico are encouraged to use and provide coverage for telehealth within the scope of their plans or policies. The state's medical assistance program is also encouraged to include telehealth within the scope of its plan or policy.</p>	
New York	<p>Statute: New York Consolidated Laws, Article 29-G Telehealth Delivery of Services § 2999-cc. Definitions. As used in this article, the following terms shall have the following meanings: 1. "Distant site" means a site at which a telehealth provider is located while delivering health care services by means of telehealth. 2. "Telehealth provider" means: (a) a physician licensed pursuant to article one hundred thirty-one of the education law; (b) a physician assistant licensed pursuant to article one hundred thirty-one-B of the education law; (c) a dentist licensed pursuant to article one hundred thirty-three of the education law; (d) a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law; (e) a registered professional nurse licensed pursuant to article one hundred thirty-nine of the education law only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring; (f) a podiatrist licensed pursuant to article one hundred forty-one of the education law;</p>	<p>No OT specific statute or regulation, but statute includes OT as a telehealth provider. The Board reports OTs may use telehealth to evaluate and provide therapy to clients, but must be licensed in the state, adhere to the same standards that apply to in-person practice, the AOTA Occupational Therapy Code of Ethics (2010), and the AOTA Standards of Practice for Occupational Therapy and the laws, rules, and regulations, governing occupational therapy practice in New York.</p>

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	<p>(g) an optometrist licensed pursuant to article one hundred forty-three of the education law; (h) a psychologist licensed pursuant to article one hundred fifty-three of the education law; (i) a social worker licensed pursuant to article one hundred fifty-four of the education law; (j) a speech language pathologist or audiologist licensed pursuant to article one hundred fifty-nine of the education law; (k) a midwife licensed pursuant to article one hundred forty of the education law; (l) a physical therapist licensed pursuant to article one hundred thirty-six of the education law; (m) an occupational therapist licensed pursuant to article one hundred fifty-six of the education law; (n) a person who is certified as a diabetes educator by the National Certification Board for Diabetes Educators, or a successor national certification board, or provided by such a professional who is affiliated with a program certified by the American Diabetes Association, the American Association of Diabetes Educators, the Indian Health Services, or any other national accreditation organization approved by the federal Centers for Medicare and Medicaid Services; (o) a person who is certified as an asthma educator by the National Asthma Educator Certification Board, or a successor national certification board; (p) a person who is certified as a genetic counselor by the American Board of Genetic Counseling, or a successor national certification board; (q) a hospital as defined in article twenty-eight of this chapter, including residential health care facilities serving special needs populations; (r) a home care services agency as defined in article thirty-six of this chapter; (s) a hospice as defined in article forty of this chapter; (t) credentialed alcoholism and substance abuse counselors credentialed by the office of alcoholism and substance abuse services or by a credentialing entity approved by such office pursuant to section 19.07 of the mental hygiene law; (u) providers authorized to provide services and service coordination under the early intervention program pursuant to article twenty-five of this chapter; (v) clinics licensed or certified under article sixteen of the mental hygiene law and certified and non-certified day and residential programs funded or operated by the office for people with developmental disabilities; and (w) any other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of alcoholism and substance abuse services, or the commissioner of the office for people with developmental disabilities pursuant to regulation.</p> <p>3. "Originating site" means a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth. Originating sites shall be limited to:</p> <p>(a) facilities licensed under articles twenty-eight and forty of this chapter; (b) facilities as defined in subdivision six of section 1.03 of the mental hygiene law; (c) certified and non-certified day and residential programs funded or operated by the office for people with developmental disabilities;</p>	<p>COVID-19 update: OTAs are allowed to provide services via telehealth during the state of emergency; Medicaid issued comprehensive guidance on expanding the use of telehealth services and authorizing the use of telehealth via telephonic means.</p>

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	<p>(d) private physician's or dentist's offices located within the state of New York;</p> <p>(e) any type of adult care facility licensed under title two of article seven of the social services law;</p> <p>(f) public, private and charter elementary and secondary schools, school age child care programs, and child day care centers within the state of New York; and</p> <p>(g) the patient's place of residence located within the state of New York or other temporary location located within or outside the state of New York.</p> <p>4. "Telehealth" means the use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. Telehealth shall not include delivery of health care services by means of audio-only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring. For purposes of this section, telehealth shall be limited to telemedicine, store and forward technology, and remote patient monitoring. This subdivision shall not preclude the delivery of health care services by means of "home telehealth" as used in section thirty-six hundred fourteen of this chapter.</p> <p>5. "Telemedicine" means the use of synchronous, two-way electronic audio visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site.</p> <p>6. "Store and forward technology" means the asynchronous, electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a provider at an originating site to a telehealth provider at a distant site.</p> <p>7. "Remote patient monitoring" means the use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an originating site that is transmitted to a telehealth provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring. Such technologies may include additional interaction triggered by previous transmissions, such as interactive queries conducted through communication technologies or by telephone. Such conditions shall include, but not be limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Remote patient monitoring shall be ordered by a physician licensed pursuant to article one hundred thirty-one of the education law, a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law, or a midwife licensed pursuant to article one hundred forty of the education law, with which the patient has a substantial and ongoing relationship.</p> <p>§ 2999-dd. Telehealth delivery of services.</p> <p>1. Health care services delivered by means of telehealth shall be entitled to reimbursement under section three hundred sixty-seven-u of the social services law.</p>	

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	<p>2. The department of health, the office of mental health, the office of alcoholism and substance abuse services, and the office for people with developmental disabilities shall coordinate on the issuance of a single guidance document, to be updated as appropriate, that shall:</p> <p>(a) identify any differences in regulations or policies issued by the agencies, including with respect to reimbursement pursuant to section three hundred sixty-seven-u of the social services law; and</p> <p>(b) be designed to assist consumers, providers, and health plans in understanding and facilitating the appropriate use of telehealth in addressing barriers to care.</p>	
North Carolina	<p>Board Statement: Telehealth and North Carolina Occupational Therapy An occupational therapy practitioner may deliver evaluation, treatment, and consultation through telecommunication and information technologies.</p> <ol style="list-style-type: none"> 1. An occupational therapy practitioner is required to be licensed in North Carolina if the practitioner provides occupational therapy services to a client who is in North Carolina. 2. An occupational therapy practitioner who is in North Carolina and does not provide occupational therapy services to clients in North Carolina does not need to be licensed in North Carolina. 3. An occupational therapy practitioner who is in North Carolina but provides occupational therapy services to clients in a state other than North Carolina is required to follow the laws and regulations of the state where the client is receiving the services. 4. An occupational therapy practitioner licensed in North Carolina may provide occupational therapy services to a client in North Carolina even if the occupational therapy practitioner is in another state. <p>An occupational therapy practitioner may provide supervision requiring direct contact through video teleconferencing.</p>	<p>No OT specific statute or regulation regarding telehealth.</p> <p>COVID-19 update: Medicaid temporarily modified its Telemedicine Clinical Coverage Policy to provide guidance for outpatient specialized therapies (including OT) that can be now be delivered via telehealth and is offering reimbursement for virtual patient communication and telephonic evaluation and management for certain beneficiaries.</p>
North Dakota	<p>Regulation: North Dakota Administrative Code 55.5-03-01-03, Scope of Services Specific occupational therapy services. The practice of occupational therapy means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness, including methods delivered via telerehabilitation to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life.</p> <p>Board Statement: Telehealth Telehealth, also known as Telemedicine, is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. (1) AOTA defines Telehealth as the application of evaluative, consultative, preventative, and therapeutic services delivered through telecommunication and information technologies.</p>	<p>COVID-19 update: Governor's Executive Order expands telehealth coverage by prohibiting private insurers from engaging in cost-sharing or charging deductibles or copayments for telehealth services; Medicaid will reimburse for covered telehealth services at the same rate as in-person services provided the service is medically appropriate, documented in member's health record, and involves either video or audio contact with the member.</p>

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	<p>(2) North Dakota uses federal definitions for "internet" and "practice of telemedicine" set in the Ryan Haight Online Pharmacy Consumer Protection Act of 2008.</p> <p>(3) Telemedicine means the practice of medicine by a practitioner, other than a pharmacist, who is at a location remote from the patient, and is communicating with the patient, or health care professional who is treating the patient, using a telecommunications system.</p> <p>(4) Telehealth is a service delivery model that allows an occupational therapy practitioner to deliver evaluation, treatment, and consultation through telecommunication and information technologies overcoming distance, transportation expenses, and patient access barriers.</p> <p>Telehealth is not a separate service. It is a medium to deliver care. Occupational Therapy practitioners must adhere to the same standards as expected for on-site service delivery. An occupational therapy practitioner is required to be licensed in North Dakota if the practitioner provides occupational therapy services to a client who is in North Dakota. The location of the patient at the time of the patient service encounter determines the location of the service. If the patient is located in North Dakota at the time of the patient service, the therapist/assistant must be licensed in North Dakota. If the therapists/assistant is connecting with a patient located in another State at the time of the patient encounter, the therapist must be licensed in that State.</p>	
Ohio	<p>Board Statement: Telehealth/Telerehab (revised June 2015)</p> <p>It is the position of the Ohio Occupational Therapy Section that an occupational therapy practitioner is required to hold a valid, current license in the State of Ohio to serve any clients residing in Ohio. Therefore, out of state occupational therapy personnel must hold a valid Ohio license to treat clients in Ohio via telehealth.</p> <p>The Section recommends that you contact the occupational therapy board in any state where the client resides to explore the requirements for practicing via telehealth in that state. In addition, the Section recommends that you review the American Occupational Therapy Association’s Position Paper: Telerehabilitation (AOTA, 2013) for additional guidance on occupational therapy practice via telehealth.</p> <p>As defined by the American Occupational Therapy Association (AOTA), telerehabilitation is the “clinical application of consultative, preventative, diagnostic, and therapeutic services via two-way interactive telecommunication technology” (AOTA, 2005, p. 656).</p> <p>The Occupational Therapy Section has seen an increase in the number of questions from practitioners on whether the Ohio Occupational Therapy Practice Act permits telerehabilitation. As stated in the AOTA Telerehabilitation Position Paper:</p> <p>Practitioners using telerehabilitation methods must comply with licensure laws and other state legislation regulating the practice of occupational therapy in the state or states in which those services are received</p>	<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: OT licensing board allows Ohio-licensed OTs and OTAs to engage in telehealth; Medicaid adopted emergency rule stating that OTs and OTAs are eligible telehealth providers, but only OTs can bill.</p>

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	<p>[emphasis added]. When telerehabilitation is used to provide individual client services (evaluation and intervention), the practitioner must be licensed in the state in which the client receives those services. The provision of consultation to another practitioner or continuing education content (e.g., workshop or seminar) using this technology may or may not be addressed by individual state regulations, and it is recommended that practitioners using the technology in these ways investigate those regulations to ensure compliance (AOTA, 2005, p. 658).</p> <p>The Occupational Therapy Section endorses the AOTA statement on state regulations for telerehabilitation. As a result, occupational therapy personnel must hold a valid Ohio license prior to providing occupational therapy services via telerehabilitation to clients physically located in Ohio.</p> <p><u>Reference</u> American Occupational Therapy Association (2005). Telerehabilitation position paper. American Journal of Occupational Therapy, 59(6), 656-660.</p>	
Oklahoma	<p>Statute: Title 59 Oklahoma Statutes, Section 888.3</p> <p>1. "Occupational therapy" is a health profession for which practitioners provide assessment, treatment, and consultation through the use of purposeful activity with individuals who are limited by or at risk of physical illness or injury, psycho-social dysfunction, developmental or learning disabilities, poverty and cultural differences or the aging process, in order to maximize independence, prevent disability, and maintain health. Specific occupational therapy services include but are not limited to the use of media and methods such as instruction in daily living skills and cognitive retraining, facilitating self-maintenance, work and leisure skills, using standardized or adapted techniques, designing, fabricating, and applying selected orthotic equipment or selective adaptive equipment with instructions, using therapeutically applied creative activities, exercise, and other media to enhance and restore functional performance, to administer and interpret tests which may include sensorimotor evaluation, psycho-social assessments, standardized or nonstandardized tests, to improve developmental skills, perceptual <u>and</u> motor skills, and sensory integrative function, and to adapt the environment for the handicapped. These services are provided individually, in groups, via telehealth or through social systems;</p> <p>8. "Telehealth" means the use of electronic information and telecommunications technologies to support and promote access to clinical health care, patient and professional health-related education, public health and health administration; and</p> <p>9. "Telerehabilitation" or "teletherapy" means the delivery of rehabilitation and habilitation services via information and communication technologies (ICT), also commonly referred to as "telehealth" technologies.</p>	<p>As of April, 2020 Board rules on telehealth are pending approval by the Governor.</p> <p>COVID-19 update: Medicaid is allowing certain OT services to be provided via telehealth during the national emergency and has expanded, until September 30, the use of telehealth to include services delivered via telephone to new and established patients; private insurers are encouraged to ensure their telehealth programs will meet demand and to waive telehealth co-payments.</p>
Oregon	<p>Regulation: Oregon Administrative Rules 339-010-0006, Standards of Practice for Telehealth</p> <p>(1) "Telehealth" is defined as the use of interactive audio and video, in real time telecommunication technology or store-and-forward technology, to deliver health care services when the occupational therapist and patient/client are not at the same physical location. Its uses include diagnosis, consultation, treatment, prevention, transfer of health or medical data, and continuing education.</p> <p>(2) Telehealth is considered the same as Telepractice for Occupational Therapists working in education settings; and Teletherapy and Telerehab in other settings.</p>	<p>COVID-19 update: Oregon Health Authority issued several emergency rules authorizing coverage for physical health telemedicine services.</p>

State	Citation and Provisions ¹	Notes
	<p>(3) In order to provide occupational therapy services via telehealth to a patient/client in Oregon, the occupational therapist providing services to a patient/client must have a valid and current license issued by the Oregon OT Licensing Board. Oregon licensed Occupational Therapists using telehealth technology with a patient/client in another state may also be required to be licensed in the state in which the patient/client receives those services and must adhere to those state licensure laws.</p> <p>(4) Occupational therapists shall obtain informed consent of the delivery of service via telehealth from the patient/client prior to initiation of occupational therapy services via telehealth and maintain documentation in the patient's or client's health record.</p> <p>(5) Occupational therapists shall secure and maintain the confidentiality of medical information of the patient/client as required by HIPAA and state and federal law.</p> <p>(6) In making the determination whether an in-person evaluation or intervention are necessary, an occupational therapist shall consider at a minimum:</p> <ul style="list-style-type: none"> (a) The complexity of the patient's/client's condition; (b) His or her own knowledge skills and abilities; (c) The patient's/client's context and environment; (d) The nature and complexity of the intervention; (e) The pragmatic requirements of the practice setting; and (f) The capacity and quality of the technological interface. <p>(7) An occupational therapist or occupational therapy assistant providing occupational therapy services via telehealth must:</p> <ul style="list-style-type: none"> (a) Exercise the same standard of care when providing occupational therapy services via telehealth as with any other mode of delivery of occupational therapy services; (b) Provide services consistent the AOTA Code of Ethics and Ethical Standards of Practice; and comply with provisions of the Occupational Therapy Practice Act and its regulations. <p>(8) Supervision of Occupational Therapy Assistant under 339-010-0035 for routine and general supervision, can be done through telehealth, but cannot be done when close supervision as defined in 339-010-0005 is required. The same considerations in (7)(A) through (F) must be considered in determining whether telehealth should be used.</p> <p>(9) An Occupational Therapist who is supervising a fieldwork student must follow the ACOTE standards and other accreditation requirements.</p> <p>(10) Failure to comply with these regulations shall be considered unprofessional conduct under OAR 339-010-0020.</p> <p><u>Board FAQs: Telehealth Q and A</u> Q. What is telehealth? "Telehealth" is defined as the use of interactive audio and video, in real time telecommunication technology or store-and-forward technology, to deliver health care services when the occupational therapist and patient/client are not at the same physical location. Its uses include diagnosis, consultation, treatment, prevention, transfer of health or medical data, and continuing education.</p>	

State	Citation and Provisions ¹	Notes
	<p>Q. What are the Standards of Practice for Telehealth? An occupational therapist or occupational therapy assistant providing occupational therapy services via telehealth must exercise the same standard of care when providing occupational therapy services via telehealth as with any other mode of delivery of occupational therapy services and provide services consistent the AOTA Code of Ethics and Ethical Standards of Practice; and comply with provisions of the Occupational Therapy Practice Act and its regulations.</p> <p>Q. What is required to provide occupational therapy services via telehealth in Oregon? An occupational therapist or occupational therapy assistant providing occupational therapy services via telehealth to a client in Oregon must have a valid and current license issued by the Oregon Occupational Therapy Licensing Board.</p> <p>Q. I am from out-of-state. Do I need an Oregon license to provide Occupational Therapy services to a client in Oregon? A. Yes, a license by the Oregon Occupational Therapy Licensing Board is required.</p> <p>Q. Do I need to reside within the state of Oregon in order to provide telehealth services to a client who resides in Oregon? A. No, you are not required to reside in Oregon but you are required to have an Oregon license and follow all the provisions of laws and regulations governing occupational therapy.</p> <p>Q. What is consent? A. Consent is the process (and document) by which an occupational therapist discloses appropriate information to a competent client so that the client may make a voluntary choice to accept or refuse treatment. It originates from the legal and ethical right the patient has to direct what happens to his or her body and from the ethical duty of the occupational therapist to involve the patient in his or her health care.</p> <p>Q. Can telehealth be used for supervision of an occupational therapy assistant? A. Supervision of Occupational Therapy Assistant under 339-010-0035 for routine and general supervision, can be done through telehealth, but cannot be done when close supervision as defined in 339-010-0005 is required. The same considerations in (6) (A) through (F) must be considered in determining whether telehealth should be used.</p>	
Pennsylvania	<p>Occupational Therapy Code of Ethics 2015: VERACITY Principle 5. Occupational therapy personnel shall provide comprehensive, accurate, and objective information when representing the profession. Veracity is based on the virtues of truthfulness, candor, and honesty. The Principle of Veracity refers to comprehensive, accurate, and objective transmission of information and includes fostering understanding of such information (Beauchamp & Childress, 2013). Veracity is based on respect owed to others, including but not limited to recipients of service, colleagues, students, researchers, and research participants.</p>	<p>No statute or regulations specific to OT and telehealth. Board reports telehealth has not been regulated beyond what is in the AOTA Code of Ethics (2015).</p> <p>COVID-19 update: Department of State temporarily suspended</p>

State	Citation and Provisions ¹	Notes
	<p>In communicating with others, occupational therapy personnel implicitly promise to be truthful and not deceptive. When entering into a therapeutic or research relationship, the recipient of service or research participant has a right to accurate information. In addition, transmission of information is incomplete without also ensuring that the recipient or participant understands the information provided.</p> <p>Concepts of veracity must be carefully balanced with other potentially competing ethical principles, cultural beliefs, and organizational policies. Veracity ultimately is valued as a means to establish trust and strengthen professional relationships. Therefore, adherence to the Principle of Veracity also requires thoughtful analysis of how full disclosure of information may affect outcomes.</p> <p>RELATED STANDARDS OF CONDUCT Occupational therapy personnel shall</p> <ul style="list-style-type: none"> A. Represent credentials, qualifications, education, experience, training, roles, duties, competence, contributions, and findings accurately in all forms of communication. B. Refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, misleading, or unfair statements or claims. C. Record and report in an accurate and timely manner and in accordance with applicable regulations all information related to professional or academic documentation and activities. D. Identify and fully disclose to all appropriate persons errors or adverse events that compromise the safety of service recipients. E. Ensure that all marketing and advertising are truthful, accurate, and carefully presented to avoid misleading recipients of service, research participants, or the public. F. Describe the type and duration of occupational therapy services accurately in professional contracts, including the duties and responsibilities of all involved parties. G. Be honest, fair, accurate, respectful, and timely in gathering and reporting fact-based information regarding employee job performance and student performance. H. Give credit and recognition when using the ideas and work of others in written, oral, or electronic media (i.e., do not plagiarize). I. Provide students with access to accurate information regarding educational requirements and academic policies and procedures relative to the occupational therapy program or educational institution. J. Maintain privacy and truthfulness when utilizing telecommunication in delivery of occupational therapy services. 	<p>regulations to authorize OTs and OTAs to provide services via telehealth. Out-of-state licensees may provide services to PA residents via telehealth without obtaining a PA license. Medicaid and private insurers have also issued guidance to expand the use and reimbursement of telehealth services.</p>
Puerto Rico		<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update:</p>
Rhode Island		<p>No statute or regulations specific to OT and telehealth. Board reports an individual must be licensed in the state</p>

State	Citation and Provisions ¹	Notes
		<p>and adhere to the state laws and rules when providing services in the state.</p> <p>COVID-19 update: Governor's Executive Order requires clinically appropriate, medically necessary telemedicine services delivered by in-network providers to be reimbursed at the same rate as in-person services; insurance bulletin clarifies that this expansion includes OT services. This order has been extended until August 3.</p>
South Carolina		<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Board issued a statement clarifying that its support for telehealth extends to OTs and OTAs; Department of Health and Human Services issued statements that temporarily extend telehealth coverage to services provided by OTs and OTAs.</p>
South Dakota		<p>No statute or regulations specific to OT and telehealth, but Board reports that it is allowed and treated the same as normal practice.</p> <p>COVID-19 update: Medicaid temporarily extended coverage of telehealth services to include OT services for patients at high risk for COVID-19 or under quarantine or social distancing during a declared emergency for COVID-19. Therapy services may only utilize telemedicine if the patient and provider have previously met for in-person services.</p>

State	Citation and Provisions ¹	Notes
Tennessee		<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Governor's Executive Order loosens regulations of telehealth, expands the use of telemedicine, and urges insurance providers to cover more telemedicine services (previous Executive Orders related to telehealth have been extended until August 29); TennCare announced that MCOs will reimburse for OT services that are appropriate to be provided via telehealth.</p>
Texas	<p>Regulation: Texas Administrative Code Title 40, Part 12</p> <p>§ 362.1 Definitions.</p> <p>(39) Telehealth--A mode of service delivery for the provision of occupational therapy services delivered by an occupational therapy practitioner to a client at a different physical location using telecommunications or information technology. Telehealth refers only to the practice of occupational therapy by occupational therapy practitioners who are licensed by this Board with clients who are located in Texas at the time of the provision of occupational therapy services. Also may be known as other terms including but not limited to telepractice, telecare, telerehabilitation, and e-health services.</p> <p>§ 372.1 Provision of Services</p> <p>(e) Evaluation.</p> <ol style="list-style-type: none"> (1) Only an occupational therapist may perform an initial evaluation or any reevaluations. (2) An occupational therapy plan of care must be based on an occupational therapy evaluation. (3) The occupational therapist is responsible for determining whether any aspect of the evaluation may be conducted via telehealth or must be conducted in person. (4) The occupational therapist must have contact with the client during the evaluation via telehealth using synchronous audiovisual technology or in person. Other telecommunications or information technology may be used to aid in the evaluation but may not be the primary means of contact or communication. (5) The occupational therapist may delegate to an occupational therapy assistant or temporary licensee the collection of data for the evaluation. The occupational therapist is responsible for the accuracy of the data collected by the assistant. <p>(f) Plan of Care.</p> <ol style="list-style-type: none"> (7) Except where otherwise restricted by rule, the occupational therapy practitioner is responsible for determining whether any aspect of the intervention session may be conducted via telehealth or must be conducted in person. 	<p>COVID-19 update: Governor suspended rules relating to telehealth, including allowing some services to be provided telephonically; Department of Insurance issued emergency rule, which has been extended until September 12, requiring payment and coverage parity between services provided via telehealth and services provided in-person.</p>

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	<p>(8) The occupational therapy practitioners must have contact with the client during the intervention session via telehealth using synchronous audiovisual technology or in person. Other telecommunications or information technology may be used to aid in the intervention session but may not be the primary means of contact or communication.</p> <p>§ 373.1 Supervision of non-Licensed Personnel (c) Supervision of other non-licensed personnel either on-site or via telehealth requires that the occupational therapy practitioner maintain line of sight.</p> <p>§374.4. Code of Ethics. VERACITY Principle 5. Occupational therapy personnel shall provide comprehensive, accurate, and objective information when representing the profession.</p> <p>RELATED STANDARDS OF CONDUCT Occupational therapy personnel shall: J. Maintain privacy and truthfulness when utilizing telecommunication in delivery of occupational therapy services.</p>	
Utah	<p>Statute: Utah Code Title 26, Chapter 60 26-60-102. Definitions. As used in this chapter:</p> <p>(1) "Asynchronous store and forward transfer" means the transmission of a patient's health care information from an originating site to a provider at a distant site.</p> <p>(2) "Distant site" means the physical location of a provider delivering telemedicine services.</p> <p>(3) "Originating site" means the physical location of a patient receiving telemedicine services.</p> <p>(4) "Patient" means an individual seeking telemedicine services.</p> <p>(5) "Provider" means an individual who is:</p> <ul style="list-style-type: none"> (a) licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; (b) licensed under Title 58, Occupations and Professions, to provide health care; or (c) licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities. <p>(6) "Synchronous interaction" means real-time communication through interactive technology that enables a provider at a distant site and a patient at an originating site to interact simultaneously through two-way audio and video transmission.</p> <p>(7) "Telehealth services" means the transmission of health-related services or information through the use of electronic communication or information technology.</p> <p>(8) "Telemedicine services" means telehealth services:</p> <ul style="list-style-type: none"> (a) including: <ul style="list-style-type: none"> (i) clinical care; (ii) health education; (iii) health administration; (iv) home health; or 	<p>No OT specific statute or regulation, but statute and regulation definition of provider does include occupational therapists. AOTA staff has reached out to the Board for clarification on potential updates to statutes, regulations, or policy statements.</p> <p>COVID-19 update: Governor issued Executive Order suspending the requirement that a telehealth platform be HIPAA compliant and any licensure requirement that impairs a practitioner's ability to provide services via telehealth; temporary emergency rule adopted on May 27 and in effect for 120 days that authorizes a Medicaid enrolled provider to deliver covered services via a synchronous or asynchronous telehealth platform as clinically appropriate.</p>

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	<p>(v) facilitation of self-managed care and caregiver support; and</p> <p>(b) provided by a provider to a patient through a method of communication that:</p> <ul style="list-style-type: none"> (i) (A) uses asynchronous store and forward transfer; or (B) uses synchronous interaction; and (ii) meets industry security and privacy standards, including compliance with: <ul style="list-style-type: none"> (A) the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended; and (B) the federal Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended. <p>26-60-103. Scope of telehealth practice.</p> <p>(1) A provider offering telehealth services shall:</p> <ul style="list-style-type: none"> (a) at all times: <ul style="list-style-type: none"> (i) act within the scope of the provider's license under Title 58, Occupations and Professions, in accordance with the provisions of this chapter and all other applicable laws and rules; and (ii) be held to the same standards of practice as those applicable in traditional health care settings; (b) in accordance with Title 58, Chapter 82, Electronic Prescribing Act, before providing treatment or prescribing a prescription drug, establish a diagnosis and identify underlying conditions and contraindications to a recommended treatment after: <ul style="list-style-type: none"> (i) obtaining from the patient or another provider the patient's relevant clinical history; and (ii) documenting the patient's relevant clinical history and current symptoms; (c) be available to a patient who receives telehealth services from the provider for subsequent care related to the initial telemedicine services, in accordance with community standards of practice; (d) be familiar with available medical resources, including emergency resources near the originating site, in order to make appropriate patient referrals when medically indicated; and (e) in accordance with any applicable state and federal laws, rules, and regulations, generate, maintain, and make available to each patient receiving telehealth services the patient's medical records. <p>(2) A provider may not offer telehealth services if:</p> <ul style="list-style-type: none"> (a) the provider is not in compliance with applicable laws, rules, and regulations regarding the provider's licensed practice; or (b) the provider's license under Title 58, Occupations and Professions, is not active and in good standing. <p>26-60-104. Enforcement.</p> <p>(1) The Division of Occupational and Professional Licensing created in Section 58-1-103 is authorized to enforce the provisions of Section 26-60-103 as it relates to providers licensed under Title 58, Occupations and Professions.</p>	

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	<p>(2) The department is authorized to enforce the provisions of Section 26-60-103 as it relates to providers licensed under this title.</p> <p>(3) The Department of Human Services created in Section 62A-1-102 is authorized to enforce the provisions of Section 26-60-103 as it relates to providers licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.</p> <p>Regulation: Utah Administrative Code Rule R156-1, General Rules of the Department of Professional Licensure</p> <p>R156-1-601. Telehealth - Definitions.</p> <p>In accordance with Section 26-60-103 and Subsection 26-60-104(1), in addition to the definitions in Title 58 and Rule R156, as used in this section:</p> <p>(1) "Asynchronous store and forward transfer" means the same as defined in Subsection 26-60-102(1).</p> <p>(2) "Standards of Practice" means those standards of practice applicable in a traditional health care setting, as provided in Subsection 26-60-103(1)(a)(ii).</p> <p>(3) "Distant site" means the same as defined in Subsection 26-60-102(2).</p> <p>(4) "Originating site" means the same as defined in Subsection 26-60-102(3).</p> <p>(5) "Patient" means the same as defined in Subsection 26-60-102(4).</p> <p>(6) "Patient Encounter" means any encounter where medical treatment and/or evaluation and management services are provided. For purposes of this rule, the entire course of an inpatient stay in a healthcare facility or treatment in an emergency department is considered a single patient encounter.</p> <p>(7) "Provider" means the same as defined in Subsection 26-60-102(5)(b), an individual licensed under Title 58 to provide health care services, and:</p> <p style="padding-left: 40px;">(a) shall include an individual exempt from licensure as defined in Section 58-1-307 who provides health care services within the individual's scope of practice under Title 58; and</p> <p style="padding-left: 40px;">(b) for purposes of this section, "provider" may include multiple providers obtaining informed consent and providing care as a team, consistent with the standards of practice applicable to a broader practice model found in traditional health care settings.</p> <p>(8) "Synchronous interaction" means the same as defined in Subsection 26-60-102(6).</p> <p>(9) "Telehealth services" means the same as defined in Subsection 26-60-102(7).</p> <p>(10) "Telemedicine services" means the same as defined in Subsection 26-60-102(8).</p> <p>R156-1-602. Telehealth - Scope of Telehealth Practice.</p> <p>(1) This rule is not intended to alter or amend the applicable standard of practice for any healthcare field or profession. The provider shall be held to the same standards of practice including maintaining patient confidentiality and recordkeeping that would apply to the provision of the same health care services in an in-person setting.</p> <p>(2) In accordance with Section 26-60-103 and Subsection 26-60-104(1), a provider offering telehealth services shall, prior to each patient encounter:</p> <p style="padding-left: 40px;">(a) verify the patient's identity and originating site;</p> <p style="padding-left: 40px;">(b) obtain informed consent to the use of telehealth services by clear disclosure of:</p>	

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	<ul style="list-style-type: none"> (i) additional fees for telehealth services, if any, and how payment is to be made for those additional fees if they are charged separately from any fees for face-to-face services provided to the patient in combination with the telehealth services; (ii) to whom patient health information may be disclosed and for what purpose, including clear reference to any patient consent governing release of patient-identifiable information to a third-party; (iii) the rights of patients with respect to patient health information; (iv) appropriate uses and limitations of the site, including emergency health situations; (v) information: <ul style="list-style-type: none"> (A) affirming that the telehealth services meet industry security and privacy standards, and comply with all laws referenced in Subsection 26-60-102(8)(b)(ii); (B) warning of potential risks to privacy notwithstanding the security measures; (C) warning that information may be lost due to technical failures, and clearly referencing any patient consent to hold the provider harmless for such loss; and (D) disclosing the website owner/operator, location, and contact information; and <p>(c) allow the patient an opportunity to select their provider rather than being assigned a provider at random, to the extent possible;</p> <p>(d) ensure that the online site from which the provider offers telehealth services does not restrict a patient's choice to select a specific pharmacy for pharmacy services.</p> <p>(3) In accordance with Subsection 26-60-103(1)(b), it is not an acceptable standard of care for a provider offering telehealth services to establish a diagnosis and identify underlying conditions and contraindications to a recommended treatment based solely on an online questionnaire, except as specifically provided in Title 58, Chapter 83, the Online Prescribing, Dispensing and Facilitation Licensing Act.</p> <p>(4) In accordance with Subsection 26-60-103(1)(c), a provider offering telehealth services shall be available to the patient for subsequent care related to the initial telemedicine services, by:</p> <ul style="list-style-type: none"> (a) providing the patient with a clear mechanism to: <ul style="list-style-type: none"> (i) access, supplement, and amend patient-provided personal health information; (ii) contact the provider for subsequent care; (iii) obtain upon request an electronic or hard copy of the patient's medical record documenting the telemedicine services, including the informed consent provided; and (iv) request a transfer to another provider of the patient's medical record documenting the telemedicine services; (b) if the provider recommends that the patient needs to be seen in person, such as where diagnosis requires a physical examination, lab work, or imaging studies: <ul style="list-style-type: none"> (i) arranging to see the patient in person, or directing the patient to the patient's regular provider, or if none, to an appropriate provider; and (ii) documenting the recommendation in the patient's medical record; and (c) upon patient request, electronically transferring to another provider the patient's medical record documenting the telemedicine services, within a reasonable time frame allowing for timely care of the patient by that provider. 	

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	<p>(5) In accordance with Subsection 26-60-103(1)(d), a provider offering telehealth services shall be familiar with available medical resources, including emergency resources near the originating site.</p> <p>(6) In settings and circumstances where an established provider-patient relationship is not present, a provider offering telehealth services shall establish a provider-patient relationship during the patient encounter, in a manner consistent with standards of practice including providing the provider's licensure and credentials.</p> <p>(7) Nothing in this section shall prohibit electronic communications consistent with standards of practice applicable in traditional health care settings, including those:</p> <ul style="list-style-type: none"> (a) between a provider and a patient with a preexisting provider-patient relationship; (b) between a provider and another provider concerning a patient with whom the other provider has a provider-patient relationship; (c) in on-call or cross coverage situations in which the provider has access to patient records; (d) in broader practice models where multiple providers provide care as a team, including, for example: <ul style="list-style-type: none"> (i) within an existing organization; or (ii) within an emergency department; or (e) in an emergency, which as used in this section means a situation in which there is an occurrence posing an imminent threat of a life-threatening condition or severe bodily harm. 	
Vermont		<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Governor signed emergency legislation expanding telehealth; Medicaid announced coverage of medically necessary, clinically appropriate services delivered via telephone at the same rate as Medicaid-covered services provided via telehealth; emergency rule requires private insurers to reimburse for health care services, including preventive services, consultation services, and services to new patients, delivered remotely through telehealth, audio-only telephone, asynchronous technology (store-and forward), and brief telecommunication services.</p>

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Virginia	<p><u>Board of Medicine Guidance Document 85-12:</u> Section One: Preamble.</p> <p>The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.</p> <p>These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For the purpose of prescribing controlled substances, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303. A practitioner should conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.</p> <p>The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.</p> <p>It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:</p> <ul style="list-style-type: none"> • Place the welfare of patients first; • Maintain acceptable and appropriate standards of practice; • Adhere to recognized ethical codes governing the applicable profession; • Adhere to applicable laws and regulations; • In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; <p>and</p> <ul style="list-style-type: none"> • Protect patient confidentiality. 	<p>COVID-19 update: DMAS announced that it will cover eligible telehealth services provided via an audio-only platform, that "telepresenters" are not required in order to bill for certain fees, that telehealth services may be obtained in a patient's home, and that telehealth services billed with or without modifiers will be reimbursed at the same rate as in-person services. Executive Order in effect for the duration of the state of emergency to allow health care practitioners with an active license in another state to provide continuity of care to their current patients who are Virginia residents through telehealth services.</p>

State	Citation and Provisions ¹	Notes
	<p>Section Two: Establishing the Practitioner-Patient Relationship. The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present (This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.) a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law. (The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.) While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.</p> <p>A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner’s identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.</p> <p>Section Three: Guidelines for the Appropriate Use of Telemedicine Services. The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.</p> <p><u>Licensure:</u> The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.</p> <p><u>Evaluation and Treatment of the Patient:</u> A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation</p>	

State	Citation and Provisions ¹	Notes
	<p>recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.</p> <p><u>Informed Consent:</u> Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:</p> <ul style="list-style-type: none"> • Identification of the patient, the practitioner, and the practitioner’s credentials; • Types of activities permitted using telemedicine services (e.g., prescription refills, appointment scheduling, patient education, etc.); • Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter; • Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures; • Hold harmless clause for information lost due to technical failures; and • Requirement for express patient consent to forward patient-identifiable information to a third party. <p><u>Medical Records:</u> The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.</p> <p><u>Privacy and Security of Patient Records and Exchange of Information:</u> Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.</p>	

State	Citation and Provisions ¹	Notes
Washington	<p>Regulation: Washington Administrative Code Title 246, Chapter 847, Section 176, Telehealth.</p> <p>(1) "Telehealth" means providing occupational therapy via electronic communication where the occupational therapist or occupational therapy assistant and the patient are not at the same physical location.</p> <p>(2) An occupational therapist or occupational therapy assistant using telehealth to provide therapy to patients in Washington must be licensed to provide occupational therapy in Washington.</p> <p>(3) Licensed occupational therapists and occupational therapy assistants may provide occupational therapy via telehealth following all requirements for supervision and standard of care, including those defined in chapters 18.59 RCW and 246-847 WAC.</p> <p>(4) The occupational therapist or occupational therapy assistant must identify in the clinical record that the occupational therapy occurred via telehealth.</p>	<p>COVID-19 update: Governor signed legislation requiring telehealth services to be reimbursed at the same rate as in-person services and prohibits insurance carriers from denying telehealth services; a subsequent Executive Order expands the new law to include health plans issued or renewed before January 1, 2020; Apple Health will cover telehealth services provided via audio and video, audio only, email, texting, and e-consults.</p>
West Virginia		<p>No statute or regulations specific to OT and telehealth.</p> <p>COVID-19 update: Board states that telehealth is allowed and that, during the pandemic, it will allow an initial visit with a client to be conducted via videoconferencing. Board also drafted permanent telehealth rules; Dept. of Health and Human Services allows enrolled providers to render non-emergent services via telehealth.</p>
Wisconsin		<p>No statute or regulations specific to OT and telehealth, Board has not taken a position. AOTA staff has reached out to the Board for clarification on potential updates to statutes, regulations, or policy statements.</p> <p>COVID-19 update: State of Emergency expired on May 11; ForwardHealth announced that it will temporarily allow currently covered services to be provided via telehealth using real-time technology provided the service can be delivered with functional equivalence to the face-to-</p>

State	Citation and Provisions ¹	Notes
		face service, and audio-only communications are allowed. OT licensing board issued a Statement of Scope announcing consideration of potential rule changes regarding telehealth.
Wyoming	<p>Statute: Wyoming Statutes §33-40-102, Definitions. (a) As used in this act: (v) "Occupational therapy telehealth" means the provision of occupational therapy services across a distance, using telecommunications technology for the evaluation, intervention or consultation without requiring the occupational therapist and recipient to be physically located in the same place;</p> <p>Regulation: Wyoming Administrative Rules Occupational Therapy Board Chapter 3, Section 4, Telehealth (a) In order to provide occupational therapy services via telehealth to a client in Wyoming, the OT providing services to a client must have a valid and current license issued by the Board. Wyoming licensed OT using telehealth technology with a client in another state may also be required to be licensed in the state in which the client receives those services and must adhere to those state licensure laws. (b) When providing occupational therapy services via telehealth, an OT shall determine whether an in-person evaluation is necessary and make every attempt to ensure that a OT is available if an on-site visit is required. (c) The OT is responsible for determining whether any aspect of the provision of services may be conducted via telehealth or must be conducted in person. An OT shall consider at a minimum: (i) the complexity of the client's condition; (ii) his or her own knowledge skills and abilities; (iii) the client's context and environment; (iv) the nature and complexity of the intervention; (v) the pragmatic requirements of the practice setting; and (vi) the capacity and quality of the technological interface. (d) OT shall obtain informed consent of the delivery of service via telehealth from the client prior to initiation of occupational therapy services via telehealth and maintain documentation in the client's health record. (e) An OT or OTA providing occupational therapy services via telehealth must: (i) Exercise the same standard of care when providing occupational therapy services via telehealth as with any other mode of delivery of occupational therapy services.</p>	<p>COVID-19 update: Board reminds licensees that telehealth is allowed under state law and regulation; Insurance Department bulletin encourages providers to liberalize telehealth policies.</p>

Question #1: Can another discipline perform audio-visual skyping during evaluations, therapist progress notes, etc. in the skilled nursing setting?

Pursuant to section 4755-27-03 (F) of the Ohio revised code, delegation of tasks related to the operation and delivery of physical therapy to other licensed personnel must be done in accordance with the scope of practice of the other licensed personnel's professional license, education and training, the level of competence as determined by the supervising physical therapist, and in consideration of the patient's overall needs and medical status.

Paragraph (G)(1-6) of this rule states that " the unlicensed personnel may be assigned routine duties that assist in the delivery of physical therapy care and operations, such as: (1) maintenance and care of equipment and supplies, (2) preparation, maintenance, and cleaning of treatment areas, (3) transportation of patients, (4) Office and clerical functions, (5) assisting patients preparing for, during, and at the conclusion of treatment, and (6) personally assisting the physical therapist, physical therapist assistant, student physical therapist, and/or student physical therapist assistance while the physical therapist, physical therapist assistant, student physical therapist, and/or student physical therapist assistant is concurrently providing services to the same patient.

Pursuant to section 4755-27-02 (B)(1-5) Physical therapist assistants are not qualified to:

- (1) Interpret physician referrals;
- (2) Conduct initial patient evaluations;
- (3) Write initial or ongoing patient plans of care;
- (4) Conduct re-evaluations of the patient or make changes to the patient plan of care; or
- (5) Perform the discharge evaluation and complete the final discharge summary.

Therefore it is the position of the PT board that it is ideal for the physical therapy to complete physical therapy evaluations, therapist progress notes, re-assessments, re-certifications, and discharges in person. In the event that this is not possible secondary to the COVID-19 pandemic, at the discretion of the physical therapy and based on their comfort level given the patient's case, electronic visits are acceptable with the physical therapy assistant only. Unlicensed personnel including, but not limited to nurses, nursing aides, occupational therapists, occupational therapy assistants, physical/occupational therapy aides, and therapists, are not permitted to participate in physical therapy assessments for public safety reasons.

From: [Sarah Heldman](#)
To: [Anthony, Melissa](#); [Mary Beth](#)
Cc: [Jodie Steiner](#)
Subject: Licensure Board updates - OOTA virtual conference
Date: Thursday, August 27, 2020 8:33:05 AM

Hi Missy and Mary Beth -

I hope you both are well! We are offering a virtual conference for OOTA throughout the month of October. Jodie Steiner and myself are coordinating this effort. Would a representative(s) of the OT section of the board be available for updates on 10/28/20 from 6-7:30? We would like to hold the session via zoom with similar content to what we normally do at in person conference. We could collect questions in advance or, you could present based on topics/questions you think are relevant.

Please let me know if you are available and what questions you may have!

Thanks!

Sarah Heldmann, BS, COTA/L
Co-Chair Northwest District of Ohio Occupational Therapy Association



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Occupational Therapy Continuing Education/Ethics Owens Community College – March 2, 2020

Mary Beth Lavey, OTA, OT Section member
Missy Anthony, Executive Director
Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board



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Topics

- OTPTAT Board Overview
- Rules updates and rulemaking process
- Legislative updates and legislative process
- Impact of Richard Strauss case and duty to report
- Occupational Therapy licensure compact
- Board updates
 - Enforcement cases
 - Frequently Asked Questions
 - Continuing Education basics
 - Jurisprudence

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Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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OTPTAT Board Overview – Occupational Therapy Section

The OT Section is committed to proactively:

- Provide education to the consumers of OT services;
- Enforce practice standards for the protection of the consumer of OT services;
- Regulate the profession of OT in an ever-changing environment;
- Regulate ethical and multicultural competency in the practice of OT;
- Regulate the practice of OT in all current and emerging areas of service delivery.

OT Section Vision Statement

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Mission of the OT Section

The mission of the OT
Section is to protect the
public, **NOT** the licensee

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Purpose of Regulatory Boards

- Establishing and checking**
 - Establishing and checking requirements for entry into the profession
- Adopting**
 - Adopting administrative rules
- Enforcing**
 - Enforcing laws related to licensure
- Assuring**
 - Assuring continued competence of licensees

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Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Composition of the Board

- Joint Board consisting of an:**
 - Occupational Therapy Section (4 OT, 1 OTA)
 - Physical Therapy Section (9 PT, 5 on joint board)
 - Athletic Trainers Section (4 AT, 1 physician)
 - One public member
- Total of nine full-time staff**

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OT Section Members

Member	City	Term Expires	Term
Beth Ann Ball, OT,	Worthington	2021	3 rd
Joanne Phillips Estes, PhD, OT,	Cincinnati	2022	2 nd
Mary Beth Lavey, OTA, Section Chair	Fremont	2021	3 rd
Anissa Siefert, MOT, OT	New Washington	2022	2 nd
Melissa Van Allen, OT, Section Secretary	Columbus	2020	1 st

All terms expire on Aug. 27 of the designated year. Pursuant to ORC 4755.01, members shall not serve for more than three (3) consecutive terms

To seek appointment to the Board, contact the Governor's Office and download the application (<http://governor.ohio.gov>)

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License Type	Number of Active Licensee (2/26/2020)
Athletic Trainer	3,055
Occupational Therapist	6,515
Occupational Therapy Assistant	5,128
Physical Therapist	10,303
Physical Therapist Assistant	8,782
Orthotics, Prosthetics, Pedorthics	368
Total	34,151

Licensure Statistics

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board
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Rules Process and Rule Updates



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What are rules?

- Part of the Practice Act
- Also known as the Ohio Administrative Code
- Hold the weight of law
- Breaking a rule can have the same consequence as breaking the law

Adopting rules is a fundamental purpose of the Board

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Initial Public Comment Period

- Rules are first reviewed by members of the Board for necessary changes.
- Once Board input is received, the rules are put out for “Early Stakeholder Release” or ESR.
- ESR rules are posted to the Board website and sent out to the license holders to whom they pertain.
- Public comments can be sent into Rules@otptat.ohio.gov.
- The public comment period is typically two weeks.

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Common Sense Initiative

- Once ESR feedback is received, it is evaluated and shared at a subsequent Board meeting. Board members decide whether to make changes in response to comments.
- Next, the rules are filed with the Common Sense Initiative (CSI) for review.
 - Operated by the Lieutenant Governor’s office
 - CSI takes a minimum of 16 days for review; may take as long as necessary
 - Rules are posted to the CSI website in addition to OTPTAT

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CSI Business Impact Analysis



Ohio | Common Sense Initiative

Mike DeWine, Governor
Jon Husted, Lt. Governor Carrie Kurus, Director

Business Impact Analysis

Agency, Board, or Commission Name: _____

Rule Contact Name and Contact Information: _____

Regulation/Package Title (a general description of the rules' substantive content): _____

Rule Number(s): _____

Date of Submission for CSI Review: _____

Public Comment Period End Date: _____

Rule Type/Number of Rules:

New/ _____ rules	No Change/ _____ rules (FYR? _____)
Amended/ _____ rules (FYR? _____)	Rescinded/ _____ rules (FYR? _____)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIPublicComments@governor.ohio.gov

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CSI Business Impact Analysis

Reason for Submission

1. R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.62. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

Which adverse impact(s) to businesses has the agency determined the rule(s) create?

The rule(s):

- a. Requires a license, permit, or any other prior authorization to engage in or operate a line of business.
- b. Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.
- c. Requires specific expenditures or the report of information as a condition of compliance.
- d. Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language. Please include the key provisions of the regulation as well as any proposed amendments.
3. Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.
4. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program? If yes, please briefly explain the source and substance of the federal requirement.
5. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.
6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?
7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

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CSI Business Impact Analysis

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.9313?
If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.
If applicable, please include the date and medium by which the stakeholders were initially contacted.

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

13. Did the Agency specifically consider a performance-based regulation? Please explain.
Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

- a. Identify the scope of the impacted business community; and
- b. Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance); and
- c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

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CSI Business Impact Analysis

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

19. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

20. What resources are available to assist small businesses with compliance of the regulation?

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CSI Recommendation

If CSI does not have suggestions it sends a memo to the agency acknowledging that its review is complete.

The agency must acknowledge receipt of the memo .

If changes were made based on the recommendation, those changes must be included in the agency's response.



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Joint Committee on Agency Rule Review

- Panel of ten legislators from both the House and Senate who review the rules to make sure state agencies do not exceed their authority based on six "prongs."
 - Do the rules exceed the agency's authority;
 - Do the rules conflict with an existing rule of that agency or another state agency;
 - Do the rules conflict with legislative intent;
 - Has the rule-making agency prepared a complete and accurate rule summary and fiscal analysis of the proposed, amended, or rescinded rule ([ORC 127.18](#));
 - Has the rule-making agency met the incorporation by reference standards for a text or other material as stated in ORC sections [121.71 through 121.75](#); and,
 - If the rule has an adverse impact on business ([ORC 107.52](#)), that the rule-making agency has demonstrated through the business impact analysis (BIA), the Common Sense Initiative Office (CSI) recommendations and the agency's memorandum of response to the CSI recommendations, that the rule's regulatory intent justifies its adverse impact on business.

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Joint Committee on Agency Rule Review

- The JCARR process requires a public hearing to be held 30-41 days after the rules are filed.
- Hearing is held at the Board office.
- This allows one more opportunity for public input on the rules.
- Rules are also posted in the Register of Ohio when they are filed. <http://registerofohio.state.ohio.us>

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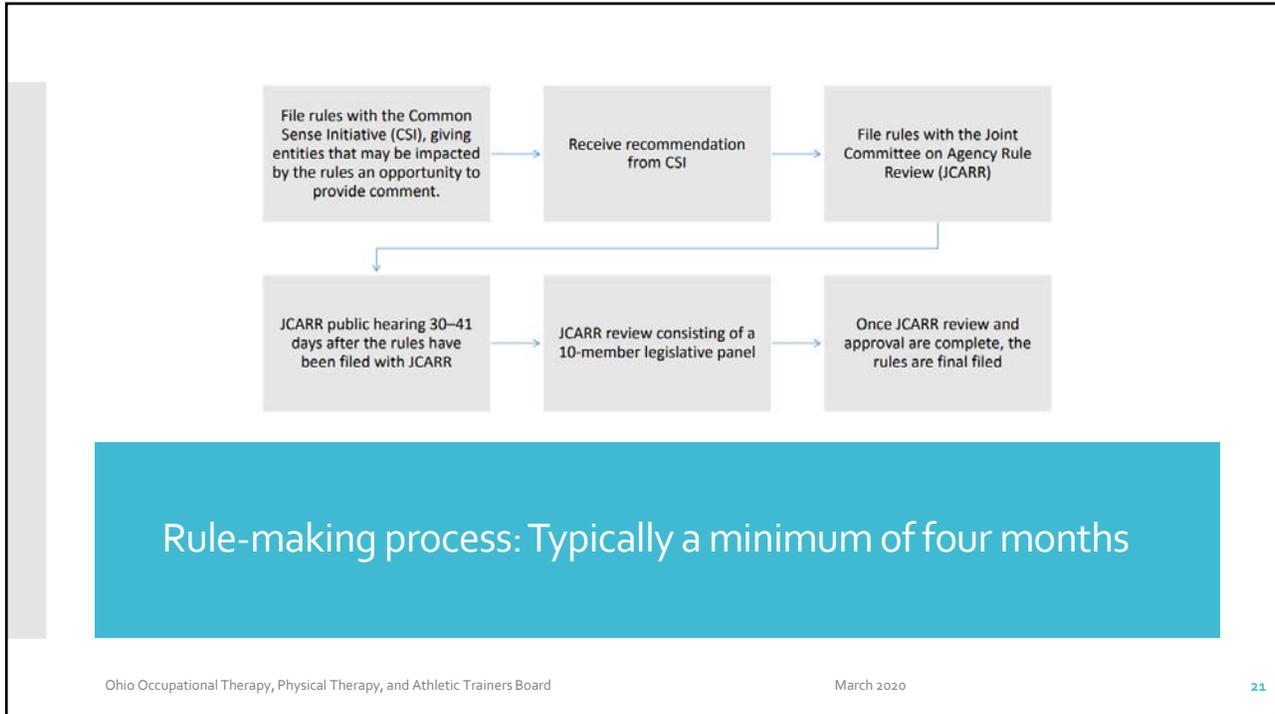
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Joint Committee on Agency Rule Review

- Once the JCARR review has happened at a regular committee meeting, the Board may final file the rules.
- If any comments are received, they come back to the Board for consideration.
- The entire JCARR process takes a minimum of 76 days.
- Once the rules are final filed, they can be effective within ten days.
- Rule changes are then communicated to the license holders and the Laws and Rules document is updated.

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Pending OT Section rules -

<https://otptat.ohio.gov/Rules-Updates>

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- Given legal concerns, it is critical for client safety to ensure that license holders and students can be held responsible for the care they provide.
- Must be 18 to receive a license
 - Increasing number of students taking college credit in high school
- Students – Effective January 1, 2021, a student OT/OTA must be at least 18 to participate in learning opportunities outside the classroom involving clients.
 - Not governing age of admission to a program
 - Focused on issues impacting consumers
- Supervision – Student must 18 years old to be supervised by an OT/OTA, including for Level I and Level II fieldwork.

Minimum Age of 18

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Rule number	Title	Description of proposed change
4755-7-02	Roles and responsibilities	Changes include: 1. Provides more clarity by referring to the "occupational therapy process" for which the occupational therapist must have responsibility instead of "activities" in (A). 2. Replacement of words such as a "must" instead of "shall" to conform with current rule drafting standards and provide consistency throughout all rules.
4755-7-03	Delegation	The changes to this rule make clear that unlicensed personnel cannot act independently.
4755-7-08	Code of ethical conduct	Changes include: 1. Specifies that eLicense records may not be forged. 2. Adds intervention in lieu of a felony as a circumstance that a license holder must report to the board within 30 days. 3. Adds the termination, revocation, suspension, or sanctioning of a professional license in the state of Ohio or another state as a circumstance that a license holder must report to the board within 30 days.
4755-7-10	Required credential to indicate licensure or student status	Reviewed for five-year rule review. No changes proposed.

Five Year Review Filed with CSI – Board will review comments in March

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Continuing Education - 4755-9-01

This rule defines what activities count toward continuing education for occupational therapists and occupational therapy assistants. The rule change adds two activities which can count as continuing education in the mentorship category. The rule change also eliminates conflicting language to make it clear that continuing education is not required for first renewals, as has been the practice.

- 1. Continuing education credit can be earned by mentoring a practitioner in the first year of practice or any practitioner entering a practice area or attempting to achieve certification in a practice area in which the mentee has no prior experience. One contact hour may be earned for every eighty hours of mentorship completed, with a maximum of four contact hours per renewal cycle. Proof of mentorship will be a written contract which includes the signatures of the mentor and the practitioner who has agreed to be mentored. The contract must also include a time log documenting the mentor's activities and the time spent completing those activities.
- 2. Continuing education credit can be earned by mentoring a practitioner of an AOTA Fellowship Program. The mentor must spend a minimum of 340 hours with the fellow while the fellow delivers occupational therapy services in the identified practice area. Four contact hours may be earned for each AOTA Fellowship Program mentorship with only one mentorship eligible for contact hours per renewal cycle. Proof of mentorship will be the written contract developed by the AOTA Fellowship Program and documentation of successful completion by this program.

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Ohio Department of Education – Related Services Rules

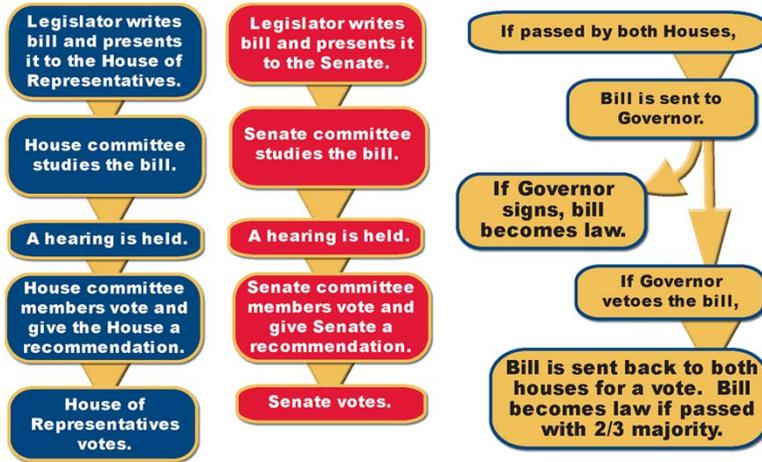
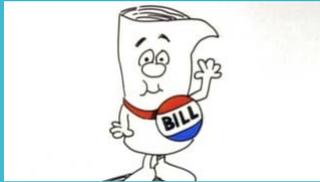
Five Year Review

- Definitions
- Workload ratios
- Use of assistants
- Draft changes out for comment in April
- Ohio Department of Education, Office for Exceptional Children

<http://education.ohio.gov/Topics/Special-Education/Office-of-Exceptional-Children-Contact-Information>

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Legislative Updates



March 2020

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Situation: The Board was made aware of non-profit work that has developed in which 3-D printers are used to print prostheses.



Technically, this falls within the scope of a license prosthetist.



Board took a look. Falls in the space of a potentially anti-competitive action, so referral made to the Common Sense Initiative (CSI).



CSI agreed that it falls within the scope of a prosthetist, but believed the work should continue.



CSI sought an amendment to the budget allowing the Board to approve people to do 3-D printing of Open-Source Prosthetics.

Example: 3-D Printing of Prosthetics

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Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Pending/ Recently Passed Legislation

- Senate Bill 7 - To require state occupational licensing agencies, under certain circumstances, to issue temporary licenses or certificates to members of the military and spouses who are licensed in another jurisdiction and have moved to Ohio for military duty. (effective end of April)
- Senate Bill 246/House Bill 432 - To require an occupational licensing authority to issue a license or government certification to an applicant who holds a license, government certification, or private certification or has satisfactory work experience in another state under certain circumstances. (pending in respective committees)
- House Bill 263 – Fresh Start Act, To revise the initial occupational licensing restrictions applicable to individuals convicted of criminal offenses. (waiting for House floor vote)
- Senate Bill 238 - To license and regulate art therapists and music therapists. (pending in committee)
- House Bill 484 - Regarding the practice of athletic training. (pending in committee)
- Senate Bill 272 - To enter into the Physical Therapy Licensure Compact. (pending in committee)

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Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Occupational Therapy Licensure Compact

What is a licensure compact?

- Allow licensed occupational therapists and occupational therapy assistants to practice across state lines (e.g., telehealth)
- Improve consumer access to occupational therapy
- Enhance mobility of occupational therapy practitioners (e.g., spouses of relocating military families, staff of travel therapy companies)
- Improve continuity of care
- Preserve and strengthen the state licensure system
- Enhance the exchange of licensure, investigatory, and disciplinary information between member states.

Goal is to have language available to states for consideration in late 2020 – Stay tuned for opportunities for public input!

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Richard Strauss case: State Medical Board of Ohio



March 2020

Governor DeWine created a working group in May to review the medical board's 1996 investigation after a separate investigation commissioned by Ohio State found that Strauss, who committed suicide in 2005, sexually assaulted at least 177 male students while working as a doctor in Ohio State's athletic department and/or student health center from the late 1970s to mid-1990s.

The working group noted an "astounding failure" of anyone in a position of authority at the university to initiate a medical board or criminal investigation into Strauss' conduct. Although medical board investigators specifically identified physicians in 1996 who may have failed to report Strauss, the board did not pursue action against those individual physicians for allegedly disregarding their statutory obligation to notify the board or law enforcement.

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Duty to report

- Licensees also have a responsibility, a duty, to report practitioners that are incompetent, unprofessional, or unlawful. When health care practitioners act outside of normal professional standards, the public loses trust in that person or potentially the profession as a whole.
- The state board's first priority is protecting the public and may use a variety of remedial and punitive sanctions to prevent future incidents. When OTs, OTAs, or employers report incidents to the Board, the complaint is investigated, and, if substantiated, appropriate action is taken. The Board will work to correct the practitioner's behavior and increase the understanding of the problem.
- If an issue is never reported, the practitioner can simply be fired or resign and seek employment at another facility with no consequence, potentially putting others at risk.

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Duty to report

- It is your duty to report another practitioner when you have reasonable cause to believe that person is unable to practice safely, has engaged in unprofessional conduct, violated laws or rules, or committed unethical practices. OAC 4755-7-08 (A)(9)
- Failure to report could result in professional disciplinary action by the state Board.
- Complaint portal:
https://elicense.ohio.gov/oh_filecomplaint

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Ohio Administrative Code 4755-7-08 Code of Ethics

(9) A licensee shall not exploit a client, or the parent/guardian of a minor client, sexually, physically, emotionally, financially, socially, or in any other manner.

(10) A licensee shall not engage in conduct that constitutes harassment or verbal or physical abuse of, or unlawful discrimination against, clients, the parent/guardian of a minor client, students, and/or colleagues.

(11) A licensee shall not engage in any sexual relationship or conduct, including dating, with any client, or engage in any conduct that may reasonably be interpreted by the client to be sexual, whether consensual or nonconsensual, while a practitioner-client relationship exists and for six months immediately following the termination of the practitioner-client relationship. In the case of minors, the practitioner-client relationship extends to the minor's parent or guardian.

(a) A licensee shall not intentionally expose or view a completely or partially disrobed client in the course of treatment if the exposure or viewing is not related to the client diagnosis or treatment under current practice standards.

(b) A licensee shall not engage in a conversation with a client that is sexually explicit and unrelated to the occupational therapy intervention plan.

Boundary violations

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Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Ohio Administrative Code 4755-7-08 Code of Ethics

(12) A licensee shall not engage in sexual harassment of clients, the parent/guardian of a minor client, students, and/or colleagues. Sexual harassment includes, but is not limited to, making unwelcome sexual advances, requesting sexual favors, and engaging in other verbal or physical conduct of a sexual nature that results in:

- (a) Withholding occupational therapy services to a client;
- (b) Creating an intimidating, hostile, or offensive environment; or
- (c) Interfering with the client's ability to recover.

Boundary
violations

March 2020

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Board Updates

Board@otptat.ohio.gov

<https://otptat.ohio.gov/>

614-466-3774



36

Escrow elimination

- With the requirements of reinstatement being so similar to restoration from escrow, this was oftentimes confusing to license holders.
- The Section came to the conclusion that very little benefit is achieved through the escrow option.
- Additionally, OT/OTA were the only license types with an escrow option at the OTPTAT Board.
- License holders will not have the ability to place their license in escrow during the upcoming OT renewal. The ability to restore a license from escrow is maintained for the licenses currently in escrow.

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OTA renewal 2020

- Renewal begins April 1, 2020.
- Visit https://elicense.ohio.gov/OH_CommunitiesLogin to complete the renewal application. Google Chrome is the preferred browser. If you are having trouble logging in, please contact the Customer Service Center at (855) 405-5514, Monday-Friday from 8:00am-5:00pm. Deadline is June 30, 2020. You cannot renew late!
- Continuing Education: As a reminder, first time renewals do not need to complete education requirements. When completing the renewal process, simply answer "0" to the number of hours you completed. All others must have 20 hours of Ohio approved CE.
- Please note, you do not have to submit your certificates during the license renewal. Please retain them for at least two years in the case that you are randomly selected for continuing education audit.

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Continuing Education

Basic requirement of 20 hours, including one hour of ethics, jurisprudence, or cultural competence

UNCHANGED

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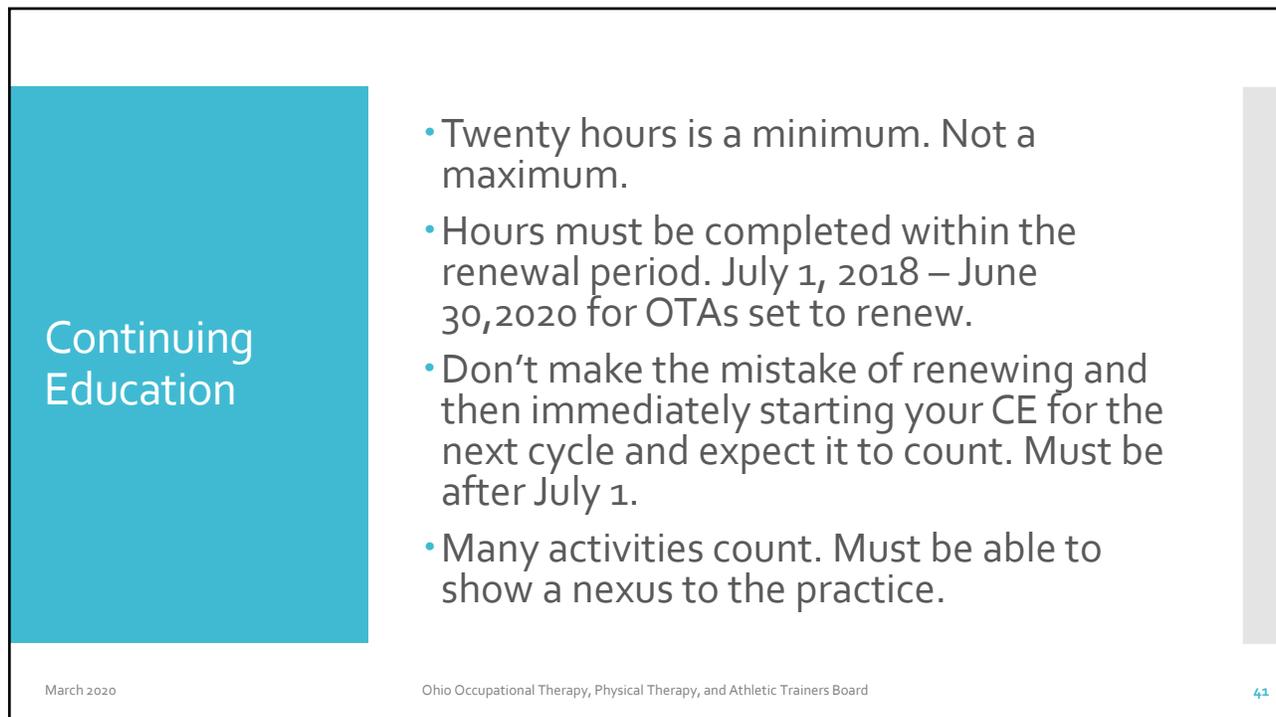
Continuing Education

Recent changes allow:

- Activities sponsored or approved by the occupational therapy section, the American occupational therapy association (AOTA), the Ohio occupational therapy association (OOTA), the national board for certification in occupational therapy, or offered by an AOTA approved provider. This includes NBCOT’s Navigator.
- Volunteer Continuing education at free clinics.

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Continuing Education

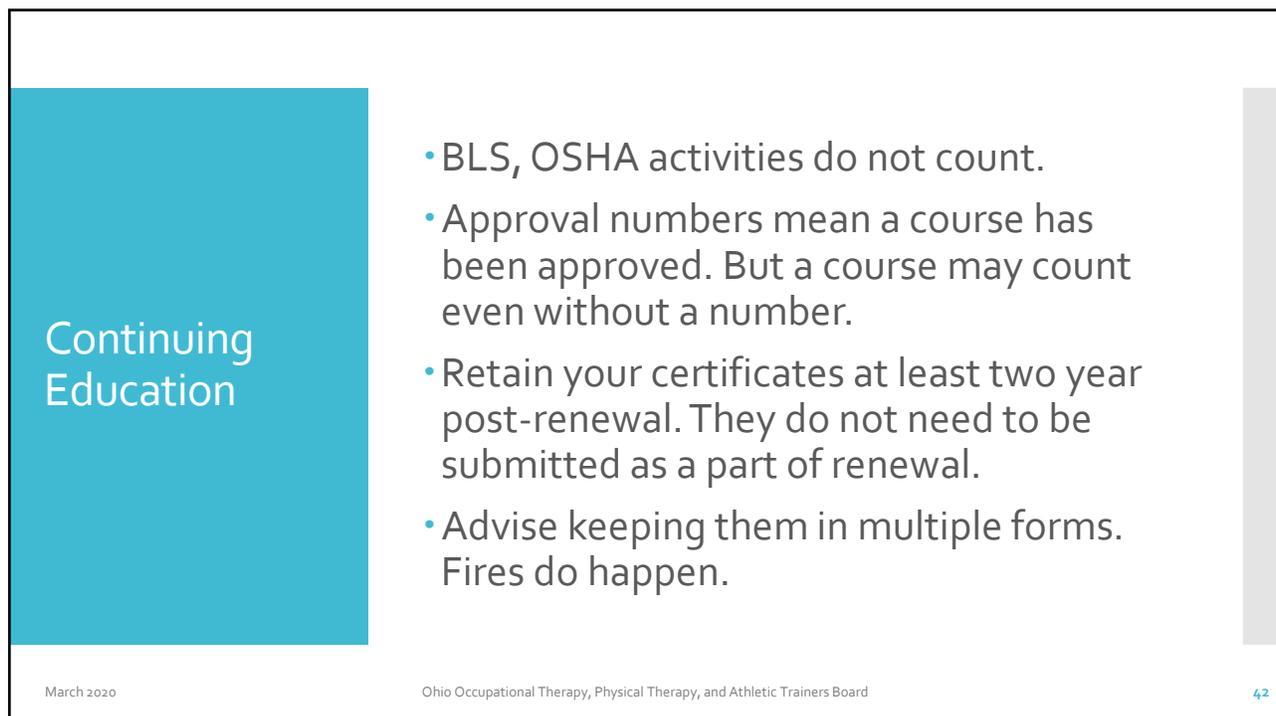
- Twenty hours is a minimum. Not a maximum.
- Hours must be completed within the renewal period. July 1, 2018 – June 30, 2020 for OTAs set to renew.
- Don't make the mistake of renewing and then immediately starting your CE for the next cycle and expect it to count. Must be after July 1.
- Many activities count. Must be able to show a nexus to the practice.

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Continuing Education

- BLS, OSHA activities do not count.
- Approval numbers mean a course has been approved. But a course may count even without a number.
- Retain your certificates at least two year post-renewal. They do not need to be submitted as a part of renewal.
- Advise keeping them in multiple forms. Fires do happen.

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License display

“The licensee shall display the license in a conspicuous place at the licensee's principal place of business.”

- Problematic for license holders who practice in multiple settings.
- Use of technology has increased – license record can be accessed anywhere at any time online.
- PDF of license will soon be available through eLicense.
- Rule will permit ability to display license electronically to meet this requirement.

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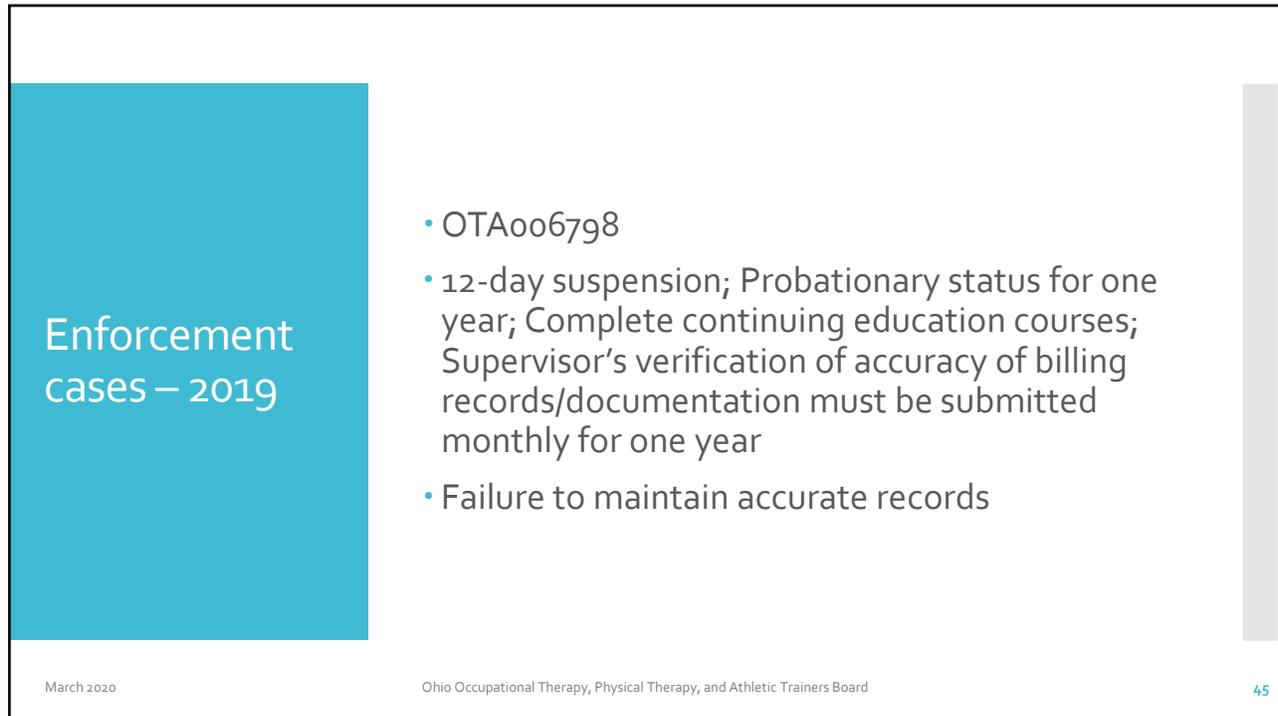
43

Enforcement cases – 2019

- OTA001277
- Voluntary surrender/simultaneous revocation
- Meyung provided zero (0) contact hours of continuing education completion within the continuing education reporting period of July 1, 2016, to June 30, 2018.

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Enforcement cases – 2019

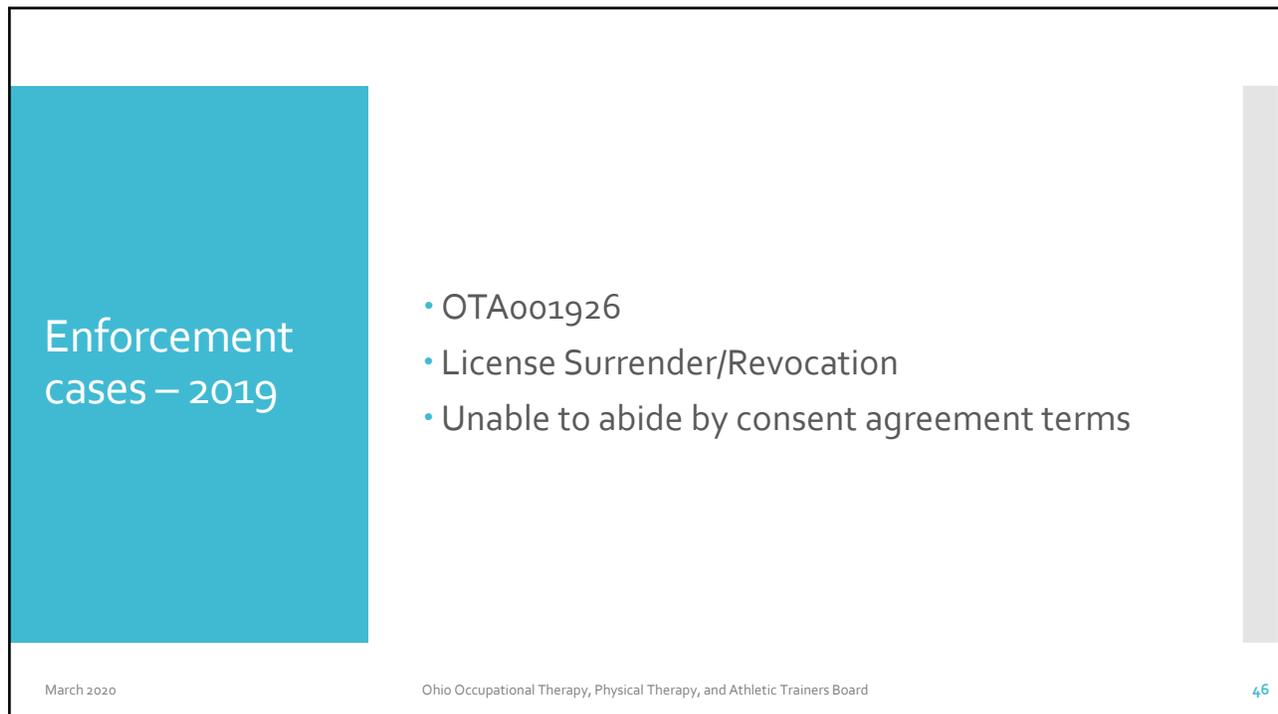
- OTA006798
- 12-day suspension; Probationary status for one year; Complete continuing education courses; Supervisor's verification of accuracy of billing records/documentation must be submitted monthly for one year
- Failure to maintain accurate records

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Enforcement cases – 2019

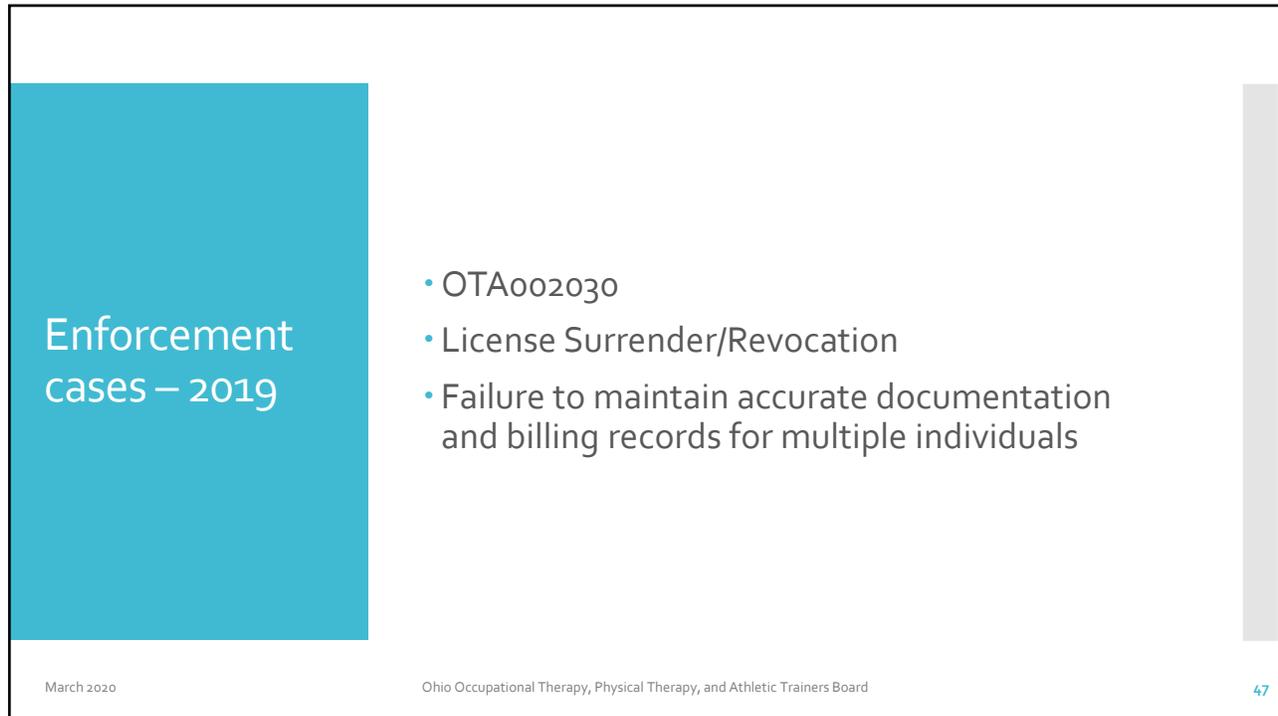
- OTA001926
- License Surrender/Revocation
- Unable to abide by consent agreement terms

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Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Enforcement cases – 2019

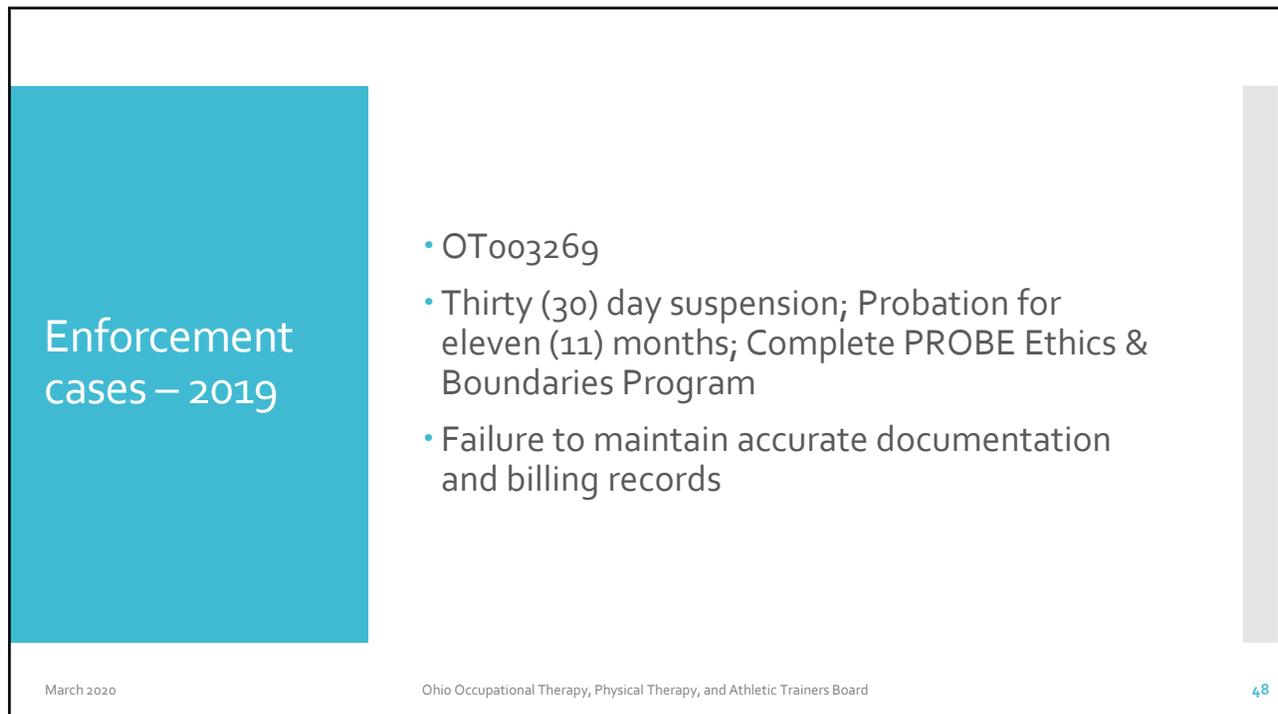
- OTA002030
- License Surrender/Revocation
- Failure to maintain accurate documentation and billing records for multiple individuals

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Enforcement cases – 2019

- OT003269
- Thirty (30) day suspension; Probation for eleven (11) months; Complete PROBE Ethics & Boundaries Program
- Failure to maintain accurate documentation and billing records

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Enforcement cases – 2019

- OTA003814
- One (1) year probation; Complete ethics course; Complete Ohio laws and rules examination; Supervision/verification of accuracy of billing records and submit monthly report of such to Board
- Failure to maintain accurate billing records; Failure to cooperate with an investigation

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Enforcement cases – 2019

- OTA001926
- Probation until 07/01/2020; Random Drug/Alcohol Screenings; Participate in Drug/Alcohol Rehabilitation Program 3/week
- Felony Conviction

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Frequently Asked Questions

My company has laid me off, and has offered to me a STNA position within the buildings for a higher wage. The VP insinuated that COTA/L would make better aides because we are shoos ins for aides anyway. She insinuated that because of our skills and education essentially, she was willing to pay us more to be STNA, and in turn we would be helping out the building. She stated we would be following the Nursing plan of care, so we would not be documenting or billing as a COTA, but we would not be documenting as an STNA either.

- When working in an alternate role, the following should be considered:
- Pursuant to rules 4755-7-04 and 4755-7-10 of the Administrative Code, the OTA, OTA/L and COTA/L credentials may only be utilized if the occupational therapy assistant is under the supervision of an occupational therapist. 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. The National Board of Certification for Occupational Therapy owns the trademark for the credential COTA, and it may used according to NBCOT’s standards.
- In fulfilling the duties as an nurses aide, it is imperative that you not present yourself in an OTA role without the appropriate OT evaluation in place and supervision of a licensed OT.

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Frequently Asked Questions

Can I perform (fill in the blank) modality?

- In accordance with section [4755.04 \(A\)\(3\)](#) of the Ohio Revised Code, it is the position of the Occupational Therapy Section that occupational therapy practitioners may use therapeutic modalities in the provision of occupational therapy services provided that the occupational therapy practitioner demonstrates and documents competency in the modality, in accordance with rule [4755-7-08](#) of the Administrative Code. Additionally, occupational therapy practitioners must be practicing within the occupational therapy scope of practice when using their modalities in the provision of services. If the modality will be administered by an occupational therapy assistant both the supervising occupational therapist and occupational therapy assistant must document and demonstrate competency in the techniques or modality.

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Frequently Asked Questions

I am looking for guidance regarding crossing state lines. We have outpatient clinics in WV and OH. Is it ok for the patient to be evaluated in WV and treatment rendered in OH?

Pursuant to the Ohio OT Practice Act, the OT who **completes the evaluation** needs to be licensed in the state where the evaluation takes place, i.e. where the client is physically located.

The OT who **provides treatment intervention** needs to be licensed in the state where the treatment occurs, i.e. where the client is physically located. Therefore, the treating OT/OTA and supervising OT have to be licensed in state where treatment takes place.

It is recommended that you refer to the West Virginia licensure law regarding their standards. Exceptions occur where state licensure laws accommodate therapists who are not licensed in said state to provide interventions (evaluation or treatment) in its state without holding a license (e.g. a state licensure law may allow an OT who is not licensed in that state to treat clients in that state if she/he is licensed in another state **and** is sponsored by an OT licensed in the state where the treatment is taking place).

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Board Communications

- “Like” the Board on Facebook at <https://www.facebook.com/OhioOTPTATBoard>
- Follow the Board’s Twitter feed at <http://twitter.com/OhioOTPTATBd>
- Each Section has its own listserv
 - To join, go to Board’s website and select “Join a Board Listserv” link on the homepage

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Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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Contacting the Board

- You may contact the Board by any of the following methods:

- Internet: <http://otptat.ohio.gov>

- Email: board@otptat.ohio.gov

- Phone: 614-466-3774

- Fax: 614-995-0816

- Mail:

Ohio OTPTAT Board
77 S. High Street, 16th Floor
Columbus, OH 43215-6108

Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board

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DRAFT OT COMPACT

1 SECTION 1. PURPOSE

2 The purpose of this Compact is to facilitate interstate practice of Occupational Therapy with the goal of
3 improving public access to Occupational Therapy services. The Practice of Occupational Therapy occurs
4 in the State where the patient/client is located at the time of the patient/client encounter. The Compact
5 preserves the regulatory authority of States to protect public health and safety through the current
6 system of State licensure.

7 This Compact is designed to achieve the following objectives:

- 8 A. Increase public access to Occupational Therapy services by providing for the mutual recognition of
9 other Member State licenses;
- 10 B. Enhance the States' ability to protect the public's health and safety;
- 11 C. Encourage the cooperation of Member States in regulating multi-State Occupational Therapy
12 Practice;
- 13 D. Support spouses of relocating military members;
- 14 E. Enhance the exchange of licensure, investigative, and disciplinary information between Member
15 States; and
- 16 F. Allow a Remote State to hold a provider of services with a Compact Privilege in that State
17 accountable to that State's practice standards.
- 18 G. Facilitate the use of Telehealth technology in order to increase access to Occupational Therapy
19 services.

20 SECTION 2. DEFINITIONS

21 As used in this Compact, and except as otherwise provided, the following definitions shall apply:

- 22 A. "Active Duty Military" means full-time duty status in the active uniformed service of the United
23 States, including members of the National Guard and Reserve on active duty orders pursuant to 10
24 U.S.C. Chapter 1209 and Section 1211.
- 25 B. "Adverse Action" means any administrative, civil, equitable or criminal action permitted by a State's
26 laws which is imposed by a Licensing Board or other authority against an Occupational Therapist or
27 Occupational Therapy Assistant, including actions against an individual's license or Compact
28 Privilege such as revocation, suspension, probation, monitoring of the Licensee, or restriction on the
29 Licensee's practice.

Commented [AM1]: I want to be sure an adverse action by another Board or state agency (such as the Department of Education) would be included.

Commented [AM2]: This term seems overly vague – too inclusive

DRAFT OT COMPACT

- 30 C. "Alternative Program" means a non-disciplinary monitoring process approved by an Occupational
31 Therapy Licensing Board to address Impaired Practitioners.
- 32 D. "Compact Privilege" means the authorization, which is equivalent to a license, granted by a Remote
33 State to allow a Licensee from another Member State to practice as an Occupational Therapist or
34 practice as an Occupational Therapy Assistant in the Remote State under its laws and rules. The
35 Practice of Occupational Therapy occurs in the Member State where the patient/client is located at
36 the time of the patient/client encounter.
- 37 E. "Continuing Competence/Education" means a requirement, as a condition of license renewal, to
38 provide evidence of participation in, and/or completion of, educational and professional activities
39 relevant to practice or area of work.
- 40 F. "Current Significant Investigative Information" means Investigative Information that a Licensing
41 Board, after an inquiry or investigation that includes notification and an opportunity for the
42 Occupational Therapist or Occupational Therapy Assistant to respond, if required by State law, has
43 reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.
- 44 G. "Data System" means a repository of information about Licensees, including but not limited to,
45 licensure, Investigative Information, Compact Privilege, and Adverse Action.
- 46 H. "Encumbered License" means a license in which an Adverse Action restricts the Practice of
47 Occupational Therapy by the Licensee and said Adverse Action has been reported to the National
48 Practitioners Data Bank (NPDB).
- 49 I. "Executive Committee" means a group of directors elected or appointed to act on behalf of, and
50 within the powers granted to them by, the Commission.
- 51 J. "Home State" means the Member State that is the Licensee's primary State of residence.
- 52 K. "Impaired Practitioner" means individuals whose professional practice is adversely affected by
53 substance abuse, addiction, or other health-related conditions.
- 54 L. "Investigative Information" means information, records, and/or documents received or generated
55 by an Occupational Therapy Licensing Board pursuant to an investigation.
- 56 M. "Jurisprudence Requirement" means the assessment of an individual's knowledge of the laws and
57 rules governing the Practice of Occupational Therapy in a State.
- 58 N. "Licensee" means an individual who currently holds an authorization from the State to practice as
59 an Occupational Therapist or as an Occupational Therapy Assistant.
- 60 O. "Member State" means a State that has enacted the Compact.

Commented [CRH3]: How will a state's information which may be protected under federal or state law, e.g., HIPAA, PHI, FERPA, also be protected when submitted to the Data System. Can a state be in violation of HIPAA if it shares protected its protected information with the Data system. Which state controls if there is a public records request.

Commented [AM4]: Do all states report? Immediately? This seems limiting. I would suggest OR instead of AND.

Commented [AM5]: This definition should just be spelled out in C. The term isn't used elsewhere.

DRAFT OT COMPACT

- 61 P. "Occupational Therapist" means an individual who is licensed by a State to practice Occupational
62 Therapy.
- 63 Q. "Occupational Therapy Assistant" means an individual who is licensed by a State to assist in the
64 Practice of Occupational Therapy.
- 65 R. "Occupational Therapy," "Occupational Therapy Practice," and the "Practice of Occupational
66 Therapy" mean the care and services provided by an Occupational Therapist or an Occupational
67 Therapy Assistant as set forth in the Member State's statutes and regulations.
- 68 S. "Occupational Therapy Compact Commission" or "Commission" means the national administrative
69 body whose membership consists of all States that have enacted the Compact.
- 70 T. "Occupational Therapy Licensing Board" or "Licensing Board" means the agency of a State that is
71 responsible for the licensing and regulation of Occupational Therapists and Occupational Therapy
72 Assistants.
- 73 U. "Remote State" means a Member State other than the Home State, where a Licensee is exercising or
74 seeking to exercise the Compact Privilege.
- 75 V. "Rule" means a regulation promulgated by the Commission that has the force of law.
- 76 W. "State" means any state, commonwealth, district, or territory of the United States of America that
77 regulates the Practice of Occupational Therapy.
- 78 X. "Single-State License" means an Occupational Therapist or Occupational Therapy Assistant license
79 issued by a Member State that authorizes practice only within the issuing State and does not include
80 a Compact Privilege in any other Member State.
- 81 Y. "Telehealth" means the application of telecommunication technology to deliver Occupational
82 Therapy services for assessment, intervention and/or consultation.

Commented [AM6]: Should supervision be included?

83 SECTION 3. STATE PARTICIPATION IN THE COMPACT

- 84 A. To participate in the Compact, a Member State shall:
- 85 1. License Occupational Therapists and Occupational Therapy Assistants
 - 86 2. Participate fully in the Commission's Data System, including using the Commission's unique
87 identifier as defined in Rules;
 - 88 3. Have a mechanism in place for receiving and investigating complaints about Licensees;
 - 89 4. Notify the Commission, in compliance with the terms of the Compact and Rules, of any Adverse
90 Action or the availability of Investigative Information regarding a Licensee;

DRAFT OT COMPACT

- 91 5. Implement or utilize procedures for considering the criminal history records of applicants for an
92 initial Compact Privilege. These procedures shall include the submission of fingerprints or other
93 biometric-based information by applicants for the purpose of obtaining an applicant's criminal
94 history record information from the Federal Bureau of Investigation and the agency responsible
95 for retaining that State's criminal records.
- 96 a. A Member State shall fully implement a criminal background check requirement,
97 within a time frame established by Rule, by receiving the results of the Federal Bureau
98 of Investigation record search on criminal background checks and use the results in
99 making licensure decisions.
- 100 b. Communication between a Member State, the Commission and among Member
101 States regarding the verification of eligibility for licensure through the Compact shall not
102 include any information received from the Federal Bureau of Investigation relating to a
103 federal criminal records check performed by a Member State under Public Law 92-544.
- 104 6. Comply with the Rules of the Commission;
- 105 7. Utilize only a recognized national examination as a requirement for licensure pursuant to
106 the Rules of the Commission; and
- 107 8. Have Continuing Competence/Education requirements as a condition for license renewal.
- 108 B. A Member State shall grant the Compact Privilege to a Licensee holding a valid unencumbered
109 license in another Member State in accordance with the terms of the Compact and Rules.
- 110 C. Member States may charge a fee for granting a Compact Privilege
- 111 D. A Member State shall provide for the State's delegate to attend all Occupational Therapy Compact
112 Commission meetings.
- 113 E. Individuals not residing in a Member State shall continue to be able to apply for a Member State's
114 Single-State License as provided under the laws of each Member State. However, the Single-State
115 License granted to these individuals shall not be recognized as granting the Compact Privilege in any
116 other Member State.
- 117 F. Nothing in this Compact shall affect the requirements established by a Member State for the
118 issuance of a Single-State License.

119 SECTION 4. COMPACT PRIVILEGE

- 120 A. To exercise the Compact Privilege under the terms and provisions of the Compact, the Licensee
121 shall:

DRAFT OT COMPACT

- 122 1. Have a valid United States Social Security or National Practitioner Identification number;
- 123 2. Hold a license in the Home State;
- 124 3. Have no encumbrance on any State license;
- 125 4. Be eligible for a Compact Privilege in any Member State in accordance with Section 4D, G and H;
- 126 5. Have not had any Adverse Action against any license or Compact Privilege within the previous 2
127 years;
- 128 6. Notify the Commission that the Licensee is seeking the Compact Privilege within a Remote
129 State(s);
- 130 7. Pay any applicable fees, including any State fee, for the Compact Privilege;
- 131 8. Meet any Jurisprudence Requirements established by the Remote State(s) in which the Licensee
132 is seeking a Compact Privilege; and
- 133 9. Report to the Commission Adverse Action taken by any non-Member State within 30 days from
134 the date the Adverse Action is taken.
- 135 B. The Compact Privilege is valid until the expiration date of the Home State license. The Licensee must
136 comply with the requirements of Section 4A to maintain the Compact Privilege in the Remote State.
- 137 C. A Licensee providing Occupational Therapy in a Remote State under the Compact Privilege shall
138 function within the laws and regulations of the Remote State.
- 139 D. Occupational Therapy Assistants practicing in a Remote State shall be supervised by an Occupational
140 Therapist licensed or holding a Compact Privilege in that Remote State.
- 141 E. A Licensee providing Occupational Therapy in a Remote State is subject to that State's regulatory
142 authority. A Remote State may, in accordance with due process and that State's laws, remove a
143 Licensee's Compact Privilege in the Remote State for a specific period of time, impose fines, and/or
144 take any other necessary actions to protect the health and safety of its citizens. The Licensee is not
145 eligible for a Compact Privilege in any State until the specific time for removal has passed and all
146 fines are paid.
- 147 F. If a Home State license is encumbered, the Licensee shall lose the Compact Privilege in any Remote
148 State until the following occur:
 - 149 1. The Home State license is no longer encumbered; and
 - 150 2. Two years have elapsed from the date of the Adverse Action.

Commented [AM7]: Why the "or" here? What is a scenario in which someone would not have a SSN but they would have an NPI?

Commented [CRH8]: "previous 2 years" from what? This is vague...consider rewording to: "previous 2 years from the date of application."

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151 G. Once an Encumbered License in the Home State is restored to good standing, the Licensee must
152 meet the requirements of Section 4A to obtain a Compact Privilege in any Remote State.

153 H. If a Licensee's Compact Privilege in any Remote State is removed, the individual shall lose the
154 Compact Privilege in any other Remote State until the following occur:

155 1. The specific period of time for which the Compact Privilege was removed has ended;

156 2. All fines have been paid;

157 3. Two years have elapsed from the date of the Adverse Action; and

158 4. Privileges are reinstated or restored through a revision to the compact Data System.

159 I. If a Licensee's Compact Privilege in any Remote State is removed due to an erroneous charge,
160 privileges shall be restored through a revision to the compact Data System.

161 J. Once the requirements of Section 4H have been met, the license must meet the requirements in
162 Section 4A to obtain a Compact Privilege in a Remote State.

163 SECTION 5: CONVERTING COMPACT PRIVILEGES

164 A. An OT/OTA may hold a license, issued by the Home State which allows for Compact Privileges, in
165 only one member-State at a time.

166 B. If an OT/OTA changes primary State of residence by moving between two Member States:

167 1. The OT/OTA shall notify the current and new Member States in accordance with applicable
168 Rules adopted by the Commission.

169 2. The current Home State shall deactivate the current license and the new Home State shall
170 activate the new license in accordance with applicable Rules adopted by the Commission.

171 3. The activation of the license in the new Home State shall be based upon the same criteria as in
172 Section 4, which allows an OT/OTA to have Compact Privileges to work in a Member State.

173 4. If the OT/OTA cannot meet the criteria in Section 4, the new Home State shall apply its
174 requirements for issuing a new Single-State License.

175 5. The OT/OTA shall pay all applicable fees to the new Home State in order to be issued a new
176 Home State license.

177 C. If an OT/OTA changes primary State of residence by moving from a Member State to a non-Member
178 State, or from a non-Member State to a Member State, the State criteria shall apply for issuance of a
179 Single-State License in the new State.

Commented [CRH9]: What does this mean

Commented [AM10R9]: Agreed.

Commented [AM11]: 1.I understand that the trend is toward reciprocity with other states with regard to licensure. But that doesn't mean that regulatory boards appreciate this new trend which blurs the constitutional lines of states' rights. Having a license from Ohio at this time still infers that the Board has conducted a review and decided to license the person via its standard review of primary source documentation.
2.The answer for most states to avoid these reciprocity bills is a compact. That should be the preferred approach. An expedited process is not necessary.
3.I am concerned this sets up two versions of reciprocity - one for compact states and one for people coming from non compact states. That is not equitable. It also sets a precedent and implies that the streamlined process should be the norm.
4.I don't think this saves a bunch of time. There would still be some verification involved.
5.Biggest concern off the top of my head is background check. Cannot be sure if another state reviews with the same standards and rigor as my state. This skips the background check review.
6."Deactivate" a license. We don't do that. They naturally expire. Not to say we couldn't, but why would we? And who verifies whether they have moved? Deactivate on the direction of the commission?

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180 D. Nothing in this compact shall interfere with a Licensee's ability to hold a Single-State License in
181 multiple States, however for the purposes of this compact, a Licensee shall have only one Home
182 State license.

183 E. Nothing in this Compact shall affect the requirements established by a Member State for the
184 issuance of a Single-State License.

185 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES

186 Active Duty Military personnel, or their spouse, shall designate a Home State where the individual
187 has a current license in good standing. The individual may retain the Home State designation during
188 the period the service member is on active duty. Subsequent to designating a Home State, the
189 individual shall only change their Home State through application for licensure in the new State.

Commented [AM12]: Shouldn't they either go with their Home State or the state where they are stationed? This would allow them to choose any state.

190 SECTION 7. ADVERSE ACTIONS

191 A. A Home State shall have exclusive power to impose Adverse Action against a license issued by the
192 Home State.

193 B. In addition to the other powers conferred by State law, a Remote State shall have the authority, in
194 accordance with existing State due process law, to:

195 1. Take Adverse Action against an Occupational Therapist's or Occupational Therapy Assistant's
196 Compact Privilege within that Member State.

197 2. Issue subpoenas for both hearings and investigations that require the attendance and testimony
198 of witnesses as well as the production of evidence. Subpoenas issued by a Licensing Board in a
199 Member State for the attendance and testimony of witnesses or the production of evidence
200 from another Member State shall be enforced in the latter State by any court of competent
201 jurisdiction, according to the practice and procedure of that court applicable to subpoenas
202 issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel
203 expenses, mileage and other fees required by the service statutes of the State in which the
204 witnesses or evidence are located.

205 3. Only the Home State shall have the power to take Adverse Action against an Occupational
206 Therapist's or Occupational Therapy Assistant's license issued by the Home State.

Commented [CRH13]: This seems to duplicate A.

207 C. For purposes of taking Adverse Action, the Home State shall give the same priority and effect to
208 reported conduct received from a Member State as it would if the conduct had occurred within the
209 Home State. In so doing, the Home State shall apply its own State laws to determine appropriate
210 action.

Commented [AM14R13]: Agreed.

Commented [CRH15]: Is this a bootleg charge

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- 211 D. The Home State shall complete any pending investigations of an Occupational Therapist or
212 Occupational Therapy Assistant who changes primary State of residence during the course of the
213 investigations. The Home State, where the investigations were initiated, shall also have the
214 authority to take appropriate action(s) and shall promptly report the conclusions of the
215 investigations to the OT Compact Commission Data System. The Occupational Therapy Compact
216 Commission Data System administrator of the coordinated licensure information system shall
217 promptly notify the new Home State of any Adverse Actions.
- 218 E. A Member State, if otherwise permitted by State law, may recover from the affected Occupational
219 Therapist or Occupational Therapy Assistant the costs of investigations and disposition of cases
220 resulting from any Adverse Action taken against that Occupational Therapist or Occupational
221 Therapy Assistant.
- 222 F. A Member State may take Adverse Action based on the factual findings of the Remote State,
223 provided that the Member State follows its own procedures for taking the Adverse Action.
- 224 G. Joint Investigations
- 225 1. In addition to the authority granted to a Member State by its respective State Occupational
226 Therapy laws and regulations or other applicable State law, any Member State may participate
227 with other Member States in joint investigations of Licensees.
- 228 2. Member States **shall** share any investigative, litigation, or compliance materials in furtherance
229 of any joint or individual investigation initiated under the Compact.
- 230 H. If an Adverse Action is taken by the Home State against an Occupational Therapist's or Occupational
231 Therapy Assistant's license, the Occupational Therapist's or Occupational Therapy Assistant's
232 Compact Privilege in all other Member States shall be deactivated until all encumbrances have been
233 removed from the State license. All Home State disciplinary orders that impose Adverse Action
234 against an Occupational Therapist's or Occupational Therapy Assistant's license shall include a
235 Statement that the Occupational Therapist's or Occupational Therapy Assistant's Compact Privilege
236 is deactivated in all Member States during the pendency of the order.
- 237 I. If a Member State takes Adverse Action, it shall promptly notify the administrator of the Data
238 System. The administrator of the Data System shall promptly notify the Home State of any Adverse
239 Actions by Remote States.
- 240 J. Nothing in this Compact shall override a Member State's decision that participation in an Alternative
241 Program may be used in lieu of Adverse Action.
- 242

Commented [AM16]: Does the license holder also have a duty to self report?

Commented [CRH17]: How will a state's information which is protected under federal or state law, e.g., HIPAA, PHI, FERPA, also be protected when submitted to the Data System. Can a state be in violation of HIPAA if it shares protected its protected information with the Data system. Which state controls if there is a public records request.

"Litigation" must exclude attorney-client privilege and work product privilege; we do not want anyone claiming that a state waived their attorney-client or work product privilege by providing that information to another state under the compact.

Also, if allowed, if the other does not a confidentiality statute, how is that handled in a public records request?

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243 SECTION 8. ESTABLISHMENT OF THE OCCUPATIONAL THERAPY COMPACT COMMISSION.

- 244 A. The Compact Member States hereby create and establish a joint public agency known as the
245 Occupational Therapy Compact Commission:
- 246 1. The Commission is an instrumentality of the Compact States.
- 247 2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely
248 and exclusively in a court of competent jurisdiction where the principal office of the Commission
249 is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts
250 or consents to participate in alternative dispute resolution proceedings.
- 251 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
- 252 B. Membership, Voting, and Meetings
- 253 1. Each Member State shall have and be limited to one (1) delegate selected by that Member
254 State's Licensing Board.
- 255 2. The delegate shall be a current member of the Licensing Board, who is an Occupational
256 Therapist, Occupational Therapy Assistant, public member, or the board administrator.
- 257 3. Any delegate may be removed or suspended from office as provided by the law of the State
258 from which the delegate is appointed.
- 259 4. The Member State board shall fill any vacancy occurring in the Commission within 60 days.
- 260 5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of Rules and
261 creation of bylaws and shall otherwise have an opportunity to participate in the business and
262 affairs of the Commission. A delegate shall vote in person or by such other means as provided in
263 the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or
264 other means of communication.
- 265 6. The Commission shall meet at least once during each calendar year. Additional meetings shall be
266 held as set forth in the bylaws.
- 267 7. Terms for delegates shall be three (3) years. Delegates shall not serve more than two (2) terms.
- 268 C. The Commission shall have the following powers and duties:
- 269 1. Establish a Code of Ethics for the Commission
- 270 2. Establish the fiscal year of the Commission;
- 271 3. Establish bylaws;

Commented [AM18]: Not sure term limits are a good idea. Many Boards may want their administrator to continue in this position.

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- 272 4. Maintain its financial records in accordance with the bylaws;
- 273 5. Meet and take such actions as are consistent with the provisions of this Compact and the
274 bylaws;
- 275 6. Promulgate uniform Rules to facilitate and coordinate implementation and administration of
276 this Compact. The Rules shall have the force and effect of law and shall be binding in all Member
277 States;
- 278 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided that
279 the standing of any State Occupational Therapy Licensing Board to sue or be sued under
280 applicable law shall not be affected;
- 281 8. Purchase and maintain insurance and bonds;
- 282 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of
283 a Member State;
- 284 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals
285 appropriate authority to carry out the purposes of the Compact, and to establish the
286 Commission's personnel policies and programs relating to conflicts of interest, qualifications of
287 personnel, and other related personnel matters;
- 288 11. Accept any and all appropriate donations and grants of money, equipment, supplies, materials
289 and services, and to receive, utilize and dispose of the same; provided that at all times the
290 Commission shall avoid any appearance of impropriety and/or conflict of interest;
- 291 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or
292 use, any property, real, personal or mixed; provided that at all times the Commission shall avoid
293 any appearance of impropriety;
- 294 13. Sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property
295 real, personal, or mixed;
- 296 14. Establish a budget and make expenditures;
- 297 15. Borrow money;
- 298 16. Appoint committees, including standing committees composed of members, State regulators,
299 State legislators or their representatives, and consumer representatives, and such other
300 interested persons as may be designated in this Compact and the bylaws;
- 301 17. Provide and receive information from, and cooperate with, law enforcement agencies;

Commented [CRH19]: What kind of actions and where can the Commission bring those actions?

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- 302 18. Establish and elect an Executive Committee; and
- 303 19. Perform such other functions as may be necessary or appropriate to achieve the purposes of
- 304 this Compact consistent with the State regulation of Occupational Therapy licensure and
- 305 practice.

306 D. The Executive Committee

307 The Executive Committee shall have the power to act on behalf of the Commission according to the

308 terms of this Compact.

- 309 1. The Executive Committee shall be composed of nine members:
- 310 a. Seven voting members who are elected by the Commission from the current membership of
- 311 the Commission;
- 312 b. One ex-officio, nonvoting member from a recognized national Occupational Therapy
- 313 professional association; and
- 314 c. One ex-officio, nonvoting member from a recognized national Occupational Therapy
- 315 certification organization
- 316 2. The ex-officio members will be selected by their respective organizations.
- 317 3. The Commission may remove any member of the Executive Committee as provided in bylaws.
- 318 4. The Executive Committee shall meet at least annually.
- 319 5. The Executive Committee shall have the following Duties and responsibilities:
- 320 a. Recommend to the entire Commission changes to the Rules or bylaws, changes to this
- 321 Compact legislation, fees paid by Compact Member States such as annual dues, and any
- 322 Commission Compact fee charged to Licensees for the Compact Privilege;
- 323 b. Ensure Compact administration services are appropriately provided, contractual or
- 324 otherwise;
- 325 c. Prepare and recommend the budget;
- 326 d. Maintain financial records on behalf of the Commission;
- 327 e. Monitor Compact compliance of Member States and provide compliance reports to the
- 328 Commission;
- 329 f. Establish additional committees as necessary; and
- 330 g. Other duties as provided in Rules or bylaws.

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331 E. Meetings of the Commission

332 1. All meetings shall be open to the public, and public notice of meetings shall be given in the same
333 manner as required under the Rulemaking provisions in Section 10.

Commented [CRH20]: Whose public records law applies?

334 2. The Commission or the Executive Committee or other committees of the Commission may
335 convene in a closed, non-public meeting if the Commission or Executive Committee or other
336 committees of the Commission must discuss:

337 a. Non-compliance of a Member State with its obligations under the Compact;

338 b. The employment, compensation, discipline or other matters, practices or procedures
339 related to specific employees or other matters related to the Commission's internal
340 personnel practices and procedures;

341 c. Current, threatened, or reasonably anticipated litigation;

342 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

343 e. Accusing any person of a crime or formally censuring any person;

344 f. Disclosure of trade secrets or commercial or financial information that is privileged or
345 confidential;

346 g. Disclosure of information of a personal nature where disclosure would constitute a clearly
347 unwarranted invasion of personal privacy;

348 h. Disclosure of investigative records compiled for law enforcement purposes;

349 i. Disclosure of information related to any investigative reports prepared by or on behalf of or
350 for use of the Commission or other committee charged with responsibility of investigation
351 or determination of compliance issues pursuant to the Compact; or

352 j. Matters specifically exempted from disclosure by federal or Member State statute.

353 3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal
354 counsel or designee shall certify that the meeting may be closed and shall reference each
355 relevant exempting provision.

356 4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a
357 meeting and shall provide a full and accurate summary of actions taken, and the reasons
358 therefore, including a description of the views expressed. All documents considered in
359 connection with an action shall be identified in such minutes. All minutes and documents of a

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360 closed meeting shall remain under seal, subject to release by a majority vote of the Commission
361 or order of a court of competent jurisdiction.

362 F. Financing of the Commission

363 1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
364 establishment, organization, and ongoing activities.

365 2. The Commission may accept any and all appropriate revenue sources, donations, and grants of
366 money, equipment, supplies, materials, and services.

367 3. The Commission may levy on and collect an annual assessment from each Member State or
368 impose fees on other parties to cover the cost of the operations and activities of the
369 Commission and its staff, which must be in a total amount sufficient to cover its annual budget
370 as approved by the Commission each year for which revenue is not provided by other sources.
371 The aggregate annual assessment amount shall be allocated based upon a formula to be
372 determined by the Commission, which shall promulgate a Rule binding upon all Member States.

373 4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to
374 meet the same; nor shall the Commission pledge the credit of any of the Member States, except
375 by and with the authority of the Member State.

376 5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts
377 and disbursements of the Commission shall be subject to the audit and accounting procedures
378 established under its bylaws. However, all receipts and disbursements of funds handled by the
379 Commission shall be audited yearly by a certified or licensed public accountant, and the report
380 of the audit shall be included in and become part of the annual report of the Commission.

381 G. Qualified Immunity, Defense, and Indemnification

382 1. The members, officers, executive director, employees and representatives of the Commission
383 shall be immune from suit and liability, either personally or in their official capacity, for any
384 claim for damage to or loss of property or personal injury or other civil liability caused by or
385 arising out of any actual or alleged act, error or omission that occurred, or that the person
386 against whom the claim is made had a reasonable basis for believing occurred within the scope
387 of Commission employment, duties or responsibilities; provided that nothing in this paragraph
388 shall be construed to protect any such person from suit and/or liability for any damage, loss,
389 injury, or liability caused by the intentional or willful or wanton misconduct of that person.

390 2. The Commission shall defend any member, officer, executive director, employee or
391 representative of the Commission in any civil action seeking to impose liability arising out of any
392 actual or alleged act, error, or omission that occurred within the scope of Commission

Commented [CRH21]: What about former members, officers, executive director, etc. Does this protection extend to this group?

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393 employment, duties, or responsibilities, or that the person against whom the claim is made had
394 a reasonable basis for believing occurred within the scope of Commission employment, duties,
395 or responsibilities; provided that nothing herein shall be construed to prohibit that person from
396 retaining his or her own counsel; and provided further, that the actual or alleged act, error, or
397 omission did not result from that person's intentional or willful or wanton misconduct.

398 3. The Commission shall indemnify and hold harmless any member, officer, executive director,
399 employee, or representative of the Commission for the amount of any settlement or judgment
400 obtained against that person arising out of any actual or alleged act, error or omission that
401 occurred within the scope of Commission employment, duties, or responsibilities, or that such
402 person had a reasonable basis for believing occurred within the scope of Commission
403 employment, duties, or responsibilities, provided that the actual or alleged act, error, or
404 omission did not result from the intentional or willful or wanton misconduct of that person.

Commented [CRH22]: What about former members, officers, executive director, etc. Does this protection extend to this group?

Commented [CRH23]: What about former members, officers, executive director, etc. Does this protection extend to this group?

405 **SECTION 9. DATA SYSTEM**

406 A. The Commission shall provide for the development, maintenance, and utilization of a coordinated
407 database and reporting system containing licensure, Adverse Action, and Investigative Information
408 on all licensed individuals in Member States.

409 B. A Member State shall submit a uniform data set to the Data System on all individuals to whom this
410 Compact is applicable as required by the Rules of the Commission, including:

- 411 1. Identifying information;
- 412 2. Licensure data;
- 413 3. Adverse Actions against a license or Compact Privilege;
- 414 4. Non-confidential information related to Alternative Program participation;
- 415 5. Any denial of application for licensure, and the reason(s) for such denial; and
- 416 6. Other information that may facilitate the administration of this Compact, as determined by the
417 Rules of the Commission.

418 7. Current Significant Investigative Information.

419 C. Investigative Information pertaining to a Licensee in any Member State will only be available to
420 other Member States.

421 D. The Commission shall promptly notify all Member States of any Adverse Action taken against a
422 Licensee or an individual applying for a license. Adverse Action information pertaining to a Licensee
423 in any Member State will be available to any other Member State.

Commented [CRH24]: How will a state's information which is protected under federal or state law, e.g., HIPAA, PHI, FERPA, also be protected when submitted to the Data System. Can a state be in violation of HIPAA if it shares protected its protected information with the Data system. Which state controls if there is a public records request.

Commented [AM25]: I have a huge problem with this. Doesn't due process apply? What determines in an investigation is significant? State law protects our investigations.

Commented [CRH26]: Which public records law would apply? What if the member state's does not have a statute that exempts investigative records from a public records request.

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- 424 E. Member States contributing information to the Data System may designate information that may
425 not be shared with the public without the express permission of the contributing State.
- 426 F. Any information submitted to the Data System that is subsequently required to be expunged by the
427 laws of the Member State contributing the information shall be removed from the Data System.

428 **SECTION 10. RULEMAKING**

- 429 A. The Commission shall exercise its Rulemaking powers pursuant to the criteria set forth in this
430 Section and the Rules adopted thereunder. Rules and amendments shall become binding as of the
431 date specified in each Rule or amendment.
- 432 B. If a majority of the legislatures of the Member States rejects a Rule, by enactment of a statute or
433 resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
434 the Rule, then such Rule shall have no further force and effect in any Member State.
- 435 C. Rules or amendments to the Rules shall be adopted at a regular or special meeting of the
436 Commission.
- 437 D. Prior to promulgation and adoption of a final Rule or Rules by the Commission, and at least thirty
438 (30) days in advance of the meeting at which the Rule will be considered and voted upon, the
439 Commission shall file a Notice of Proposed Rulemaking:
- 440 1. On the website of the Commission or other publicly accessible platform; and
- 441 2. On the website of each Member State Occupational Therapy Licensing Board or other publicly
442 accessible platform or the publication in which each State would otherwise publish proposed
443 Rules.
- 444 E. The Notice of Proposed Rulemaking shall include:
- 445 1. The proposed time, date, and location of the meeting in which the Rule will be considered and
446 voted upon;
- 447 2. The text of the proposed Rule or amendment and the reason for the proposed Rule;
- 448 3. A request for comments on the proposed Rule from any interested person; and
- 449 4. The manner in which interested persons may submit notice to the Commission of their intention
450 to attend the public hearing and any written comments.
- 451 F. Prior to adoption of a proposed Rule, the Commission shall allow persons to submit written data,
452 facts, opinions, and arguments, which shall be made available to the public.

Commented [CRH27]: Will this express permission by the contributing state be controlled or governed by that state's public records law?

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- 453 G. The Commission shall grant an opportunity for a public hearing before it adopts a Rule or
454 amendment if a hearing is requested by:
- 455 1. At least twenty-five (25) persons;
- 456 2. A State or federal governmental subdivision or agency; or
- 457 3. An association or organization having at least twenty-five (25) members.
- 458 H. If a hearing is held on the proposed Rule or amendment, the Commission shall publish the place,
459 time, and date of the scheduled public hearing. If the hearing is held via electronic means, the
460 Commission shall publish the mechanism for access to the electronic hearing.
- 461 1. All persons wishing to be heard at the hearing shall notify the executive director of the
462 Commission or other designated member in writing of their desire to appear and testify at the
463 hearing not less than five (5) business days before the scheduled date of the hearing.
- 464 2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair
465 and reasonable opportunity to comment orally or in writing.
- 466 3. All hearings will be recorded. A copy of the recording will be made available on request.
- 467 4. Nothing in this section shall be construed as requiring a separate hearing on each Rule. Rules
468 may be grouped for the convenience of the Commission at hearings required by this section.
- 469 I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if
470 the hearing was not held, the Commission shall consider all written and oral comments received.
- 471 J. If no written notice of intent to attend the public hearing by interested parties is received, the
472 Commission may proceed with promulgation of the proposed Rule without a public hearing.
- 473 K. The Commission shall, by majority vote of all members, take final action on the proposed Rule and
474 shall determine the effective date of the Rule, if any, based on the Rulemaking record and the full
475 text of the Rule.
- 476 L. Upon determination that an emergency exists, the Commission may consider and adopt an
477 emergency Rule without prior notice, opportunity for comment, or hearing, provided that the usual
478 Rulemaking procedures provided in the Compact and in this section shall be retroactively applied to
479 the Rule as soon as reasonably possible, in no event later than ninety (90) days after the effective
480 date of the Rule. For the purposes of this provision, an emergency Rule is one that must be adopted
481 immediately in order to:
- 482 1. Meet an imminent threat to public health, safety, or welfare;

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- 483 2. Prevent a loss of Commission or Member State funds;
- 484 3. Meet a deadline for the promulgation of an administrative Rule that is established by federal
- 485 law or Rule; or
- 486 4. Protect public health and safety;

487 M. The Commission or an authorized committee of the Commission may direct revisions to a previously

488 adopted Rule or amendment for purposes of correcting typographical errors, errors in format, errors

489 in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website

490 of the Commission. The revision shall be subject to challenge by any person for a period of thirty

491 (30) days after posting. The revision may be challenged only on grounds that the revision results in a

492 material change to a Rule. A challenge shall be made in writing and delivered to the chair of the

493 Commission prior to the end of the notice period. If no challenge is made, the revision will take

494 effect without further action. If the revision is challenged, the revision may not take effect without

495 the approval of the Commission.

496 SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

497 A. Oversight

- 498 1. The executive, legislative, and judicial branches of State government in each Member State shall
- 499 enforce this Compact and take all actions necessary and appropriate to effectuate the
- 500 Compact's purposes and intent. The provisions of this Compact and the Rules promulgated
- 501 hereunder shall have standing as statutory law.
- 502 2. All courts shall take judicial notice of the Compact and the Rules in any judicial or administrative
- 503 proceeding in a Member State pertaining to the subject matter of this Compact which may
- 504 affect the powers, responsibilities or actions of the Commission.
- 505 3. The Commission shall be entitled to receive service of process in any such proceeding, and shall
- 506 have standing to intervene in such a proceeding for all purposes. Failure to provide service of
- 507 process to the Commission shall render a judgment or order void as to the Commission, this
- 508 Compact, or promulgated Rules.

509 B. Default, Technical Assistance, and Termination

- 510 1. If the Commission determines that a Member State has defaulted in the performance of its
- 511 obligations or responsibilities under this Compact or the promulgated Rules, the Commission
- 512 shall:

Commented [CRH28]: What's the difference between (L)(1) and (L)(4)? What's the purpose of (L)(4) for passage of an emergency rule when (L)(1) covers public health and safety. If the threshold or trigger under (L)(4) is protecting the public health and safety, why would this rise to an emergency rule-making.

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- 513 a. Provide written notice to the defaulting State and other Member States of the nature of the
514 default, the proposed means of curing the default and/or any other action to be taken by
515 the Commission; and
- 516 b. Provide remedial training and specific technical assistance regarding the default.
- 517 2. If a State in default fails to cure the default, the defaulting State may be terminated from the
518 Compact upon an affirmative vote of a majority of the Member States, and all rights, privileges
519 and benefits conferred by this Compact may be terminated on the effective date of termination.
520 A cure of the default does not relieve the offending State of obligations or liabilities incurred
521 during the period of default.
- 522 3. Termination of membership in the Compact shall be imposed only after all other means of
523 securing compliance have been exhausted. Notice of intent to suspend or terminate shall be
524 given by the Commission to the governor, the majority and minority leaders of the defaulting
525 State's legislature, and each of the Member States.
- 526 4. A State that has been terminated is responsible for all assessments, obligations, and liabilities
527 incurred through the effective date of termination, including obligations that extend beyond the
528 effective date of termination.
- 529 5. The Commission shall not bear any costs related to a State that is found to be in default or that
530 has been terminated from the Compact, unless agreed upon in writing between the Commission
531 and the defaulting State.
- 532 6. The defaulting State may appeal the action of the Commission by petitioning the U.S. District
533 Court for the District of Columbia or the federal district where the Commission has its principal
534 offices. The prevailing member shall be awarded all costs of such litigation, including reasonable
535 attorney's fees.
- 536 C. Dispute Resolution
- 537 1. Upon request by a Member State, the Commission shall attempt to resolve disputes related to
538 the Compact that arise among Member States and between member and non-Member States.
- 539 2. The Commission shall promulgate a Rule providing for both mediation and binding dispute
540 resolution for disputes as appropriate.
- 541 D. Enforcement
- 542 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
543 Rules of this Compact.

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544 2. By majority vote, the Commission may initiate legal action in the United States District Court for
545 the District of Columbia or the federal district where the Commission has its principal offices
546 against a Member State in default to enforce compliance with the provisions of the Compact
547 and its promulgated Rules and bylaws. The relief sought may include both injunctive relief and
548 damages. In the event judicial enforcement is necessary, the prevailing member shall be
549 awarded all costs of such litigation, including reasonable attorney's fees.

550 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
551 may pursue any other remedies available under federal or State law.

552 **SECTION 12. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR OCCUPATIONAL**
553 **THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT**

554 A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in
555 the tenth Member State. The provisions, which become effective at that time, shall be limited to the
556 powers granted to the Commission relating to assembly and the promulgation of Rules. Thereafter,
557 the Commission shall meet and exercise Rulemaking powers necessary to the implementation and
558 administration of the Compact.

559 B. Any State that joins the Compact subsequent to the Commission's initial adoption of the Rules shall
560 be subject to the Rules as they exist on the date on which the Compact becomes law in that State.
561 Any Rule that has been previously adopted by the Commission shall have the full force and effect of
562 law on the day the Compact becomes law in that State.

563 C. Any Member State may withdraw from this Compact by enacting a statute repealing the same.

564 1. A Member State's withdrawal shall not take effect until six (6) months after enactment of the
565 repealing statute.

566 2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Occupational
567 Therapy Licensing Board to comply with the investigative and Adverse Action reporting
568 requirements of this act prior to the effective date of withdrawal.

569 D. Nothing contained in this Compact shall be construed to invalidate or prevent any Occupational
570 Therapy licensure agreement or other cooperative arrangement between a Member State and a
571 non-Member State that does not conflict with the provisions of this Compact.

572 E. This Compact may be amended by the Member States. No amendment to this Compact shall
573 become effective and binding upon any Member State until it is enacted into the laws of all Member
574 States.

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576 SECTION 13. CONSTRUCTION AND SEVERABILITY

577 This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of
578 this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is
579 declared to be contrary to the constitution of any Member State or of the United States or the
580 applicability thereof to any government, agency, person or circumstance is held invalid, the validity
581 of the remainder of this Compact and the applicability thereof to any government, agency, person
582 or circumstance shall not be affected thereby. If this Compact shall be held contrary to the
583 constitution of any Member State, the Compact shall remain in full force and effect as to the
584 remaining Member States and in full force and effect as to the Member State affected as to all
585 severable matters.

586 SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS

- 587 A. A Licensee providing Occupational Therapy in a Remote State under the Compact Privilege shall
588 function within the laws and regulations of the Remote State.
- 589 B. Nothing herein prevents the enforcement of any other law of a Member State that is not
590 inconsistent with the Compact.
- 591 C. Any laws in a Member State in conflict with the Compact are superseded to the extent of the
592 conflict.
- 593 D. Any lawful actions of the Commission, including all Rules and bylaws promulgated by the
594 Commission, are binding upon the Member States.
- 595 E. All agreements between the Commission and the Member States are binding in accordance with
596 their terms.
- 597 F. In the event any provision of the Compact exceeds the constitutional limits imposed on the
598 legislature of any Member State, the provision shall be ineffective to the extent of the conflict with
599 the constitutional provision in question in that Member State.

Commented [AM29]: Would this mean that my investigative information would not/could not be shared because our Ohio law protects it?