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**OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD**  
**Room N208, 4822 Madison Yards Way, 2<sup>nd</sup> Floor, Madison**  
**Contact: Valerie Payne (608) 266-2112**  
**November 19, 2019**

*The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.*

**AGENDA**

**9:30 A.M.**

**OPEN SESSION – CALL TO ORDER – ROLL CALL**

**A. Adoption of Agenda (1-3)**

**B. Approval of Minutes of September 10, 2019 (4-10)**

**C. Conflicts of Interest**

**D. Administrative Matters – Discussion and Consideration**

- 1) Department, Staff and Board Updates
- 2) Board Members – Term Expiration Dates
- 3) Wis. Stat. s. 15.085(3)(b) – Biannual Meeting with the Medical Examining Board

**E. Legislative and Policy Matters – Discussion and Consideration**

**F. Administrative Rule Matters – Discussion and Consideration**

- 1) Preliminary Draft Rules for OT 3, Relating to Biennial Registration **(11-17)**
- 2) Pending and Possible Rulemaking Projects

**G. Potential Changes to OT Administrative Code – Discussion and Consideration (18)**

- 1) Creation of Occupational Therapy Examining Board **(19)**
- 2) Eliminating Oral Exam Requirement
- 3) Process for OTs and OTAs Practicing Occupational Therapy Using Telemedicine **(20-42)**
- 4) Potential Changes to Rules Related to AOTA/NBCOT Compact Agreement for Reciprocity Between States **(43)**

**H. Licensing OTs, OTAs and Graduates – Discussion and Consideration**

**I. Speaking Engagements, Travel, or Public Relation Requests, and Reports**

- 1) Consider Attendance: 2020 AOTA Annual Conference and Expo – March 26-29, 2020 – Boston, MA **(51-52) Added to Agenda**

J. Discussion and Consideration of Items Added After Preparation of Agenda:

- 1) Introductions, Announcements and Recognition
- 2) Administrative Matters
- 3) Election of Officers
- 4) Appointment of Liaisons and Alternates
- 5) Delegation of Authorities
- 6) Education and Examination Matters
- 7) Credentialing Matters
- 8) Practice Matters
- 9) Legislative and Policy Matters
- 10) Administrative Rule Matters
- 11) Liaison Reports
- 12) Board Liaison Training and Appointment of Mentors
- 13) Informational Items
- 14) Division of Legal Services and Compliance (DLSC) Matters
- 15) Presentations of Petitions for Summary Suspension
- 16) Petitions for Designation of Hearing Examiner
- 17) Presentation of Stipulations, Final Decisions and Orders
- 18) Presentation of Proposed Final Decisions and Orders
- 19) Presentation of Interim Orders
- 20) Petitions for Re-Hearing
- 21) Petitions for Assessments
- 22) Petitions to Vacate Orders
- 23) Requests for Disciplinary Proceeding Presentations
- 24) Motions
- 25) Petitions
- 26) Appearances from Requests Received or Renewed
- 27) Speaking Engagements, Travel, or Public Relation Requests, and Reports

K. Public Comments

**CONVENE TO CLOSED SESSION to deliberate on cases following hearing (s. 19.85(1)(a), Stats.); to consider licensure or certification of individuals (s. 19.85(1)(b), Stats.); to consider closing disciplinary investigations with administrative warnings (ss. 19.85(1)(b), and 448.02(8), Stats.); to consider individual histories or disciplinary data (s. 19.85(1)(f), Stats.); and to confer with legal counsel (s. 19.85(1)(g), Stats.).**

L. Deliberation on DLSC Matters

**1) Stipulations, Final Decisions and Orders**

a.18 OTB 005 – Erin A. Paul, O.T. **(44-50)**

M. Open Cases

N. Deliberation of Items Added After Preparation of the Agenda

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) DLSC Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP) Matters
- 6) Petitions for Summary Suspensions
- 7) Petitions for Designation of Hearing Examiner
- 8) Proposed Stipulations, Final Decisions and Order

- 9) Proposed Interim Orders
- 10) Administrative Warnings
- 11) Review of Administrative Warnings
- 12) Proposed Final Decisions and Orders
- 13) Matters Relating to Costs/Orders Fixing Costs
- 14) Case Closings
- 15) Board Liaison Training
- 16) Petitions for Assessments and Evaluations
- 17) Petitions to Vacate Orders
- 18) Remedial Education Cases
- 19) Motions
- 20) Petitions for Re-Hearing
- 21) Appearances from Requests Received or Renewed

O. Consulting with Legal Counsel

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

P. Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate

Q. Open Session Items Noticed Above Not Completed in the Initial Open Session

R. Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

**ADJOURNMENT**

**ORAL EXAMINATION OF CANDIDATES FOR LICENSURE**

**ROOM N207**

**10:00 A.M. OR IMMEDIATELY FOLLOWING FULL BOARD MEETING**

**CLOSED SESSION** – Reviewing Applications and Conducting Oral Examinations of Zero (at the time of agenda publication) Candidate for Licensure and Any Additional Examinations Added After Agenda Preparation – Brian Holmquist & Laura O’Brien

**NEXT DATE: MARCH 10, 2020 (TENTATIVE)**

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 MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held at 4822 Madison Yards Way, Madison, Wisconsin, unless otherwise noted. In order to confirm a meeting or to request a complete copy of the board’s agenda, please call the listed contact person. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of disciplinary hearings may be changed by the examiner for the convenience of the parties. Interpreters for the hearing impaired provided upon request by contacting the Affirmative Action Officer, 608-266-2112.

**OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD  
MEETING MINUTES  
SEPTEMBER 10, 2019**

**PRESENT:** Teresa Black, Terry Erickson, Laura O'Brien, Amy Summers

**EXCUSED:** Brian Holmquist

**STAFF:** Christian Albouras, Executive Director; Jameson Whitney, Legal Counsel; Dale Kleven, Administrative Rules Coordinator; Megan Glaeser, Bureau Assistant; and other Department staff

**CALL TO ORDER**

Laura O'Brien, Vice Chairperson, called the meeting to order at 9:37 a.m. A quorum of four (4) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments to the Agenda**

**MOTION:** Teresa Black moved, seconded by Terry Erickson to adopt the Agenda as published. Motion carried unanimously.

**APPROVAL OF MINUTES**

**Amendments to the Minutes**

**MOTION:** Teresa Black moved, seconded by Terry Erickson, to approve the Minutes of September 11, 2018 as published. Motion carried unanimously.

**Elections**

***Chairperson***

**NOMINATION:** Teresa Black nominated herself for the Office of Chairperson.

**NOMINATION:** Laura O'Brien nominated herself for the Office of Chairperson.

Christian Albouras, Executive Director, called for nominations three (3) times.

Laura O'Brien was elected as Chairperson by majority voice vote.

***Vice Chairperson***

**NOMINATION:** Terry Erickson nominated Teresa Black for the Office of Vice Chairperson.

Christian Albouras, Executive Director, called for nominations three (3) times.

Teresa Black was elected as Vice Chairperson by unanimous voice vote.

*Secretary*

**NOMINATION:** Laura O'Brien nominated Amy Summers for the Office of Secretary.

Christian Albouras, Executive Director, called for nominations three (3) times.

Amy Summers was elected as Secretary by unanimous voice vote.

<b>2019 ELECTION RESULTS</b>	
<b>Chairperson</b>	Laura O'Brien
<b>Vice Chairperson</b>	Teresa Black
<b>Secretary</b>	Amy Summers

**Appointment of Liaisons and Alternates**

<b>2019 LIAISON APPOINTMENTS</b>	
<b>Credentialing Liaisons</b>	Laura O'Brien, Teresa Black <i>Alternate: Amy Summers</i>
<b>Education and Exams Liaisons</b>	Laura O'Brien, Teresa Black <i>Alternate: Amy Summers</i>
<b>Monitoring Liaisons</b>	Amy Summers <i>Alternate: Laura O'Brien</i>
<b>Professional Assistance Procedure Liaisons</b>	Amy Summers <i>Alternate: Laura O'Brien</i>
<b>Legislative Liaisons</b>	Teresa Black <i>Alternate: Terry Erickson</i>
<b>Travel Liaisons</b>	Teresa Black <i>Alternate: Amy Summers</i>
<b>Administrative Rules Liaisons</b>	Laura O'Brien <i>Alternate: Teresa Black</i>
<b>Screening Panel</b>	Terry Erickson, Teresa Black <i>Alternate: Laura O'Brien</i>

**Delegation of Authorities**

***Document Signature Delegation Updated Language***

**MOTION:** Teresa Black moved, seconded by Terry Erickson, to delegate authority to the Chairperson (or in absence of the Chairperson, the highest-ranking officer or longest serving board member in that succession) to sign

documents on behalf of the Board in order to carry out its duties. Motion carried unanimously.

**MOTION:** Terry Erickson moved, seconded by Teresa Black, in order to carry out duties of the Board, the Chairperson (or in absence of the Chairperson, the highest-ranking officer or longest serving board member in that succession) has the ability to delegate signature authority for purposes of facilitating the completion of assignments during or between meetings. The members of the Board hereby delegate to the Executive Director or DPD Division Administrator, the authority to sign on behalf of a board member as necessary. Motion carried unanimously.

#### *Delegated Authority for Urgent Matters*

**MOTION:** Laura O'Brien moved, seconded by Terry Erickson, that, in order to facilitate the completion of urgent matters between meetings, the Board delegates its authority to the Board Chairperson (or, in the absence of the Chairperson, the highest-ranking official or longest serving board member in that succession), to appoint liaisons to the Department to act in urgent matters. Motion carried unanimously.

#### *Monitoring Delegations*

**MOTION:** Teresa Black moved, seconded by Laura O'Brien, to adopt the "Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor" as presented in the 9/10/2019 Agenda materials. Motion carried unanimously.

#### *Credentialing Authority Delegations*

##### **Delegation of Authority to Credentialing Liaison (Generic)**

**MOTION:** Terry Erickson moved, seconded by Laura O'Brien, to delegate authority to the Credentialing Liaison(s) to serve as a liaison between DSPS and the Board and to act on behalf of the Board in regard to credentialing applications or questions presented to them. Motion carried unanimously.

##### **Delegation of Authority to DSPS When Rule and Statute Criteria is Met**

**MOTION:** Laura O'Brien moved, seconded by Terry Erickson, to delegate credentialing authority to DSPS to act upon applications that meet all credentialing statutory and regulatory requirements without Board or Board liaison review. Motion carried unanimously.

#### *Delegated Authority for Application Denial Reviews*

**MOTION:** Laura O'Brien moved, seconded by Teresa Black, that the Department's Attorney Supervisors, DLSC Administrator, and their designee are

authorized to serve as the Board's designee for purposes of reviewing and acting on requests for hearing as a result of a denial of a credential. Motion carried unanimously.

### ***Voluntary Surrenders***

**MOTION:** Teresa Black moved, seconded by Amy Summers, to delegate authority to the assigned case advisor to accept or refuse a request for voluntary surrender pursuant to Wis. Stat. § 440.19 for a credential holder who has a pending complaint or disciplinary matter. Motion carried unanimously.

### ***Education, Continuing Education and Education Delegation(s)***

**MOTION:** Terry Erickson moved, seconded by Laura O'Brien, to delegate authority to the Education and Examination Liaisons to address all issues related to education, continuing education, and examinations. Motion carried unanimously.

### ***Authorization for DSPS to Provide Board Member Contact Information to National Regulatory Related Authorities***

**MOTION:** Laura O'Brien moved, seconded by Terry Erickson, to authorize Department staff to provide national regulatory related authorities with all Board member contact information that the DSPS retains on file. Motion carried unanimously.

### ***Optional Renewal Notice Insert Delegation***

**MOTION:** Teresa Black moved, seconded by Laura O'Brien, to the Chairperson (or, in the absence of the Chairperson, the highest-ranking officer or longest serving board member in that succession), to provide a brief statement or link relating to board-related business within the license renewal notice at the Board's or Board designee's request. Motion carried unanimously.

### ***Legislative Liaison Delegation***

**MOTION:** Terry Erickson moved, seconded by Laura O'Brien, to delegate authority to the Legislative Liaisons to speak on behalf of the Board regarding legislative matters. Motion carried unanimously.

### ***Travel Delegation***

**MOTION:** Laura O'Brien moved, seconded by Terry Erickson, to delegate authority to the Travel Liaisons to approve any Board Member travel. Motion carried unanimously.

**PUBLIC HEARING**  
**CLEARINGHOUSE RULE CR 19-108 – OT 4 RELATING TO SUPERVISION AND PRACTICE OF OCCUPATIONAL THERAPY ASSISTANTS**

**MOTION:** Teresa Black moved, seconded by Terry Erickson, to accept all Clearinghouse comments for Clearinghouse Rule CR 19-108, relating to supervision and practice of occupational therapy assistants. Motion carried unanimously.

**MOTION:** Terry Erickson moved, seconded by Teresa Black, to authorize the Chairperson, the highest ranking officer of the Board, or the longest serving member of the Board, in order of succession, to approve the Legislative Report and Draft for Clearinghouse Rule CR 19-108, relating to supervision and practice of occupational therapy assistants, for submission to the Governor’s Office and Legislature. Motion carried unanimously.

**MOTION:** Teresa Black moved, seconded by Terry Erickson, authorize the Chairperson, the highest ranking officer of the Board, or the longest serving member of the Board, in order of succession, to approve the Adoption Order for Clearinghouse Rule CR 19-108, relating to supervision and practice of occupational therapy assistants. Motion carried unanimously.

**CLOSED SESSION**

**MOTION:** Teresa Black moved, seconded by Terry Erickson, to convene to Closed Session to deliberate on cases following hearing (§ 19.85(1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02(8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). Laura O’Brien, Chairperson, read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Teresa Black-yes; Terry Erickson-yes; Laura O’Brien-yes; and Amy Summers-yes. Motion carried unanimously.

The Board convened into Closed Session at 11:39 a.m.

**DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS**

**Deliberation on Stipulations and Final Decisions and Orders**

*16 OTB 001 – Abbigail J. Mertig, O.T.*

**MOTION:** Terry Erickson moved, seconded by Laura O’Brien, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary

proceedings against Abbigail J. Mertig, O.T., DLSC Case Number 16 OTB 001. Motion carried unanimously.

### **Case Closings**

#### ***17 OTB 002 – P.M.***

**MOTION:** Terry Erickson moved, seconded by Laura O'Brien, to close DLSC Case Number 17 OTB 002, against P.M., for Prosecutorial Discretion (P5). Motion carried unanimously.

#### ***17 OTB 004 – J.S.***

**MOTION:** Laura O'Brien moved, seconded by Terry Erickson, to close DLSC Case Number 17 OTB 004, against P.M., for Insufficient Evidence. Motion carried unanimously.

#### ***18 OTB 001 – K.E.***

**MOTION:** Laura O'Brien moved, seconded by Terry Erickson, to close DLSC Case Number 18 OTB 001, against K.E., for Insufficient Evidence. Motion carried unanimously.

#### ***18 OTB 006 – R.V.B.***

**MOTION:** Teresa Black moved, seconded by Laura O'Brien, to close DLSC Case Number 18 OTB 006, against P.M., for Insufficient Evidence. Motion carried unanimously.

### **RECONVENE TO OPEN SESSION**

**MOTION:** Terry Erickson moved, seconded by Teresa Black, to reconvene in Open Session. Motion carried unanimously.

The Board reconvened to Open Session at 11:57 a.m.

### **VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION, IF VOTING IS APPROPRIATE**

**MOTION:** Teresa Black moved, seconded by Terry Erickson, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

*(Be advised that any recusals or abstentions reflected in the closed session motions stand for the purposes of the affirmation vote.)*

### **DELEGATION OF RATIFICATION OF LICENSES AND CERTIFICATES**

**MOTION:** Laura O'Brien moved, seconded by Terry Erickson, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

## ADJOURNMENT

**MOTION:** Terry Erickson moved, seconded by Teresa Black, to adjourn the meeting.  
Motion carried unanimously.

The meeting adjourned at 11:59 a.m.

DRAFT

**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  <b>Dale Kleven</b> <b>Administrative Rules Coordinator</b>		<b>2) Date When Request Submitted:</b>  <b>11/7/19</b> Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  <b>Occupational Therapists Affiliated Credentialing Board</b>			
<b>4) Meeting Date:</b>  11/19/19	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> <b>Administrative Rule Matters – Discussion and Consideration</b> 1. Preliminary Draft Rules for OT 3, Relating to Biennial Registration 2. Pending and Possible Rulemaking Projects	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  <div style="height: 100px;"></div>			
<b>11) Authorization</b>			
<i>Dale Kleven</i>		<i>November 7, 2019</i>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATE OF WISCONSIN  
OCCUPATIONAL THERAPISTS  
AFFILIATED CREDENTIALING BOARD

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IN THE MATTER OF RULE-MAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	OCCUPATIONAL THERAPISTS
OCCUPATIONAL THERAPISTS	:	AFFILIATED CREDENTIALING
AFFILIATED CREDENTIALING	:	BOARD
BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE )

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PROPOSED ORDER

An order of the Occupational Therapists Affiliated Credentialing Board to **repeal** OT 3.06 (3) (Note); to **amend** ch. OT 3 (title), OT 3.01 to 3.04, 3.05 (intro.), (1), (2), and (3) (intro.) and (a), 3.06 (1) to (3), Table OT 3.06 lines (c), (d), (f), (n), (p), and (q), and 3.06 (4) and (5); and to **create** Table OT 3.06 (title), relating to biennial registration.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

Section 440.03 (4m), Stats.

**Statutory authority:**

Sections 15.085 (5) (b) and 448.965 (1) (b), Stats.

**Explanation of agency authority:**

Section 15.085 (5) (b), Stats., provides an affiliated credentialing board “[s]hall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . .” The proposed rule will provide guidance concerning the supervision and practice of occupational therapy assistants.

Section 448.965 (1) (b), Stats., provides the Occupational Therapists Affiliated Credentialing Board may promulgate rules that establish “[c]ontinuing education requirements for license renewal for an occupational therapist or occupational therapy assistant under s. 448.967 (2).”

**Related statute or rule:**

None.

**Plain language analysis:**

- Section OT 3.05 (2) and (3) (intro.) are revised to clarify the requirements for reinstatement apply to a licensee whose license has been denied at renewal.

- Section OT 3.06 (5) is revised to comply with s. 440.03 (4m), Stats., as created by 2017 Wisconsin Act 59. Under this provision, the Board may require a credential holder to submit proof of completing continuing education programs or courses only if a complaint is made against the credential holder.
- Other provisions throughout ch. OT 3 have been revised to ensure consistency in terminology and compliance with current standards for drafting style and format and applicable Wisconsin statutes.

**Summary of, and comparison with, existing or proposed federal regulation:**

None.

**Comparison with rules in adjacent states:**

**Illinois:** 68 Ill. Admin. Code 1315.145 f) 2) provides the requirements for retention and production of evidence of compliance with the continuing education requirements. The Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation may require additional evidence demonstrating compliance with the continuing education requirements. It is the responsibility of each applicant for renewal to retain or otherwise produce evidence of such compliance.

**Iowa:** 645 IAC 4.11 provides the requirements for retention and production of evidence of compliance with the continuing education requirements. The Iowa Board of Physical and Occupational Therapy may select licensees for audit following license renewal. Upon audit, a licensee is required to provide an individual certificate of completion issued to the licensee or evidence of successful completion of the course from the course sponsor. All licensees must retain documentation of compliance with the continuing education requirements for two years following license renewal.

**Michigan:** Mich Admin Code, R 338.1251 provides the requirements for certification of compliance and requirements for retention and production of evidence of compliance with the continuing education requirements. Submission of an application for renewal constitutes an applicant's certification of compliance with the continuing education requirements, and all licensees are required to retain documentation of meeting the requirements for a period of 4 years from the date of applying for license renewal. The Michigan Board of Occupational Therapists may require an applicant or licensee to submit evidence to demonstrate compliance with the continuing education requirements.

**Minnesota:** The Minnesota Statutes provide the requirements for retention and production of evidence of compliance with the continuing education requirements (Minnesota Statutes 2017, section 148.6443, Subds. 5. and 6.). Within one month following licensure expiration, each licensee must submit a continuing education report form provided by the Minnesota Board of Occupational Therapy Practice verifying the continuing education requirements have been met. The Board may audit a percentage of the continuing education reports based on random selection. In addition, renewal applications that are received after the expiration date and any licensee against whom a complaint is filed may be subject to a continuing education report audit. Licensees are required to maintain all required documentation for two years after the last day of the biennial licensure period in which the continuing education was obtained.

**Summary of factual data and analytical methodologies:**

The proposed rules were developed by reviewing the provisions of ch. OT 3 to ensure consistency with current standards for drafting style and format and applicable Wisconsin statutes.

**Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:**

The proposed rules will be posted for a period of 14 days to solicit public comment on economic impact, including how the proposed rules may affect businesses, local government units, and individuals.

**Effect on small business:**

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department’s Regulatory Review Coordinator may be contacted by email at Daniel.Hereth@wisconsin.gov, or by calling (608) 267-2435.

**Agency contact person:**

Dale Kleven, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, P.O. Box 8366, Madison, Wisconsin 53708-8366; telephone 608-261-4472; email at DSPSAdminRules@wisconsin.gov.

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TEXT OF RULE

SECTION 1. Chapter OT 3 (title) is amended to read:

CHAPTER OT 3

BIENNIAL REGISTRATION LICENSE RENEWAL

SECTION 2. OT 3.01 to 3.04 are amended to read:

**OT 3.01 Authority and purpose.** The rules in this chapter are adopted by the board under the authority of ss. 15.085 (5) (b), 227.11 (2), and 448.965, Stats., to govern biennial registration renewal requirements for occupational therapists and occupational therapy assistants.

**OT 3.02 Registration Renewal required; method of registration renewal.** Each licensee shall ~~register~~ renew biennially with the board. Prior to June 1 of each odd numbered year, the department shall mail an application for renewal to each licensee at ~~his or her~~ the licensee’s last known address as it appears in the records of the board ~~an application form for registration~~. Each licensee shall complete the application ~~form~~ and return it with the required fee to the department. The board shall notify a licensee within 30 business days of receipt of a completed renewal application whether renewal is approved or denied.

**OT 3.03 Initial registration renewal.** ~~Any~~ A licensee who is initially granted and issued a license ~~during a given calendar year shall register for that biennium~~ renew the license as provided under s. OT 3.02 by the date specified in s. 440.08 (2) (a) 52. or 53., Stats., as applicable. ~~The board shall notify the licensee within 30 business days of receipt of a completed registration form whether the application for registration is approved or denied.~~

**OT 3.04 Registration Renewal prohibited.** ~~Any~~ The license of an occupational therapist or occupational therapy assistant ~~required to comply who has not complied with the provisions of s. OT 3.06; and s. 448.967; (2), Stats., and who has not so complied, will~~ may not be permitted to register renewed.

SECTION 3. OT 3.05 (intro.), (1), (2), and (3) (intro.) and (a) are amended to read:

**OT 3.05 (intro.) Late renewal and reinstatement.** Failure to renew ~~a license by June 1 of an odd-numbered year to~~ as required under s. OT 3.02 shall cause ~~the a~~ a license to expire. A licensee who allows ~~the a~~ a license to expire may apply to the board for late renewal or reinstatement of the license by completing one of the following:

(1) ~~LATE RENEWAL BEFORE~~ WITHIN 5 YEARS. If ~~the a~~ a licensee applies for renewal ~~of the license less than~~ within 5 years after ~~its expiration~~ the renewal date, the license shall be renewed upon ~~payment~~ submission of the renewal completed application and fee required under s. OT 3.02, payment of the late fee under s. 440.08 (3) (a), Stats., and fulfillment of the continuing education requirements under s. OT 3.06.

(2) ~~LATE RENEWAL AFTER~~ 5 YEARS. If ~~the a~~ a licensee applies for renewal ~~of the~~ license more than 5 years after ~~its expiration~~ the renewal date, the board shall make such inquiry as it finds necessary to determine whether the applicant is competent to practice under the license in this state; ~~and~~ Subject to s. 440.08 (3) (b), Stats., the board shall impose any reasonable conditions on the renewal of the license, including oral examination, as the board deems appropriate. All applicants under this section subsection shall be required to pass the open book examination on statutes and rules, which is the same examination given to initial applicants. This Except as provided under sub. (3) (a), this subsection does not apply to licensees who have unmet disciplinary requirements or whose licenses have been denied at renewal, surrendered, or revoked.

(3) (intro.) ~~REINSTATEMENT.~~ A licensee who has unmet disciplinary requirements and failed to renew within 5 years of the renewal date or whose license has been ~~denied at renewal, surrendered, or revoked, may apply to have the license reinstated, in accordance with~~ An application for reinstatement shall include all of the following:

(a) Evidence of ~~the~~ completion of the requirements under sub. (2).

SECTION 4. OT 3.06 (1) to (3) are amended to read:

**OT 3.06 (1)** Each holder of a license as an occupational therapist shall, at the time of applying for renewal of ~~a the license of registration under s. 448.967, Stats.,~~ certify that ~~he or she the licensee~~ has, in the 2 years preceding the renewal application, completed at least 24 points of acceptable continuing education during the 2-year period immediately preceding the renewal date under s. 440.08 (2) (a) 52., Stats.

(2) Each holder of a license as an occupational therapy assistant shall, at the time of applying for renewal of ~~a the license of registration under s. 448.967, Stats.,~~ certify that ~~he or she the licensee~~ has, in the 2 years preceding the renewal application, completed at least 24 points of acceptable continuing education during the 2-year period immediately preceding the renewal date under s. 440.08 (2) (a) 53., Stats.

(3) At least 12 of the points of the continuing education required under subs. (1) and (2) shall be accumulated through one or more professional development activities listed under Table OT 3.06 that are related to occupational therapy in the following categories set forth in the following table. In Table OT 3.06, “contact hour” means not less than 50 minutes of actual professional activity.

SECTION 5. Table OT 3.06 (title) is created to read:

**TABLE OT 3.06**

SECTION 6. Table OT 3.06 lines (c), (d), (f), (n), (p), and (q) are amended to read:

PROFESSIONAL DEVELOPMENT ACTIVITIES	PROFESSIONAL DEVELOPMENT POINTS
(c) Satisfactory completion of a self-study course approved by the American occupational therapy association (AOTA) Occupational Therapy Association or other related recognized professional associations.	4 points per continuing education unit.
(d) Satisfactory completion <u>Review</u> of an AOTA American Occupational Therapy Association continuing education article <del>(review and successful completion of the associated examination).</del>	1 point per article.
(f) Initial completion of specialty board certification in occupational therapy, including <del>but not limited to</del> certification in neurorehabilitation, pediatrics, hand therapy, gerontology, driver rehabilitation, advanced practice, neuro-developmental treatment, case management, and rehabilitation counseling.	12 points.
(n) Professional presentations. <b>Note:</b> <del>No additional points are given for subsequent presentations of the same content.</del>	2 points per contact hour. <u>No additional points are given for subsequent presentations of the same content.</u>
(p) Student fieldwork supervision – Level I <u>fieldwork.</u>	2 points.
(q) Student fieldwork supervision – Level II <u>fieldwork.</u>	8 points.

SECTION 7. OT 3.06 (3) (Note) is repealed.

SECTION 8. OT 3.06 (4) and (5) are amended to read:

**OT 3.06 (4) Evidence** Certificates of completion or other evidence of compliance with this section ~~such as certificates of completion~~ shall be retained by each license holder ~~through the biennium~~ for at least 2 years following the biennium ~~for~~ in which ~~credit is required for renewal of license~~ the continuing education was completed.

(5) The board ~~may require~~ shall audit any ~~license holder to submit evidence of licensee who is under investigation by the board for alleged misconduct for compliance with this section to the board for an audit at any time during the biennium following the biennium for which credit is required for license renewal.~~

SECTION 9. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)  
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**State of Wisconsin  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Valerie Payne, Executive Director, on behalf of Teri Black		<b>2) Date When Request Submitted:</b>  10/31/19 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
<b>3) Name of Board, Committee, Council, Sections:</b>  Occupational Therapists Affiliated Credentialing Board			
<b>4) Meeting Date:</b>  11/19/19	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Potential changes to OT administrative code	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  1. Creating an OT Examining Board (not affiliated with the MEB) 2. Eliminating oral exam requirement 3. Include process for OTs and OTAs practicing OT using telemedicine 4. Discuss potential changes to rules related to AOTA/NBCOT compact agreement for reciprocity between states			
<b>11) Authorization</b>			
Valerie Payne		10/31/19	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

## Creating an OT Examining Board.

I am requesting that the OTACB consider creating an independent Occupational Therapy Examining Board through the Department of Safety and Professional Services (DPS). Under the current DPS Occupational Therapy functions as an affiliated credentialing board. They are affiliated with the Medical Examining Board. This means the MEB has oversight of the OT Affiliated credentialing Board and any changes made to the OT administrative rules. This relationship between the Medical Examining board and the OT certification board was established with OTs regulation in 1989 and it has served OT well for many years. However, the scope of OT practice has expanded to more community based practice in the last 27 years. While OT maintains its practice in medical settings, hospitals, clinics, and skilled nursing facilities, the context of OT practice in Wisconsin has expanded and the need for oversight from the Medical Examining Board has greatly decreased. The primary reason for this request is that as of 2016 Occupational Therapy no longer requires physician referral to access their services unless reimbursement requires it. OTs work with large populations that are not acutely ill or under the care of physician for a current medical condition, such as children with behavioral issues, altering home, school and work environments so individuals who have had health issues can engage in their occupations in those settings. Therefore, OTs no longer need to be overseen by the Medical Examining Board. Physical Therapy is the therapeutic counterpart to OT in many practice settings and has been overseen by an independent Examining Board for 10 years. They were affiliated with the Medical Examining Board until they established the PT Examining board in 2009. It is anticipated that there would not be a cost for this change since the OTACB would continue to perform the same functions, just without the general oversight from the MEB

The WI Occupational Licensing Study Legislative Report from December 2018 identified several goals of the study. This request is one that could help meet this goal for OT and the MEB.

*Provide coordination among state licensing agencies to maximize existing regulatory flexibility and efficiencies, and partner with the state Legislature and stakeholders to advance legislative proposals that promote occupational licensure reform.*

The Medical Examining Board has oversight of 9 Boards and Councils. Creating a separate OT Examining Board could take away at least one of the Boards that the MEB has oversight of

# 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.<sup>1</sup> 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;
- 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, Liddle, Gustafsson, Lamont & Silburn, 2016),
- The Mini-Mental State Exam (Ciemins, 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 et al., 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); and
- 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, 2013; 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, Liddle, Gustafsson, Lamont, & Silburn, 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* (2015; 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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## 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; Vanbellinghen, 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"> <li>• Videoconferencing software for health care (e.g., Vsee, Zoom, Doxy.Me)</li> <li>• Consumer high-definition television videoconferencing</li> <li>• Telephone/POTS</li> <li>• Telehealth network with commercial videoconferencing system</li> <li>• Sensor technologies (with live-streaming data to remote practitioner)</li> </ul>	<ul style="list-style-type: none"> <li>• Confidentiality (security, privacy)</li> <li>• Integrity (information protected from changes by unauthorized users)</li> <li>• Availability (information, services)</li> <li>• Cost–benefit ratio</li> <li>• Socioeconomic considerations</li> <li>• Leveraging existing infrastructure (equipment and personnel)</li> <li>• Technology connection requirements (e.g., broadband, T1 line)</li> <li>• Sound and image quality</li> <li>• Equipment accessibility</li> </ul>
Asynchronous	<ul style="list-style-type: none"> <li>• Mobile messaging</li> <li>• Data from wearables or remote patient-monitoring devices</li> <li>• Digital images, videos, or files</li> <li>• Sensor technologies (with store-and-forward data to remote practitioner)</li> </ul>	

Synchronous (interactive) or asynchronous (store-and-forward data)	Telemonitoring technologies <ul style="list-style-type: none"> <li>– Home monitoring systems/devices</li> <li>– Sensor/wearable technologies</li> </ul> Sensor technologies <ul style="list-style-type: none"> <li>– Remote use of gaming and VR systems/devices</li> </ul>	
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Source. From “Telerehabilitation: An Adjunct Service Delivery Model for Early Intervention Services,” by J. Cason, 2011, *International Journal of Telerehabilitation*, 3(1), p. 24. <http://dx.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 prior to implementing telehealth: examine state telehealth laws and regulations that may impact 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, and
- 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><b>Mathew</b> 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. 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</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>

	for countersignatures) is established in adherence with supervision requirements set forth in the state's practice act.	
<b>Lisa</b> , 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.	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.	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.
<b>José</b> , 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.	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. 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. 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.	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. 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.
<b>Angela</b> , age 10 years, has a complicated medical history that includes spina bifida. She is	Angela has trouble traveling and sitting for long distances. She and her mother meet with an OT in person at a	After interviewing Angela and her mother and observing Angela navigate in her current chair, the

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.

**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.

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.

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.

**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.

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

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.

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. Ethan completes a home program and a daily journal sent to him by his OT through ICT.

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

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. Angela benefited from services without the need to travel a long distance. The local OT gained additional knowledge about wheeled mobility and seating options.

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.

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.

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

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.

**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.

**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

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.

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.

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

in therapeutic sessions and facilitates the use of therapeutic strategies throughout the week. 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.

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.

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

<p>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>company's HIPAA-compliant videoconferencing software. Rick logs into the company's web portal twice weekly 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>company's web portal. Rick downloaded and printed materials provided by his OT after each session.</p>
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*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**

<b>Ethical Considerations</b>	<b>Strategies for Ethical Practice</b>
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<p>Fully inform the client regarding the implications of a telehealth service delivery model vs. an in-person service delivery model.</p>	<p>Occupational therapy personnel shall . . .</p> <ul style="list-style-type: none"> <li>• “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)</li> <li>• “Establish a collaborative relationship with recipients of service and relevant stakeholders to promote shared decision making” (Principle 3D)</li> <li>• “Obtain consent after disclosing appropriate information and answering any questions posed by the recipient of service or research participant to ensure voluntariness” (Principle 3C)</li> </ul>
<p>Abide by laws and scope of practice related to licensure and provision of occupational therapy services using telehealth.</p>	<p>Occupational therapy personnel shall . . .</p> <ul style="list-style-type: none"> <li>• “Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy” (Principle 4E)</li> </ul>
<p>Adhere to professional standards.</p>	<p>Occupational therapy personnel shall . . .</p> <ul style="list-style-type: none"> <li>• “Provide occupational therapy services, including education and training, that are within each practitioner’s level of competence and scope of practice” (Principle 1E)</li> <li>• “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)</li> <li>• “Maintain competency by ongoing participation in education relevant to one’s practice area” (Principle 1G)</li> <li>• “Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy” (Principle 4E)</li> </ul>
<p>Understand and abide by approaches that ensure that privacy, security, and confidentiality are not compromised as a result of using telehealth.</p>	<p>Occupational therapy personnel shall . . .</p> <ul style="list-style-type: none"> <li>• “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</li> </ul>

	<p>Portability and Accountability Act [Pub. L. 104-191], Family Educational Rights and Privacy Act [Pub. L. 93-380])” (Principle 3H)</p>
<p>Understand and adhere to procedures if there is any compromise of security related to health information.</p>	<p>Occupational therapy personnel shall . . .</p> <ul style="list-style-type: none"> <li>• “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)</li> <li>• “Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy.” (Principle 4E)</li> </ul>
<p>Assess the effectiveness of interventions provided through telehealth by consulting current research and conducting ongoing monitoring of client response.</p>	<p>Occupational therapy personnel shall . . .</p> <ul style="list-style-type: none"> <li>• “Refer to other providers when indicated by the needs of the client” (Principle 1I)</li> <li>• “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)</li> <li>• “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)</li> </ul>
<p>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.</p>	<p>Occupational therapy personnel shall . . .</p> <ul style="list-style-type: none"> <li>• “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)</li> <li>• “Assist those in need of occupational therapy services in securing access through available means” (Principle 4B)</li> <li>• “Address barriers in access to occupational therapy services by offering or referring clients to financial aid, charity care, or pro bono services</li> </ul>

	within the parameters of organizational policies” (Principle 4C)
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Note. HIPAA = Health Insurance Portability and Accountability Act. Ethical principles are from AOTA’s (2015a) *Occupational Therapy Code of Ethics* (2015).

<sup>1</sup>When 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).

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## For

### The Commission on Practice:

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

*Adopted by the Representative Assembly Coordinating Council (RACC) for the Representative Assembly, 2018.*

*Note.* This revision replaces the 2012 document, Telehealth previously published and copyrighted in 2013 by the American Occupational Therapy Association in the American Journal of Occupational Therapy, November/December 2013, Vol. 67, S69-S90. doi:10.5014/ajot.2013.67S69

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## Compact Agreement between AOTA/NBCOT regulation

The American Occupational Therapy Association (AOTA®) and the National Board for Certification in Occupational Therapy (NBCOT®) will be collaborating over the next four years to create an interstate licensure compact for the occupational therapy profession. AOTA and NBCOT will be working with the Council of State Governments (CSG), state occupational therapy regulatory entities, state occupational therapy associations, and other stakeholders to allow state licensure reciprocity. A compact is a legal agreement between states that will allow licensed occupational therapists (OTs) and occupational therapy assistants (OTAs) to practice in those states that join the compact. Currently, OTs and OTAs must obtain licensure in each state in which they want to practice. An interstate licensure compact for the occupational therapy profession will:

- Improve consumer access to occupational therapy
- Increase opportunities to practice across state lines (e.g., telehealth, telerehabilitation, distance education)
- Enhance mobility of occupational therapy practitioners and their families
- Support spouses of relocating military families
- Improve continuity of care
- Preserve and strengthen the state licensure system
- Enhance the exchange of licensure verification, investigatory, and disciplinary information between member states.

CSG's nationally recognized National Center for Interstate Compacts will lead stakeholders through a consensus-based process to develop the licensure compact language. The draft language will then be circulated for input from the profession.

The occupational therapy licensure compact legislation must be passed in each state where it will apply. The goal is to begin state participation by 2024.

AOTA and NBCOT are committed to working together throughout the process of creating and implementing the licensure compact. Major funding from NBCOT will support the licensure compact initiative; AOTA and state associations will lead advocacy efforts to enact compact legislation in the states.