



OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD

Room 121C, 1400 East Washington Avenue, Madison

Contact: Tom Ryan (608) 266-2112

June 10, 2015

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**
- B) Approval of Minutes of March 3, 2015 (3-7)**
- C) Administrative Updates**
 - 1) Department and Staff Updates
 - 2) Appointments/Reappointments/Confirmations
 - 3) Wis. Stat. s 15.085 (3)(b) – Biannual Meeting with the Medical Examining Board
 - 4) OT 1,3,4 Relating to Self-Referral of Occupational Therapy Services (**8**)
 - 5) Other Informational Items
- D) Legislative/Administrative Rule Matters**
 - 1) Current and Future Rule Making and Legislative Initiatives
 - 2) Administrative Rules Report
 - 3) Update OT 4 Relating to Self-Referral of Occupational Therapy Services (**9-16**)
- E) Telehealth – Discussion (17-57)**
- F) North Carolina Board of Dental Examiners vs. Federal Trade Commission (58-59)**
- G) Speaking Engagement(s), Travel, or Public Relation Request(s)**
 - 1) NBCOT State Visits – Discussion
 - 2) WOTA Spring Conference
- H) Informational Item(s)**
- I) Items Added After Preparation of Agenda:**
 - 1) Introductions, Announcements and Recognition
 - 2) Administrative Updates
 - 3) Education and Examination Matters
 - 4) Credentialing Matters
 - 5) Practice Matters

- 6) Legislation/Administrative Rule Matters
- 7) Liaison Report(s)
- 8) Informational Item(s)
- 9) Disciplinary Matters
- 10) Presentations of Petition(s) for Summary Suspension
- 11) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
- 12) Presentation of Proposed Decisions
- 13) Presentation of Interim Order(s)
- 14) Petitions for Re-Hearing
- 15) Petitions for Assessments
- 16) Petitions to Vacate Order(s)
- 17) Petitions for Designation of Hearing Examiner
- 18) Requests for Disciplinary Proceeding Presentations
- 19) Motions
- 20) Petitions
- 21) Appearances from Requests Received or Renewed
- 22) Speaking Engagement(s), Travel, or Public Relation Request(s)

J) Public Comments

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 § 440.205, Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).

K) Deliberation on Administrative Warnings

- 1) 13 OTB 013 **(60-63)**
- 2) 14 OTB 008 **(64-65)**

L) Case Status Report (66)

M) Deliberation of Items Added After Preparation of the Agenda

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) Application Matters
- 4) Disciplinary Matters
- 5) Monitoring Matters
- 6) Professional Assistance Procedure (PAP) Matters
- 7) Petition(s) for Summary Suspensions
- 8) Proposed Stipulations, Final Decisions and Orders
- 9) Administrative Warnings
- 10) Proposed Decisions
- 11) Matters Relating to Costs
- 12) Complaints
- 13) Case Closings
- 14) Case Status Report
- 15) Petition(s) for Extension of Time
- 16) Proposed Interim Orders
- 17) Petitions for Assessments and Evaluations
- 18) Petitions to Vacate Orders
- 19) Remedial Education Cases
- 20) Motions
- 21) Petitions for Re-Hearing

22) Appearances from Requests Received or Renewed

N) Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

O) Open Session Items Noticed Above not Completed in the Initial Open Session

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

Q) Ratification of Licenses and Certificates

ADJOURNMENT

**OCCUPATIONAL THERAPISTS AFFILIATED CREDENTIALING BOARD
MARCH 3, 2015**

PRESENT: Mylinda Barisas-Matula (*via GoToMeeting*), Brian Holmquist, Gaye Meyer (*via GoToMeeting*), Laura O'Brien, Dorothy Olson (*via GoToMeeting*)

EXCUSED: Corliss Rice

STAFF: Tom Ryan, Executive Director; Taylor Thompson, Bureau Assistant; and other Department staff

CALL TO ORDER

Brian Holmquist, Chair, called the meeting to order at 9:33 A.M. A quorum of five (5) members was confirmed.

ADOPTION OF AGENDA

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, to adopt the agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES

MOTION: Laura O'Brien moved, seconded by Dorothy Olson, to approve the minutes of September 16, 2014 as published. Motion carried unanimously.

ELECTION OF OFFICERS

BOARD CHAIR

NOMINATION: Laura O'Brien nominated Brian Holmquist for the Office of Board Chair.

Tom Ryan called for other nominations three (3) times.

Brian Holmquist was elected as Chair by unanimous vote.

VICE CHAIR

NOMINATION: Brian Holmquist nominated Laura O'Brien for the Office of Vice Chair.

Tom Ryan called for other nominations three (3) times.

Laura O'Brien was elected as Vice Chair by unanimous vote.

SECRETARY

NOMINATION: Laura O'Brien nominated Gaye Meyer for the Office of Secretary.

Tom Ryan called for other nominations three (3) times.

Gaye Meyer was elected as Secretary by unanimous vote.

2015 OFFICERS	
Board Chair	Brian Holmquist
Vice Chair	Laura O'Brien
Secretary	Gaye Meyer

APPOINTMENT OF LIAISONS

2015 LIAISON APPOINTMENTS	
Credentialing Liaison	Laura O'Brien, Gaye Meyer <i>Alternate: Brian Holmquist, Dorothy Olson</i>
Monitoring Liaison	Laura O'Brien <i>Alternate: Dorothy Olson, Gaye Meyer</i>
Education and Exams Liaison	Laura O'Brien, Brian Holmquist <i>Alternate: Gaye Meyer, Dorothy Olson</i>
Legislative Liaison	Laura O'Brien <i>Alternate: Brian Holmquist</i>
Travel Liaison	Brian Holmquist <i>Alternate: Laura O'Brien</i>
Rules Liaison	Laura O'Brien <i>Alternate: Gaye Meyer, Brian Holmquist</i>
Professional Assistance Procedure Liaison	Gaye Meyer <i>Alternate: Laura O'Brien, Brian Holmquist</i>
Screening Panel	Laura O'Brien, Gaye Meyer, Brian Holmquist <i>Alternates: Dorothy Olson</i>

MOTION: Laura O'Brien moved, seconded by Dorothy Olson, to affirm the Chair's appointment of liaisons for 2015. Motion carried unanimously.

DELEGATED AUTHORITY MOTIONS

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, that, in order to facilitate the completion of assignments between meetings, the Board delegates its authority by order of succession to the Chair, highest ranking officer, or longest serving member of the Board, to appoint liaisons to the Department to act in urgent matters, to fill vacant appointment positions, and to act where knowledge or experience in the profession is required to carry out the duties of the Board in accordance with the law. Motion carried unanimously.

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, that the Board delegates authority to the Chair, highest ranking officer, or longest serving member of the Board, to sign documents on behalf of the Board. In order to carry out duties of the Board, the Chair, highest ranking officer, or longest serving member of the Board have the ability to delegate this signature authority to the Board's Executive Director for purposes of facilitating the completion of assignments during or between meetings. Motion carried unanimously.

MOTION: Laura O'Brien moved, seconded by Dorothy Olson, that Board Counsel or another Department attorney is formally authorized to serve as the Board's designee for purposes of Wis. Admin. Code § SPS 1.08(1). Motion carried unanimously.

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, to adopt the 'Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor' document as presented. Motion carried unanimously.

LEGISLATIVE/ADMINISTRATIVE RULE MATTERS

OT AND SELF-REFERRAL

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, to designate Brian Holmquist and Laura O'Brien to serve as liaisons to DSPS staff for drafting and approving OT 4 regarding Physician Referral/Orders to be published for EIA comments and forwarded to the Clearinghouse. Motion carried unanimously.

CLOSED SESSION

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, 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 § 440.205, Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Mylinda Barisas-Matula - yes; Brian Holmquist - yes; Gaye Meyer - yes; Laura O'Brien - yes; Dorothy Olson - yes. Motion carried unanimously.

The Board convened into Closed Session at 10:56 A.M.

RECONVENE TO OPEN SESSION

MOTION: Laura O'Brien moved, seconded by Dorothy Olson, to reconvene in Open Session at 11:02 A.M. Motion carried unanimously.

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

MOTION: Mylinda Barisas-Matula moved, seconded by Laura O'Brien, to affirm all Motions made and Votes taken in Closed Session. Motion carried unanimously.

**DELIBERATION AND PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS BY
THE DIVISION OF LEGAL SERVICES AND COMPLIANCE**

**13 OTB 004
JAMIE A KURTZ**

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, to adopt the Findings of Fact, Conclusions of Law, Stipulation and Final Decision and Order, in the matter of 13 OTB 004 – Jamie Kurtz. Motion carried unanimously.

CASE CLOSINGS

12 OTB 008 (J.C.)

MOTION: Mylinda Barisas-Matula moved, seconded by Laura O'Brien, to close case 12 OTB 008 (J.C.) for Prosecutorial Discretion (P4). Motion carried unanimously.

13 OTB 011 (S.S.)

MOTION: Gaye Meyer moved, seconded by Laura O'Brien, to close case 13 OTB 011 (S.S.) for no violation (NV). Motion carried unanimously.

RATIFICATION OF LICENSES AND CERTIFICATES

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

ADJOURNMENT

MOTION: Laura O'Brien moved, seconded by Mylinda Barisas-Matula, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 11:04 A.M.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Taylor Thompson, Bureau Assistant on behalf of Tom Ryan, Executive Director		2) Date When Request Submitted: 4/22/15 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Occupational Therapists Affiliated Credentialing Board			
4) Meeting Date: 6/10/15	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Wis. Stat. s 15.085(3)(b) - Affiliated Credentialing Boards' Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest 1. OT 1, 3, 4 Relating to Self-Referral of Occupational Therapy Services 2. Other	
7) Place Item in: <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Motion from the April 15, 2015 Medical Examining Board Meeting: LEGISLATIVE/ADMINISTRATIVE RULE MATTERS REVIEW OF OT 1, 3, 4 RELATING TO SELF-REFERRAL OF OCCUPATIONAL THERAPY SERVICES MOTION: Timothy Swan moved, seconded by Robert Zondag, to invite the Chair of the Occupational Therapists Affiliated Credentialing Board to a Medical Examining Board meeting to discuss concerns of the Board. Motion carried unanimously.			
11) Authorization			
Taylor Thompson		4/22/15	
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
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Katie Paff Administrative Rules Coordinator		2) Date When Request Submitted: 5/14/2015 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Occupational Therapy Affiliated Credentialing Board			
4) Meeting Date: June 10, 2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Update on OT 4 relating to self-referral of occupational therapy services.	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: The Medical Examining Board has the authority under s. 15.085 (5) (b) 1. to review and comment on rules promulgated by the affiliated credentialing boards prior to submittal to the Legislative Clearinghouse. Chairperson Brian Holmquist will make an appearance at the Medical Examining Board meeting on July 15, 2015 to discuss OT 4 relating to self-referral of occupational therapy services.			
11) Authorization			
Katie Paff		5/14/2015	
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

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)

PROPOSED ORDER

An order of the Occupational Therapists Affiliated Credentialing Board to repeal OT 1.02 (17), 4.03 (2) (a), and 4.03 (2) (c) and (d); to amend OT 3.05 (title) and (intro.), 3.05 (2), 4.02 (2) (f), 4.03 (2) (title), 4.03 (2) (b), 4.03 (3) (a), and 4.03 (3) (f); to create OT 3.05 (1) (title) and 3.05 (3) relating to self-referral of occupational therapy services.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Section 448.965, Stats.

Statutory authority:

Sections 15.085 (5) (b), 227.11 (2) (a), 440.08 (3) (b), 448.965 (1) (c), Wisconsin Statutes.

Explanation of agency authority:

Section 15.085 (5) (b), Stats., provides that affiliated credentialing boards such as the Occupational Therapists 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 to occupational therapists regarding the topic of who may refer occupational therapy services.

Section 227.11 (2) (a), Stats., provides that, “[e]ach agency may promulgate rules interpreting the provisions of any statute enforced or administered by the agency, if the agency considers it necessary to effectuate the purpose of the statute, but a rule is not valid if the rule exceeds the bounds of correct interpretation.”

Section 440.08 (3) (b), Stats., provides that affiliated credentialing boards such as the Occupational Therapists Affiliated Credentialing Board, “[...] may promulgate rules

requiring the holder of a credential who fails to renew the credential within 5 years after its renewal date to complete requirements in order to restore the credential, in addition to the applicable requirements for renewal established under chs. 440 to 480, that the [...] affiliated credentialing board determines are necessary to protect the public health, safety, or welfare.”

Section 448.965 (1) (c), Stats., provides that the affiliated credentialing board shall promulgate rules that establish, “[s]tandards of practice for occupational therapy, including a code of ethics and criteria for referral.”

Related statute or rule:

None.

Plain language analysis:

Under the current administrative rules, an occupational therapist may receive an order or a referral to perform occupational therapy services for a patient. Orders identify the need for occupational therapy evaluation and intervention while a referral is the act of requesting occupational therapy services. Currently, physicians, dentists, or podiatrists may order occupational therapy evaluation. However, occupational therapists may accept referrals from a variety of health care professionals including advance practice nurses, chiropractors, optometrists, physical therapists and physician assistants (Wisconsin Administrative Code OT 4.03 (2) (b)). Furthermore there are some services occupational therapist can perform without the need of a referral such as consultation, habilitation, screening, client education, wellness, prevention, environmental assessments, and work-related ergonomic services. According to Wisconsin Administrative Code OT 4.03 (2) (e) neither an order or a referral from a physician is required for evaluation or intervention if OT services are provided in an educational environment, including in a child’s home if the child has disabilities.

The proposed rule seeks to clarify that occupational therapists are able to self-refer occupational therapy services along with the host of other health care professionals that are listed above. Currently, the rule allows other health care professionals to refer occupational therapy services. However, the rule does not specifically state that occupational therapists are allowed to self-refer. Occupational therapists self-referring would allow patients greater access to health care and would alleviate occupational therapists from relying solely on receiving orders and referrals from other health care professionals in order to provide health care services. The proposed rule will also remove all references to orders received by health care professionals as this is outdated terminology that no longer reflects current practices.

The proposed rule will also provide clarity to the process of renewing a license after 5 years by updating provisions regarding late renewal and reinstatement. The term reinstatement will be defined as a process by which a licensee whose license has been surrendered or revoked or has a license with unmet disciplinary requirements which has

not been renewed within five years of the renewal date may apply to have their license reinstated with or without conditions.

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

None.

Comparison with rules in adjacent states:

Illinois: Illinois state statute provides that the implementation of direct occupational therapy treatment to individuals for their specific health care conditions shall be based upon a referral from a licensed physician, dentist, podiatric physician, or advanced practice nurse who has a written collaborative agreement with a collaborating physician to provide or accept referrals from licensed occupational therapists, physician assistant who has been delegated authority to provide or accept referrals from or to licensed occupational therapists, or optometrist (225 ILCS 75/3.1). An occupational therapist may consult with, educate, evaluate, and monitor services for individuals groups, and populations concerning occupational therapy needs without referral. A referral is not required for providing consultation, habilitation, screening, education, wellness, prevention, environmental assessments, and work-related ergonomic services to individuals, groups, or populations. Referral from a physician or other health care provider is not required for evaluation or intervention for children and youths if an occupational therapist or occupational therapy assistant provides services in a school-based or educational environment, including the child's home (225 ILCS 75/3.1).

Illinois administrative code provides that an occupational therapist seeking to restore a license that has expired or been placed on inactive status for 5 years must file an application, pay the required fees, demonstrate completion of 24 hours of continuing education within 24 months prior to the restoration and one of the following: (1) Sworn evidence of active practice in another jurisdiction; (2) An affidavit attesting to military service; (3) Verification of successful completion of the Certification Examination of the NBCOT for licensure as a registered occupational therapist or certified occupational therapy assistant within the last 5 years prior to applying for restoration; or (4) Evidence of successful completion of 48 hours of continuing education in occupational therapy, including attendance at college level courses, professionally oriented continuing education classes, special seminars, or any other similar program completed within 2 years prior to application for restoration (68 Ill. Admin. Code pt. 1315.160).

Iowa: Iowa statutes provide that occupational therapy may be provided by an occupational therapist without referral from a physician, podiatric physician, dentist, or chiropractor, except that a hospital may require that occupational therapy provided in the hospital be performed only following prior review by and authorization of the performance of the occupational therapy by a member of the hospital medical staff (Iowa Code s. 148B.3A).

Iowa administrative code provides that an occupational therapist seeking to reactivate a license that has been inactive for 5 years or less must provide verification of the license(s) from every jurisdiction in which the applicant is or has been practicing during the time period the Iowa license was inactive and verification of 15 hours of continuing education for an occupational therapy assistant and 30 hours of continuing education for an occupational therapist within two years of application for reactivation. If the license has been on inactive status for more than five years, an applicant must provide verification of the license(s) from every jurisdiction in which the applicant is or has been practicing during the time period the Iowa license was inactive and verification of completion of 30 hours of continuing education for an occupational therapy assistant and 60 hours of continuing education for an occupational therapist within two years of application for reactivation; or evidence of successful completion of the professional examination required for initial licensure completed within one year prior to the submission of an application for reactivation (Iowa Admin. Code r. 645 – 206.11). A licensee whose license has been revoked, suspended, or voluntarily surrendered must reinstate their license in accordance with the terms and conditions of the order of revocation or suspension, unless the order of revocation provides that the license is permanently revoked. If the order of revocation or suspension did not establish terms and conditions upon which reinstatement might occur, or if the license was voluntarily surrendered, an initial application for reinstatement may not be made until one year has elapsed from the date of the order or the date of the voluntary surrender. An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the revocation or suspension of the respondent's license no longer exists and that it will be in the public interest for the license to be reinstated. If the board determines that the license can be reinstated, then the license reactivation process is followed (Iowa Admin. Code r. 645 – 206.11 and Iowa Admin. Code r. 645 – 11.31).

Michigan: Michigan statutes and code are silent with regards to required orders or referrals from other healthcare providers. An applicant whose license has lapsed for 3 years or more may be relicensed by meeting the following: (1) Passing the examination on state laws and rules related to the practice of occupational therapy; (2) Completing supervised practice experience requirements; (3) Verifying any license or registration from another state that was held while the license was lapsed; and (4) Either completing of the NBCOT's certification examination for occupational therapists or presenting evidence that he or she was registered or licensed as an occupational therapist in another state during the 3-year period immediately preceding the application for relicensure (Mich. Admin. Code R. 338.1227).

Minnesota: Minnesota statutes do not require referral from a healthcare provider, however, in the absence of a physician referral or prior authorization, an occupational therapist must provide the following written notification: "Your health care provider, insurer, or plan may require a physician referral or prior authorization and you may be obligated for partial or full payment for occupational therapy services rendered." (Minn. Stat. s. 148.6438).

Summary of factual data and analytical methodologies:

The Board received input from the Wisconsin Occupational Therapy Association, and adjacent states’ administrative rules were reviewed. No other factual data or analytical methodologies were used.

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

The rule was posted for public comment on the economic impact of the proposed rule, including how this proposed rule may affect businesses, local government units, and individuals, for a period of 14 days. No comments were received.

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis are attached.

Effect on small business:

These proposed rules do not have a negative 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 Eric.Esser@wisconsin.gov, or by calling (608) 267-2435.

Agency contact person:

Katie Paff, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4472; email at Kathleen.Paff@wisconsin.gov.

Place where comments are to be submitted and deadline for submission:

Comments may be submitted to Katie Paff, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, WI 53708-8935, or by email to Kathleen.Paff@wisconsin.gov. ~~Comments must be received on or before * to be included in the record of rule-making proceedings.~~

TEXT OF RULE

SECTION 1. OT 1.02 (17) is repealed.

SECTION 2. OT 3.05 (title) and (intro.) are amended to read:

~~OT 3.05 Failure to be registered~~ Late renewal and reinstatement. Failure to be registered. Failure to renew a license by June 1 of an odd numbered year shall cause the license to ~~lapse~~ expire. A licensee who allows the license to ~~lapse~~ expire may apply to the board for late renewal or reinstatement of the license as follows by completing one of the following:

SECTION 3. OT 3.05 (1) (title) is created to read:

OT 3.05 (1) LATE RENEWAL BEFORE 5 YEARS.

SECTION 4. OT 3.05 (2) is amended to read:

OT 3.05 (2) LATE RENEWAL AFTER 5 YEARS. If the licensee applies for renewal of the license more than 5 years after its expiration, 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 shall impose any reasonable conditions on ~~reinstatement~~ the renewal of the license, including oral examination, as the board deems appropriate. All applicants under this section shall be required to pass the open book examination on statutes and rules, which is the same examination given to initial applicants. This section does not apply to licensees who have unmet disciplinary requirements or whose licenses have been surrendered or revoked.

SECTION 5. OT 3.05 (3) is created to read:

OT 3.05 (3) REINSTATEMENT. A licensee who has unmet disciplinary requirements and failed to renew within 5 years of the renewal date or whose license has been surrendered or revoked, may apply to have the license reinstated in accordance with all of the following:

- (a) Evidence of the completion of the requirements under sub. (2).
- (b) Evidence of completion of disciplinary requirements, if applicable.
- (c) Evidence of rehabilitation or change in circumstances warranting reinstatement of the license.

SECTION 6. OT 4.02 (2) (f) is amended to read:

OT 4.02 (2) (f) Application of physical agent modalities based on a physician ~~order~~ referral as an adjunct to or in preparation for engagement in treatment. Application is performed by an experienced therapist with demonstrated and documented evidence of theoretical background, technical skill and competence

SECTION 7. OT 4.03 (2) (title) is amended to read:

OT 4.03 (2) REFERRALS AND ORDERS.

SECTION 8. OT 4.03 (2) (a) is repealed.

SECTION 9. OT 4.03 (2) (b) is amended to read:

OT 4.03 (2) (b) Referrals may be accepted from advanced practice nurses, chiropractors, dentists, optometrists, physical therapists, physicians, physician assistants, podiatrists, psychologists, or other health care professionals.

SECTION 10. OT 4.03 (2) (c) and (d) are repealed.

SECTION 11. OT 4.03 (3) (a) is amended to read:

OT 4.03 (3) (a) The occupational therapist directs the evaluation process upon receiving ~~an order or~~ a referral from another health care professional. An occupational therapist alone or in collaboration with the occupational therapy assistant shall prepare an occupational therapy evaluation for each individual ordered for occupational therapy services. The occupational therapist interprets the information gathered in the evaluation process.

SECTION 12. OT 4.03 (3) (f) is amended to read:

OT 4.03 (3) (f) Evaluation results shall be communicated to the ~~ordering~~ referring health care professional and to the appropriate persons in the facility and community

SECTION 13. 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.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson
Occupational Therapists
Affiliated Credentialing Board

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Brian Holmquist		2) Date When Request Submitted: 5/29/2015	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Occupational Therapists Affiliated Credentialing Board			
4) Meeting Date: 6/10/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Telehealth – Board Discussion	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Board Discussion.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

**The American Occupational Therapy Association
Advisory Opinion for the Ethics Commission**

Telehealth

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

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

Occupational therapy practitioners are among the rehabilitation health care providers who may use telehealth technologies for service delivery. Potential uses include consultation, client evaluation, client monitoring, supervision, and intervention (AOTA, 2013). Reports in the literature describe interventions such as wheeled mobility and seating assessments (Schein, Schmeler, Saptoni, & Brienza, 2010); post-stroke arm rehabilitation delivered over the Internet (Hermann et al., 2010); evaluation of rural clients (Dreyer, Dreyer, Shaw, & Wittman, 2001); and polytrauma rehabilitation (Bendixen et al., 2008).

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

General Considerations for Occupational Therapy Practice

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

Client Comfort and Competence

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

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

Provider Competence

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

Ethical Considerations for Occupational Therapy Practice

Occupational therapists and occupational therapy assistants who provide services via telehealth technology face unique ethical considerations. The *Occupational Therapy Code of Ethics and Ethics Standards (2010)* (Code and Ethics Standards; AOTA, 2010), in conjunction with other AOTA official documents, offers guidance for these considerations. Specific issues that may arise relate to attaining consent to treat, protecting clients' privacy and confidentiality, and adhering to professional standards to ensure the highest level of quality care or best alternative when delivering services using a telehealth model.

Consent to Treat

As guided by Principle 3 (Autonomy, Confidentiality) and Principle 4 (Social Justice) of the Code and Ethics Standards, occupational therapy practitioners must fully disclose information about the specific occupational therapy services (e.g., benefits, risks, potential outcomes, providers of services, reasonable alternatives; AOTA, 2010) and about the implications of the use of technology during intervention. Clients should be informed of the risks and benefits, their rights (including the right to refuse treatment) and responsibilities, and organizational policies for the retention and storage of audio and video recordings and electronic medical records (Grosch et al., 2011).

Some risks related to providing services via telecommunication include the potential for loss of privacy or confidentiality; knowledge and skills of care recipient or extender when needed for equipment use; the possibility for equipment malfunction; costs; potential feelings of less

personalized care; or modifications to assessment administration and scoring procedures (Bauer, 2001; Grosch et al., 2011; van Wynsberghe & Gastmans, 2009). Practitioners should consider all these risks as well as benefits when determining whether to provide occupation therapy services via telehealth technology.

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

Privacy and Confidentiality

As stipulated in Principle 3G of the Code and Ethics Standards, occupational therapy practitioners must “Ensure that confidentiality and the right to privacy are respected and maintained regarding all information obtained about recipients of services” (AOTA, 2010, p. S21). Providers should ensure that clear policies related to service provision; documentation; and transmission, retention, and storage of audio, video, and electronic recordings and records are in place and are in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191) privacy rule to protect the privacy and confidentiality of clients' protected health information. Strategies include ensuring that equipment and connections are secure (Hyler & Gangure, 2004) and taking steps to make certain unauthorized third parties do not accidentally enter the room during a videoconferencing session (Grosch et al., 2011). Practitioners should inform clients of the possibility of third-party presence (e.g., technology assistant) and obtain client permission for the same (Grosch et al., 2011).

Clients have the right to know that, despite efforts to protect their privacy and confidentiality, breaches may occur. In these instances, practitioners should understand and adhere to appropriate procedures addressing the compromise of the client's privacy and confidentiality of protected health information (AOTA, 2013). To maximize privacy and confidentiality, organizations and practitioners should use authentication or encryption technology (Brennan et al., 2010). Authentication technology ensures that people accessing the technology are whom they claim to

be, and encryption ensures that no one can copy information transported via the Internet (Chadwick et al., 2000).

Quality Care and Adherence to Standards

Occupational therapy practitioners delivering services using a telehealth model must consider the impact of the technology on the services delivered to ensure they provide the best care possible and adhere to all professional and legal standards. Determination for appropriateness of occupational therapy intervention using telehealth technology should be made on a case-by-case basis according to sound clinical reasoning and should be consistent with published professional standards (Brennan et al., 2010). That is, a decision to implement telehealth service delivery should be client-centered and based on advocating for recipients to attain needed services (Principle 4E) rather than on factors related to convenience or administrative directives.

In addition, when using telehealth, practitioners must be aware of the potential impact of technology on the communication process (e.g., distorted or delayed audio or video transmission) and take steps to facilitate meaningful communication and comprehension (Principle 3I) and promote open and collaborative dialogue (Principle 3J; Code and Ethics Standards; AOTA, 2010). Finally, practitioners should be knowledgeable as to how technology could affect the reliability of assessments when performing client evaluations using telehealth delivery methods. Consistent with Principle 1F, practitioners should remain abreast of the current evidence related to conducting evaluations using telehealth technology (AOTA, 2013).

Telehealth delivery opens the door to the provision of service with clients from a variety of diverse backgrounds. According to Principle 4F of the Code and Ethics Standards, occupational therapy personnel shall “Provide services that reflect an understanding of how occupational therapy service delivery can be affected by factors such as economic status, age, ethnicity, race, geography, disability, marital status, sexual orientation, gender, gender identity, religion, culture, and political affiliation” (AOTA, 2010, p. S22). Practitioners should recognize and consider issues related to their own cultural competence, especially if language and ethnicity issues could affect the delivery or effectiveness of services (AOTA, 2010).

Practitioners also must meet their ethical responsibilities to “comply with institutional rules, local, state, federal, and international laws and AOTA documents” as stipulated in Principle 5 (Procedural Justice) of the Code and Ethics Standards (AOTA, 2010, p. S22). Principle 5E states that therapists should “hold the appropriate national, state, or other requisite credentials for the occupational therapy services they provide” (AOTA, 2010, p. S23). As mentioned previously, practitioners must be aware of state licensure laws (of each state where involved parties reside) and of each state’s regulations related to telehealth practice. At this time, a practitioner who delivers occupational therapy services via telehealth technology to a client who lives in a different state from the one in which the practitioner is licensed must adhere to the licensure regulations of his or her home state as well as the state where the client receives services, including possibly obtaining additional licensure in the state where the client resides (AOTA, 2013).

Knowledge of and adherence to billing and reimbursement regulations are also important considerations when providing occupational therapy services via telehealth technology (AOTA, 2013). As of the writing of this paper, Medicare does not provide reimbursement for occupational therapy services provided using telehealth technology, and Medicaid reimbursement practices vary on a state-by-state basis (AOTA, 2013). Private insurance, school systems, state early intervention systems, workers’ compensation programs, and other payers may have rules that guide or restrict interventions provided using a telehealth service delivery model. Principles 5 (Procedural Justice) and 6 (Veracity) of the Code and Ethics Standards direct practitioners to collect fees legally (Principle 5O) and ensure that documentation for reimbursement meets laws, guidelines, and regulations (Principle 6D). Thus, practitioners should be transparent in describing services delivered via technology when documenting telehealth encounters and ensure that the documentation meets professional (or practice) standards.

As stated in the Code and Ethics Standards, occupational therapists and occupational therapy assistants are obligated to provide services within their level of competence and scope of practice (Principle 1E) and to take responsibility for maintaining high standards and continuing competence in practice (Principle 5F). Principle 1G specifically refers to situations in which “generally recognized standards do not exist in emerging technology” and directs therapists to

take steps to ensure their own competence and weigh benefits of service provision with the potential for client harm (AOTA, 2010, p. S19).

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

Case Scenarios

Case 1. Client with Cerebral Palsy

Carrie is an occupational therapist, licensed in West Virginia and Ohio, and employed by a children's hospital in Ohio who specializes in adapted seating and positioning systems for individuals with cerebral palsy (CP). She is considered an expert in this area and has earned a reputation for providing high-quality services by designing innovative seating systems for children with multiple and complex impairments.

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

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

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

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

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

In this scenario, a well-intentioned situation turned out poorly. Becky was in need of specialized occupational therapy services that were geographically inaccessible to her. In arranging for Becky to receive services via live videoconferencing, Sam was meeting his ethical responsibility to advocate for Becky to receive these services in the only available way according to Principle 4E (Social Justice) of the Code and Ethics Standards (AOTA, 2010). After being fully informed about procedures, Becky and her mother readily consented to the videoconferencing session, in accordance with Principle 3B (Autonomy, Confidentiality), as this potentially resolved two issues for them (i.e., they did not have to travel for services, and Becky could receive the treatment she needed).

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

Carrie and Sam might have avoided the problem all together. According to Principle 3A (Autonomy, Confidentiality) of the Code and Ethics Standards (AOTA, 2010), they should have more fully informed Becky about what to expect during and about potential risk of her removal of clothing and being touched by Sam.

Case 2. Supervision

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

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

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

While Scott still travels to Brookhaven twice per month, using videoconferencing technology decreases the amount of time he spends there. Abby also appreciates having weekly face-to-face time with him, as it enables more regular and effective discussions about client needs. Furthermore, Scott and Abby plan to expand their use of video teleconferencing to include his observation of Abby treating clients; Scott's provision of instruction as Abby implements

treatments in real-time; and Abby's participation in staff continuing education activities conducted at Scott's worksites (e.g., journal club, case discussions).

Both models of Scott and Abby's supervisory process were appropriate and effective. In ensuring that both met state licensure regulations, they have complied with the Code and Ethics Standards (AOTA, 2010). Specifically, Principle 5H directs that occupational therapists provide appropriate supervision "in accordance with AOTA official documents and local, state, and federal or national laws, rules, regulations, policies, procedures, standards, and guidelines" (AOTA, 2010, p. S23). Furthermore, these processes met standards and guidelines delineated in the *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2009) in that the frequency, methods, and content were appropriate to ensure safe and effective delivery of services and also supported Abby's current and advancing competency.

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

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

situations for which it is used, is the best way to meet their needs, and is not used as a convenient replacement for situations that call for an in-person meeting.

Conclusion

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

Practitioners using telehealth must be cognizant of and practice according to ethical standards outlined in the *Occupational Therapy Code of Ethics and Ethics Standards* (AOTA, 2010). In addition to attaining consent to treat and to treat in this manner, practitioners may need to take extra measures to protect clients' privacy and confidentiality. Practitioners also should take several measures to ensure they provide optimal interventions. Such measures relate to the responsibility to ensure competency in delivery of services and adherence to local, state, and federal standards and regulations. Practitioners must understand how to operate the technology and how the use of technology can affect the communication, intervention, and assessment processes and to make adjustments as needed.

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

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

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

References

- American Occupational Therapy Association. (2009). Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. *American Journal of Occupational Therapy*, 63, 797–803. <http://dx.doi.org/doi:10.5014/ajot.63.6.797>
- American Occupational Therapy Association. (2010). Occupational therapy code of ethics and ethics standards (2010). *American Journal of Occupational Therapy*, 64(Suppl.), S17–S26. <http://dx.doi.org/doi:10.5014/ajot.2010.64S17>
- American Occupational Therapy Association. (2013). Telehealth. *American Journal of Occupational Therapy*, 67(Suppl.), S69-S90. <http://dx.doi.org/10.5014/ajot.2013.67S69>
- Bauer, K. A. (2001). Home-based telemedicine: A survey of ethical issues. *Cambridge Quarterly of Healthcare Ethics*, 10, 137–146.
- Bendixen, R. M., Levy, C., Lutz, B. J., Horn, K. R., Chronister, K., & Mann, W. C. (2008). A telerehabilitation model for victims of polytrauma. *Rehabilitation Nursing*, 33(5), 215–220.
- Brennan, D., Tindall, L., Theodoros, D., Brown, J., Campbell, M., Christiana, D., Smith, D., Cason, J., & Lee, A. (2010). A blueprint for telerehabilitation guidelines. *International Journal of Telerehabilitation*, 2(2), 31–34. <http://dx.doi.org/doi:10.5195/IJT.2010.6063>

- Cason, J. (2011). Telerehabilitation: An adjunct service delivery model for early intervention services. *International Journal of Telerehabilitation*, 3(1), 19–29. <http://dx.doi.org/doi:10.5195/IJT.2011.6071>
- Chadwick, D. W., Crook, P. J., Young, A. J., McDowell, D. M., Dornan, T. L., & New, J. P. (2000). Using the Internet to access confidential patient records: A case study. *British Medical Journal*, 321, 612–614.
- Denton, D. R. (2003). Ethical and legal issues related to telepractice. *Seminars in Speech and Language*, 24(4), 313–322.
- Dreyer, N. C., Dreyer, K. A., Shaw, D. K., & Wittman, P. P. (2001). Efficacy of telemedicine in occupational therapy: A pilot study. *Journal of Allied Health*, 30, 39–42.
- Grosch, M. C., Gottlieb, M. C., & Collum, C. M. (2011). Initial practice recommendations for teleneuropsychology. *The Clinical Neuropsychologist*, 25(7), 1119–1133.
- Health Insurance Portability and Accountability Act of 1996, P. L. 104-191, 110 Stat. 1938.
- Health Resources and Services Administration. (n.d.). *Telehealth*. Retrieved from <http://www.hrsa.gov/ruralhealth/about/telehealth/index.html>
- Hermann, V. H., Herzog, M., Jordan, R., Hofherr, M., Levine, P., & Page, S. J. (2010). Telerehabilitation and electrical stimulation: An occupation-based, client-centered stroke intervention. *American Journal of Occupational Therapy*, 64(1), 73–81. <http://dx.doi.org/doi:10.5014/ajot.64.1.73>
- Hylar, S. E., & Gangure, D. P. (2004). Legal and ethical challenges in telepsychiatry. *Journal of Psychiatric Practice*, 10(4), 272–276.
- Pramuka, M., & van Roosmalen, L. (2009). Telerehabilitation technologies: Accessibility and usability. *International Journal of Telerehabilitation*, 1(1), 85–98.
- Russell, T. G. (2009). Telerehabilitation: A coming of age. *Australian Journal of Physiotherapy*, 55, 5–6.
- Schein, R. M., Schmeler, M. R., Saptani, A., & Brienza, D. M. (2010). Telerehabilitation wheeled mobility and seating assessments compared with in person. *Archives of Physical Medicine and Rehabilitation*, 91, 874–878.

Torsney, K. (2003). Advantages and disadvantages of telerehabilitation for persons with neurological disabilities. *NeuroRehabilitation*, 18, 183–185.

Van Wynsberghe, A., & Gastmans, C. (2009). Telepsychiatry and the meaning of in-person contact: A preliminary ethical appraisal. *Medicine, Health Care, and Philosophy*, 12, 469–476.

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Telehealth

The purpose of this paper is to provide the current position of the American Occupational Therapy Association (AOTA) regarding the use of telehealth by occupational therapists and occupational therapy assistants¹ to provide occupational therapy services. This document describes the use of telehealth within occupational therapy practice areas, as described in the existing research. Additionally, occupational therapy practitioner² 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.

Telecommunication and information technologies have prompted the development of an emerging model of health care delivery called *telehealth*, which involves health care services, health information, and health education. AOTA defines *telehealth* as the application of evaluative, consultative, preventative, and therapeutic services delivered through telecommunication and information technologies. Occupational therapy services provided by means of a telehealth service delivery model 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, and plays, if that is needed or desired (AOTA, 2010d). An overview of telehealth technologies is included in Appendix A. *Telerehabilitation* within the larger realm of telehealth is the application of telecommunication and information technologies for the delivery of rehabilitation services. Key terms related to telehealth and telehealth technologies are defined in Appendix B.

Use of Telehealth Within Occupational Therapy

Occupational therapy practitioners use telehealth as a service delivery model to help clients develop skills; incorporate assistive technology and adaptive techniques; modify work, home, or school environments; and create health-promoting habits and routines. Benefits of a telehealth service delivery model include increased accessibility of services to clients who live in remote or underserved areas, improved access to providers and specialists otherwise unavailable to clients, prevention of unnecessary delays in receiving care, and workforce enhancement through consultation and research among others (Cason, 2012a, 2012b). By removing barriers to accessing care, including social stigma, travel, and socioeconomic and cultural barriers, the use of telehealth as a service delivery model within occupational therapy leads to improved access to care and ameliorates the impact of personnel shortages in underserved areas. Occupational therapy outcomes aligned with telehealth include the facilitation of occupational performance, adaptation, health and wellness, prevention, and quality of life.

¹The *occupational therapist* is responsible for all aspects of occupational therapy service delivery and is accountable for the safety and effectiveness of the occupational therapy service delivery process. The *occupational therapy assistant* delivers occupational therapy services under the supervision of and in partnership with the occupational therapist (AOTA, 2009).

²When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

Telehealth has potential as a service delivery model in each major practice area within occupational therapy. Note that 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 with selections firmly based on clinical judgment, client’s informed choice, and professional standards of care” (Brennan et al., 2010, p. 33). See Appendix C for applications and evidence supporting the use of telehealth within occupational therapy practice areas.

Evaluation Using Telehealth Technologies: Tele-Evaluation

The traditional telephone system continues to be a low-cost alternative for effectively conducting interview assessments by various health care professionals (Cooper et al., 2002; Dreyer, Dreyer, Shaw, & Wittman, 2001; Winters, 2002), and advanced communication technologies have 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 wheelchair prescription (Barlow, Liu, & Sekulic, 2009; Schein, Schmeler, Brienza, Saptono, & Parmanto, 2008; Schein, Schmeler, Holm, Saptono, & Brienza, 2010; Schein et al., 2011), neurological assessment (Savard, Borstad, Tkachuck, Lauderdale, & Conroy, 2003), adaptive equipment prescription and home modification (Sanford et al., 2007), and ergonomic assessment (Baker & Jacobs, 2013).

Clinical reasoning guides the selection and application of appropriate telehealth technologies necessary to evaluate client needs and environmental factors. Therapists should consider the reliability and validity of specific assessment tools when administered remotely. Researchers have investigated the reliability of assessments such as 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); and the FIM™, the Jamar Dynamometer, the Preston Pinch Gauge, the Nine-Hole Peg Test, and the Unified Parkinson’s Disease Rating Scale (Hoffman, Russell, Thompson, Vincent, & Nelson, 2008) and found these tools to be reliable when administered remotely through telehealth technologies. In some cases, an in-person assistant, such as a paraprofessional or other support person, 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 choosing a telehealth model for conducting an evaluation, occupational therapists need to consider the client’s diagnosis, client’s preference, access to technology, and ability to measure outcomes when using that model. The occupational therapist may determine that an in-person evaluation 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 about the appropriate use of telehealth technologies for conducting evaluations.

Intervention Using Telehealth Technologies: Teleintervention and Telerehabilitation

A telehealth model of service delivery may be used for providing interventions that are preventative, habilitative, or rehabilitative in nature. When planning and providing interventions delivered with telehealth technologies, Scheideman-Miller et al. (2003) reported that the appropriateness and maintenance of the technology and the sustainability of participation by the client are important factors to consider. As related to occupational therapy interventions, some factors to consider include technology availability and options for the occupational therapy practitioner and the client; the safety, effectiveness, sustainability, and quality of interventions provided exclusively through telehealth or in combination with in-person interventions; the client’s choice about receiving interventions by means of telehealth technologies; the client’s outcomes, including the client’s perception of services provided; reimbursement; and compliance with federal and state laws, regulation, and policy, including licensure requirements (Cason & Brannon, 2011).

Consultation Using Telehealth Technologies: Teleconsultation

Teleconsultation is a virtual consultation that includes the

- Expert provider and client,
- Expert provider and local provider with the client present, or
- Expert provider and local provider without the client present.

Teleconsultation uses telecommunication and information technologies for the purpose of obtaining 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 or prosthetist can remotely evaluate and adjust 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 and client (Whelan & Wagner, 2011). Similarly, Schein et al. (2008) demonstrated positive outcomes associated with teleconsultation between a remote seating specialist and a local therapist for evaluating wheelchair prescriptions. The Veterans Health Administration is using teleconsultation for veterans with traumatic brain injuries in a process that involves interactive videoconferencing technology and Web-based management systems (Girard, 2007). In the practice area of pediatrics, Wakeford (2002) used videoconferencing technologies to consult on play performance in children with special needs.

Practitioners should contact state professional licensure boards in their state as well as in the state where the client is located for further clarification on policies related to teleconsultation before rendering services. Some states do have consultation and licensure exemption provisions, although application of the consultation and licensure exemption provisions to facilitate temporary (i.e., consultative) interstate occupational therapy practice using telehealth technologies has not been established (Cason & Brannon, 2011).

Monitoring Using Telehealth Technologies: Telemonitoring

Occupational therapy practitioners can use telehealth technologies to monitor a client's adherence to an intervention program, assist a client in progressing toward achieving desired outcomes, and track and respond to follow-up issues and concerns within a client's natural environments. For example, the Gator Tech Smart House (Mann & Milton, 2005) developed at the University of Florida provides an array of self-monitoring analysis and reporting technology (SMART) technologies that monitor and cue clients remotely. Examples include the SmartShoe (Naditz, 2009), which determines fall risk by analyzing walking behavior patterns in a client's own environment and sends the information to a remote site. Similarly, home exercise programs can be monitored remotely using a *haptic* (touch-sensitive) control interface to track a client's hand position while providing resistive forces remotely (Popescu, Burdea, Bouzit, & Hentz, 2000).

Tang and Venables (2000) used smartphones to deliver rehabilitation interventions remotely by using wireless Internet or Intranet access and by providing frequent prompts and cues regarding when and how to complete daily living occupations. Wireless technologies such as these are expanding opportunities for occupational therapy practitioners to implement interventions using telehealth technologies where clients live, work, and play and to provide services throughout the day rather than only within the occupational therapy clinic.

Appendix D provides case examples of how occupational therapy practitioners use telehealth technologies to support health and participation in occupations.

Practitioner Qualifications and Ethical Considerations

AOTA asserts that the same ethical and professional standards that apply to in-person delivery of occupational therapy services also apply to the delivery of services by means of telehealth technologies. Occupational therapy practitioners should refer to the *Occupational Therapy Code of Ethics and Ethics Standards (2010)* (AOTA, 2010a). As stated in this document, occupational therapy practitioners are responsible for ensuring their individual competence in the areas in which they provide services. In addition, Principle 1B of the *Code and Ethics Standards* states that “occupational therapy personnel shall provide appropriate evaluation and a plan of intervention for all recipients of occupational therapy services specific to their needs” (AOTA, 2010a, p. S19). 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, appropriate delivery of services. To determine whether providing occupational therapy by means of telehealth is in the best interest of the client, the occupational therapist must consider the following:

- Complexity of the client’s condition
- Knowledge, skill, and competence of the occupational therapy practitioner
- Nature and complexity of the intervention
- Requirements of the practice setting
- Client’s context and environment.

Additionally, the American Telemedicine Association’s “A Blueprint for Telerehabilitation Guidelines” outlines important administrative, clinical, technical, and ethical principles associated with the use of telehealth (Brennan et al., 2010). Occupational therapy practitioners may use various educational approaches to gain competency in using telehealth technologies. They may gain an understanding about basic telehealth service delivery model and telehealth technologies as a part of entry-level education (Standard B.1.8; Accreditation Council for Occupational Therapy Education, 2012) or may participate in continuing education opportunities as clinicians to acquire expertise in this area (Theodorus & Russell, 2008). Examples of ethical considerations related to telehealth are outlined in Table 1.

The *Specialized Knowledge and Skills in Technology and Environmental Interventions for Occupational Therapy Practice* document (AOTA, 2010b) describes the knowledge and skills necessary for entry- and advanced-level practice in technology. 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 (Schopp, Hales, Brown, & Quetsch, 2003). They should use evidence, mentoring, and continuing education to maintain and enhance their competency related to the use of a telehealth service delivery model within occupational therapy.

Supervision Using Telehealth Technologies

State licensure laws, institution-specific guidelines regarding supervision of occupational therapy students and personnel, the AOTA *Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2009), and the *Occupational Therapy Code of Ethics and Ethics Standards (2010)* (AOTA, 2010a) must be followed, regardless of the method of supervision. Telehealth technologies may be used within those guidelines to the extent that they take into account the unique characteristics of telehealth supervision, to support students and practitioners working in isolated or rural areas (Miller, Miller,

Table 1. Ethical Considerations and Strategies for Practice Using Telehealth Technologies

ETHICAL CONSIDERATIONS	STRATEGIES FOR ETHICAL PRACTICE
Fully inform the client regarding the implications of a telehealth service delivery model versus an in-person service delivery model.	<p>Occupational therapy personnel shall . . .</p> <p>“Establish a collaborative relationship with recipients of service including families, significant others, and caregivers in setting goals and priorities throughout the intervention process. This includes full disclosure of the benefits, risks, and potential outcomes of any intervention; the personnel who will be providing the intervention(s); and/or any reasonable alternatives to the proposed intervention.” (Principle 3A)</p> <p>“Obtain consent before administering any occupational therapy service, including evaluation, and ensure that recipients of service (or their legal representatives) are kept informed of the progress in meeting goals specified in the plan of intervention/care.” (Principle 3B)</p>
Abide by laws and scope of practice related to licensure and provision of occupational therapy services using telehealth technologies.	<p>“Occupational therapy personnel shall comply with institutional rules, local, state, federal, and international laws and AOTA documents applicable to the profession of occupational therapy.” (Principle 5)</p>
Adhere to professional standards.	<p>Occupational therapy personnel shall . . .</p> <p>“Provide occupational therapy services that are within each practitioner’s level of competence and scope of practice (e.g., qualification, experience, the law).” (Principle 1E)</p> <p>“Take responsible steps (e.g., continuing education, research, supervision, training) and use careful judgment to ensure their own competence and weigh potential for client harm when generally recognized standards do not exist in emerging technology or areas of practice.” (Principle 1G)</p> <p>“Take responsibility for maintaining high standards and continuing competence in practice, education, and research by participating in professional development and educational activities to improve and update knowledge and skills.” (Principle 5F)</p> <p>“Occupational therapy personnel shall comply with institutional rules, local, state, federal, and international laws and AOTA documents applicable to the profession of occupational therapy.” (Principle 5)</p>
Understand and abide by approaches that ensure that privacy, security, and confidentiality are not compromised as a result of using telehealth technologies.	<p>Occupational therapy personnel shall . . .</p> <p>“Ensure that confidentiality and the right to privacy are respected and maintained regarding all information obtained about recipients of service, students, research participants, colleagues, or employees. The only exceptions are when a practitioner or staff member believes that an individual is in serious foreseeable or imminent harm. Laws and regulations may require disclosure to appropriate authorities without consent.” (Principle 3G)</p> <p>“Maintain the confidentiality of all verbal, written, electronic, augmentative, and nonverbal communications, including compliance with HIPAA regulations.” (Principle 3H)</p>
Understand and adhere to procedures if there is any compromise of security related to health information.	<p>Report any breach of security to an appropriate health privacy officer, or seek guidance of an independent legal counsel.</p>

(Continued)

Table 1. Ethical Considerations and Strategies for Practice Using Telehealth Technologies (Cont.)

ETHICAL CONSIDERATIONS	STRATEGIES FOR ETHICAL PRACTICE
Assess the effectiveness of interventions provided through telehealth technologies by consulting current research and conducting ongoing monitoring of client response.	Occupational therapy personnel shall . . . “Refer to other health care specialists solely on the basis of the needs of the client.” (Principle 1I) “Reevaluate and reassess recipients of service in a timely manner to determine if goals are being achieved and whether intervention plans should be revised.” (Principle 1C) “Use, to the extent possible, evaluation, planning, intervention techniques, and therapeutic equipment that are evidence-based and within the recognized scope of occupational therapy practice.” (Principle 1F)
Recognize the need to be culturally competent in the provision of services via telehealth, including language, ethnicity, socioeconomic and educational background that could affect the quality and outcomes of services provided.	Occupational therapy personnel shall . . . “Provide services that reflect an understanding of how occupational therapy service delivery can be affected by factors such as economic status, age, ethnicity, race, geography, disability, marital status, sexual orientation, gender, gender identity, religion, culture, and political affiliation.” (Principle 4F) “Make every effort to facilitate open and collaborative dialogue with clients and/or responsible parties to facilitate comprehension of services and their potential risks/benefits.” (Principle 3J)

Note. HIPAA = Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191). Ethical principles are from AOTA’s (2010a) *Occupational Therapy Code of Ethics and Ethics Standards (2010)*.

Burton, Sprang, & Adams, 2003; Hubbard, 2000). However, practitioners engaged in telehealth supervision should be cautious when relying on legal or other standards that were not necessarily established with telehealth supervision in mind. 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, 2009). Supervision must comply with applicable state and federal practice regulations, state and federal insurance programs, relevant workplace policies, and the *Occupational Therapy Code of Ethics and Ethics Standards (2010)* (AOTA, 2010a).

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 (Cwiek, Rafiq, Qamar, Tobey, & Merrell, 2007). Given the inconsistent adoption and nonuniformity of language regarding the use of telehealth within occupational therapy, 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. Typically, information may be found on state licensure boards’ Web sites. The absence of statutes, regulations, or policies that guide the practice of occupational therapy by means of telehealth delivery should not be viewed as authorization to do so. State regulatory boards should be contacted directly in the absence of written guidance to determine the appropriateness of using telehealth technologies for the delivery of occupational therapy services within their jurisdictions. In addition, the policies and guidelines of payers should be consulted. At this time, occupational therapy practitioners are to comply with the licensure and regulatory requirements in the state where they are located and the state where the client is located (Cason & Brannon, 2011).

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 (Watzlaf, Moeini, & Firouzan, 2010; Watzlaf, Moeini, Matusow, & Firouzan, 2011). Occupational therapy practitioners are to consult with their practice setting’s privacy officer or legal counsel or to consult with independent legal counsel if they are in independent or other practice outside of an institutional setting 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 with telehealth technologies 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 technologies. 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 use occupational therapy practitioners for select telehealth programming.

Opportunities for reimbursement exist through some state Medicaid programs; insurance companies; and private pay with individuals, school districts, agencies, and organizations. Medicaid reimbursement is available at the discretion of each state, because it is subject to specific requirements or restrictions within a state. It is recommended that occupational therapy practitioners contact their state Medicaid or other third-party payers to determine the guidelines for reimbursement of services provided through telehealth technologies.

When billing occupational therapy services provided by means of telehealth technologies, practitioners must distinguish the service delivery model, often designated with a *modifier* (Cason & Brannon, 2011). However, regardless of whether the services are reimbursed or the practitioner is responsible for completing paperwork related to billing, the nature of the service delivery as being performed through telehealth should be thoroughly documented.

Summary

Telehealth is a service delivery model that uses telecommunication technologies to deliver health-related services at a distance. Occupational therapy practitioners are using synchronous or asynchronous telehealth technologies 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 the *Occupational Therapy Code of Ethics and Ethics Standards (2010)* (AOTA, 2010a), maintain the *Standards of Practice for Occupational Therapy* (AOTA, 2010c), 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 through a telehealth service delivery model will best meet the client’s needs and provide the most appropriate method of providing services given the individual’s situation. Clinical and ethical reasoning guides the selection and application of appropriate telehealth technology necessary to evaluate and meet client needs.

References

- Accreditation Council for Occupational Therapy Education. (2012). 2011 Accreditation Council for Occupational Therapy Education (ACOTE®) standards. *American Journal of Occupational Therapy*, 66(6, Suppl.), S6–S74. <http://dx.doi.org/10.5014/ajot.2012.66S6>

- American Medical Association. (2011). *CPT 2012*. Chicago: Author.
- American Occupational Therapy Association. (2006). Policy 1.44: Categories of occupational therapy personnel. In *Policy manual* (2009 ed., pp. 33–34). Bethesda, MD: Author.
- American Occupational Therapy Association. (2009). Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. *American Journal of Occupational Therapy*, 63, 797–803. <http://dx.doi.org/10.5014/ajot.63.6.797>
- American Occupational Therapy Association. (2010a). Occupational therapy code of ethics and ethics standards (2010). *American Journal of Occupational Therapy*, 64(6, Suppl.), S17–S26. <http://dx.doi.org/10.5014/ajot.2010.64S17>
- American Occupational Therapy Association. (2010b). Specialized knowledge and skills in technology and environmental interventions for occupational therapy practice. *American Journal of Occupational Therapy*, 64(6, Suppl.), S44–S56. <http://dx.doi.org/10.5014/ajot.2010.64S44>
- American Occupational Therapy Association. (2010c). Standards of practice for occupational therapy. *American Journal of Occupational Therapy*, 64(6, Suppl.), S106–S111. <http://dx.doi.org/10.5014/ajot.2010.64S106>
- American Occupational Therapy Association. (2010d). Telerehabilitation. *American Journal of Occupational Therapy*, 64(6, Suppl.), S92–S102. <http://dx.doi.org/10.5014/ajot.2010.64S92>
- Backman, C. L., Village, J., & Lacaille, D. (2008). The Ergonomic Assessment Tool for arthritis: Development and pilot testing. *Arthritis and Rheumatism*, 59, 1495–1503. <http://dx.doi.org/10.1002/art.24116>
- Baker, N., & Jacobs, K. (2010). Tele-ergonomics: A novel approach to computer workstation ergonomic assessment and modification. In *Proceedings of the Human Factors and Ergonomics Society 54th Annual Meeting (2010)* (p. 36). Santa Monica, CA: Human Factors and Ergonomics Society.
- Baker, N., & Jacobs, K. (2013). Tele-ergonomics. In S. Kumar & E. Cohn (Eds.), *Telerehabilitation* (pp. 163–174). London: Springer.
- Barlow, I. G., Liu, L., & Sekulic, A. (2009). Wheelchair seating assessment and intervention: A comparison between telerehabilitation and face-to-face service. *International Journal of Telerehabilitation*, 1, 17–28. <http://dx.doi.org/10.5195/ijt.2009.868>
- Bendixen, R., Horn, K., & Levy, C. (2007). Using telerehabilitation to support elders with chronic illness in their homes. *Topics in Geriatric Rehabilitation*, 23, 47–51.
- Bendixen, R., Levy, C., Lutz, B. J., Horn, K. R., Chronister, K., & Mann, W. C. (2008). A telerehabilitation model for victims of polytrauma. *Rehabilitation Nursing*, 33, 215–220. <http://dx.doi.org/10.1002/j.2048-7940.2008.tb00230.x>
- Bendixen, R., Levy, C., Olive, E., Kobb, R., & Mann, W. (2009). Cost-effectiveness of a telerehabilitation program to support chronically ill and disabled elders in their homes. *Telemedicine and e-Health*, 15, 31–38. <http://dx.doi.org/10.1089/tmj.2008.0046>
- Brennan, D., Tindall, L., Theodoros, D., Brown, J., Campbell, M., Christiana, D., . . . Lee, A. (2010). A blueprint for telerehabilitation guidelines. *International Journal of Telerehabilitation*, 2, 31–34. <http://dx.doi.org/10.5195/ijt.2010.6063>
- Brewer, B. R., Fagan, M., Klatzky, R. L., & Matsuoka, Y. (2005). Perceptual limits for a robotic rehabilitation environment using visual feedback distortion. *IEEE Transactions on Neural Systems and Rehabilitation Engineering*, 13, 1–11. <http://dx.doi.org/10.1109/TNSRE.2005.843443>
- Bruce, C., & Sanford, J. A. (2006). Development of an evidence-based conceptual framework for workplace assessment. *Work*, 27, 381–389.

- Cason, J. (2009). A pilot telerehabilitation program: Delivering early intervention services to rural families. *International Journal of Telerehabilitation*, 1, 29–38. <http://dx.doi.org/10.5195/ijt.2009.6007>
- Cason, J. (2011). Telerehabilitation: An adjunct service delivery model for early intervention services. *International Journal of Telerehabilitation*, 3, 19–28. <http://dx.doi.org/10.5195/ijt.2011.6071>
- Cason, J. (2012a). An introduction to telehealth as a service delivery model within occupational therapy. *OT Practice*, 17(7), CE1–CE8.
- Cason, J. (2012b). Telehealth opportunities in occupational therapy through the Affordable Care Act. *American Journal of Occupational Therapy*, 66, 131–136. <http://dx.doi.org/10.5014/ajot.2012.662001>
- Cason, J., & Brannon, J. A. (2011). Telehealth regulatory and legal considerations: Frequently asked questions. *International Journal of Telerehabilitation*, 3, 15–18. <http://dx.doi.org/10.5195/ijt.2011.6077>
- Chumbler, N., Quigley, P., Sanford, J., Griffiths, P., Rose, D., Morey, M., . . . Hoenig, H. (2010). Implementing telerehabilitation research for stroke rehabilitation with community dwelling veterans: Lessons learned. *International Journal of Telerehabilitation*, 2, 15–21. <http://dx.doi.org/10.5195/ijt.2010.6047>
- Cooper, R., Fitzgerald, S., Boninger, M. L., Cooper, R. A., Shapcott, N., & Cohen, L. (2002). Using telerehabilitation to aid in selecting a wheelchair. In R. Simpson (Ed.), *RESNA 2002 annual conference proceedings* (pp. 245–247). Minneapolis, MN: RESNA Press.
- Cwiek, M. A., Rafiq, A., Qamar, A., Tobey, C., & Merrell, R. C. (2007). Telemedicine licensure in the United States: The need for a cooperative regional approach. *Telemedicine and e-Health*, 13, 141–147. <http://dx.doi.org/10.1089/tmj.2006.0029>
- Darkins, A., Ryan, P., Kobb, R., Forster, L., Edmonson, E., Wakefield, B., & Lancaster, A. E. (2008). Care coordination/home telehealth: The systematic implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic conditions. *Telemedicine and e-Health*, 14, 1118–1126. <http://dx.doi.org/10.1089/tmj.2008.0021>
- Diamond, B. J., Shreve, G. M., Bonilla, J. M., Johnston, M. V., Morodan, J., & Branneck, R. (2003). Telerehabilitation, cognition and user accessibility. *NeuroRehabilitation*, 18, 171–177.
- Dreyer, N. C., Dreyer, K. A., Shaw, D. K., & Wittman, P. P. (2001). Efficacy of telemedicine in occupational therapy: A pilot study. *Journal of Allied Health*, 30, 39–42.
- Federal Communications Commission. (2010). *Voice-over-Internet protocol*. Retrieved from www.fcc.gov/voip/
- Forducey, P. G., Ruwe, W. D., Dawson, S. J., Scheideman-Miller, C., McDonald, N. B., & Hantla, M. R. (2003). Using telerehabilitation to promote TBI recovery and transfer of knowledge. *NeuroRehabilitation*, 18, 103–111.
- Gallagher, T. E. (2004). Augmentation of special-needs services and information to students and teachers “ASSIST”—A telehealth innovation providing school-based medical interventions. *Hawaii Medical Journal*, 63, 300–309.
- Germain, V., Marchand, A., Bouchard, S., Drouin, M. S., & Guay, S. (2009). Effectiveness of cognitive behavioural therapy administered by videoconference for posttraumatic stress disorder. *Cognitive Behaviour Therapy*, 38, 42–53. <http://dx.doi.org/10.1080/16506070802473494>
- Girard, P. (2007). Military and VA telemedicine systems for patients with traumatic brain injury. *Journal of Rehabilitation Research and Development*, 44, 1017–1026. <http://dx.doi.org/10.1682/JRRD.2006.12.0174>
- Gros, D. F., Yoder, M., Tuerk, P. W., Lozano, B. E., & Acierno, R. (2011). Exposure therapy for PTSD delivered to veterans via telehealth: Predictors of treatment completion and outcome and comparison to treatment delivered in person. *Behavior Therapy*, 42, 276–283. <http://dx.doi.org/10.1016/j.beth.2010.07.005>

- Harada, N. D., Dhanani, S., Elrod, M., Hahn, T., Kleinman, L., & Fang, M. (2010). Feasibility study of home telerehabilitation for physically inactive veterans. *Journal of Rehabilitation Research and Development*, 47, 465–475. <http://dx.doi.org/10.1682/JRRD.2009.09.0149>
- Harrison, A., Derwent, G., Enticknap, A., Rose, F. D., & Attree, E. A. (2002). The role of virtual reality technology in the assessment and training of inexperienced powered wheelchair users. *Disability and Rehabilitation*, 24, 599–606. <http://dx.doi.org/10.1080/09638280110111360>
- Health Insurance Portability and Accountability Act, Pub. L. 104–191, 101 Stat. 1936 (1996).
- Hegel, M. T., Lyons, K. D., Hull, J. G., Kaufman, P., Urguhart, L., Li, Z., & Ahles, T. A. (2011). Feasibility study of a randomized controlled trial of a telephone-delivered problem solving occupational therapy intervention to reduce participation restrictions in rural breast cancer survivors undergoing chemotherapy. *Psycho-Oncology*, 20, 1092–1101. <http://dx.doi.org/10.1002/pon.1830>
- Heimerl, S., & Rasch, N. (2009). Delivering developmental occupational therapy consultation services through telehealth. *Developmental Disabilities Special Interest Section Quarterly*, 32(3), 1–4.
- Hermann, V. H., Herzog, M., Jordan, R., Hofherr, M., Levine, P., & Page, S. J. (2010). Telerehabilitation and electrical stimulation: An occupation-based, client-centered stroke intervention. *American Journal of Occupational Therapy*, 64, 73–81. <http://dx.doi.org/10.5014/ajot.64.1.73>
- Hoffman, H. G., Patterson, D. R., & Carrougher, G. J. (2000). Use of virtual reality for adjunctive treatment of adult burn pain during physical therapy: A controlled study. *Clinical Journal of Pain*, 16, 244–250. <http://dx.doi.org/10.1097/00002508-200009000-00010>
- Hoffmann, T., Russell, T., Thompson, L., Vincent, A., & Nelson, M. (2008). Using the Internet to assess activities of daily living and hand function in people with Parkinson's disease. *NeuroRehabilitation*, 23, 253–261.
- Hori, M., Kubota, M., Kihara, T., Takahashi, R., & Kinoshita, A. (2009). The effect of videophone communication (with Skype and webcam) for elderly patients with dementia and their caregivers. *Gan To Kagaku Ryoho*, 36S, 36–38. Retrieved from www.ncbi.nlm.nih.gov/pubmed/20443395
- Hubbard, S. (2000, December 4 & 18). A case example of remote supervision. *OT Practice*, 5, 16–18.
- Individuals With Disabilities Education Act Amendments of 1997, Pub. L. 105–117, 20 U.S.C. § 1400 *et seq.*
- Kairy, D., Lehoux, P., Vincent, C., & Visintin, M. (2009). A systematic review of clinical outcomes, clinical process, healthcare utilization and costs associated with telerehabilitation. *Disability and Rehabilitation*, 31, 427–47. <http://dx.doi.org/10.1080/09638280802062553>
- Kelso, G., Fiechtl, B., Olsen, S., & Rule, S. (2009). The feasibility of virtual home visits to provide early intervention: A pilot study. *Infants and Young Children*, 22, 332–340. <http://dx.doi.org/10.1097/IYC.0b013e3181b9873c>
- Kim, J. B., & Brienza, D. M. (2006). Development of a remote accessibility assessment system through three-dimensional reconstruction technology. *Journal of Rehabilitation Research and Development*, 43, 257–272. <http://dx.doi.org/10.1682/JRRD.2004.12.0163>
- Kim, J. B., Brienza, D. M., Lynch, R. D., Cooper, R. A., & Boninger, M. L. (2008). Effectiveness evaluation of a remote accessibility assessment system for wheelchair users using virtualized reality. *Archives of Physical Medicine and Rehabilitation*, 89, 470–479. <http://dx.doi.org/10.1016/j.apmr.2007.08.158>
- Lewis, J. A., Boian, R. F., Burdea, G., & Deutsch, J. E. (2005). Remote console for virtual telerehabilitation. *Studies in Health Technology and Informatics*, 111, 294–300.
- Lewis, J. A., Deutsch, J. E., & Burdea, G. (2006). Usability of the remote console for virtual reality telerehabilitation: Formative evaluation. *Cyberpsychology and Behavior*, 9, 142–147. <http://dx.doi.org/10.1089/cpb.2006.9.142>

- Mann, W. C., & Milton, B. R. (2005). Home automation and SMART homes to support independence. In W. C. Mann (Ed.), *Smart technology for aging, disability, and independence* (pp. 33–66). Hoboken, NJ: Wiley.
- Merians, A. S., Jack, D., Boian, R., Tremaine, M., Burdea, G. C., Adamovich, S. V., . . . Poizner, H. (2002). Virtual reality–augmented rehabilitation for patients following stroke. *Physical Therapy, 82*, 898–915.
- Miller, T. W., Miller, J. M., Burton, D., Sprang, R., & Adams, J. (2003). Telehealth: A model for clinical supervision in allied health. *Internet Journal of Allied Health Sciences and Practice, 1*(2), 1–8.
- Naditz, A. (2009). Still standing: Telemedicine devices and fall prevention. *Telemedicine and e-Health, 15*, 137–141. <http://dx.doi.org/10.1089/tmj.2009.9989>
- Neubeck, L., Redfern, J., Fernandez, R., Briffad, T., Bauman, A., & Freedman, S. B. (2009). Telehealth interventions for the secondary prevention of coronary heart disease: A systematic review. *European Journal of Preventive Cardiology, 16*, 281–289. <http://dx.doi.org/0.1097/HJR.0b013e32832a4e7a>
- Palsbo, S. E., Dawson, S. J., Savard, L., Goldstein, M., & Heuser, A. (2007). Televideo assessment using Functional Reach Test and European Stroke Scale. *Journal of Rehabilitation Research and Development, 44*, 659–664. <http://dx.doi.org/10.1682/JRRD.2006.11.0144>
- Popescu, V. G., Burdea, G. C., Bouzit, M., & Hentz, V. R. (2000). A virtual-reality-based telerehabilitation system with force feedback. *IEEE Transactions on Information Technology in Biomedicine, 4*, 45–51. <http://dx.doi.org/10.1109/4233.826858>
- Rand, D., Katz, N., & Weiss, P. L. (2009). Intervention using the VMall for improving motor and functional ability of the upper extremity in poststroke participants. *European Journal of Physical and Rehabilitation Medicine, 45*, 113–121.
- Rand, D., Kizony, R., & Weiss, P. T. (2008). The Sony PlayStation II EyeToy: Low-cost virtual reality for use in rehabilitation. *Journal of Neurologic Physical Therapy, 32*, 155–163. <http://dx.doi.org/10.1097/NPT.0b013e31818ee779>
- Rand, D., Weiss, P. L., & Katz, N. (2009). Training multitasking in a virtual supermarket: A novel intervention after stroke. *American Journal of Occupational Therapy, 63*, 535–542. <http://dx.doi.org/10.5014/ajot.63.5.535>
- Sanford, J., Hoenig, H., Griffiths, P., Butterfield, T., Richardson, P., & Hargraves, K. (2007). A comparison of televideo and traditional in-home rehabilitation in mobility impaired older adults. *Physical and Occupational Therapy in Geriatrics, 25*, 1–18. http://dx.doi.org/10.1080/J148v25n03_01
- Savard, L., Borstad, A., Tkachuck, J., Lauderdale, D., & Conroy, B. (2003). Telerehabilitation consultations for clients with neurologic diagnoses: Cases from rural Minnesota and American Samoa. *NeuroRehabilitation, 18*, 93–102.
- Scheideman-Miller, C., Clark, P. G., Moorad, A., Post, M. L., Hodge, B. G., & Smeltzer, S. (2003, January). Efficacy and sustainability of a telerehabilitation program. In *Proceedings of the 36th Annual Hawaii International Conference on System Sciences* (pp. 11–21). Washington, DC: IEEE Computer Society.
- Schein, R. M., Schmeler, M. R., Brienza, D., Saptono, A., & Parmanto, B. (2008). Development of a service delivery protocol used for remote wheelchair consultation via telerehabilitation. *Telemedicine and e-Health, 14*, 932–938.
- Schein, R. M., Schmeler, M. R., Holm, M. B., Pramuka, M., Saptono, A., & Brienza, D. M. (2011). Telerehabilitation assessment using the Functioning Everyday with a Wheelchair-Capacity instrument. *Journal of Rehabilitation Research and Development, 48*, 115–124. <http://dx.doi.org/10.1682/JRRD.2010.03.0039>
- Schein, R. M., Schmeler, M. R., Holm, M. B., Saptono, A., & Brienza, D. M. (2010). Telerehabilitation wheeled mobility and seating assessments compared with in person. *Archives of Physical Medicine and Rehabilitation, 91*, 874–878. <http://dx.doi.org/10.1016/j.apmr.2010.01.017>

- Schmeler, M. R., Schein, R. M., McCue, M., & Betz, K. (2009). Telerehabilitation and clinical applications: Research, opportunities, and challenges. *International Journal of Telerehabilitation*, 1, 59–72. <http://dx.doi.org/10.5195/ijt.2009.6014>
- Schopp, L. H., Hales, J. W., Brown, G. D., & Quetsch, J. L. (2003). A rationale and training agenda for rehabilitation informatics: Roadmap for an emerging discipline. *NeuroRehabilitation*, 18, 159–170.
- Sheridan, T. B. (1992). Musings on telepresence and virtual presence. *Presence*, 1, 120–125.
- Steel, K., Cox, D., & Garry, H. (2011). Therapeutic videoconferencing interventions for the treatment of long-term conditions. *Journal of Telemedicine and Telecare*, 17, 109–117. <http://dx.doi.org/10.1258/jtt.2010.100318>
- Tang, P., & Venables, T. (2000). “Smart” homes and telecare for independent living. *Journal of Telemedicine and Telecare*, 6, 8–14. <http://dx.doi.org/10.1258/1357633001933871>
- Theodorus, D., & Russell, T. (2008). Telerehabilitation: Current perspectives. *Current Principles and Practices of Telemedicine and e-Health*, 131, 191–209.
- Verburg, G., Borthwick, B., Bennett, B., & Rumney, P. (2003). Online support to facilitate the reintegration of students with brain injury: Trials and errors. *NeuroRehabilitation*, 18, 113–123.
- Wakeford, L. (2002, November 25). Telehealth technology for children with special needs. *OT Practice*, 7, 12–16.
- Watzlaf, V., Moeini, S., & Firouzan, P. (2010). VoIP for telerehabilitation: A risk analysis for privacy, security, and HIPAA compliance, Part I. *International Journal of Telerehabilitation*, 2, 3–14. <http://dx.doi.org/10.5195/ijt.2010.6056>
- Watzlaf, V., Moeini, S., Matusow, L., & Firouzan, P. (2011). VoIP for telerehabilitation: A risk analysis for privacy, security, and HIPAA compliance, Part II. *International Journal of Telerehabilitation*, 3, 3–10. <http://dx.doi.org/10.5195/ijt.2011.6070>
- Weiss, P. L., & Jessel, A. S. (1998). Virtual reality applications to work. *Work*, 11, 277–293.
- Whelan, L., & Wagner, N. (2011). Technology that touches lives: Teleconsultation to benefit persons with upper limb loss. *International Journal of Telerehabilitation*, 3, 19–22. <http://dx.doi.org/10.5195/ijt.2011.6080>
- Winters, J. M. (2002). Telerehabilitation research: Emerging opportunities. *Annual Review of Biomedical Engineering*, 4, 287–320. <http://dx.doi.org/10.1146/annurev.bioeng.4.112801.121923>

Additional Resources

- American Telemedicine Association’s Telerehabilitation Special Interest Group/Resources, www.americantelemed.org/i4a/pages/index.cfm?pageid=3328
- Center for Telehealth and e-Health Law (CTel), <http://ctel.org/>
- International Journal of Telerehabilitation*, <http://telerehab.pitt.edu/ojs/index.php/telerehab>
- Journal of Telemedicine and Telecare*, <http://jtt.rsmjournals.com/>
- Rehabilitation Engineering Research Center for Telerehabilitation, www.rerctr.pitt.edu
- Telehealth Resource Centers, <http://www.telehealthresourcecenter.org/>
- Telemedicine and e-Health*, www.liebertpub.com/TMJ

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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 videoconferencing are available; they include voice over the Internet protocol (VoIP) services, mobile videoconferencing systems, “plain old telephone service” (POTS), videoconferencing, and high-definition television (HDTV) technologies (see Table A1).

VoIP services use a computer, special VoIP phone, or traditional phone with adapter to convert voice into a digital signal that travels over the Internet (Federal Communications Commission, 2010). Integrated with video software, VoIP provides a mechanism for Internet-based videoconferencing. Similarly, mobile videoconferencing uses a mobile device (e.g., smartphone, electronic tablet) with videoconferencing capabilities to transmit audio and video over a wireless or cellular network. POTS videoconferencing primarily uses an analog telephone line or landline to support audio and video transmission through a videophone or specialized equipment connected to a television. HDTV videoconferencing requires an HD television, console, HD camera, remote control, and high-speed broadband connection at both locations. Unlike the technologies described above and marketed for consumer use, telehealth networks use high-end videoconferencing technologies (e.g., Polycom, Tandberg) and fiber-optic telephone lines (e.g., T1 lines) or high-speed Internet to connect sites.

Advantages of VoIP, mobile, POTS, and consumer HDTV technologies 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 A1).

Asynchronous Technologies

Telehealth applications that are asynchronous, commonly referred to as “store-and-forward” data transmission, may include video clips, digital photographs, virtual technologies, and other forms of electronic communications. With *asynchronous technologies*, the provider and client are not connected at the same time. Potential applications for asynchronous telehealth technologies 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 segments 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 self-monitoring analysis and reporting technology (SMART) to monitor a client’s occupational performance within the home and community. SMART technologies that are wireless allow the occupational therapy practitioner to provide services within varied environments without restricting the client’s movements within those environments. These technologies provide information that allows an offsite occupational therapy practitioner to assess performance and modify services and the environment and 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, occupational therapy 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.

Virtual Reality Technologies

Virtual reality (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 (Sheridan, 1992; Weiss & Jessel, 1998). Although typical use of VR 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 VR technologies within a telehealth service delivery model. Occupational therapy practitioners can use a telehealth service delivery model with VR technologies when conducting evaluations and providing interventions. A remote console telerehabilitation system (ReCon, Rutgers University, New Brunswick, NJ) incorporating VR technology provides occupational therapy practitioners with three-dimensional representations of the client's movements, VR-based exercise progress, and motor performance updates (Lewis, Boian, Burdea, & Deutsch, 2005; Lewis, Deutsch, & Burdea, 2006). Telehealth combined with VR has been used to provide feedback and information remotely as part of occupational therapy intervention (Merians et al., 2002), to distract people from physical pain, and to improve their adherence to therapeutic exercises (Hoffman, Patterson, & Carrougher, 2000).

Further, VR provided through telehealth technologies is effective in enabling people to compare the difference between their desired level of occupational engagement and their current functional status after a stroke (Brewer, Fagan, Klatzky, & Matsuoka, 2005; Merians et al., 2002; Rand, Katz, & Weiss, 2009; Rand, Weiss, & Katz, 2009), using virtual environments as part of the assessment and training of users of power wheelchairs (Harrison, Derwent, Enticknap, Rose, & Attree, 2002), and evaluating and determining home accessibility using three-dimensional construction of the architectural features of the environment (Kim & Brienza, 2006; Kim, Brienza, Lynch, Cooper, & Boninger, 2008).

Low-cost video capture gaming systems (e.g., Nintendo Wii, Sony Playstation's EyeToy and MOVE, XBOX-360 Kinect) were not developed specifically for rehabilitation, but they offer an easy-to-set-up, fun, and less expensive alternative to the expensive VR systems (Rand, Kizony, & Weiss, 2008). 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 an occupational therapy practitioner to monitor and adjust a client's course of treatment would constitute a telehealth application of the devices.

Table A1. Telehealth Technologies

TECHNOLOGY TYPE	EXAMPLES	CONSIDERATIONS
Synchronous	<ul style="list-style-type: none"> • Voice over Internet protocol software • Mobile videoconferencing • Consumer high-definition television videoconferencing • “Plain old telephone service” • Videoconferencing • Telehealth network with commercial videoconferencing system • Virtual reality (VR) technologies (with live-streaming data to remote practitioner) 	<ul style="list-style-type: none"> • Confidentiality (security, privacy) • Integrity (information protected from changes by unauthorized users) • Availability (information, services) • Cost–benefit ratio • Socioeconomic considerations • Leveraging existing infrastructure (equipment and personnel) • Technology connection requirements (e.g., broadband, T1 line) • Sound and image quality
Asynchronous	<ul style="list-style-type: none"> • Video recording devices • Cameras (photographs) • Devices enabling electronic communication • VR technologies (with store-and-forward data to remote practitioner) 	<ul style="list-style-type: none"> • Equipment accessibility • Provider and end-user comfort, experience, and expertise with technology
Synchronous (interactive) or asynchronous (store-and-forward data)	<ul style="list-style-type: none"> • Telemonitoring technologies <ul style="list-style-type: none"> – Home monitoring systems/devices – Wireless sensors • VR technologies <ul style="list-style-type: none"> – Remote use of VR systems/devices 	

Note. 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.

Appendix B. Glossary

asynchronous—A method of exchanging health information whereby the provider and patient or client are not connected at the same time; commonly referred to as “store-and-forward” data transmission and may include video clips, digital photographs, virtual technologies, and other forms of electronic communications.

eHealth—A broad term encompassing health-related information and educational resources (e.g., health literacy Web sites and repositories, videos, blogs), commercial “products” (e.g., apps), and direct services delivered electronically (often through the Internet) by professionals, nonprofessionals, businesses, or consumers. May also be written as *e-Health* or *E-Health*; sometimes used interchangeably with *health informatics*.

haptic technology A tactile feedback technology that takes advantage of a user’s sense of touch by applying forces, vibrations, or motions upon the user.

health informatics—Use of information technologies for health care data collection, storage, and analysis to enhance health care decisions and improve quality and efficiency of health care services.

mHealth—The delivery of health-related information and services using mobile communication technology (e.g., smartphone, electronic tablet, or other mobile devices).

modifier—A modifier used in conjunction with a *Current Procedural Terminology* (American Medical Association, 2011) code to identify the type of technology used within a telehealth service delivery model. GT is the most common modifier; it indicates use of interactive audio and video telecommunications technology. The GQ modifier designates the use of asynchronous technologies; reimbursement for this modifier is limited.

privacy officer A position or office that responds to concerns over the use of personal information, including medical data and financial information. It ensures adherence to regulations but is not limited to legislation concerning the protection of patient medical records (e.g., Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191).

protocol A written document specifying standard operating policies and procedures for application of telehealth technologies in delivering services.

synchronous A method of exchanging health information in real time (i.e., live) between the patient or client and a health care provider located at a distant site.

telehealth The application of evaluative, consultative, preventative, and therapeutic services delivered through telecommunication and information technologies.

telehealth technologies The hardware and software used in delivering services remotely by means of a telehealth service delivery model.

telemedicine—Medical services delivered through communication and information technologies.

telerehabilitation The application of telecommunication and information technologies for the delivery of rehabilitation services.

virtual reality—A computer-simulated environment of the real world; can be coupled with telehealth technologies as part of a telehealth service delivery model.

Appendix C. Applications of Telehealth Within Occupational Therapy Practice Areas

Children and Youth

Evidence supports the use of a telehealth service delivery model to deliver appropriate early intervention (EI) and school-based services effectively and efficiently. EI services, mandated by Part C of the Individuals With Disabilities Education Act Amendments of 1997 (IDEA; Pub. L. 105–117), are designed to promote development of skills and enhance the quality of life of infants and toddlers who have been identified as having a disability or developmental delay (Cason, 2011). Telehealth technology supports delivery of EI services (Cason, 2009, 2011; Heimerl & Rasch, 2009; Kelso, Fiechtl, Olsen, & Rule, 2009).

Similarly, evidence supports the use of telehealth for the delivery of occupational therapy services within the school setting for evaluation and intervention (Gallagher, 2004) as well as for reintegration of students with traumatic injury following acute rehabilitation (Verburg, Borthwick, Bennett, & Rumney, 2003). Telehealth may be used within school-based interprofessional team models for wellness programming, including efforts to combat the obesity epidemic among children and for programming targeting prevention of violence among youth (Cason, 2012b). School-based occupational therapy services focus on helping children with disabilities participate in and, thus, benefit from the instructional program.

In addition to what has been stated, telehealth technology may provide another avenue for the occupational therapy practitioner to observe the child's level of participation in a school setting without risk of altering the setting by being physically present. This unobtrusive observation strategy can allow the occupational therapy practitioner to consult with the teacher and offer strategies to alter the child's level of participation (e.g., strategies to facilitate a child's use of self-regulation skills, encourage appropriate interaction with peers, or facilitate the child's physical participation in an instructional activity).

The potential benefit of this observation strategy is to ensure the maintenance of the day-to-day integrity of the classroom while providing the practitioner with an understanding of the specific sensory, cognitive, physical, and emotional demands placed on the child in the setting. This technology may also provide the ability to record observations that contribute to the therapist's data collection during evaluation; this information can then be used as a baseline from which to support Individualized Education Program teams in developing goals and objectives and measuring progress in the child's level of participation in the setting. In rural or large urban school districts, this technology can assist the occupational therapy practitioner with more efficiently supporting multiple campuses that may be located across large distances, thereby facilitating the interprofessional team process as well as reducing costs incurred to allow a practitioner the time and transportation resources to support multiple campuses.

Productive Aging

The growing number of older adults in the United States creates opportunities for occupational therapy practitioners to use telehealth to promote health and wellness, prevention, and productive aging while reducing health care costs. The use of telerehabilitation to remotely monitor and provide self-management strategies to older adults who are chronically ill and living in their homes has been found to decrease hospitalizations and nursing home stays (Bendixen, Levy, Olive, Kobb, & Mann, 2009). Interactive videoconferencing technologies promote health and aging in place among older adults (Bendixen, Horn, & Levy, 2007; Harada et al., 2010; Hori, Kubota, Kihara, Takahashi, & Kinoshita, 2009). The use of home monitoring devices such as *self-monitoring analysis and reporting technology* (SMART) enable occupational therapy practitioners to remotely monitor clients' occupational performance and provide recommendations for environmental modifications and interventions to support occupational performance (Mann & Milton, 2005).

Health and Wellness

Telehealth also supports health and wellness and prevention programming through assessment and management of obesity (Neubeck et al., 2009) and chronic diseases such as diabetes mellitus, congestive heart failure, and hypertension (Darkins et al., 2008; Steel, Cox, & Garry, 2011).

Mental Health

Opportunities exist for occupational therapy practitioners to use telehealth to promote participation and psychological and social functioning for clients within the home, at work, and in the community through engagement in meaningful occupations. Research demonstrates efficacy of telehealth as a delivery model for psychological and behavioral interventions among individuals with posttraumatic stress disorder (PTSD) and other mental health issues (Germain, Marchand, Bouchard, Drouin, & Guay, 2009; Gros, Yoder, Tuerk, Lozano, & Acierno, 2011).

Rehabilitation, Disability, and Participation

In the practice area of rehabilitation, disability, and participation, the use of a telehealth service delivery model promotes occupational performance, adaptation, participation, and quality of life for clients with polytrauma, neurological, and orthopedic conditions. Telehealth provides remote access to occupational therapy services through assessment of physical function and goal setting, integration of individualized exercise interventions, training in adaptive strategies such as environmental modifications and energy conservation, and consultation on durable medical and adaptive equipment (Chumbler et al., 2010; Sanford et al., 2007).

Published studies support the use of telehealth in improving functional outcomes with individuals with stroke (Chumbler et al., 2010; Hermann et al., 2010), survivors of breast cancer (Hegel et al., 2011), veterans with polytrauma (Bendixen et al., 2008), and individuals with traumatic brain injury (Diamond et al., 2003; Forducey et al., 2003; Girard, 2007; Verburg et al., 2003). Additional studies have used a telehealth service delivery model to evaluate activities of daily living and hand function in individuals with Parkinson's disease (Hoffman, Russell, Thompson, Vincent, & Nelson, 2008) and other neurological impairments (Savard, Borstad, Tkachuck, Lauderdale, & Conroy, 2003). Seating experts used telehealth to provide remote wheelchair prescription and consultation to individuals with neurological and orthopedic conditions (Barlow, Liu, & Sekulic, 2009; Schein, Schmeler, Holm, Saptono, & Brienza, 2010; Schein et al., 2011). In addition to positive clinical outcomes, evidence indicates a high level of practitioner and client satisfaction associated with a telehealth service delivery model (Kairy, Lehoux, Vincent, & Visintin, 2009; Steel et al., 2011).

Work and Industry

Schmeler, Schein, McCue, and Betz (2009) detailed the use of assistive technology via a telehealth service delivery model for clinical and vocational applications. Telehealth is also being used to support work through remote assessment and analysis of work spaces. Bruce and Sanford (2006) described using teleconferencing to complete remote assessments and discussed the need for a highly structured and comprehensive assessment tool to be able to complete remote assessments.

Backman, Village, and Lacaille (2008) developed the Ergonomic Assessment Tool for Arthritis (EATA) to evaluate the workplace for people with arthritis. The EATA was designed so that the worker could gather the data for the assessment without an expert visiting the workplace. Pilot testing of the method indicated that workers could successfully gather the necessary information for appropriate intervention identifica-

tion (Baker & Jacobs, 2013). Baker and Jacobs (2010) developed a systematic two-step program, the Telerehabilitation Computer Ergonomics System (*tele-CES*). This systematic program will allow ergonomically trained health professionals to (1) remotely assess the computer workstation and (2) on basis of the assessment, generate explicit, participant-specific workstation modification recommendations. The recommendations will be easily implemented; reduce pain, discomfort, and fatigue; and eliminate barriers to productivity.

Appendix D. Telehealth Case Examples

CASE DESCRIPTION	USE OF TELEHEALTH	OUTCOME
<p>Lisa is a 70-year-old woman who has difficulty performing her daily occupations because of a stroke resulting in right-sided weakness. Although she had learned compensatory techniques for completing activities of daily living (ADLs), instrumental ADLs, and work, she still wants to increase the use of her right hand, particularly for tasks related to managing her farm. Lisa learned of a program in a nearby community using new technology that might be beneficial for people with hemiparesis; however, the clinic is 2 hours from her home.</p>	<p>Lisa meets with her occupational therapist in a clinic for the initial evaluation. During the evaluation, Lisa learns additional strategies for incorporating the use of 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 occupational therapist by computer, using a Web camera and online video software. As Lisa continues to make progress, the occupational therapist instructs her in how to more effectively use her right hand for completion of ADLs and farm chores.</p>	<p>Lisa is able to make 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 two trips to the clinic and without therapist travel.</p>
<p>José is a 35-year-old administrative assistant working at an urban university. He has been employed in this position for 5 years. Recently, he began experiencing discomfort in his neck, shoulder, and back areas. He reported this discomfort, which he associated with computer work, to his immediate supervisor.</p>	<p>Josh scheduled an appointment with an occupational therapist who had expertise in ergonomic workstation evaluation. During his initial contact with the occupational therapist, he requested that because of his busy schedule, he would prefer to have his evaluation conducted through telehealth technology. The occupational therapist asked Josh to have photographs taken of him while working at his office computer workstation. The occupational therapist requested that the photographs be from multiple angles and then e-mailed to a secure platform, where the therapist would be able to review them. In addition, Josh 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 telephone consultation was arranged, during which the occupational therapist reviewed findings from the photographs along with the time log. Josh 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 Josh was using a notebook computer, which placed him in an awkward posture for computing.</p>	<p>Explicit workstation modification recommendations were provided by the occupational therapist by means of a telephone consultation with Josh. 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 occupational therapist encouraged Josh to change his work behaviors by taking regular stretch breaks every 20 minutes. A second telephone consultation occurred within 2 weeks. Josh reported that his supervisor ordered the external notebook computer accessories and that this new workstation arrangement had reduced his discomfort.</p>

(Continued)

Appendix D. Telehealth Case Examples (Cont.)

CASE DESCRIPTION	USE OF TELEHEALTH	OUTCOME
<p>Angela is a 10-year-old girl with a complicated medical history that includes spina bifida. She is significantly limited in her ability to be mobile in the home and community. Although she uses a basic power wheelchair to drive around town and attend her family activities, it is in poor condition and too small for her. Angela cannot adequately reposition herself or properly perform a weight shift because of decreased upper-extremity strength and range of motion.</p>	<p>Angela has trouble traveling and sitting for long distances. She and her mother meet with an occupational therapy generalist in person at a nearby clinic. Concurrently, an occupational therapist who has expertise in wheeled mobility participates in an occupational therapy session remotely using a videoconferencing system. The remote occupational therapist provides consultation to the local occupational therapist, Angela, and her mother about seating system frames, bases, and accessories; policy implications and funding mechanisms; and wheeled mobility and seating options.</p>	<p>After interviewing Angela and her mother and observing Angela navigate in her current chair, the remote occupational therapist recommends the appropriate power wheelchair and power seat functions. Upon approval from the insurance company, the remote occupational therapist uses the videoconferencing system 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 has benefited from services without the need to travel a long distance. The local practitioner gained additional knowledge about wheeled mobility and seating options.</p>
<p>Ethan is a 55-year-old 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. Meanwhile, Ethan has difficulties with eating, fatigue, facial-body image, depression, and pain. He lives alone and over 50 minutes away from the hospital/outpatient therapy clinic.</p> <p>Ethan was seen by an occupational therapist in the hospital and prescribed outpatient occupational therapy for his physical and mental impairments. 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 secure videoconferencing technology.</p>	<p>Ethan completed a telehealth participation screening and initial occupational therapy evaluation during his hospital stay. It was determined that he would continue with occupational therapy twice a week via telehealth using secure videoconferencing software and a Web camera within his home environment. During the biweekly occupational therapy sessions delivered via telehealth technologies, 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 occupational therapist through electronic communications technology.</p>	<p>Ethan is able to manage his physical and mental impairments 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 technologies. Ethan continues his daily journaling. The occupational therapist will follow up with Ethan via telehealth technologies weekly until reconstruction surgery and again after surgery to make sure Ethan continues his wellness plan.</p>

Telehealth Statement/Law/Comment

State	Telehealth Authorized for Practice?	Law/Regulation/Board Position
Alabama	Yes: Board cites AOTA position	At present, use the AOTA position paper on telehealth as a benchmark for care, and reference it when queried on the topic by practitioners. In addition to that, usually provide the following advice: <ul style="list-style-type: none"> • If the patient/client resides in our state, the practitioner must have licensure in Alabama. • Our suggestion to all those interested in providing telehealth to residents in our state would be to consider being extra vigilant in addressing potential quality of care and/or supervision risks, and to be particularly attentive that documentation clearly articulates reasonable safeguards and precautions. • The practitioner is still fully culpable to provide appropriate quality of care, regardless of whether or not services are provided via telehealth. If appropriate measures cannot be taken to insure that this is the case, the practitioner would be at risk of disciplinary action by the board, include the possibly of fines and license revocation. • Related to that, all supervision requirements are the same, regardless of whether or not services are provided via telehealth.
Alaska	Yes: Regulation Adopted	12 AAC 54.825. STANDARDS FOR PRACTICE OF TELEREHABILITATION BY OCCUPATIONAL THERAPIST. (a) The purpose of this section is to establish standards for the practice of telerehabilitation by means of an interactive telecommunication system by an occupational therapist licensed under AS 08.84 and this chapter in order to provide occupational therapy to patients who are located at distant sites in the state which are not in close proximity of an occupational therapist. (b) An occupational therapist licensed under AS 08.84 and this chapter conducting telerehabilitation by means of an interactive telecommunication system (1) must be physically present in the state while performing telerehabilitation under this section; (2) must interact with the patient maintaining the same ethical conduct and integrity required under 12 AAC 54.800; (3) must comply with the requirements of 12 AAC 54.810 for any licensed occupational therapist assistant providing services under this section; (4) may conduct one-on-one consultations, including initial evaluation, under this section; and (5) must provide and ensure appropriate client confidentiality and HIPAA compliance, establish secure connections, activate firewalls, and encrypt confidential information.
Arizona	No	
Arkansas	None	The OT and OTA must write to the board and provide the precise type of service to be provided and it will be subject to the Committees ruling.
California	Yes: Regulation Adopted	§ 4172. Standards of Practice for Telehealth (a) In order to provide occupational therapy services via telehealth as defined in Section 2290.5 of the Code, an occupational therapist or occupational therapy assistant providing services to a patient or client in this State must have a valid and current license issued by the Board. (b) An occupational therapist shall obtain informed consent from the patient or client prior to delivering occupational therapy services via telehealth consistent with Section 2290.5 of the Code. (c) Prior to providing occupational therapy services via telehealth: (1) an occupational therapist shall determine whether an in-person evaluation is necessary and ensure that a therapist must be available if an onsite visit is required and; (2) an occupational therapist shall determine whether in-person interventions are necessary. If it is determined that in-person interventions are necessary, an on-site occupational therapist or occupational therapy assistant shall provide the appropriate interventions. (d) In making the determination whether an in-person evaluation or in-person interventions are necessary, an occupational therapist shall consider: the complexity of the patient's/client's condition; his or her own knowledge, skills, and abilities; the nature and complexity of the intervention; the requirements of the practice setting; and the patient's/client's context and environment. (e) An occupational therapist or occupational therapy assistant providing occupational therapy services via telehealth must: (1) Exercise the same standard of care when providing occupational therapy services via telehealth as with any other mode of delivery of occupational therapy services; (2) Provide services consistent with section 2570.2(k) of the Code; and (3) Comply with all other provisions of the Occupational Therapy Practice Act and its attending regulations, including the ethical standards of practice set forth in section 4170, as well as any other applicable provisions of law. (f) Failure to comply with these regulations shall be considered unprofessional conduct as set forth in the Occupational Therapy Practice Act.
Colorado	Yes: Practice Act, no rules adopted	(XIV) The use of telehealth pursuant to rules as may be adopted by the director.
Connecticut	Undetermined; No board position adopted at this time.	
Delaware	none	
District of Columbia	Yes; Board cites AOTA policy	The DC Board has no set rules on telepractice or telehealth in their regulations. We normally refer enquires to follow AOTA standards and also contact the state in which they are planning to practice or are located at in if it's not DC.

Florida	none	
Georgia		
Hawaii	Undetermined; No board position adopted at this time.	
Idaho	none	
Illinois	Yes: Practice Act	Occupational therapy may be provided via technology or telecommunication methods, also known as telehealth, however the standard of care shall be the same whether a patient is seen in person, through telehealth, or other method of electronically enabled health care.
Indiana	Yes; Board cites AOTA policy	The OT committee has discussed this issue but has not made any definitive statements. The committee plans to adopt the recommendations from the AOTA position paper.
Iowa	No response	No position provided. "Look at the regulations and see for yourself if you can do it." Judy Licensing office
Kansas	Yes	No specific regulation. "Same rules and regs apply in person and telehealth" Marsha from the Board of Healing Arts.
Kentucky	Yes: Practice Act	<p>319A.300 Duty of treating occupational therapist utilizing telehealth to ensure patient's informed consent and maintain confidentiality -- Board to promulgate administrative regulations -- Definition of "telehealth". "</p> <p>(1) A treating occupational therapist who provides or facilitates the use of telehealth shall ensure:</p> <p>(a) That the informed consent of the patient, or another appropriate person with authority to make the health care treatment decision for the patient, is obtained before services are provided through telehealth; and</p> <p>(b) That the confidentiality of the patient's medical information is maintained as required by this chapter and other applicable law. At a minimum, confidentiality shall be maintained through appropriate processes, practices, and technology as designated by the board and that conform to applicable federal law.</p> <p>(2) The board shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and as necessary to:</p> <p>(a) Prevent abuse and fraud through the use of telehealth services;</p> <p>(b) Prevent fee-splitting through the use of telehealth services; and</p> <p>(c) Utilize telehealth in the provision of occupational therapy services and in the provision of continuing education.</p> <p>For purposes of this section, "telehealth" means the use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of health or medical data, and continuing education.</p>
Louisiana		
Maine	Undetermined; No board position adopted at this time.	
Maryland	Yes: Board cites AOTA position	<p>The Maryland Board of Occupational Therapy has experienced an increase in the number of questions from practitioners on whether the Maryland Board of Occupational Therapy Practice permits the use of telerehabilitation.</p> <p>The intent of this position statement is to acknowledge the "intra-State" use of telerehabilitation by Maryland licensees practicing occupational therapy within the State of Maryland and to clarify that:</p> <p>(1) Occupational therapy personnel must hold a valid Maryland license prior to providing occupational therapy services via telerehabilitation to clients physically located in Maryland; and,</p> <p>(2) The practice of occupational therapy, via telerehabilitation or otherwise, in the State of Maryland must be in accordance with the Annotated Code of Maryland, Health Occupations Article, Title 10, and The Code of Maryland Regulations (COMAR), 10.46.01 – 10.46.07.</p>
Massachusetts	No	"Must be in the regulation"
Michigan		
Minnesota		
Mississippi		
Missouri	Yes; No board position adopted at this time.	In the state of Missouri, you are required to be licensed as an OT/OTA if providing services.
Montana	Undetermined; No board position adopted at this time.	
Nebraska	Yes: Board cites AOTA position	It is the Board's opinion to support the AOTA's position on telehealth and to state that a practitioner must be licensed in the same state as the patient being treated by the use of a telehealth service delivery model.
Nevada	Undetermined; No board position adopted at this time.	
New Hampshire	Yes; Board position stated	The Board noted that this question has been answered in the past. Anyone who provides Occupational Therapy to clients in the State of New Hampshire must be licensed by the New Hampshire Board of Occupational Therapy
New Jersey	None	Have to write in and ask the board

New Mexico		
New York	Yes; Board position stated	In accordance with New York State statute, full licensure and current registration are required of any professional who practices in New York State. All New York State licensed professionals are responsible for adhering to the same laws, rules and regulations and for upholding the same standards and competencies when engaging in telepractice as they are when practicing without the use of technology over a distance. This understanding is essential to ensure public protection and the integrity of the professions.
North Carolina	Yes; Practice Act	An occupational therapy practitioner may deliver evaluation, treatment, and consultation through telecommunication and information technologies. N.C.G.S. 90-270.67.4 <ol style="list-style-type: none"> 1. An occupational therapy practitioner is required to be licensed in North Carolina if the practitioner provides occupational therapy services to a client who is in North Carolina. 2. An occupational therapy practitioner who is in North Carolina and does not provide occupational therapy services to clients in North Carolina does not need to be licensed in North Carolina. 3. An occupational therapy practitioner who is in North Carolina but provides occupational therapy services to clients in a state other than North Carolina is required to follow the laws and regulations of the state where the client is receiving the services. 4. An occupational therapy practitioner licensed in North Carolina may provide occupational therapy services to a client in North Carolina even if the occupational therapy practitioner is in another state.
North Dakota	Yes; Regulation Adopted	Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness, including methods delivered via telerehabilitation to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.
Ohio	Yes; Board cites AOTA position	The Occupational Therapy Section has seen an increase in the number of questions from practitioners on whether the Ohio Occupational Therapy Practice Act permits telerehabilitation. As stated in the AOTA Telerehabilitation Position Paper: Practitioners using telerehabilitation methods must comply with licensure laws and other state legislation regulating the practice of occupational therapy in the state or states in which those services are received [emphasis added]. When telerehabilitation is used to provide individual client services (evaluation and intervention), the practitioner must be licensed in the state in which the client receives those services [emphasis added]. The provision of consultation to another practitioner or continuing education content (e.g., workshop or seminar) using this technology may or may not be addressed by individual state regulations, and it is recommended that practitioners using the technology in these ways investigate those regulations to ensure compliance (AOTA, 2005, p. 658). The Occupational Therapy Section endorses the AOTA statement on state regulations for telerehabilitation. As a result, occupational therapy personnel must hold a valid Ohio license prior to providing occupational therapy services via telerehabilitation to clients physically located in Ohio.
Oklahoma	Yes; Board cites AOTA policy	
Oregon	Rules Pending	(1) "Telehealth" is defined as the use of interactive audio and video, in real time telecommunication technology or store-and-forward technology, to deliver health care services when the occupational therapist and patient/client are not at the same physical location. Its uses include diagnosis, consultation, treatment, prevention, transfer of health or medical data, and continuing education. (2) In order to provide occupational therapy services via telehealth to a patient/client in Oregon, the occupational therapist providing services to a patient/client must have a valid and current license issued by the Oregon OT Licensing Board. (a) Oregon licensed Occupational Therapists using telehealth technology with a patient/client in another state may also be required to be licensed in the state in which the patient/client receives those services and must adhere to those state licensure laws. (3) Occupational therapists shall obtain informed consent of the delivery of service via telehealth from the patient/client prior to initiation of occupational therapy services via telehealth and maintain documentation in the patient's or client's health record. (4) Occupational therapists shall secure and maintain the confidentiality of medical information of the patient/client as required by HIPAA and state and federal law. (5) Prior to providing occupational therapy services via telehealth, an occupational therapist shall determine whether an in-person evaluation is necessary and ensure that a local therapist is available if an on-site visit is required. (a) If it is determined in-person interventions are necessary, an on-site occupational therapist or occupational therapy assistant shall provide the appropriate interventions. (b) The obligation of the occupational therapist to determine whether an in-person re-evaluation or intervention is necessary continues during the course of treatment. (6) In making the determination whether an in-person evaluation or intervention are necessary, an occupational therapist shall consider: (a) the complexity of the patient's/client's condition; (b) his or her own knowledge skills and abilities; (c) the patient's/client's context and environment; (d) the nature and complexity of the intervention; (e) the pragmatic requirements of the practice setting; and (f) the capacity and quality of the technological interface. (7) An occupational therapist or occupational therapy assistant providing occupational therapy services via telehealth must:

		<p>(a) Exercise the same standard of care when providing occupational therapy services via telehealth as with any other mode of delivery of occupational therapy services;</p> <p>(b) Provide services consistent the AOTA Code of Ethics and Ethical Standards of Practice; and comply with provisions of the Occupational Therapy Practice Act and its regulations.</p> <p>(8) When an Occupational Therapist has determined that telehealth is an appropriate delivery of services, the therapist must ensure that, if required, there is an adequately trained person available to set up and help with hands on delivery of services to the patient/client and who works under the direction of the therapist.</p> <p>(9) Supervision of Occupational Therapy Assistant under 339-010-0035 for routine and general supervision, can be done through telehealth, but cannot be done when close supervision as defined in 229-010-0005 is required. The same considerations in (6) (A) through (F) must be considered in determining whether telehealth should be used.</p> <p>(10) An Occupational Therapist who is supervising a fieldwork student must follow the ACOTE standards and other accreditation requirements.</p> <p>(11) Failure to comply with these regulations shall be considered unprofessional conduct under OAR 339-010-0020.</p>
Pennsylvania		
Rhode Island	No	"Not in the rules and regulation. Call a lawyer as this is a legal issues not a board issue."
South Carolina	Yes; Board cites AOTA policy	In addition to adhering to standard South Carolina licensing qualifications, occupational therapy practitioners using telehealth as a method of service delivery should display best practice and competences related to service delivery, operating hardware and software systems, and access to technical support. As with all licensed occupational therapy practice, it is the responsibility of the occupational therapy provider to obtain and maintain appropriate education and training related to patient populations being served and to practice setting
South Dakota		
Tennessee	Undetermined; No board position adopted at this time.	
Texas	No	Board has stated in absence of rule/law, telehealth is not authorized
Utah	Yes	Must be licensed where the patient is. No formal regulations regarding telehealth.
Vermont	Undetermined; No board position adopted at this time.	
Virginia	Yes	Adopted guidance document on telemedicine for the Board of Medicine
Washington	Yes; No board position adopted at this time.	The board has not offered any policy statement on this. They defer to the statute and regulations in RCW 18.59 and WAC 246-84 7, and they support the opinion that practitioners must be licensed in Washington to provide services to patients physically located in Washington.
West Virginia	No	Reconsidering writing position paper at next board meeting
Wisconsin		
Wyoming		

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Taylor Thompson, Bureau Assistant on behalf of Tom Ryan, Executive Director		2) Date When Request Submitted: 3/30/15 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Occupational Therapists Affiliated Credentialing Board			
4) Meeting Date: 06/10/15	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? North Carolina Board of Dental Examiners vs. Federal Trade Commission - Review	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:			
11) Authorization			
Taylor Thompson		3/30/15	
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.			

1. The Department is aware that on February 25, 2015, the U.S. Supreme Court issued a decision in North Carolina State Board of Dental Examiners v. Federal Trade Commission.
2. The Department, while continuing to analyze this decision, has developed preliminary opinions and guidance to regulatory boards.
 - a. This decision should not affect regulatory boards who are acting within their regulatory authority. For example, when a regulatory board disciplines a credential holder for unprofessional conduct, such board action is within the acceptable parameters of the board's authority and should not trigger anti-trust issues.
 - b. The investigation and discipline of unlicensed practice should be left to the Department. This has been the Department's long-standing position and should not trigger anti-trust issues.
 - c. The Department is, and has been, aware of potential anti-trust issues concerning regulatory boards. As such, this decision is not a surprise.
 - d. The Department has consistently advised regulatory boards to act within their powers set out in the statutes. This advice remains the same following this decision.
 - e. The Department will continue to analyze the decision and to monitor discussions about the decision especially in areas with potential anti-trust implications such as unlicensed practice, scope of practice and advertising. The Department will update the boards on any important developments.