LEGISLATION UPDATE

The following is attached for review:

A. Review Assembly Bills (AB) 1310, 1542, 2385, 2466, and Senate Bills (SB) 294, 999, 1111, 1282, and discussion of Board's position(s).
B. Legislative Proposals for 2011 legislative session:
   1) Business and Professions Code (BPC) Section 146, Violations of specified authorization statutes as infractions; Punishment.
   2) BPC Section 149, Notice to cease advertising in telephone directory; Contest and hearing; Disconnection of service.
   3) BPC Section 2570.2, Definitions.
   4) BPC Section 2570.3, Licensing requirement.
   5) BPC Section 2570.16, Fees.
   6) BPC Section 2570.17, Retired status.
   7) BPC Section 2570.18, Representation.
   8) BPC Section 2290.5, Telemedicine informed consent, and establishing BPC Section 2572, Standards of practice for telemedicine by OTs.
   9) New BPC section requiring registration of occupational therapy aides.
   10) New BPC section regarding limiting liability of occupational therapists providing services in an emergency, disaster, or state of war.
   11) New BPC section regarding mandatory reporting of employees who are terminated or suspended for cause, as specified, and consequences for failure to report.
   12) Nothing here; issue addressed in numbers 4 and 5 above
C. Nothing here.

AGENDA ITEM 18(B)

146. (a) Notwithstanding any other provision of law, a violation of any code section listed in subdivision (c) is an infraction subject to the procedures described in Sections 19.6 and 19.7 of the Penal Code when either of the following applies:

(1) A complaint or a written notice to appear in court pursuant to Chapter 5c (commencing with Section 853.5) of Title 3 of Part 2 of the Penal Code is filed in court charging the offense as an infraction unless the defendant, at the time he or she is arraigned, after being advised of his or her rights, elects to have the case proceed as a misdemeanor.

(2) The court, with the consent of the defendant and the prosecution, determines that the offense is an infraction in which event the case shall proceed as if the defendant has been arraigned on an infraction complaint.

(b) Subdivision (a) does not apply to a violation of the code sections listed in subdivision (c) if the defendant has had his or her license, registration, or certificate previously revoked or suspended.

(c) The following sections require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions regulated by this code:

(1) Sections 2052 and 2054.
(2) Section 2630.
(3) Section 2903.
(4) Section 3660.
(5) Sections 3760 and 3761.
(6) Section 4080.
(7) Section 4825.
(8) Section 4935.
(9) Section 4980.
(10) Section 4996.
(11) Section 5536.
(12) Section 6704.
(13) Section 6980.10.
(14) Section 7317.
(15) Section 7502 or 7592.
(16) Section 7520.
(17) Section 7617 or 7641.
(18) Subdivision (a) of Section 7872.
(19) Section 8016.
(20) Section 8505.
(21) Section 8725.
(22) Section 9681.
(23) Section 9840.
(24) Subdivision (c) of Section 9891.24.
(25) Section 19049.
(26) Section 2570.18.

(d) Notwithstanding any other provision of law, a violation of any of the sections listed in subdivision (c), which is an infraction, is punishable by a fine of not less than two hundred fifty dollars ($250) and not more than one thousand dollars ($1,000). No portion of the minimum fine may be suspended by the court unless as a condition of that suspension the defendant is required to submit proof of a current valid license, registration, or certificate for the profession or vocation which was the basis for his or her conviction.

149. (a) If, upon investigation, an agency designated in subdivision (e) has probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services, without being properly licensed by or registered with the agency to offer or perform those services, the agency may issue a citation under Section 148 containing an order of correction that requires the violator to do both of the following:

(1) Cease the unlawful advertising.

(2) Notify the telephone company furnishing services to the violator to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.

(b) This action is stayed if the person to whom a citation is issued under subdivision (a) notifies the agency in writing that he or she intends to contest the citation. The agency shall afford an opportunity for a hearing, as specified in Section 125.9.

(c) If the person to whom a citation and order of correction is issued under subdivision (a) fails to comply with the order of correction after that order is final, the agency shall inform the Public Utilities Commission of the violation and the Public Utilities Commission shall require the telephone corporation furnishing services to that person to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.

(d) The good faith compliance by a telephone corporation with an order of the Public Utilities Commission to terminate service issued pursuant to this section shall constitute a complete defense to any civil or criminal action brought against the telephone corporation arising from the termination of service.

(e) Subdivision (a) shall apply to the following boards, bureaus, committees, commissions, or programs:

(1) The Bureau of Barbering and Cosmetology.

(2) The Cemetery and Funeral Bureau.

(3) The Veterinary Medical Board.

(4) The Landscape Architects Technical Committee.

(5) The California Board of Podiatric Medicine.

(6) The Respiratory Care Board of California.

(7) The Bureau of Electronic and Appliance Repair, Home Furnishings, and Thermal Insulation.

(8) The Bureau of Security and Investigative Services.

(9) The Bureau of Automotive Repair.

(10) The California Architects Board.

(11) The Speech-Language Pathology and Audiology Board.

(12) The Board for Professional Engineers and Land Surveyors.

(13) The Board of Behavioral Sciences.

(14) The Structural Pest Control Board within the Department of Pesticide Regulation.

(15) The Acupuncture Board.

(16) The Board of Psychology.

(17) The California Board of Accountancy.

(18) The Naturopathic Medicine Committee.

(19) The Physical Therapy Board of California.

(20) The Bureau for Private Postsecondary Education.

(21) The California Board of Occupational Therapy.

Amend Business & Professions Code Section 2570.2(k)

(k) "~~Practice of~~ ~~o~~Occupational therapy" means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and promote or maintain health, well being, and quality of life. Occupational therapy services encompass research, education of students, occupational therapy assessment, treatment, education of, and consultation with~~, individuals who have been referred for occupational therapy services subsequent to diagnosis of disease or disorder (or who are receiving occupational therapy services as part of an Individualized Education Plan (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA)).~~ individuals, groups, programs, organizations, or communities.

(1) Occupational therapy assessment identifies performance abilities and limitations that are necessary for self-maintenance, learning, work, and other similar meaningful activities. Occupational therapy treatment is focused on developing, improving, or restoring functional daily living skills, compensating for and preventing dysfunction, or minimizing disability. Occupational therapy techniques that are used for treatment involve teaching activities of daily living (excluding speech-language skills); designing or fabricating selective temporary orthotic devices, and applying or training in the use of assistive technology or orthotic and prosthetic devices excluding gait training). Occupational therapy consultation provides expert advice to enhance function and quality of life. Consultation or treatment may involve modification of tasks or environments to allow an individual to achieve maximum independence. Services are provided individually~~,~~ or in groups.~~, or through social groups.~~

(2) The licensed occupational therapist or occupational therapy assistant may assume a variety of roles in their profession, including but not limited to, clinician, supervisor of occupational therapy students and volunteers, researcher, scholar, consultant, administrator, faculty, clinical instructor, continuing education instructor and educator of consumers/clients. The term "client" is used to name the entity that receives occupational therapy services. Clients may be categorized as:

a) individuals, including individuals who may be involved in supporting or caring for the client (i.e. caregiver, teacher, parent, employer, spouse);

b) individuals within the context of a group (e.g., a family, a class); or

c) individuals within the context of a population (e.g., an organization, a community).

(l) "Hand therapy" is the art and science of rehabilitation of the hand, wrist, and forearm requiring comprehensive knowledge of the upper extremity and specialized skills in assessment and treatment to prevent dysfunction, restore function, or reverse the advancement of pathology. This definition is not intended to prevent an occupational therapist practicing hand therapy from providing other occupational therapy services authorized under this act in conjunction with hand therapy.

(m) "Physical agent modalities" means techniques that produce a response in soft tissue through the use of light, water, temperature, sound, or electricity. These techniques are used as adjunctive methods in conjunction with, or in immediate preparation for, occupational therapy services.

Amend Business & Professions Code Section 2570.3(k)

~~(k) The amendments to subdivisions (d), (e), (f), and (g) relating to advanced practices, that are made by the act adding this subdivision, shall become operative no later than January 1, 2004, or on the date the board adopts regulations pursuant to subdivision (h), whichever first occurs.~~

(k) The board may approve a provider of post-professional education courses, that on or after January 1, 2012, submits an application to the Board and pays the fee set forth in section 2570.16. Each approved provider shall expire on June 30, 2014, and biennially thereafter.

(l) On or after January 1, 2012, the board may approve a post-professional education course, when the provider submits a post-professional education course application to the Board and pays the fee set forth in section 2570.16.

Business and Professions Code Section 2570.16.

Initial license and renewal fees shall be established by the board in an amount that does not exceed a ceiling of one hundred fifty dollars ($150) per year. The board shall establish the following additional fees:

(a) An application fee not to exceed fifty dollars ($50).
(b) A late renewal fee as provided for in Section 2570.10.
(c) A limited permit fee.
(d) A fee to collect fingerprints for criminal history record checks.
(e) A fee to query the National Practitioner Data Bank and the Healthcare Integrity Protection Data Bank.
(f) An initial application fee for providers of post-professional education courses shall be a non-refundable fee of three hundred dollars ($300).
(g) A biennial renewal fee for an approved post-professional education course provider shall be established in regulation, but no more than five hundred-fifty dollars ($550) per renewal cycle.
(h) A one-time, non-refundable fee for review of each post-professional educational course shall be established in regulation, but no more than ninety dollars ($90) per course.

No Item 18(B)(6)

Amend Business & Professions Code Section 2570.18 to read:

(a) A person shall not represent to the public by title, education, or background, by description of services, methods, or procedures, or otherwise, that the person is authorized to practice occupational therapy in this state, unless authorized to practice occupational therapy under this chapter.
(b) Unless licensed to practice as an occupational therapist under this chapter, a person may not use the professional abbreviations "O.T.," "O.T.R.," or "O.T.R./L.," or "Occupational Therapist," or "Occupational Therapist Registered," or any other words, letters, or symbols with the intent to represent that the person practices or is authorized to practice occupational therapy.
(c) A licensed occupational therapist or occupational therapy assistant who has earned a doctoral degree, granted by an institution accredited by the Western Association of Schools and Colleges, the Accreditation Council on Occupational Therapy Education, or by an accrediting agency recognized by the National Commission on Accrediting or the United States Department of Education that the board determines is equivalent to the Western Association of Schools and Colleges, may do the following:
(1) In a written communication, use the initials conferred with that earned degree, as applicable, following the licensee's name.
(2) In a written communication, use the title "Doctor" or the abbreviation "Dr." preceding the licensee's name, and the licensee's name shall be immediately followed by an unabbreviated specification of the applicable earned doctoral degree held by the licensee, or the unabbreviated term occupational therapist or occupation therapy assistant, as applicable.
(3) In a spoken communication while engaged in the practice of occupational therapy, use the title "doctor" preceding the person's name, and the speaker specifies that he or she is an occupational therapist or occupational therapy assistant.
(d) A licensed occupational therapist or occupational therapy assistant who has been granted an honorary degree by an educational institution accredited by the Western Association of Schools and Colleges, the Accreditation Council on Occupational Therapy Education, or by an accrediting agency recognized by the National Commission on Accrediting or the United States Department of Education that the board determines is equivalent to the Western Association of Schools and College, may do the following:
(1) In a written communication, use the initials granted with that honorary degree, as applicable, followed by the designation "(Hon.)" or "(Honorary)," following the licensee's name.
(2) In a written communication, use the title "Doctor" or the abbreviation "Dr." preceding the licensee's name, and the licensee's name shall be immediately followed by an unabbreviated specification of the applicable honorary doctoral degree held by the licensee with the designation "(Hon.)" or "(Honorary)," and the unabbreviated term occupational therapist or occupational therapy assistant, as applicable.
(3) In a spoken communication when engaged in the practice of occupational therapy, use the title "doctor" preceding the person's name, and the speaker specifies that he or she has been granted an honorary degree and specifies that he or she is an occupational therapist or occupational therapy assistant.

~~(c)~~ (e) Unless licensed to assist in the practice of occupational therapy as an occupational therapy assistant under this chapter, a person may not use the professional abbreviations "O.T.A.," "O.T.A/L.," "C.O.T.A.," "C.O.T.A./L.," or "Occupational Therapy Assistant," "Licensed Occupational Therapy Assistant," or any other words, letters, or symbols, with the intent to represent that the person assists in, or is authorized to assist in, the practice of occupational therapy as an occupational therapy assistant.

~~(d)~~(f) The unauthorized practice or representation as an occupational therapist or as an occupational therapy assistant constitutes an unfair business practice under Section 17200 and false and misleading advertising under Section 17500.

BPC 2290.5. Telemedicine informed consent

(a)(1) For the purposes of this section, "telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes "telemedicine" for purposes of this section.

(2) For purposes of this section, "interactive" means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

(b) For the purposes of this section, "health care practitioner" has the same meaning as "licentiate" as defined in paragraph (2) of subdivision (a) of Section 805 and also includes a person licensed as an occupational therapist pursuant to Chapter 5.6 (commencing with Section 2570 or a person licensed an optometrist pursuant to Chapter 7 (commencing with Section 3000).

(c) Prior to the delivery of health care via telemedicine, the health care practitioner who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient's legal representative. The informed consent procedure shall ensure that at
least all of the following information is given to the patient or the patient's legal representative verbally and in writing:

(1) The patient or the patient's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.

(2) A description of the potential risks, consequences, and benefits of telemedicine.

(3) All existing confidentiality protections apply.

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.

(d) A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided pursuant to subdivision (a), and that this information has been discussed with the health care practitioner, or his or her designee.

(e) The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.

(f) The failure of a health care practitioner to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(g) All existing laws regarding surrogate decisionmaking shall apply. For purposes of this section, "surrogate decisionmaking" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(h) Except as provided in paragraph (3) of subdivision (c), this section shall not apply when the patient is not directly involved in the telemedicine interaction, for example when one health care practitioner consults with another health care practitioner.

(i) This section shall not apply in an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.

(j) This section shall not apply to a patient under the jurisdiction of the Department of Corrections or any other correctional facility.

(k) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

2572 Standards of Practice for Telemedicine by Occupational Therapists

(a) The provision of telemedicine is intended to provide equitable access or increased access to occupational therapy services, promote independence, and increase the quality and standards of care when a patient or client has a disability, illness, injury or has a need for consultative, preventative, diagnostic, or therapeutic service, or is located in a remote area and would have to endure excessive travel times to access occupational therapy services.

(b) The purpose of this section is to establish standards for the practice of telemedicine by means of an interactive telecommunication system by an occupational therapist licensed under this chapter in order to provide occupational therapy to patients who are located at distant sites in the state which, among other things, are not in close proximity of an occupational therapist. The standard of care provided to patients is the same whether the patient is seen in-person, via telemedicine, telehealth, or telerehabilitation, or other methods of electronically enabled occupational therapy, health care or education. Occupational therapists need not reside in California, as long as they have a valid, current California license.

(c) Occupational therapists must obtain verbal and written informed consent from the patient prior to delivering health care via telemedicine, and also requires that this signed written consent statement becomes part of the patient's medical record.

(d) An occupational therapist licensed under this chapter conducting telemedicine by means of an interactive telecommunication system must do all of the following:

(1) provide services and/or treatment consistent with the practice of occupational therapy as defined in section 2570.2(k) of the Code,

(2) be physically present in the state while practicing telemedicine under this section;

(3) interact with the patient maintaining the same ethical standards of practice required pursuant to Section 4170, California Code of Regulations;

(3) comply with the supervision requirements for any licensed occupational therapist assistant providing services under this section;

(4) conduct one-on-one consultations, including initial evaluation, under this section; and

(5) provide and ensure appropriate client confidentiality and HIPAA compliance, establish secure connections, activate firewalls, and encrypt confidential information.

(e) Occupational therapists shall be reimbursed for therapy services, including services provided via telemedicine, pursuant to section 10123.147 of the Insurance Code.

(f) For purposes of this section:

(1) "Telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications as defined in Section 2290.5.

(2) "Telerehabilitation" means the provision, at a distance, of telemedicine-based physical rehabilitation services using various technologies including real-time videoconferencing,

personal computer-based camera usage, videophones, home-applied technology for recording and submission of images, and includes the use of other technologies, including virtual reality videogame-based rehabilitation systems or other virtual reality systems with haptic interfaces.

(3) "Telehealth" means the provision of health care, health information, or health education, at a distance, using telecommunications technology, other technologies used when providing telerehabilitation, or via other specially adapted equipment.

TELEREHABILITATION POSITION PAPER

The purpose of this paper is to provide the current position of the American Occupational Therapy Association (AOTA) regarding the use of telerehabilitation technologies by occupational therapists and occupational therapy assistants[1] to provide occupational therapy services, based on the existing research. This document examines the research and issues related to telerehabilitation for evaluation and intervention, telemonitoring, practitioner qualifications, ethics, and regulatory issues and reimbursement. Occupational therapy practitioners[2] are the intended audience for this document, although others involved in supervising, planning, delivering, and paying for occupational therapy services also may find it helpful.

Telecommunication has prompted the development of an emerging model of health care delivery called *telehealth,* which involves providing health care, health information, and health education across a distance, using telecommunications technology…It allows physicians, nurses, and health care specialists to assess, diagnose, and [provide interventions to clients] without requiring both individuals to be physically located in the same place. (Center for Telehealth and E-Health Law, 2010, para. 1)

Telerehabilitation within the larger realm of telehealth is the application of communication technology for supporting rehabilitation services (Russell, 2007). On the basis of this definition, telerehabilitation includes the application of evaluation, preventative, diagnostic, and therapeutic services via two-way or multipoint interactive telecommunication technology. Occupational therapy practitioners can use telerehabilitation as a mechanism to provide services at a location that is physically distant from the client, thus allowing for services to occur where the client lives, works, and plays, if that is needed or desired. Telerehabilitation also allows occupational therapy practitioners to use new technologies to provide interventions through alternative methods such as through virtual reality. Key terms related to telerehabilitation and telehealth are defined in Appendix A.

As in other health care fields, the use of telehealth and telerehabilitation is expanding. Research to measure its effectiveness and utility by professionals in a variety of health care fields is ongoing. This paper includes an overview of some of the research that is relevant to the use of telerehabilitation for providing occupational therapy services. This paper also highlights some of the current topics being discussed regarding the use of telerehabilitation for providing occupational therapy services.

Telerehabilitation in Evaluation and Intervention

In general, the use of telerehabilitation to conduct evaluations depends on real-time two-way or multipoint observation, communication, and interaction between the practitioner and the client.

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[1]The *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).

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

The use of telerehabilitation to conduct evaluations has expanded in recent years. Although 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; Shaw, Dreyer, & Wittman, 2001; Winters, 2002;), the proliferation of advanced communication technologies has broadened the possibilities of conducting evaluations using new and more sophisticated technology. Studies have described the use of telerehabilitation 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, in press), neurological assessment (Savard, Borstad, Tkachuck, Lauderdale, & Conroy, 2003), lower-limb amputation care or ulcer management (Rintala et al., 2004), and early childhood intervention (Cason, 2009; Heimerl & Rasch, 2009). Schmeler et al. (2009) also details the use of assistive technology via telerehabilitation for clinical and vocational applications.

Clinical reasoning guides the selection and application of appropriate telerehabilitation technology necessary to evaluate client needs and environmental factors. As part of their clinical reasoning, occupational therapists should consider the appropriateness of the use of telerehabilitation to ensure the safe and effective delivery of occupational therapy services that are appropriate for the client's needs and context. Reliability of telerehabilitation technologies for providing safe and effective occupational therapy services is one important factor when deciding to use telerehabilitation for assessing the client's ability to engage in specific occupations and activities and for administering specific assessments. In addition, occupational therapists should consider the reliability of the particular assessment when considering using it to conduct an evaluation via telerehabilitation. Studies have investigated the reliability of using telerehabilitation with such assessments 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, Dreyer, Shaw, & Wittman, 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).

Occupational therapists also need to consider the client's diagnosis, implementation issues (e.g., technology available to client), impact on and choice of the client, and the ability to measure outcomes when considering using telerehabilitation to conduct an evaluation. Because of the evolving knowledge and technology related to telerehabilitation, occupational therapists should review the latest research to remain current about the appropriate use of telerehabilitation for conducting evaluations. The occupational therapist may determine that a face-to-face evaluation is required for some clients.

When planning and providing interventions via telerehabilitation, 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 telerehabilitation or in combination with face-to-face interventions; the client's choice about receiving interventions via telerehabilitation;

the client's outcomes; the client's perception of quality of life and services provided; reimbursement; and state and federal legislation regarding interstate usage.

Technology Used in Telerehabilitation

Virtual Reality

Occupational therapy practitioners can integrate virtual-reality options when conducting evaluations and providing interventions via telerehabilitation. Virtual reality has the capacity to allow for creation and control of three-dimensional built environments. Because of this capacity, virtual reality offers evaluation and intervention options that are not available with traditional occupational therapy approaches (Schultheis & Rizzo, 2002). For example, virtual reality can be used to provide occupational therapy interventions for people with cognitive impairments. Virtual reality allows for controllable input stimuli and gradual modifications to the environment, which have been shown to support generalization of knowledge. Using virtual reality during the initial stages of the intervention may provide increased safety compared to real-world situations (Strickland, 1997). Telerehabilitation using virtual reality also is being examined for its effectiveness in enabling people to compare the difference between their desired level of occupational engagement and their current functional status following a stroke (Brewer, Fagan, Klatzky, & Matsuoka, 2005; Merians et al., 2002). Virtual reality as part of telerehabilitation also is being used to evaluate and determine home accessibility using three-dimensional construction of the architectural features of the environment (Kim & Brienza, 2006; Kim, Brienza, Lynch, Cooper, & Boninger, 2008). The potential effectiveness of using virtual environment as part of the assessment and training of powered wheelchair users also has been demonstrated (Harrison, Derwent, Enticknap, Rose, & Attree, 2002).

In addition, a remote console telerehabilitation system (ReCon) including virtual reality designed by the University of Medicine and Dentistry of New Jersey now provides occupational therapists the tools necessary to conduct a client's rehabilitation session in real-time from a distant location (Lewis, Boian, Burdea, & Deutsch, 2005). This system provides occupational therapists with three-dimensional representations of the client's movements, virtual reality–based exercise progress, and motor performance updates (Lewis et al., 2005; Lewis, Deutsch, & Burdea, 2006). Telerehabilitation combined with virtual reality 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 therapy exercises (Hoffman, Patterson, & Carrogher, 2000).

Telemonitoring

Occupational therapy practitioners also can use telemonitoring as part of telerehabilitation to monitor a client's adherence to the intervention program, and progress toward achieving desired outcomes. It also can be used to track and respond to follow-up issues. For example, occupational therapy practitioners providing telerehabilitation 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. SMART technologies provide information that allows an offsite occupational therapy practitioner to assess performance and

modify services and the environment. These technologies also enable occupational therapy practitioners to understand the real-life occupations and performance challenges of the client and to plan appropriate interventions. As a result, 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.

The Gator Tech Smart House (Mann & Milton, 2005) developed at the University of Florida provides an array of SMART technologies that monitor and cue clients remotely. Examples include the SmartShoe (Naditz, 2009), which determines fall risk by analyzing walking behavior patterns in the client's own environment and sending the information to a remote site. Similarly, home exercise programs can be monitored remotely using a *haptic* (touch-sensitive) control interface to track individuals' hand position while providing resistive forces remotely (Popescu, Burdea, Bouzit, & Hentz, 2000). Use of smartphones and personal data assistants (PDAs) allow for remote ongoing support of persons with cognitive disabilities within natural environments. Tang and Venables (2000) utilized 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. Gentry (2008; Gentry, Wallace, Kvarford, & Bodisch-Lynch, 2008) implemented use of PDAs, labeling them "cognitive orthoses," for cueing persons with traumatic brain injury and multiple sclerosis regarding how and when to complete daily life occupations. Wireless technologies such as these are expanding opportunities for occupational therapy practitioners to implement telerehabilitation interventions where persons live, work, and play and to provide services throughout the day rather than only within the occupational therapy clinic.

Appendix B provides case examples of how occupational therapy practitioners use telerehabilitation to support health and participation in occupations.

Practitioner Qualifications and Ethical Considerations

AOTA asserts that the same ethical and professional standards that apply to the traditional delivery of occupational therapy services also apply to the delivery of services received via telerehabilitation. Occupational therapy practitioners should refer to the *Occupational Therapy Code of Ethics and Ethics Standards* (AOTA, 2010a). As stated in this document, occupational therapy practitioners are responsible for ensuring their individual competence in the area in which they provide services. Occupational therapy practitioners may use various educational approaches to gain competency in using telerehabilitation when providing occupational therapy services. Occupational therapy practitioners may learn about telerehabilitation as a part of entry-level education or may participate in continuing education to acquire expertise (Theodorus & Russell, 2008).

The *Specialized Knowledge and Skills in Technology and Environmental Interventions for Occupational Therapy Practice* (AOTA, 2010b) describes the knowledge and skills necessary for entry- and advanced-level practice in technology. They 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 utilize evidence, mentoring, and continuing education to maintain and enhance their competency and provide best practice interventions.

Occupational therapy practitioners are to abide by state licensure laws and related occupational therapy regulation regarding the use of telerehabilitation (Cwiek, Rafiq, Qamar, Tobey, & Merrell, 2007). At this time, occupational therapy practitioners are to abide by the licensure and regulatory requirements in the state where they live and the state where the client is located in order to provide services.

Occupational therapy practitioners are to abide by Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) regulations to maintain client confidentiality of all records and interactions, including the use of telerehabilitation to send or receive data. This also includes using HIPAA-compliant channels such as encrypted portals. 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 their telerehabilitation practices are consistent with HIPAA regulations. Examples of ethical considerations related to telerehabilitation are outlined in Table 1.

Table 1. Ethical Considerations and Strategies for Practice in Telerehabilitation

ETHICAL CONSIDERATIONS	STRATEGIES FOR ETHICAL PRACTICE
Fully inform the client regarding the implications of a telerehabilitation approach vs. a face-to-face occupational therapy approach.	Use a written informed-consent procedure, with opportunity for the client to ask questions about the provision of the telerehabilitation services.
Abide by laws and scope of practice related to licensure and provision of occupational therapy services using telerehabilitation.	Before providing telerehabilitation services, become familiar with the laws that relate to the provision of services using communication or other technologies, such as communication requirements that prohibit recording conversation over telephone systems without the individual's permission.
Adhere to professional standards.	Study and apply occupational therapy standards of practice when using telerehabilitation to provide occupational therapy service. Take responsible steps (e.g., continuing education, research, supervision, and training), and use careful judgment to ensure one's own competence. Review existing literature to weigh the benefits and potential for client harm when considering using telerehabilitation to provide occupational therapy services.

Understand and abide by approaches that ensure confidentiality is not compromised as a result of using distance technologies.	Become fully informed of technological security concerns with providing telerehabilitation, and utilize security approaches consistent with HIPAA for the transmission of all health-related information. Maintain the confidentiality of all verbal, written, electronic, augmentative, and nonverbal communications to conform to HIPAA standards.
Understand and adhere to procedures if there is any compromise of security related to health information.	Report any breach of security to an appropriate health privacy officer, or seek guidance of an independent legal counsel.
Assess the effectiveness of telerehabilitation interventions within specific practice areas by consulting current research and conducting ongoing monitoring of client response.	Continually monitor the effectiveness of interventions, and consider alternative approaches, including traditional face-to-face approaches and/or referral to another provider, if the telerehabilitation services do not appear to be effective. Maintain knowledge of current research about effectiveness.
Recognize the need to be culturally competent in the provision of services via telerehabilitation, including in language and ethnicity issues that could affect the quality and outcomes of services provided.	Understand the issues of cultural competence, and consider them when deciding if a telerehabilitation approach is appropriate for a particular client.

Funding and Reimbursement

Reimbursement is an important consideration that often influences the delivery of occupational therapy services. Currently, reimbursement for telerehabilitation is limited and variable. Beginning January 1, 1999, Medicare reimbursement was authorized for certain services to be provided as telehealth services in rural areas that have professional shortages. This provision, enacted in the Balanced Budget Act of 1997 (P. L. 105-33), represented Medicare's first national reimbursement policy for telehealth services (Cepelewicz, 1998; Health Care Financing Administration, 1998; U.S. Department of Health and Human Services Health (DHHS), Resources and Services and Administration, 2003). However, as of this writing, occupational therapy practitioners are not yet listed as an eligible provider under Medicare reimbursement for telehealth services. It is recommended that occupational therapy practitioners providing telerehabilitation services review "Chapter 15. Covered Medical and Other Health Services" within the *Medicare Benefit Policy Manual* (DHSS, Centers for Medicare and Medicaid Services, 2009), as the manual provides definitions, conditions of payment, and eligibility criteria for telehealth services.

Medicaid reimbursement is available at the discretion of each state, because it is subject to specific requirements or restrictions within a state. Often, states must obtain approval from the federal government for implementation of telerehabilitation or telehealth within their Medicaid

programs. It is recommended that occupational therapy practitioners contact their state Medicaid or other third-party payers to determine the guidelines for reimbursement of telerehabilitation services. Occupational therapy practitioners also are encouraged to contact the Veteran's Administration and other grantors regarding reimbursement options. When billing occupational therapy, practitioners must distinguish between actual occupational therapy services that require the skills of an occupational therapist or occupational therapy assistant and telerehabilitation services that do not require this skill level.

Summary

As telerehabilitation services continue to grow as a complement to traditional face-to-face services, there is an increasing need to develop guidelines and health care policy for appropriate use, reimbursement, legal and ethical ramifications, and cost. There is a significant need for occupational therapy practitioners to document, research, and publish on the effectiveness of evaluation, consultation, intervention, and follow-up services provided via telerehabilitation technologies and to determine how to best integrate telerehabilitation technology into various practice settings and home environments. Occupational therapy practitioners using telerehabilitation methods must adhere to the *Occupational Therapy Code of Ethics and Ethics Standards* (AOTA, 2010a), maintain the *Standards of Practice for Occupational Therapy* (AOTA, 2010c), and comply with state regulations to ensure their competencies as practitioners and the well-being of their clients.

References

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. (2008). Occupational therapy practice framework: Domain and process (2nd ed.). *American Journal of Occupational Therapy, 62,* 525–683.

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.

American Occupational Therapy Association. (2010a). Occupational therapy code of ethics and ethics standards. *American Journal of Occupational Therapy, 64*(November/December).

American Occupational Therapy Association. (2010b). Specialized knowledge and skills in technology and environmental interventions for occupational therapy practice. *American Journal of Occupational Therapy, 64*(November/December) .

American Occupational Therapy Association. (2010c). Standards of practice for occupational therapy. *American Journal of Occupational Therapy, 64*(November/December).

Balanced Budget Act of 1997, P. L. 105-33, 111 Stat. 251).

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.

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.

Cason, J. (2009). A pilot telerehabilitation program: Delivering early intervention services to rural families. *International Journal of Telerehabilitation, 1*, 29–38.

Center for Telehealth and E-Health Law. (2010). *What is telehealth?* Retrieved June 12, 2010, from http://www.telehealthlawcenter.org/content/?page=18

Cepelewicz, B. (1998, October). *Telemedicine and strategies to minimize risks of liability.* Paper presented at the Telemedicine National Conference on Legal and Policy Developments, Washington, DC.

Cooper, R., Fitzgerald, S., Boninger, M. L., Cooper, R. A., Shapcott, N., Cohen, L., et al. (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.

Dreyer, N., Dreyer, K., Shaw, D., & Wittman, P. (2001). Efficacy of telemedicine in occupational therapy: A pilot study. *Journal of Allied Health, 30*, 39–42.

Gentry, T. (2008). PDAs as cognitive aids for people with multiple sclerosis. *American Journal of Occupational Therapy, 62*, 18–27.

Gentry, T., Wallace, J., Kvarford, C., & Bodisch-Lynch, K. (2008). Personal digital assistants as cognitive aids for individuals with severe traumatic brain injury: A community-based trial. *Brain Injury, 22*, 19–24.

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 power wheelchair users. *Disability and Rehabilitation, 24,* 599–606.

Health Care Financing Administration. (1998, November 2). Payment for teleconsultation in rural health professional shortage areas. *Federal Register, 63*(211), 58879–58886.

Health Insurance Portability and Accountability Act, P. L. 104-191, 101 Stat. 1936. Available online at http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf

Heimerl, S., & Rasch, N. (2009, September). Delivering developmental occupational therapy consultation services through telehealth. *Developmental Disabilities Special Interest Section Quarterly, 32*(3), 1–4.

Hoffman, H. G., Patterson, D. R., & Carrogher, G. J. (2000). Use of virtual reality for adjunction treatment of adult burn pain during physical therapy: A controlled study. *Clinical Journal of Pain, 16*, 244–250.

Hoffman, 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.

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.

Kim, J. B., Brienza, D. M., Lynch, R. D., Cooper, R. A., & Boninger, M. L. (2008). Effectiveness evaluation of a remote accessibility assessment for wheelchair users using virtual reality. *Archives of Physical Medicine Rehabilitation, 89*, 470–479.

Lewis, J. A., Boian, R. F., Burdea, G., & Deutsch, J. E. (2005). Remote console for virtual rehabilitation. *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.

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., et al. (2002). Virtual reality–augmented rehabilitation for patients following stroke. *Physical Therapy, 82*, 898–915.

Naditz, A. (2009). Still standing: Telemedicine devices and fall prevention. *Telemedicine and e-Health, 15*, 137–141.

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.

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.

Rintala, D. H., Krouskop, T. A., Wright, J. V., Garber, S. L., Frnka. J., Henson, H. K., et al. (2004). Telerehabilitation for veterans with a lower-limb amputation or ulcer: Technical acceptability of data. *Journal of Rehabilitation Research and Development, 41*, 481–490.

Russell, T. G. (2007). Physical rehabilitation using telemedicine. *Journal of Telemedicine and Telecare, 13*, 217–220.

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). Efficacy and sustainability of a telerehabilitation program. In *Proceedings of the 36th Annual Hawaii International Conference on System Sciences* (pp. 11–21). Hawaii: IEEE.

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., Saptono, A., & Brienza, D. M. (in press). Telerehabilitation: Wheeled mobility and seating assessments compared to in-person. *Archives of Physical Medicine and Rehabilitation.*

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.

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.

Schultheis, M. T., & Rizzo, A. A. (2002). Application of virtual reality technology in rehabilitation. *Rehabilitation Psychology, 46*, 296–311.

Shaw, D. K, Dreyer, N. C., Dreyer, K. A., & Wittman, P. P. (2001). The efficacy of telemedicine in occupational therapy. *Journal of Allied Health, 30*, 39–42.

Strickland, D. (1997). Virtual reality for the treatment of autism. *Studies in Health Technology and Informatics, 44*, 81–86.

Tang P., & Venables, T. (2000). "Smart" homes and telecare for independent living. *Journal of Telemedicine and Telecare, 6*, 8–14.

Theodorus, D., & Russell, T. (2008). Telerehabilitation: Current perspectives. *Current Principles and Practices of Telemedicine and e-Health*, 131, 191–209.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2009). Covered medical and other health services. *Medicare benefit policy manual.* Retrieved January 4, 2010, from http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

U.S. Department of Health and Human Services Health, Resources and Services Administration. (2003). *Telemedicine reimbursement report prepared by the Center for Telemedicine Law for the Office for the Advancement for Telehealth*. Retrieved January 4, 2010, from http://www.hrsa.gov/telehealth/pubs/reimbursement.htm

Winters, J. M. (2002). Telerehabilitation research: Emerging opportunities. *Annual Review of Biomedical Engineering*, *4*, 287–320.

Additional Resources

Canadian Occupational Therapy Association, http://www.caot.ca/

International Journal of Telerehabilitation, http://ethnology.pitt.edu/ojs/index.php/Telerehab

Journal of Telemedicine and Telecare, http://jtt.rsmjournals.com/

Rehabilitation Engineering Research Center for Telerehabilitation, http://www.rerctr.pitt.edu

Telemedicine and e-Health, www.liebertpub.com/TMJ

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Appendix A. Glossary of Terms

bandwidth—A measure of the amount of data that can be transmitted over a network connection.

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

occupational therapy—A profession that supports health and participation in life of people through engagement in occupations **(AOTA, 2008).**

privacy officer—A position or office that responds to concerns over the use of personal information, including medical data and financial information. It includes regulations but is not limited to legislation concerning the protection of patient medical records (e.g., HIPAA).
protocol—In telepractice, a written document specifying standard operating policies and procedures for application of computer and information technologies to the delivery of services.

real time—Data acquisition, processing, transmission, and presentation of patients/patient data are all occurring simultaneously. The term means there is *synchronous* (i.e., live) communication between the parties at either end of the telecommunications link.

teleconsultation—Standard "face-to-face" telemedicine model using interaction videoconferencing between a provider (and client) and a rehabilitation expert to gain access to specialized expertise.

telehealth—The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, and public health and health administration.

telehealth technology—The hardware and software used in, as well as the overall process of, doing telemedicine and telerehabilitation.

telemedicine—The use of medical information exchanged from one site to another via electronic communications to improve patients' health status.

telepractice—Service delivery characteristic of a particular profession, preformed by means of telehealth technology rather than traditional face-to-face methods.

telerehabilitation—The provision of rehabilitation services such as occupational therapy, physical therapy, and speech–language therapy using telehealth technology.

virtual reality—A computer-simulated environment of the real world.

Appendix B. Case Examples

CASE DESCRIPTION	TELEREHABILITATION USE	OUTCOME
Lisa		
is a 70-year-old woman who has difficulty performing her daily occupations because of a stroke that left her with right-sided weakness. Although she had learned compensatory techniques for completing activities of daily living (ADLs), instrumental activities of daily living (IADLs), 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 those with hemiparesis; however, the clinic is 2 hours from her home.	Lisa meets with her occupational therapist in clinic for 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 (FES) orthosis that she can use at home once it is programmed in the clinic. Twice each week, Lisa meets with her occupational therapist via computer, using a Web camera and online video software. Initially, the occupational therapist assesses Lisa as she performs work chores via virtual reality. As Lisa continues to make progress, the occupational therapist instructs her as to how to more effectively use her right hand for completion of ADLs and actual farm chores.	Lisa is able to make functional gains with using her right hand for everyday occupations. She reports that she is able to rely less on compensatory strategies and use her right hand more easily, especially while completing ADLs. Lisa achieved these outcomes with only 2 trips to the clinic and without therapist travel.

José		
is a 25-year-old man with traumatic brain injury following a motor vehicle accident that occurred 1 year ago. He has participated in vocational rehabilitation and outpatient occupational therapy for the past 6 months. He continues to struggle with cognitive aspects of occupations that require initiation and short-term memory. These difficulties negatively affect his ability to complete his job as a school custodian and his ability to complete his ADLs and IADLs. The cognitive difficulties also negatively affect his social interactions. José recently moved into his own apartment. José greatly values his independence and living in his own place. His family checks on him frequently, but they are concerned about his safety due to a few recent incidents he encountered at home and work.	On the basis of an analysis of José's daily routines, the occupational therapist programs a smartphone to provide reminders to José to perform his daily occupations at home and work. The occupational therapist then teaches José's family how to remotely monitor his ADL and IADL performance, his safety within his home environment, his medication routine, and the temperature and security of his apartment.	The simple motion detectors in combination with a software program allow the family to determine whether or not José is maintaining his daily routine. Using a portable smartphone with automated messages; visual cues; and a secure, wireless Internet connection allows José to be successful in multiple environments and social settings. The assistive device of a smartphone does not "stick out," as many of friends also use their smartphone to help remind them of appointments
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 utilizes a basic power wheelchair to drive around town and attend her family activities, it is in poor	Angela has trouble traveling and sitting for long distances. She and her mother meet with an occupational therapy generalist face-to-face at a nearby clinic. Concurrently, an occupational therapist who has expertise in wheeled mobility participates in an occupational therapy session remotely using a secure videoconferencing	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

condition and too small for her. Angela cannot adequately reposition herself or properly perform a weight shift due to decreased upper-extremity strength and range of motion.	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.	monitor the delivery, evaluate the fitting, and provide feedback and advice to Angela regarding utilization within the community and home. Angela has benefitted from the provision of services without traveling a long distance. The local practitioner gained additional knowledge about wheeled mobility and seating options.

ITEM
TO BE
PROVIDED

New Business and Professions Code Section

Any occupational therapist or occupational therapy assistant who renders services during any state of war emergency, a state of emergency, disaster, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for an injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission, or when the person is grossly negligent.

New BPC Section 2570.34

(a) Any employer of an occupational therapy practitioner shall report to the California Board of Occupational Therapy the suspension or termination for cause of any practitioner in their employ. The reporting required herein shall not act as a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800, and shall not be subject to discovery in civil cases.

(b) For purposes of the section, "suspension or termination for cause" is defined to mean suspension or termination from employment for any of the following reasons:

(1) Use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice occupational therapy.

(2) Unlawful sale of controlled substances or other prescription items.

(3) Patient neglect, physical harm to a patient, or sexual contact with a patient.

(4) Falsification of medical, treatment, client consultation or billing records.

(5) Incompetence or negligence.

(6) Theft from patients, other employees, or the employer.

(c) The first failure of an employer to make a report required by this section shall result in a letter educating the employer of their reporting responsibilities. The second failure to make a report by this section shall result in a letter reminding the employer of their reporting responsibilities and advising of consequences for future non-compliance. The third violation shall result in an administrative fine not to exceed one thousand dollars ($1,000). The fourth and any subsequent violations shall be punishable by an administrative fine not to exceed five thousand dollars ($5,000) per violation.

New BPC Code Section 2570.35

(a) In addition to the reporting required under Section 2570.34, an employer shall also report to the board the name, professional licensure type and number, and title of the person supervising the licensee who has been suspended or terminated for cause, as defined in subdivision (b) of Section 2570.34. If the supervisor is a licensee under this chapter, the board shall investigate whether due care was exercised by that supervisor in accordance with this chapter. If the supervisor is a health professional, licensed by another licensing board under this division, the employer shall report the name of that supervisor and any and all information pertaining to the suspension or termination for cause of the person licensed under this chapter to the appropriate licensing board.

(b) The failure of an employer to make a report required by this section shall be punishable consistent with Section 2570.34(c).

BPC Code Section 2570.36 (current language)

If a licensee has knowledge that another person may be in violation of, or has violated, any of the statutes or regulations administered by the board, the licensee shall report this information to the board in writing and shall cooperate with the board in furnishing information or assistance as may be required.