REPORT OF THE
VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
VIRGINIA BOARD OF HEALTH PROFESSIONS

Study on the Appropriate Level of Regulation for Certified Occupational Therapy Assistants

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 7

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COMMONWEALTH of VIRGINIA

Department of Health Professions

John W. Hasty
Director

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717

http://www.dhp.state.va.us/
TEL (804) 662-9900
FAX (804) 662-9943
TDD (804) 662-7197

November 2, 2000

To: The Honorable Senator R. Edward Houck

The Members of the General Assembly of Virginia

It is our privilege to present this report which constitutes the response of the Board of Health Professions to the request contained in Senate Joint Resolution 153 of the 2000 Session of the General Assembly.

The report provides the findings of the board from its Study of the Appropriate Level of Regulation for Certified Occupational Therapy Assistants (COTAs) in Virginia. This study cost approximately $4,500 to conduct. The final report is available to the public on the website for the Department of Health Professions at http://www.dhp.state.va.us.

The Board acknowledges the work of the Regulatory Research Committee of the Board of Health Professions and the staff who conducted the research and prepared the final report.

John W. Hasty
Director
Department of Health Professions

Hugh C. Cannon
Executive Director
Board of Health Professions

VIRGINIA BOARD OF HEALTH PROFESSIONS
DEPARTMENT OF HEALTH PROFESSIONS

Study to determine the appropriate level of regulation for Certified Occupational Therapy Assistants (COTAs) in Virginia Pursuant to SJR 153 (2000)

Members of the Board of Health Professions
2000

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*Member of the Regulatory Research Committee

Kirsten Barrett, Policy Research Analyst for the Board, provided staff and research assistance for the Regulatory Research Committee.

Ackowledgements

The members of the Board of Health Professions gratefully acknowledge the American Occupational Therapy Association, the Virginia Occupational Therapy Association, the National Board of Certification in Occupational Therapy, Inc, states with existing regulatory oversight, and the occupational therapy licensees of the Virginia Board of Medicine for providing information and assisting the Board with its deliberations.

Final Recommendation of the Board

In response to Senate Joint Resolution 153, the Board of Health Professions has recommended that no state regulatory oversight is needed for Certified Occupational Therapy Assistants at this time.

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Executive Summary

Background for the Study

Senate Joint Resolution 153, patroned by Senator R. Edward Houck and passed by the 2000 Session of the General Assembly, requested the Virginia Department of Health Professions to study the appropriate level of regulation for Certified Occupational Therapy Assistants (COTAs). By virtue of the statutory authority of the Board of Health Professions to advise the Governor, the General Assembly, and the Department Director on matters related to the regulation and level of regulation of health care occupations and professions, the Board will conduct the study and provide recommendations through the Director and Secretary of Health and Human Resources accordingly (see §54.1-2510 of the *Code of Virginia*).

Methodology

The sunrise review methodology detailed in the Board of Health Professions Policies and Procedures for Evaluation of the Need to Regulate Health Occupations and Professions (1998) was employed in this study. Successful application of these methods is rooted in the following:

- The Board's ability to accurately determine the risk of harm to the public posed by the unregulated group.
- Its full understanding of the educational and training requirements for competent practice of the profession or occupation.
- Clear understanding of the level of autonomy of the practitioners of the profession or occupation.
- Comprehension of the actual scope of practice of the profession or occupation.
- An assessment of the economic impact of regulating the profession or occupation based upon economic variables which speak to costs at the level of the individual practitioner.
- An evaluation of the alternatives to state regulation.

The Board undertook the following efforts to address these issues:

- A policy literature review was conducted which relates to trends in the practice of occupational therapy with special emphasis on the oversight, both public and private, of COTAs.
- Current relevant federal and states' laws and regulations were examined.
- Disciplinary information was obtained from states regulating COTAs and from the National Board of Certification in Occupational Therapy, Inc.

- A survey of occupational therapy licensees in Virginia was conducted to obtain information related to supervision of and task delegation to COTAs.
- Available malpractice information was obtained.
- The Board solicited and received public comment in writing and through a public hearing.

Results and Conclusions

Throughout the course of the study, the following issues related to COTA practice were identified:

- **There are accredited educational programs that prepare graduates for practice as occupational therapy assistants.**

  There are two levels of practice that are generally recognized in the field of occupational therapy. Practitioners are designated as either occupational therapists (OTs) or occupational therapy assistants (OTAs) depending on their educational preparation. Occupational therapists enter the field with either a bachelors or an entry-level masters degree from an accredited university. According to the AOTA, there are 131 accredited OT programs nationwide. Occupational therapy assistants enter the field with either an associates degree or certificate from an OTA program. Both OTs and OTAs complete supervised clinical internships during their academic preparation. The majority of OT and OTA graduates elect to take the national examination offered by the National Board of Certification in Occupational Therapy, Inc. so that they can use the recognized credentials OTR (registered occupational therapist) or COTA (certified occupational therapy assistant) respectively.

- **Occupational therapist assistants must pass the NBCOT certification examination to use the COTA credential.**

  In this respect, title protection appears to exist for COTAs through NBCOT certification.

- **Based on information from the NBCOT and information from states with regulatory processes in place, there is little evidence that public harm has occurred when OT services are rendered by a COTA.**

  The following chart contains information about the aggregate number of complaints and disciplinary actions involving occupational therapists and occupational therapy assistants across all responding states in an approximate time period of two years.

Number of States Responding	Total # of OTs	Complaints OTs	Discipline OT	Total # of OTA	Complaints OTA	Discipline OTA
28*	32,706	113**	23	10,426	40**	9

*Of responding states, 26 regulated both OTs and OTAs and 2 regulated OTs only.
**One state reported a total of 9 complaints for both OT/OTAs without. Since 70% of occupational therapy licensees in that state were OTs, 6 complaints were classified as involving OTs and 3 as OTAs.

These findings indicate that less than one percent of OT and OTA licensees in responding states have had complaints lodged against them. For both OTs and COTAs, less than 25% of the complaints actually resulted in any disciplinary action.

- **Supervision processes are addressed in the Virginia regulations governing the practice of occupational therapy. Responses on the survey conducted by the Board suggest that the frequency and nature of supervision for COTAs and occupational therapy aides is consistent with that required in the regulations.**

The supervisory responsibilities of the licensed occupational therapist are specified in Board of Medicine regulation §18 VAC 85-80-110 as follows:

A. An occupational therapist shall be responsible for supervision of occupational therapy personnel who work under his direction.
B. The occupational therapist providing clinical supervision shall meet with the occupational therapy personnel to review and evaluate treatment and progress of the individual patient at least once every fifth treatment session or 21 calendar days, whichever comes first.
C. An occupational therapist shall not provide clinical supervision for more than six occupational therapy personnel.
D. An occupational therapist shall be responsible for the direct treatment actions of persons providing occupational therapy under his clinical supervision.

The COTA provides occupational therapy services to individuals under the supervision of a registered occupational therapist (OTR).

- **The NBCOT, Inc. has authority to investigate complaints issued against OTRs and COTA and, if appropriate, to take disciplinary action against the OTRs and/or COTAs certification.**

  In regard to complaints and felony-related matters, the NBCOT indicated that since 1993 they have received five "complaints" involving OTRs and COTAs. In addition, NBCOT has reviewed six felony related matters pertaining to applicants wishing to sit for the certification examination. The chart below reflects the level of practitioner and nature and disposition of each case.

Practitioner Level	Nature of Complaint	Status of Case	Disposition
OTR	"patient harm"	Closed	No violation
OTR	Fraudulent billing	Closed	No violation
OTR	"documentation problems"	Closed	No violation
OTR	Unethical behavior	Closed	No violation
COTA	Sexual misconduct	Closed	Revocation of license
Unknown (n=5)	Exam candidate – felony-related	Closed	No violation
Unknown	Early determination review – felony-related	Pending	

Information from: S. Conway, NBCOT, phone conversation, September 5, 2000

- **The scope of practice of a COTA appears to be broader than that of an occupational therapy aide based on task delegation reported in the survey of occupational therapists practicing in Virginia.**

- **It has been reported that Trigon has denied payment for occupational therapy services rendered by a COTA due to a lack of state regulatory oversight.**

  There are conflicting reports regarding denial of payment by Trigon for services provided by COTAs in Virginia. In one section of their policy, Trigon states that "..unlicensed occupational therapy personnel are not covered providers under the terms of our member's contracts." However, in another section of their policy, Trigon lists covered services as those rendered by certain professionals including COTAs. Within the same section, however, the policy states "services provided by unlicensed/non-certified physical medicine personnel are not covered" (Trigon, provider contract effective 12/1/00). During the course of this study, one COTA did report denial of payment for services provided by a COTA in his agency to patients covered by Trigon (B. Litton, personal communication, August 9, 2000).

- **Employment of COTAs in non-traditional settings was reported during the public hearing. Although public hearing participants indicated that supervision would still be necessary, it is likely that the COTA would practice with a greater degree of autonomy in non-traditional settings such as adult day care centers and community-based wellness programs. Employment of COTAs in these settings provides cost-savings for the employer and may result in lower consumer cost for services rendered.**

Final Recommendation of the Board of Health Professions

In response to Senate Joint Resolution 153, the Board of Health Professions has recommended that no state regulatory oversight is needed for Certified Occupational Therapy Assistants at this time.

Study to determine the appropriate level of regulation for Certified Occupational Therapy Assistants (COTAs) in Virginia Pursuant to SJR 153 (2000)

I. Background

This study was conducted pursuant to Senate Joint Resolution 153 of the 2000 Session of the General Assembly patroned by Senator R. Edward Houck to determine the appropriate level of regulation of Certified Occupational Therapy Assistants (COTAs) in Virginia. A copy of SJR 153 can be found in Appendix 1.

To govern the evaluation, the Board followed its formal criteria and policies referenced in its publication *Policies and Procedures for Evaluation of the Need to Regulate Health Occupations and Professions, 1998*. Among other things, these criteria assess the degree of risk from unregulated practice, the costs and benefits of various levels of regulation, and the advantages of disadvantages of the various alternatives to regulation that might protect the public. By adopting these criteria and application policies, the Board has endorsed a consistent standard by which to judge the need to regulate any health profession. The aim of this standard is to lead decision-makers to consider the least governmental restriction possible that is consistent with the public's protection. This standard is in keeping with regulatory principles established in Virginia law and is accepted in the national community of regulators. These criteria and application policies are detailed in Appendix 2.

The general scope of the study was to review the competencies and standards of practice for Certified Occupational Therapy Assistants (COTAs) in the Commonwealth and other jurisdictions to the degree that they exist. Generally, following the *Policies and Procedures*, the research attempted to answer these key questions:

- What is the potential risk of harm to consumers?
- What specialized skills and training do COTAs possess?
- To what degree is independent judgement required in their practices?
- Is their scope of practice distinguishable from other regulated occupations or professions?
- What would be the economic impact to the public if this group were regulated?
- Are there alternatives other than state regulation of this occupation which would adequately protect the public?
- Finally, if the Board determines that this occupation requires state regulation, what is the least restrictive level that is consistent with the public's protection?

In an attempt to answer these questions, the Board of Health Professions undertook the following steps:

- A policy literature review was conducted which relates to trends in the practice of occupational therapy with special emphasis on the oversight, both public and private, of COTAs.
- Current relevant federal and states' laws and regulations were examined.
- Disciplinary information was obtained from states regulating COTAs and from the National Board of Certification in Occupational Therapy, Inc.
- A survey of occupational therapy licensees in Virginia was conducted to obtain information related to supervision of and task delegation to COTAs.
- Available malpractice information was obtained.
- A public hearing was held to obtain feedback from interested parties on the issues of COTA regulation.

II. Definition of Occupational Therapy Practice

The American Occupational Therapy Association (AOTA) describes the practice of occupational therapy as follows:

> "...the therapeutic use of purposeful and meaningful occupations (goal-directed activities) to evaluate and treat individuals who have a disease or disorder, impairment, activity limitation, or participation restriction which interferes with their ability to function independently in daily life roles, and to promote health and wellness." (OTA Information Packet, 2000, p.7)

In the Virginia Code, Section 54.1-2900, occupational therapy is defined as follows:

> "....the evaluation, analysis, assessment, and delivery of education and training in activities of daily living (ADL); the design, fabrication, and application of orthoses (splints); guidance in selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaptation of physical environments for individuals who have disabilities."

III. Levels of Practice

There are two levels of practice that are generally recognized in the field of occupational therapy. Practitioners are designated as either occupational therapists (OTs) or occupational therapy assistants (OTAs) depending on their educational preparation. Occupational therapists enter the field with either a bachelors or an entry-level masters degree from an accredited university. According to the AOTA, there are 131 accredited OT programs nationwide. The three located in Virginia are the Community Hospital of Roanoke Valley, Shenandoah University, and Virginia Commonwealth University. James Madison University offers a program in OT but is not yet fully accredited. Occupational therapy assistants enter the field with either an associates degree or certificate from an OTA program. There are 170 accredited OTA programs nationwide. The four located in Virginia are the Community Hospital of Roanoke Valley, J. Sargeant Reynolds Community College, Southwest Virginia Community College, and Tidewater Community College (AOTA website, March 2000).

Both OTs and OTAs complete supervised clinical internships during their academic preparation. The majority of OT and OTA graduates elect to take the national examination offered by the National Board of Certification in Occupational Therapy, Inc. so that they can use the recognized credentials OTR (registered occupational therapist) or COTA (certified occupational therapy assistant) respectively.

IV. Regulation of Occupational Therapists in Virginia

The Virginia General Assembly voted to certify occupational therapists in 1989. Regulations pertaining to certification were effective 1991. During the 1998 General Assembly, Senate Bill 599 patroned by Senator R. Edward Houck was passed that converted the requirements for certification of occupational therapists to requirements for licensure. This change occurred without formal study by the Board of Health Professions or application of any additional criteria than that already set forth in sections 54.1-2956.1, 54.1-2956.4 and 54.1-2956.5 of the Code of Virginia. According to Alexander Macaulay, counsel, Virginia Occupational Therapy Association, the shift from certification to licensure was based on anecdotal reports of denial of reimbursement by third party payors (A. Macaulay, personal communication, May 5, 2000).

There are conflicting reports regarding denial of payment by Trigon for services provided by COTAs in Virginia. In one section of their policy, Trigon states that "..unlicensed occupational therapy personnel are not covered providers under the terms of our member's contracts." However, in another section of their policy, Trigon lists covered services as those rendered by certain professionals including COTAs. Within the same section, however, the policy states "services provided by unlicensed/non-certified physical medicine personnel are not covered" (Trigon, provider contract effective 12/1/00). During the course of this study, one COTA did report denial of payment for

services provided by a COTA in his agency to patients covered by Trigon (B. Litton, personal communication, August 9, 2000).

A representative from the AOTA's Reimbursement and Regulatory Policy Department stated that there is no evidence, nationally, that suggests that payment for occupational therapy services has been denied due to lack of state regulatory oversight of the occupational therapist assistant rendering services (Heather Hostetler, Heath Policy Analyst, AOTA Reimbursement and Regulatory Policy Department, personal communication, May, 18, 2000).

The supervisory responsibilities of the licensed occupational therapist are specified in Board of Medicine regulation §18 VAC 85-80-110 as follows:

A. An occupational therapist shall be responsible for supervision of occupational therapy personnel who work under his direction.
B. The occupational therapist providing clinical supervision shall meet with the occupational therapy personnel to review and evaluate treatment and progress of the individual patient at least once every fifth treatment session or 21 calendar days, whichever comes first.
C. An occupational therapist shall not provide clinical supervision for more than six occupational therapy personnel.
D. An occupational therapist shall be responsible for the direct treatment actions of persons providing occupational therapy under his clinical supervision.

The COTA provides occupational therapy services to individuals under the supervision of a registered occupational therapist (OTR).

V. Description of Practice

According to the American Occupational Therapy Associations booklet entitled "Occupational Therapy Roles and Career Exploration and Development" (1994), the following is a summary of the roles and key performance areas for the OTR and the COTA.

OTR Role and Performance Areas

The OTR provides occupational therapy services, including assessment, intervention, program planning and implementation, record-keeping and communication. Service provision may be direct or may take the form of consultation.

The OTR's skill level varies along a continuum from entry-level to advanced depending on experience, patient population, practice site and ongoing professional development

Selected Key Performance Areas for the OTR:

- Screen individuals to determine the need for intervention.
- Interpret evaluation findings.
- Develop and implement intervention plans directly or in coordination with others.
- Monitor the individual's response to intervention and modifies the plan as needed.
- Supervise / teach occupational therapy practitioners, students, and other staff performing supportive services and/or other aspects of service provision.
- Perform advanced, specialized evaluations or interventions.

COTA Role and Performance Areas

The role of the COTA is to provide occupational therapy services to individuals under the supervision of a registered occupational therapist (OTR). Like the OTR, the COTA's skill level varies along a continuum from entry-level to advanced depending on experience, patient population, practice site and ongoing professional development. The supervision of the COTA, by the OTR, varies from close supervision to general supervision depending on the experience and competence of the COTA.

Selected Key performance areas for the COTA include the following:

- Assist with data collection and evaluation under the supervision of an OTR.
- Develop treatment goals under the supervision of an OTR.
- Select, adapt, and implement intervention under the supervision of an OTR.
- Administer standardized tests under the supervision of an OTR after service competency has been established.
- Monitor own performance and identify supervisory needs.
- Supervise volunteers, COTAs, OTA students and personnel other than OT practitioners under the direction of an OTR.
- Maintain records and documentation required by work settings under the supervision of an OTR.

In the National Study for Occupational Therapy Practice (1997), COTAs were asked to describe the percent of time they performed tasks within various domains of practice. The following is a breakdown of task performance identified by the 648 COTA respondents:

- Determine needs and priorities for intervention 11.7%
- Identify / design interventions 10.3%
- Implement interventions 43.5%
- Report / evaluate intervention effectiveness 13.5%
- Provide OT services for populations 9.7%
- Manage delivery of OT services 6.3%
- Advance effectiveness of the OT profession 4.9%

VI. Description of Supervision

The AOTA has defined the continuum of supervision in occupational therapy practice as follows:

TYPE OF SUPERVISION	DESCRIPTION
Close	Daily, direct contact at the site or work.
Routine	Direct contact as least every 2 weeks at the site of work, with interim supervision occurring by other methods such as telephone or written communication.
General	At least monthly direct contact, with supervision available as needed by other methods.
Minimal	Provided only on a need basis, and may be less than monthly.

The AOTA states that COTAs at all levels require at least general supervision by an OTR. Typically, novice, entry-level COTAs will require close supervision whereas more experience COTAs will require routine or general supervision (Occupational therapy roles and career exploration and development, AOTA, 1994). Virginia regulations, as outlined previously, require supervision every fifth visit or 21 calendar days. Thus, the minimum level of supervision for COTAs in Virginia would be characterized as "routine" as defined above.

In the National Study for Occupational Therapy Practice (1997), COTA respondents were asked the following questions: "On average, how many hours of direct supervision do you receive from your immediate supervisor (e.g., formally or informally reviewing your work by observation, document review, telephone consultation, or face to face meetings)?" Of the 1,170 COTA respondents, the majority (approximately 53-65%) received at least three hours of supervision per week. This finding was consistent across acute, post-acute, and school practice settings.

VII. Certification Processes

The National Board of Certification in Occupational Therapy, Inc. (NBCOT) is responsible for administering the examination that, if successfully passed, allows one to

use the OTR or COTA credential. To be eligible to take the examination, the applicant must meet the following requirements:

1. Complete fieldwork experiences required by the educational program in which the applicant is enrolled.
2. Attain a degree / certificate from an accredited occupational therapy or occupational therapy assistant program or be cleared for graduation from such a program.
3. Submit official final transcript prior to the date that the examination is administered (NBCOT Certification Examination Eligibility).

The NBCOT has had ownership over the OTR and COTA trademarks since 1988. In order for an occupational therapist or occupational therapist assistant to use the credential OTR or COTA respectively, the practitioner must pass the certification examination and be currently certified through NBCOT. To maintain "active" certification, the occupational therapy practitioner must renew his/her certification every five years. The practitioner is required to complete the certification renewal application that contains questions about illegal, unethical or incompetent behavior. In addition, there is a $75 fee that must accompany the application (NBCOT Certification Renewal Program).

If one fails to renew at five year intervals, he cannot legally use the OTR or COTA certification titling (NBCOT press release; S. Conway, NBCOT, phone conversation, May 2000). There are no limitations to those who renew certification after the renewal deadline. They simply submit a renewal application.

VIII. Issue of Continuing Competence

When NBCOT, Inc. was designing their re-certification process, they intended to have two distinct phases. Phase one, which has been implemented, focused on the certification and renewal process. This included the application process and the monetary requirements for the maintenance of registration or certification. The second phase was to be implemented by 2002 and was to focus on continuing competence. Due to unexpected occurrences, financial and human resources have been diverted away from this phase. Thus, it is unlikely that a continuing competence program will be in place by 2002. Continued competence is expected to be discussed at the NBCOT, Inc. strategic planning meeting in July 2000 (S. Conway, NBCOT, May 24, 2000).

Of the 51 jurisdictions regulating occupational therapy practitioners, 32 have mandatory continuing education requirements (AOTA, State Policy Department, March 2000). Although there is an effort being made to add continuing education requirements to the existing regulation, Virginia does not presently require continuing education units to be accrued for licensure renewal for occupational therapists. A complete list of continuing education requirements by state can be found in Appendix 3.

IX. Employment Settings

Occupational therapy practitioners have traditionally worked in settings that include acute care hospitals, rehabilitation hospitals, out-patient therapy settings, hand therapy centers, skilled nursing facilities, cognitive rehabilitation settings, school settings, vocational training centers, and academia. Clientele range from neonates to the elderly.

Based on findings from the National Occupational Therapy Practice Analysis (1997), approximately 60% of occupational therapy assistants work in skilled nursing facilities and school systems. A similar trend is seen for occupational therapists (National Study of Occupational Therapy Practice, Executive Summary, 1997).

Johansson (2000) has identified ten emerging practice areas in the 20th century. These are:

- Ergonomics consulting
- Driver rehabilitation and training
- Home modification consulting
- Low vision services
- Community health services
- Private practice community health services
- Assistive technology – development and consulting
- Welfare-to-work programs
- Health and wellness consulting
- Ticket-to-work services
- Services to address the psychosocial needs of children and youth

Written comment was received in regard to the expansion of occupational therapy practice into practice settings such as those listed above. Michelle Stoll, COTA (personal communication, August 9, 2000), stated that, "With the 10 emerging practice areas listed it puts the COTA and OTR into more autonomous roles where supervision will be key. It also takes the COTA out of the 'traditional' medical model setting and puts the OT consumer at more risk for harm."

The issue of autonomy in practice was also raised during the public hearing held on August 10, 2000. Michelle Stoll, COTA stated, "....what we're finding out in the community is that occupational therapists can do really well working with disadvantaged teens or working in early intervention centers with infants, in the school system with developmentally delayed or even mentally retarded children, you know, in adult day care centers. Stoll further stated, "And I think you will find occupational therapy practitioners in those areas as well as wellness. There's a whole wellness craze. And there's lots of people looking at alternative medicine" (Stoll, Selections from transcription of public hearing comments, August 10, 2000).

It is unclear how expansion of occupational therapy services into alternative practice settings will impact consumers of occupational therapy services. Regardless of

practice site and/or reimbursement scheme, if personnel are carrying out OT services, they are to be supervised by a licensed OT every fifth visit or 21 calendar days per the present occupational therapy regulations in Virginia.

X. Mean Earnings

The following chart provides information about the mean hourly rates and annual salaries for occupational therapists and occupational therapy assistants and aides in Virginia and selected states.

Designation	Virginia* Annual / Hourly	North Carolina** Annual / Hourly	Tennessee** Annual / Hourly	West Virginia** Annual / Hourly
OT	$54, 160 / $26.04	$50,840 / $24.44	$51,240 / $23.26	$54,610 / $26.25
OTA & Aides	$34,310 / $14.73	$33,350 / $14.96	$32,650 / $15.64	$24,830 / $9.70

* Licensure of OT only **Licensure of both OT and OTAs

From: http://stats.bls.gov/oesst/oessrch2.htm

It is questionable if the mean hourly rate and annual salary for occupational therapy assistants and aides are equivalent as the table suggests. Given the difference in educational level and clinical training, it is likely that the assistant would be making more than an aide with on-the-job training.

XI. Number of OTRs and COTAs in Virginia as of August 1999

CREDENTIAL	NUMBER
OTR	1,854
COTA	501

From: Shaun Conway, NBCOT (phone conversation, April 2000)

The numbers indicated above for OTRs closely approximate the number of OTs licensed by the Virginia Board of Medicine (n=1871). This means that nearly all of the licensed OTs in Virginia are currently certified through NBCOT, Inc.

XII. Projected Employment – National

The Bureau of Labor Statistics projects 12,000 job openings for occupational therapy assistants and aides by the year 2008 due to both growth and net replacement. In 1998, there were 19,000 employees holding occupational assistant and aide positions. In 2008, it is anticipated that there will be 26,000 such positions filled (Bureau of Labor Statistics Employment Projections, Accessed May 17, 2000).

XIII. State Regulation of OTRs and COTAs

The following chart indicates the total number of states that regulate OT and OTAs:

	States Licensure	States Certification	States Registration
Both OT & OTA	39	1	5
OT only	2	------	1
OTA only	0	1	0

XIV. Cost of Regulation

The projected cost of regulation for COTAs is $11,500 annually. The projected annual budget, and assumptions therein, can be found in Appendix 4

XV. Risk of Harm

To get a sense of the potential risk of harm posed by occupational therapy practice, the Board of Health Professions surveyed all states that regulate occupational therapists or occupational therapy assistants. A copy of the survey as well as a detailed report of the findings can be found in Appendix 5. The following chart contains information about the aggregate number of complaints and disciplinary actions involving occupational therapists and occupational therapy assistants across all responding states in an approximate time period of two years.

Number of States Responding	Total # of OTs	Complaints OTs	Discipline OT	Total # of OTA	Complaints OTA	Discipline OTA
28*	32,706	113**	23	10,426	40**	9

*Of responding states, 26 regulated both OTs and OTAs and 2 regulated OTs only.
**One state reported a total of 9 complaints for both OT/OTAs without. Since 70% of occupational therapy licensees in that state were OTs, 6 complaints were classified as involving OTs and 3 as OTAs.

These findings indicate that less than one percent of OT and OTA licensees in responding states have had complaints lodged against them. For both OTs and COTAs, less than 25% of the complaints actually resulted in any disciplinary action.

In Virginia, since 1993, there have been six complaints against licensed occupational therapists. There were two cases involving fraud and one case each involving unlicensed activity, standard of care, unprofessional conduct, and business

practice / issues. None of the six cases resulted in disciplinary action against the practitioner.

The Virginia Advisory Board on Occupational Therapy indicates that within the last five years there has been one case involving allegations of sexual misconduct involving a COTA. The Board of Medicine referred the case to the NBCOT, Inc. Due to a lack of state regulatory oversight, action on the part of the Board was not feasible (Virginia Advisory Board on Occupational Therapy, written correspondence, September 1, 2000).

According to Ranke & Moriarty (1997), there were 76 malpractice claims filed against occupational therapists nationwide from 1991 – 1994. The following chart indicates the nature of the claims that had the highest frequency of occurrence. In addition, settlement information is provided:

Nature	Number of Claims	Paid/Unpaid	Average Amount Paid
Improper treatment	11	1 / 10	$25,000
Burns from hot pack	9	4 / 5	$29,062
Fall	9	2 / 7	$27,000
Sexual misconduct	2	1 / 1	$25,000
Unknown	13	0 / 13	----------

From: Ranke, B.A., & Moriarty, M.P. (1997). An overview of liability in occupational therapy. The American Journal of Occupational Therapy, 51(8), 671-680.

Further, according to NBCOT, of approximately 1570 OTRs and 485 COTAs in Virginia renewing in the 1997-2000 interval, none reported any malpractice involvement in the preceding five years. During the course of this study, malpractice settlement information was requested from the AOTA. Unfortunately, no meaningful information was forthcoming regarding malpractice as it related to the practice of COTAs (C. Willmarth, AOTA, electronic mail communication, June 5, 2000).

For the NBCOT certification renewal period from 1997-2000, two OTRs responded affirmatively to the following question, "In the past five years, have you been denied a license or registration to practice or had it suspended, revoked or subject to probationary conditions by the regulatory authority of a state, territory or country?" One OTR responded affirmatively to the following question, "In the past five years, have you been disciplined, terminated, or allowed to resign, in lieu of termination, from an employment setting due to alleged incompetence, negligence, or unethical or unprofessional conduct?" All three cases were closed without violation. For the renewal period 1997-2000, there were no COTAs from Virginia who responded affirmatively to any questions that would require NBCOT investigation prior to renewal (S. Conway, NBCOT, phone conversation, September 5, 2000).

In regard to complaints and felony-related matters, the NBCOT indicated that since 1993 they have received five "complaints" involving OTRs and COTAs. In addition, NBCOT has reviewed six felony related matters pertaining to applicants

wishing to sit for the certification examination. The chart below reflects the level of practitioner and nature and disposition of each case.

Practitioner Level	Nature of Complaint	Status of Case	Disposition
OTR	"patient harm"	Closed	No violation
OTR	Fraudulent billing	Closed	No violation
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COTA	Sexual misconduct	Closed	Revocation of license
Unknown (n=5)	Exam candidate – felony-related	Closed	No violation
Unknown	Early determination review – felony-related	Pending	

Information from: S. Conway, NBCOT, phone conversation, September 5, 2000

XVI. Survey of Occupational Therapy Licensees in Virginia:

To obtain insight into what is occurring in Virginia with regard to the use of COTAs, the Board of Health Professions surveyed licensed occupational therapists in Virginia to determine the following:

- Type of practice setting and primary work role
- Number of OTs and assistive personnel, including COTAs, in one's work setting
- Knowledge of assistive personnel holding themselves out to be COTAs without the requisite education and national certification
- Nature and extent of supervision
- Nature of delegated activities

The Department of Health Professions requested a mailing list of COTAs in Virginia from the NBCOT, Inc. However, NBCOT, Inc. indicated they do not release such information to external parties. (S.Conway, NBCOT, phone conversation, May, 24, 2000). Thus, surveying COTAs in Virginia was not feasible.

Methodology:

The survey in Appendix 6 was sent to all licensed occupational therapists in Virginia (n=1871). A postage paid return envelope was included with each survey mailed. A four week response window was provided. A total of 662 surveys were returned for a response rate of 35.4%.

Results

The following chart provides information regarding the demographic profile of the survey respondents presently practicing in Virginia (n=560).

Variable	Results
Age	Mean = 39.12 years old (sd 9.3 years)
Gender	Female = 515 Male = 43
Years in Practice	Mean = 13.2 years (sd 8.9 years)
Work Status	Full-time = 429 (76.7%) Part-time = 64 (11.4%) PRN = 66 (11.8%)
Practice Location	Rural = 97 (17.7%) Suburban = 317 (58%) Urban = 125 (22.9%) Multiple Sites = 8 (1.5%)
Primary Practice Area	School system = 137 (24.5%) Skilled nursing facility = 75 (13.4%) Acute care = 60 (10.7%) Out-patient = 59 (10.5%) Adult rehabilitation facility = 59 (10.5%) <10% of respondents in industrial rehab, pediatric rehab, vocational training, academia, and home health
Work Role	Staff OT = 348 (62.5%) Senior OT/Clinical Specialist = 129 (23.2%) Manager/Administration/Clinical Coordinator = 49 (8.8%) Academic faculty = 12 (2.2%) Multiple roles = 11 (2.0%)
# of COTAs in present work setting	n=579
Presently Supervising COTAs and/or aides	Yes = 285 (50.9%) No = 275 (49.1%)

The following question was asked to determine the extent to which persons are using the COTA title without the necessary education and/or certification: "Are you aware of people who are calling themselves Certified Occupational Therapy Assistants (COTAs) but ***DO NOT*** have the requisite associates degree and current certification through the National Board of Certification in Occupational Therapy, Inc. (NBCOT)?" Of the 560 in-state respondents, 11 responded affirmatively to this question. The sum of persons reported as holding themselves out as COTAs without the requisite education and national certification was 17.

The following question was included in an attempt to quantify the number of persons with on-the-job training calling themselves occupational therapy assistants: "Are you aware of people who ***ONLY*** have on-the-job training and call themselves occupational therapy assistants?" Of the 560 in-state respondents, 42 responded affirmatively to this question. The sum of persons reported as calling themselves occupational therapy assistants was 108. It should be noted that respondents ranged from knowledge of 1 to knowledge of 20 persons calling themselves occupational therapy assistants. Thirty-seven of the forty-two respondents indicating knowledge of 4 or less of these persons.

The following results are based on respondents (n=285) who indicated that they are presently practicing in Virginia and are presently supervising COTAs and/or aides on a regular basis.

Question	Respondents
• Total number of COTA and other assistive personnel supervised by the 285 respondents on a typical workday	n=473
• Are you on-site during supervision?	Yes = 231 (82.5%) No = 49 (17.5%)
• How often do you discuss patient status, goals, and plan of care with the COTA and other assistive personnel?	Daily = 117 (41.3%) A couple of times a week = 112 (39.6%) A couple of times a month = 52 (18.4%) Never = 2 (.7%)
• What is the primary mechanism you use to discuss patient status, goals, and plan of care with the COTA(s) and other assistive personnel?	Face-to-face meeting = 230 (82.1%) Discussion over the phone = 14 (5.0%) Written correspondence = 12 (4.3%) Multiple = 20 (7.1%)

In an effort to clarify the scope of practice of COTAs and aides, respondents were asked to identify their delegation patterns for a variety of activities including interviewing, screening for services, administering standardized tests, documentation, selecting and performing interventions, referral to other agencies, evaluating progress, developing home programs, instructing caregivers, and terminating services.

The following chart provides a comparison of delegation patterns of OTs in regard to COTAs and OT aides. Delegation patterns were described as independently, under supervision of OTL, or never delegated. Supervision was defined as "licensed OT is sufficiently aware of patient's needs and status and is in ongoing written and/or verbal communication with assistive personnel providing OT services." Independent was defined as "no oversight by the licensed OT." The delegation pattern with the highest percentage of respondents is indicated for each task for both the COTA and the OT aide.

TASK	DELEGATION TO A COTA	DELEGATION TO AN OT AIDE
• **Interviewing to obtain background and social history**	Never delegate (37.6%)	Never delegate (93.3%)
• **Screening for OT services**	Never delegate (40.3%)	Never delegate (96.6%)
• **Administering standardized assessment instruments**	Never delegate (44.5%)	Never delegate (97.1%)
• **Recommend referral to appropriate professionals and agencies**	Under supervision (57.1%)	Never delegate (94%)
• **Select appropriate interventions to restore function**	Under supervision (63.9%)	Never delegate (85.1%)
• **Document intervention / treatment plan**	Under supervision (60.1%)	Never delegate (83%)
• **Provide therapeutic interventions**	Independently (49.5%)	Under supervision (64.4%)
• **Evaluate patient progress**	Under supervision (71.4%)	Never delegate (85.3%)
• **Modify intervention plan**	Under supervision (68.2%)	Never delegate (92.7%)
• **Instruct caregivers in assisting patient in discharge environment**	Under supervision (50.2%)	Never delegate (78.9%)
• **Develop home programs**	Under supervision (59.6%)	Never delegate (91%)
• **Terminate services when goals are achieved**	Under supervision (60.7%)	Never delegate (97.9%)
• **Serve as a resource person or consultant**	Under supervision (48.9%)	Never delegate (82.1%)

According to the survey respondents, the majority of time, the only task delegated to the OT aide under the supervision of the OT is that of performing therapeutic interventions. Additionally, the chart reflects that activities that entail discretionary judgement such as the selection of appropriate interventions and evaluating patient progress are often delegated to the COTA under the supervision of the OT. Rarely, COTAs delegated activities which they perform independently.

XVII. Public Hearing:

A public hearing was held on August 10, 2000 before the Regulatory Research Committee of the Board of Health Professions. Public comment was received from Alexander Macaulay, counsel, VOTA, Michelle Stohl, COTA, and Portia Vaughan, COTA.

The key issues that were identified during the hearing involved the use of occupational therapy aides and the delivery of occupational therapy services in alternative practice settings such as adult day care centers. Occupational therapy aides are persons who provide services under the supervision of a licensed occupational therapist. Unlike the COTA, aides are not required to have any particular educational preparation or clinical training prior to starting employment. The skills performed by aides are primarily learned through on-the-job training.

Participants in the public hearing argued that the use of aides pose a risk of harm to the public. When asked how heightened regulation would serve to decreased this risk, respondents indicated that regulation would offer restrictions to the scope of practice available to aide-level personnel (A. Macauly, M. Stoll, public hearing, August 10,

2000). It should be noted that occupational therapy aides providing services are required by Virginia regulation to be supervised by a licensed OT.

Participants also addressed practice autonomy as occupational therapy practitioners are now functioning in emerging "non-medical" practice areas such as adult day care centers. Again, pursuant to Virginia regulations, regardless of practice setting, if a person is providing OT services, they must either be a licensed OT or supervised by a licensed OT every fifth visit or 21 calendar days.

XVIII. Policy Considerations:

Throughout the course of this study, efforts were made to address the six criteria for regulation outlined in the Policies and Procedures. Information gathered through literature review, policy analysis, surveys, public hearings, and secondary data sources suggest the following:

- There are accredited educational programs that prepare graduates for practice as occupational therapy assistants.
- Occupational therapist assistants must pass the NBCOT certification examination to use the COTA credential.
- Based on information from the NBCOT and information from states with regulatory processes in place, there is little evidence that public harm has occurred when OT services are rendered by a COTA.
- Supervision processes are addressed in the Virginia regulations governing the practice of occupational therapy. Responses on the survey suggest that the frequency and nature of supervision for COTAs and occupational therapy aides is consistent with that required in the regulations.
- The NBCOT, Inc. has authority to investigate complaints issued against OTRs and COTA and, if appropriate, to take disciplinary action against the OTRs and/or COTAs certification.
- The scope of practice of a COTA appears to be broader than that of an occupational therapy aide based on task delegation reported in the survey of occupational therapists practicing in Virginia.
- Title protection appears to exist for COTAs through NBCOT certification.
- It has been reported that Trigon has denied payment for occupational therapy services rendered by a COTA due to a lack of state regulatory oversight.
- Employment of COTAs in non-traditional settings was reported during the public hearing. Although public hearing participants indicated that supervision would still be necessary, it is likely that the COTA would practice with a greater degree of autonomy in non-traditional settings such as adult day care centers and community-based wellness programs. Employment of COTAs in these settings provides cost-savings for the employer and may result in lower consumer cost for services rendered.

Adoption of a Final Recommendation:

On September 19, 2000, the Board of Health Professions considered the information contained in the study report as well as public and written comment received. In response to Senate Joint Resolution 153, the Board voted unanimously to recommend to the Governor and General Assembly that no state regulatory oversight is needed for Certified Occupational Therapy Assistants (COTAs) at this time. The Board's decision was based on a lack of evidence suggesting that practice by COTAs, in the present regulatory context, presents a risk of harm to consumers of occupational therapy services in Virginia.

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APPENDIX 1

COMMONWEALTH OF VIRGINIA

April 3, 2000

John W. Hasty, R.Ph.
Director
Department of Health Professions
6606 West Broad Street, 4th Floor
Richmond, Virginia 23230-1717

Dear Mr. Hasty:

As directed by the 2000 General Assembly, I am enclosing Senate Joint Resolution No. 153 requesting the Department of Health Professions to study the need for an appropriate level of regulation for Certified Occupational Therapy Assistants.

The patron of this resolution is Senator R. Edward Houck, P. O. Box 7, Spotsylvania, Virginia 22553-000. The resolution was agreed to by the Senate on February 15, 2000, and the House of Delegates on March 8, 2000.

Enclosed are the guidelines of the Division of Legislative Automated Systems for the processing of legislative documents.

With kind regards, I am

Sincerely yours,

Susan Clarke Schaar

SCS/rr

Enclosures

cc: The Honorable R. Edward Houck

ENROLLED

SENATE JOINT RESOLUTION NO. 153

Requesting the Department of Health Professions to study the need for an appropriate level of regulation for Certified Occupational Therapy Assistants.

Agreed to by the Senate, February 15, 2000
Agreed to by the House of Delegates, March 8, 2000

WHEREAS, occupational therapy is the use of purposeful activity or interventions designed to achieve functional outcomes which promote health, prevent injury or disability, and which develop, improve, sustain, or restore the highest possible level of independence of any individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, or other disorder or condition; and

WHEREAS, occupational therapy services include assessment and treatment, interventions designed to restore daily living skills, developing and improving basic functional areas, and educating family members in providing assistance; and

WHEREAS, Virginia currently licenses occupational therapists; assistants are not licensed but may choose voluntary certification instead; and

WHEREAS, within the past eight years, the number of college programs in Virginia offering occupational therapy assistant programs has tripled and currently there are 500 occupational therapy assistants in the Commonwealth; and

WHEREAS, the trend of nontraditional workplace environments, change in the healthcare delivery system, and the increase in the number of occupational therapy assistants has changed the role of assistants; and

WHEREAS, the lack of regulation is seen by some to be a contributing factor to the reluctance of third-party payors to reimburse for services by assistants because of the lack of standards for training and enforcement; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Health Professions be requested to study the need for an appropriate level of regulation for Certified Occupational Therapy Assistants.

All agencies of the Commonwealth shall provide assistance to the Department of Health Professions for this study, upon request.

The Department of Health Professions shall complete its work in time to submit its findings and recommendations to the Governor and the 2001 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX 2

VIRGINIA BOARD OF HEALTH PROFESSIONS

CRITERIA FOR EVALUATING THE NEED FOR PROFESSIONAL REGULATION

Initially adopted October, 1991
Readopted, February, 1998

Criterion One: Risk for harm to the Consumer
The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (4) from any combination of these factors.

Criterion Two: Specialized Skills and Training
The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

Criterion Three: Autonomous Practice
The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

Criterion Four: Scope of Practice
The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

Criterion Five: Economic Impact
The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

Criterion Six: Alternatives to Regulation
There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

Criterion Seven: Least Restrictive Regulation
When it is determined that State regulation of the occupation is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

APPENDIX 3

Occupational Therapy - Continuing Competence Requirements

State	Status	Requirements
Alabama	Mandatory	**OT:** 3.0 CEUs (or 30 contact hours) biennially **OTA:** 2.0 CEUs (or 20 contact hours) biennially
Alaska	Mandatory	**OT:** 20 contact hours of CE biennially **OTA:** 20 contact hours of CE biennially
Arizona	Mandatory	**OT:** 20 clock-hours for renewal of a 2-year license period **OTA:** 12 clock-hours for renewal of a 2-year license period
Arkansas	Mandatory	**OT:** 10 contact hours of continuing education each year **OTA:** 10 contact hours of continuing education each year
California	No requirements	**OT:** No requirements **OTA:** No requirements
Colorado	No requirements	**OT:** No requirements **OTA:** No requirements
Connecticut	Mandatory	**OT:** 12 units of qualifying continuing competency activity during the preceding registration period renewed biennially every odd year **OTA:** 9 units of qualifying continuing competency activity during the preceding registration period renewed biennially every odd year
Delaware	Mandatory	**OT:** ▪ 20 hours CEUs for each license renewed biennially: ▪ new licensees prorated **OTA:** ▪ 20 hours CEUs for each license renewed biennially ▪ new licensees prorated
District of Columbia	Mandatory	**OT:** 24 hours of approved continuing education credit during a 2 year licensure period **OTA:** 12 hours of approved continuing education credit during a 2 year licensure period
Florida	Mandatory	**OT:** 24 hours continuing education + 2 hours HIV/AIDS education = total 26 hours biennially **OTA:** 24 hours continuing education + 2 hours HIV/AIDS education = total 26 hours biennially
Georgia	Mandatory	**OT:** 12 contact hours biennially **OTA:** 12 contact hours biennially
Hawaii	No requirements	**OT:** No requirements **OTA:** No requirements
Idaho	Voluntary	**OT** ▪ No requirements ▪ May send in continuing education credit voluntarily with license renewal **OTA** ▪ No requirements ▪ May send in continuing education credit voluntarily with license renewal
Illinois	No requirements	**OT:** No requirements **OTA:** No requirements
Indiana	No requirements	**OT:** No requirements **OTA:** No requirements
Iowa	Mandatory	**OT:** 30 hours of continuing education each biennium (by birth month) **OTA:** 15 hours of continuing education each biennium (by birth month)
Kansas	Mandatory	**OT:** 40 hours every 2 years (from Jan 1st of odd year until Dec. 31st of even year) **OTA:** 40 hours every 2 years (from Jan 1st of odd year until Dec 31st of even year)
Kentucky	No requirements	**OT:** No requirements **OTA:** No requirements
Louisiana	Mandatory	**OT:** 15 contact hours or 1.5 continuing education units (CEUs) annually **OTA:** 15 contact hours or 1.5 continuing education units (CEUs) annually
Maine	Mandatory	**OT:** 36 contact hours of study equivalent to 3.6 CEUs which shall be completed for every biennial license renewal on March 31st of the odd year **OTA:** 36 contact hours of study equivalent to 3.6 CEUs which shall be completed for every biennial license renewal on March 31st of the odd year
Maryland	Mandatory	**OT:** ▪ If licensed for more than 2 years, 24 contact hours of continuing education activities obtained within a 2-year period ▪ If licensed for less than 2 years, but more than 1 year, 12 contact hours of continuing education activities required ▪ If licensed less than 1 year, no continuing education required **OTA:** ▪ 24 contact hours of continuing education activities obtained within a 2-year period ▪ if licensed less than 2 years, 12 contact hours of continuing education activities ▪ if licensed less than 1 year, no continuing education requirements
Massachusetts	No requirements	**OT:** No requirements **OTA:** No requirements

State	Status	Requirements
Michigan	No requirements	**OT:** No requirements **OTA:** No requirements
Minnesota	Mandatory	**OT:** 24 contact hours of continuing education in the 2 year licensure period **OTA:** 18 contact hours of continuing education in the 2 year licensure period
Mississippi	Mandatory	**OT:** 20 contact hours accrued during the 2 year licensure period **OTA:** 20 contact hours accrued during the 2 year licensure period
Missouri	No requirements	**OT:** No requirements **OTA:** No requirements
Montana	Mandatory	**OT:** 10 contact hours of continuing education annually **OTA:** 10 contact hours of continuing education annually
Nebraska	No requirements	**OT:** No requirements **OTA:** No requirements
Nevada	Mandatory	**OT:** 10 hours of continuing education at annual renewal on June 30th **OTA:** 10 hours of continuing education at annual renewal on June 30th
New Hampshire	Mandatory	**OT:** ▪ 12 hours of continuing professional education annually ▪ 24 hours of continuing professional education biennially **OTA:** ▪ 12 hours of continuing professional education annually ▪ 24 hours of continuing professional education biennially
New Jersey	No requirements	**OT:** No requirements **OTA:** No requirements
New Mexico	Mandatory	**OT:** 2 CEUs (20 contact hours) will be required (annually) for each year of expired licensure **OTA:** 2 CEUs (20 contact hours) will be required (annually) for each year of expired licensure
New York	No requirements	**OT:** No requirements **OTA:** No requirements
North Carolina	Mandatory	**OT:** 15 contact hours each (annual) renewal year **OTA:** 10 contact hours each (annual) renewal year
North Dakota	No requirements	**OT:** No requirements **OTA:** No requirements
Ohio	Mandatory	**OT:** 20 contact hours of continuing education activities within a 2-year period **OTA:** 20 contact hours of continuing education activities within a 2-year period
Oklahoma	Mandatory	**OT:** 20 contact hours every 2 years **OTA:** 20 contact hours every 2 years
Oregon	Mandatory	**OT:** 15 points of CE during the year immediately preceding the date of the annual license renewal **OTA:** 15 points of CE during the year immediately preceding the date of the annual license renewal
Pennsylvania	No requirements	**OT:** No requirements **OTA:** No requirements
Rhode Island	Mandatory	**OT:** 20 hours biennially **OTA:** 20 hours biennially
South Carolina	No requirements	**OT:** No requirements **OTA:** No requirements
South Dakota	Mandatory	**OT:** 12 continuing competency points in one year period **OTA:** 12 continuing competency points in one year period
Tennessee	No requirements	**OT:** No requirements **OTA:** No requirements
Texas	Mandatory	**OT:** 30 contact hours of continuing education each biennial renewal **OTA:** 30 contact hours of continuing education each biennial renewal
Utah	No requirements	**OT:** No requirements **OTA:** No requirements
Vermont	Mandatory	**OT:** 20 hours of continuing education during the preceding two-year licensure period **OTA:** 20 hours of continuing education during the preceding two-year licensure period
Virginia	No requirements	**OT:** No requirements **OTA:** No requirements
Washington	Mandatory	**OT:** 30 hours of continuing education every two years **OTA:** 30 hours of continuing education every two years
West Virginia	Mandatory	**OT:** 12 contact hours of continuing competency activities obtained within 1 year **OTA:** 12 contact hours of continuing competency activities obtained within 1 year
Wisconsin	Mandatory	**OT:** 18 points of acceptable continuing education in a 2 year period **OTA:** 12 points of acceptable continuing education in a 2 year period
Wyoming	Mandatory	**OT:** 16 contact hours of continuing education per year **OTA:** 16 contact hours of continuing education per year

APPENDIX 4

PROJECTED ANNUAL EXPENSE OF REGULATING CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS (COTAs) WITHIN THE BOARD OF MEDICINE

Prepared: July 17, 2000

Allocated Charges	Projected Annual Expense
DP - Operations & Equipment	$0
Administration & Finance	1,000
Director's Office	600
Human Resources	0
Enforcement Division	3,500
Administrative Proceedings	1,400
Practitioner Intervention	500
Attorney General's Office	500
Board on Health Professions	300
Total Allocated	$7,800

Direct Charges: COTAs

Personal Services	$0
Contractual Services	3,500
Supplies and Materials	200
Transfer Payments	0
Continuous Charges	0
Equipment	0
Total Direct	$3,700
TOTAL PROJECTED BUDGET	**$11,500**

Assumptions:

Direct Cost: No additional staff; no additional computer equipment; addition of COTA member on Board.

Allocated Cost: Administration & Finance, Director's Office, and BHP additional expense for increase licensees; Enforcement, APD, AG and Practitioner's Intervention additional expense based on 1-2 cases per year.

Budget amounts based on 1999-2000

F:Bgt:Proposed Regulating COTAs.xls

APPENDIX 5

COMMONWEALTH of VIRGINIA

Department of Health Professions

John W. Hasty
Director

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
(804) 662-9900
FAX (804) 662-9943
TDD (804) 662-7197

April 12, 2000

The Virginia Board of Health Professions is undertaking a study pursuant to Virginia Senate Joint Resolution 153 that was passed during the 2000 General Assembly session. This piece of legislation directs the Board to study the need for an appropriate level of regulation for occupational therapist assistants.

As a component of the study, we are interested in information that can help us determine the potential risk of harm posed by the practice of occupational therapy by assistive personnel. To this end, we are asking you to complete the following survey regarding complaints and disciplinary actions that have been taken against occupational therapy licensees in your state.

For convenience, we have enclosed a self-addressed stamped envelope in which to return the survey. We look forward to receiving your completed survey by May 31, 2000. If you have any questions, please do not hesitate to contact me at 804-662-7691 or via e-mail at ecarter@dhp.state.va.us.

Thank you in advance for your time and participation.

Sincerely,

Elizabeth Carter, PhD
Deputy Executive Director
Board of Health Professions

NOTE: The American Occupational Therapy Association list of state contacts was used to generate the labels for this mailing. If you have received this survey in error, please forward it to the appropriate person in your department or agency.

♦ CONTACT INFORMATION:

Please provide the following contact information in case we need to follow-up on your survey:

NAME: _____
PHONE NUMBER: _____
STATE: _____

♦ NUMBER OF ACTIVE LICENSEES:

Number of Occupational Therapists: _____

Number of Occupational Therapy Assistants: _____

♦ COMPLAINTS:

FOR THE TWO YEAR PERIOD FROM 1998-2000, PLEASE INDICATE THE FOLLOWING:

NOTE: If you do not have information available for the 1998-2000 time period, please provide us with information for the time period that you do have available. Indicate the time period here: _____

1. Number of complaints received against occupational therapists:_____

   Of the total complaints received, please indicate the number that were related to each of the following categories:

   ____ Unlicensed activity
   ____ Standard of care
   ____ Scope of practice
   ____ Continuing education
   ____ Other – Explain:_____

2. Number of complaints received against occupational therapy assistants: _____

   Of the total complaints received, please indicate the number that were related to each of the following categories:

   ____ Unlicensed activity
   ____ Standard of care
   ____ Scope of practice
   ____ Continuing education
   ____ Other – Explain:_____

CONTINUE TO NEXT PAGE ⟶

- **DISCIPLINARY ACTIONS:**

1. Number of disciplinary actions against occupational therapists: _____

   Of the total disciplinary actions, please indicate the number that were related to each of the following categories:

   ____ Reprimand
   ____ Probation
   ____ Suspension of license
   ____ Revocation of license
   ____ Other – Explain: _____

2. Number of disciplinary actions against occupational therapy assistants: _____

   Of the total disciplinary actions, please indicate the number that were related to each of the following categories:

   ____ Reprimand
   ____ Probation
   ____ Suspension of license
   ____ Revocation of license
   ____ Other – Explain: _____

- **Would you like a copy of study once it is completed?**

  ☐ Yes:

  Mailing Address:_____
  _____
  _____

  ☐ No

PLEASE RETURN SURVEY IN THE ENCLOSED ENVELOPE BY MAY 31, 2000.
THANK YOU FOR YOUR PARTICIPATION

RESULTS OF STATE SURVEY REGARDING COMPLAINTS AND DISCIPLINARY ACTIONS

Occupational Therapists and Occupational Therapy Assistants

STATE	NUMBER OF LICENSEES	REPORTING INTERVAL	COMPLAINTS OT	COMPLAINTS OTA	DISCIPLINARY ACTIONS OT	DISCIPLINARY ACTIONS OTA
1. Oregon	OT: 936 OTA: 249	Three years	1 - Unlicensed Activity 2 - Scope of Practice **TOTAL:** 3	None	None	None
2. North Dakota	OT: 311 OTA: 139	One year	1 Unlicensed Activity 2 Scope of Practice **TOTAL:** 3	1 Unlicensed Activity **TOTAL:** 1	1 Reprimand	1 Reprimand
3. South Carolina	OT: 917 OTA: 339	Two years	None	None	None	None
4. Kentucky	OT: 1181 OTA: 293	Two years	1 Unlicensed Activity 8 Other (i.e., Code of Ethics) **TOTAL:** 9	2 Other (Code of Ethics) **TOTAL:** 2	1 Reprimand	None
5. Vermont	OT: 240 OTA: 76	Two years	None	None	None	None
6. Mississippi	OT: 678 OTA: 188	Two years	3 Scope of Practice 1 Supervision 1 Sexual Misconduct **TOTAL:** 5	1 Unlicensed Activity **TOTAL:** 1	1 Probation 1 Fine	1 Fine

STATE	NUMBER OF LICENSEES	REPORTING INTERVAL	COMPLAINTS OT	COMPLAINTS OTA	DISCIPLINARY ACTIONS OT	DISCIPLINARY ACTIONS OTA
7. South Dakota	OT: 281 OTA: 58	Two years	None	None	None	None
8. Connecticut	OT: 1,356 OTA: 485	Two years	1 Unlicensed activity **TOTAL:** 1	None	1 Fine	None
9. Arizona	OT: 933 OTA: 424	Ten years	3 Standard of Care 1 Documentation **TOTAL:** 4	1 Unlicensed activity 1 Unsupervised practice **TOTAL:** 2	1 Probation	1 Reprimand
10. Montana	OT: 244 OTA: 81	Two years	1 Inappropriate supervision of a COTA **TOTAL:** 1	None	1 Quarterly reports and peer review	None
11. Wyoming	OT: 173 OTA: 40	Two years	None	None	None	None
12. Utah	OT: 341 OTA: 122	Four years	None	None	None	None
13. Rhode Island	OT: 531 OTA: 176	Two years	None	None	None	None
14. West Virginia	OT: 325 OTA: 159	Two years	1 Unlicensed activity 5 Supervision, Ethical Issues **TOTAL:** 6	None	2 Probation 1 Revocation of License	None
15. Kansas	OT: 1128 OTA: 323	Two years	None	None	None	None
16. Hawaii	OT: 240 OTA: Not regulated	1/99 to 4/00	None	N/A	None	N/A

17. Washington	OT: 2004 OTA: 539	Two years	4 Unlicensed activity 2 Standard of Care 1 Scope of Practice 2 Continuing Education 1 Drug Diversion 2 Fraud **TOTAL:** 12	2 Unlicensed activity 1 Continuing education 1 Convicted pedophile **TOTAL:** 4	1 Reprimand 1 Probation 1 Suspension of license 1 Revocation	1 Revocation of license
18. Virginia	OT:	Since 1993	1 Unlicensed activity 1 Standard of Care 1 Unprofessional Conduct 1 Business Practice / Issues 2 Fraud TOTAL: 6	N/A	None	N/A
19. Alabama	OT: 800 OTA: 376	Two years	2 Unlicensed Activity * 7 Scope of Practice * * combined OT/OTA TOTAL: 9	See preceding cell	None	1 Probation
20. Georgia	OT: 1676 OTA: 314	Two years	6 Unlicensed Activity 1 Standard of Care 1 Unprofessional conduct TOTAL: 9	1 Continuing Education 1 Felony Conviction 1 Unprofessional Conduct 1 Signature Forgery TOTAL: 4	3 Revocation of license * 4 closed, 2 open TOTAL: 3	1 Revocation of license * 3 open cases TOTAL: 1
21. Maine	OT: 636 OTA: 137	Two years	1 Did not disclose criminal conviction on application TOTAL: 1	1 Did not disclose criminal conviction on application TOTAL: 1	1 Reprimand and fine	1 Reprimand and fine

22. New York	OT: 7,253 OTA: 3,126	Two years	4 Fraud 6 Negligence 1 Illegal Practice 3 Record Keeping 3 Physical / Sexual Misconduct 3 MC Question 2 General Dissatisfaction 2 Improper Supervision TOTAL: 24	1 Illegal Practice 1 Violation of Regents Penalty 3 Conviction of a crime 1 Negligence 1 Physical / Sexual Abuse 3 MC Question 2 Improper supervision TOTAL: 12	1 Stayed suspension with fine and probation	1 Suspension with fine and probation
23. Michigan	OT: 3,625 OTA: 825	One year	4 allegations * 1 complaint * Nature not specified Total: 5	None	None	None
24. Delaware	OT: 256 OTA: 116	Two years	1 Fraud – falsified records Total: 1	None	None	None
25. Wisconsin	OT: 2758 OTA: 1212	Two years, five months	9 *Nature not specified **Total: 9**	5 *Nature not specified	None	None
26. New Hampshire	OT: 774 OTA: 223	Two years	Not available	Not available	None	None
27. Iowa	OT: 715 OTA: 316	Two years	1 Unlicensed activity 2 Standard of care 1 Scope of practice **TOTAL: 4**	1 Unlicensed activity 2 Standard of care 2 Scope of practice **TOTAL: 5**	3 reprimands	1 Reprimand
28. Nevada	OT: 523 OTA: 90	Two years	2 Scope of practice 2 Fraud in Documentation **TOTAL: 4**	None	1 (action not reported)	None

APPENDIX 6

COMMONWEALTH of VIRGINIA

Department of Health Professions

John W. Hasty
Director

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
(804) 662-9900
FAX (804) 662-9943
TDD (804) 662-7197

May 26, 2000

The Board of Health Professions is conducting a study to determine the appropriate level of regulation of Certified Occupational Therapy Assistants in Virginia. This study is pursuant to Senate Joint Resolution 153 that was passed during the 2000 General Assembly session.

You will find an enclosed survey that contains questions pertaining to your experiences as a practicing occupational therapist in Virginia. The answers will serve to inform the Board of Health Profession's Regulatory Research Committee about the present status of occupational therapy practice in the state. The survey responses will be anonymous. In addition, all respondent information will be shared in aggregate form only.

Please complete the survey by July 7, 2000 and return it in the enclosed, self-addressed stamped envelope. If you have any questions, please do not hesitate to call Kirsten Barrett, Policy Research Analyst, at 804-662-7218.

Thank you in advance for your time and participation.

Sincerely,

Kirsten Barrett

Kirsten Barrett
Policy Research Analyst
Kbarrett@dhp.state.va.us
804-662-7218

VIRGINIA BOARD OF HEALTH PROFESSIONS
SURVEY OF LICENSED OCCUPATIONAL THERAPISTS (OTs)

SECTION I:

1. Age:_____

2. Gender: ☐ Male ☐ Female

3. How many years have you been practicing as an OT? _____(# of years)

4. What best describes your present work status as an OT? Check one:

   ☐ Working full-time as an occupational therapist (more than 20 hours a week)
   ☐ Working part-time as an occupational therapist (consistent work up to 20 hours a week)
   ☐ Working PRN as an occupational therapist (sporadic work, hours vary based on need)
   ☐ Not working at all as an occupational therapist (**please return survey in enclosed envelope**)

5. Do you presently practice as an OT in Virginia? Check one:

   ☐ Yes
   ☐ No – In which state do you practice? _____

6. What best describes your location of practice? Check one:

   ☐ Rural ☐ Suburban ☐ Urban

7. Indicate your primary area of practice as an OT: Check one:

   ☐ Acute care hospital
   ☐ Out-patient clinic
   ☐ School system
   ☐ Industrial rehabilitation setting
   ☐ Skilled nursing facility
   ☐ Other: _____(describe)
   ☐ Adult rehabilitation facility
   ☐ Pediatric rehabilitation facility
   ☐ Vocational training center
   ☐ Academia - junior college / university faculty
   ☐ Home health agency

8. What best describes your primary work role? Check one:

   ☐ Staff occupational therapist
   ☐ Senior occupational therapist and/or clinical specialist
   ☐ Manager / administrator / clinical coordinator
   ☐ Academic faculty
   ☐ Other:_____(describe)

SECTION II:

1. How many OTs, including yourself, work in your immediate practice setting? _____ (indicate number)

2. How many Certified Occupational Therapy Assistants (COTAs) work in your immediate practice setting? _____(indicate number)

OVER →

3. Are you aware of people who call themselves Certified Occupational Therapy Assistants (COTAs) but ***DO NOT*** have the requisite associates degree and current certification through the National Board of Certification in Occupational Therapy, Inc. (NBCOT)?

   ☐ Yes – How many people?_____
   ☐ No

4. Are you aware of people who ***ONLY*** have on-the-job training and call themselves Occupational Therapy Assistants?

   ☐ Yes – How many people? _____
   ☐ No

5. In your work setting, ***on average***, how many COTAs and other assistive personnel provide OT services under your supervision during a typical workday? _____ (indicate number)

6. In general, are you on-site (i.e., in the same building) while providing supervision? Check one:

   ☐ Yes
   ☐ No

7. How often do you discuss patient status, goals and plan of care with the ***COTA(s) and other assistive personnel*** you supervise? Check one:

   ☐ Daily
   ☐ A couple times a week
   ☐ A couple times a month
   ☐ Never

8. What is the primary mechanism that you use to discuss patient status, goals and plan of care with the ***COTA(s) and other assistive personnel***: Check one:

   ☐ Face-to-face meeting
   ☐ Discussion over the phone
   ☐ Through written correspondence (e.g, written treatment plan, progress notes in chart)
   ☐ Other: _____(describe)

OVER ⟶

- **For each activity, indicate if a COTA and/or OT aide can perform it independently or under your supervision. If the activity is never delegated, indicate so by checking the box provided.**

  → **COTA:** Practitioner who has a minimum of an associates degree from an accredited occupational therapy assistant program and is currently certified through the NBCOT.
  → **OT Aide:** Practitioner who has developed skills solely through on-the-job training.
  → **Supervision:** Licensed OT is sufficiently aware of patient's needs and status and is in ongoing written and/or verbal communication with assistive personnel providing OT services.
  → **Independent:** No oversight by the licensed OT

ACTIVITY	COTA	OT AIDE
Interview patient and significant others in order to obtain background and social history	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Screen for appropriateness of OT services	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Administer standardized assessment instruments	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Recommend referral to appropriate professionals and agencies	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Select appropriate interventions to restore function	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Document intervention / treatment plan	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Provide therapeutic interventions	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Evaluate patient progress	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Modify intervention plan	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Instruct caregivers in assisting patient in discharge environment	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Develop home programs	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Terminate services when goals are achieved	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide
Serve as a resource person or consultant	☐ Independently ☐ Under supervision of OTL ☐ Never delegate to COTA	☐ Under supervision of OTL ☐ Independently ☐ Never delegate to OT aide

OVER →

- **Please list occupational therapy activities that you would *never* delegate to assistive personnel (COTAs, occupational therapy assistants, occupational therapy aides):**

- **Do you have any thoughts on the need to regulate Certified Occupational Therapy Assistants (COTAs) in Virginia (beyond the requisite associates degree and current NBCOT, Inc. certification)? If so, please use the space below to describe your thoughts:**

PLEASE RETURN YOUR COMPLETED SURVEY IN THE ENCLOSED ENVELOPE BY JULY 7, 2000.