AK OT Scope Modernization Work Group - April 8, 2025

Alaska Division of Corporations, Business and Professional Licensing
Zoom
2025-04-08 12:00 - 14:00 AKDT

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AK OT Scope Modernization Work Group - April 8, 2025

Alaska Division of Corporations, Business and Professional Licensing
Tuesday, April 8, 2025 at 12:00 PM AKDT to Tuesday, April 8, 2025 at 2:00 PM AKDT
Zoom

Meeting Details: https://us02web.zoom.us/j/83028654693
Meeting ID: 830 2865 4693
Call-in: +1 253 215 8782 US

Agenda

1. Call to Order — 12:00 PM

Please update your Zoom to Name, City

A. Roll Call — 12:05 PM

Brief Introductions

- Victoria "Tori" Daugherty, OTR - Board Member
- Sheri Ryan, Licensing Examiner 3
- Reid Bowman, Program Coordinator 2
- Shane Bannarbie, Program Coordinator 1

Update on workgroup members

- Kristen Neville, AOTA
- Jean Keckhut
- Sarah Huot

B. Review future meeting dates — 12:10 PM

- April 22 - 12pm - 2pm
- May 13 - 12pm - 2pm - scheduling conflicts for several members - reschedule?

2. Public Comment — 12:15 PM

3. Purpose and Summary of Workgroup - review — 12:30 PM

Presenter: Victoria Daugherty

A. OT Workgroup Objectives

1. Develop a collaborative plan to address modernization of our scope of practice between all stakeholders (including the state licensing board, AKOTA, national organizations, and licensees) to create statutory change.
2. Identify needs for change/improvement in the current draft of scope of practice language.
3. Modify the current language to address any needs that the workgroup identifies.
4. Address the role of OTAs in scope of practice language

5. Develop and updated draft of scope of practice language for future action steps for recommendation to the PHY Board.

4. Physical Agent Modalities **12:35 PM**

Discussion of wording for Physical Agent Modalities (PAMs) in the new draft scope of practice language.

5. Feeding, eating, and swallowing **12:50 PM**

- Discuss concerns that this topic has been omitted from the new draft scope of practice language
- Create initial draft language

6. Pelvic Floor and Women's Health **1:05 PM**

- Comment made at last meeting that this topic was not explicitly referenced; but comment also made that this topic was likely included in other language. Do we need to explore this topic further?

7. Diagnostic Imaging **1:15 PM**

- How do we support/justify OT's role and skillset to order diagnostic imaging?
- Does an OT/OTA have the skill to perform a diagnostic ultrasound during a treatment session? If so, is this an entry level skill or advanced education?

8. Definition of OTA **1:30 PM**

- Review current language for OTA
- Discuss language re: competency as related to performing advanced skills
- Create a list of additional needs to include in this language and attempt an initial draft

9. Brainstorm **1:45 PM**

Explore additional topics/concerns

10. Action Steps **1:55 PM**

1. PAMS
2. Feeding, eating and swallowing
3. Pelvic floor and Women's Health
4. Diagnostic Imaging
5. Definition of OTA
6. New Topics

11. Adjourn **2:00 PM**

sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

SECTION 11. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR PHYSICAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

(a) The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

(b) Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any member state may withdraw from this Compact by enacting a statute repealing the same.

(1) A member state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing state's physical therapy licensing board to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 12. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any party state, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

ARTICLE 5.
GENERAL PROVISIONS

Section

190. Definitions
200. Short title

Sec. 08.84.190. Definitions. In this chapter, unless the context otherwise requires,

(1) "board" means the State Physical Therapy and Occupational Therapy Board;

(2) "occupational therapist" means a person who practices occupational therapy;

(3) "occupational therapy" means, for compensation, the use of purposeful activity, evaluation, treatment, and consultation with human beings whose ability to cope with the tasks of daily living are threatened with, or impaired by developmental deficits, learning disabilities, aging, poverty, cultural differences, physical injury or illness, or psychological and social disabilities to maximize independence, prevent disability, and maintain health; "occupational therapy" includes

(A) developing daily living, play, leisure, social, and developmental skills;

(B) facilitating perceptual-motor and sensory integrative functioning;

(C) enhancing functional performance, prevocational skills, and work capabilities using specifically designed exercises, therapeutic activities and measure, manual intervention, and appliances;

(D) design, fabrication, and application of splints or selective adaptive equipment;

(E) administering and interpreting standardized and nonstandardized assessments, including sensory, manual muscle, and range of motion assessments, necessary for planning effective treatment; and

(F) adapting environments for the disabled;

(4) "occupational therapy assistant" means a person who assists in the practice of occupational therapy under the supervision of an occupational therapist;

(5) “physical therapist” means a person who practices physical therapy;

(6) “physical therapist assistant” means a person who assists in the practice of physical therapy or an aspect of physical therapy as initiated, supervised, and terminated by a licensed physical therapist; the responsibilities of a physical therapist assistant do not include evaluation;

(7) “physical therapy” means the examination, treatment and instruction of human beings to detect, assess, prevent, correct, alleviate and limit physical disability, bodily malfunction, pain from injury, disease and other bodily or mental conditions and includes the administration, interpretation and evaluation of tests and measurements of bodily functions and structures; the planning, administration, evaluation and modification of treatment and instruction including the use of physical measures, activities and devices for preventive and therapeutic purposes; the provision of consultative, educational and other advisory services for the purpose of reducing the incidence and severity of physical disability, bodily malfunction and pain; “physical therapy” does not include the use of roentgen rays and radioactive materials for diagnosis and therapeutic purposes, the use of electricity for surgical purposes, and the diagnosis of disease.

Sec. 08.84.200. Short Title. This chapter may be cited as the Physical Therapists and Occupational Therapists Practice Act.

LEGISLATIVE PROJECT - Scope of Practice – Occupational Therapy

Occupational Therapy Scope of Practice Update Recommendation – Final Draft

PHY SOP WG – OT Scope of Practice Recommendation 05-22-2023

(3) "occupational therapy" means the therapeutic use of goal-directed life activities (occupations) with individuals, groups, or populations who have, or are at risk for injury, disorder, impairment, disability, activity limitation or participation restriction. Occupational therapists evaluate, analyze, and diagnose occupational challenges and provide interventions to support, improve, and/or restore function and engagement in meaningful tasks and activities. This includes treating pain and/or physical, cognitive, psychological, sensory-perceptive, visual, and other aspects of performance in a variety of contexts to support and enhance engagement and participation in occupations that affect health, well-being, and quality of life. Occupational therapy services include but are not limited to:

A. Evaluation, treatment and consultation to promote or enhance safety and performance in areas of activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation.
B. Establishment, remediation, compensation or prevention of barriers to performance skills including; client factors (body structures, body functions), performance patterns (habits, routines, roles), performance skills (physical, neuromusculoskeletal, cognitive, psychological, sensory-perceptive, communication and interaction, pain), and contexts (environmental, personal factors)
C. Design, fabrication, application, fitting, and training in seating and positioning; assistive technology; adaptive devices; orthotic devices; and training in the use of prosthetic devices
D. Assessment, recommendation, and training in techniques to enhance functional and community mobility
E. Application of adjunctive interventions and therapeutic procedures in preparation for or concurrently with occupation-based activities including but not limited to therapeutic and instrument assisted modalities, wound care, and manual therapy
F. Provide therapeutic interventions to prevent pain and dysfunction, restore function and/or reverse the progression of pathology in order to enhance an individual's ability to execute tasks and to participate fully in life activities

Final language approved and adopted 06-16-2023 by unanimous vote of Physical Therapy and Occupational Board

LEGISLATIVE PROJECT - Scope of Practice – Occupational Therapy

Occupational Therapy Scope of Practice Update Recommendation – Final Draft

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Final language approved and adopted 06-16-2023 by unanimous vote of Physical Therapy and Occupational Board

AOTA Position Statement

Physical Agent, Mechanical, and Instrument-Assisted Modalities Within Occupational Therapy Practice

Introduction

The American Occupational Therapy Association (AOTA) asserts that physical agent, mechanical, and instrument-assisted modalities (PAMIMs) may be used by occupational therapy practitioners (i.e., occupational therapists and occupational therapy assistants) as part of a comprehensive plan of intervention designed to enhance engagement in occupation (AOTA, 2020c). Occupational therapy practitioners (OTPs) possess the foundational knowledge of basic sciences, understanding of relevant theory and evidence, and clinical reasoning to recommend and safely apply PAMIMs to support achievement of occupation-based client goals.

This Position Statement clarifies the context for the appropriate use of PAMIMs in occupation-based occupational therapy practice. As guided by the *Occupational Therapy Practice Framework: Domain and Process, 4th Edition* (*OTPF-4*) (AOTA, 2020c), exclusive or stand-alone use of PAMIMs without linking it to a client-centered, occupation-based intervention plan and outcomes is not occupational therapy. Consistent with the 2018-2019 Choosing Wisely initiative, AOTA recommends that practitioners "don't use [PAMIMs] without providing purposeful and occupation-based intervention activities" (Gillen et al., 2019). To ensure client-centered care, practitioners who choose to incorporate PAMIMs into their practice should evaluate the available evidence on the efficacy and effectiveness of each modality and its place in the treatment of a client's condition.

Definitions

The term *therapeutic modalities* refers to the systematic application of various forms of energy or force to effect therapeutic change in the physiology of tissues. *Physical agents* such as heat, cold, water, light, sound, and electricity may be applied to the body to affect client factors, including the neurophysiologic, musculoskeletal, integumentary, circulatory, or metabolic functions of the body. Physical agents may be used to reduce or modulate pain, reduce inflammation, increase tissue extensibility and range of motion, promote circulation, decrease edema, facilitate healing, stimulate muscle activity, and facilitate occupational performance (Bracciano, 2022).

Physical agent modalities may be categorized on the basis of their properties:

1. *Thermal modalities* are those physical agents that provide a change in tissue temperature by either heating or cooling the tissue. Thermal modalities can also be categorized into superficial thermal agents and deep thermal agents on the basis of the depth of energy penetration into the underlying tissue or body structure they are targeting. Thermal agents (heat or cold) facilitate the transfer of energy between two systems through conduction, convection, or conversion.
    a. *Superficial thermal agents*
        i. *Conduction:* Heat or cold is transferred from an object to the body with direct contact with the modality. Examples include, but are not limited to, hot packs, cold packs, and paraffin (Vargas e Silva et al., 2019).

        ii. *Convection:* Heat or cold is transferred between two objects where one is moving or flowing around the body part. Examples include, but are not limited to, whirlpool or hydrotherapy, which can be done with hot or cold water, and Fluidotherapy™ or dry whirlpool, which uses dry heat to circulate dry cellulose medium around the distal extremity (Kumar et al., 2015).
    b. *Deep thermal agents*
        i. *Conversion:* Energy from low-frequency sound waves is converted into heat. A common example is therapeutic ultrasound, where the mechanical waves in sound energy are converted to heat using an ultrasound machine. Therapeutic ultrasound can be used to penetrate deeper tissue structures. Deep thermal agents include, but are not limited to, therapeutic ultrasound and phonophoresis (Morishita et al., 2014).
2. *Electromagnetic modalities* use electromagnetic waves such as radio waves, microwaves, and light waves to transport electrical and magnetic energy through space to effect changes in body structures (Post & Nolan, 2016).
    a. *Diathermy:* Diathermy uses short-wave frequencies to affect healing tissue or higher frequencies that cause tissue heating.
    b. *Low-level laser (light) therapy (LLLT):* Low-intensity, nonthermal (cold) lasers use light energy to cause a photochemical reaction in body tissue that can influence tissue repair, inflammation, and pain (Baktir et al., 2018).
3. *Electrotherapy* uses electrotherapeutic currents and waveforms to influence physiological effects on client body structures (Bellew, 2016). Electrotherapy has many potential clinical uses and may be and may act upon tissues in the following ways:
    a. Influence physiologic change in tissues to increase circulation, facilitate tissue healing, modify edema, and modulate pain. An example includes, but is not limited to, high-voltage galvanic stimulation for tissue and wound repair. A specific electrotherapeutic agent, iontophoresis, uses direct electrical current to move ions of medication across skin into target tissues (Bracciano, 2022).
    b. Facilitate neuromuscular or sensory activity to improve muscle strength, reeducate muscle function, or modulate pain response. Examples include, but are not limited to, neuromuscular electrical stimulation (NMES), functional electrical stimulation (FES), transcutaneous electrical nerve stimulation (TENS), and interferential current (IFC) (Bracciano, 2022).
4. *Mechanical modalities* refers to the therapeutic use of mechanical devices to apply force, such as compression, distraction, vibration, or controlled mobilization, to modify biomechanical properties and functions of tissues. Effects of these mechanical modalities include increased circulation and lymphatic flow or increased tissue and joint mobility. Examples include, but are not limited to, mechanical traction, vasopneumatic devices, and continuous passive motion machines.
5. *Instrument-assisted modalities* (IM) refers to the therapeutic use of an instrument or tool that is manually applied by a trained practitioner to target specific tissues, like skin, fascia, and other connective tissues, or muscle. In contrast to a mechanical modality, the instrument or tool is skillfully and manually guided by a trained practitioner to effect change on the soft tissue. While the true physiologic mechanisms of such interventions are less known, IMs are theorized to achieve the following physiologic effects: mechanical deformation (e.g., stretch, movement of collagen fibers), localized inflammatory response (e.g., increased blood flow by vasodilation), and activation of the immune system (Altaş, Birlik, Şahin Onat et al, 2022; Baburao & Gurudut, 2023; Bitra & Sudhan, 2019). Through these mechanisms, the skilled practitioner seeks to achieve the ultimate therapeutic outcomes of pain reduction or analgesia, tissue healing, and improved functioning at the level of client factors (e.g., musculoskeletal functions, lymphatic flow, etc.) and occupational performance. Examples include, but are not limited to, thin filiform needles used in dry needling, stainless steel instruments applied to target tissue using a scraping technique, and suction instruments used in cupping therapy (Al-Bedah et al, 2018; Bush et al, 2020; Chyrs et al., 2023; Sánchez-Infante et al., 2021).

Occupational Therapy Practitioner Qualifications and Ethical Obligations

The Accreditation Council for Occupational Therapy Education (ACOTE®; 2018) requires that entry-level educational programs must prepare occupational therapists to *demonstrate* and occupational therapy assistants to *define* "the safe and effective application of superficial thermal agents, deep thermal agents, electrotherapeutic agents, and mechanical devices as a preparatory measure to improve occupational performance. This must include indications, contraindications, and precautions" for use (p. 31). Foundational knowledge such as human anatomy, physiology, and biomechanics is part of entry-level education for the occupational therapist and occupational therapy assistant.

Occupational therapy practitioners should also refer to the *Occupational Therapy Code of Ethics* (AOTA, 2020a) for relevant principles and the *Standards of Practice for Occupational Therapy* (AOTA, 2021) to guide their practice. Many states where occupational therapy practitioners practice have additional regulatory requirements for demonstrating competence beyond entry-level education and for specific types of therapeutic modalities. Occupational therapy practitioners must be aware of and comply with these state specific requirements, which may include, but are not limited to, continuing professional education, institution-specific procedures for ascertaining service competence, and supervised contact hours by a qualified practitioner in the respective state (AOTA, 2020a).

The efficacy of PAMIMs, including the use of new technology is routinely updated, revised, and developed on the basis of the most currently available evidence. Practitioners are responsible for evaluating the evidence and for maintaining their awareness of new developments, as well as maintaining their competency in the safe and effective application of these technologies.

Insurance coverage and billing policies for therapeutic modalities set forth by federal and state payers (e.g., Medicare, Veterans Administration, state Medicaid programs), and commercial payers may vary widely. Practitioners are responsible for checking their payer policies and state practice acts to learn of any restrictions in coverage and usage. As part of their ethical responsibility, occupational therapy practitioners should also be mindful of the client's ability to access services that include PAMIMs. In situations in which a practitioner has limited access to PAMIMs equipment or tools, they should apply clinical and professional reasoning skills to use low-tech substitutes to which the client has access and that have known therapeutic effects.

Occupational Therapy Process

The *OTPF–4* provides guidance to occupational therapy practitioners when evaluating the need for PAMIMs and incorporating their use as interventions to support occupations (AOTA, 2020c). Throughout the occupational therapy process, an occupational therapist and an occupational therapy assistant may collaborate and play distinct roles.

Evaluation

During the evaluation process, occupational therapists establish an occupational profile to identify client priorities, gain an appreciation of the client's health and well-being, and understand the contextual supports and barriers to performance. Therapists further analyze client performance in chosen occupations to identify the specific focus of the intervention, including impairments in client factors, deficits in performance skills, and overall limitations in occupational performance. The presence of impairments in body functions and body structures as barriers to occupational performance may facilitate clinical reasoning in choosing appropriate PAMIMs. Therapists consider the evidence, pragmatics, and benefits of PAMIMs as an integral component of the occupation-based intervention plan. Occupational therapy assistants may contribute to the evaluative process, especially in establishing the occupational profile of the client, as well as once competency is achieved in the administration of standardized and

nonstandardized assessments (ACOTE, 2018; AOTA, 2021).

Intervention

Occupational therapists may collaborate on the implementation of the intervention plan that involves the use of PAMIMs with occupational therapy assistants who demonstrate service competence (AOTA, 2020b). The occupational therapist has overall responsibility for providing supervision of the occupational therapy assistant and their safe use of PAMIMs with clients. The occupational therapy assistant is also responsible for understanding how the use of PAMIMs supports the client's occupational therapy goals (AOTA, 2020b). Both occupational therapists and occupational therapy assistants should monitor and appropriately document the outcome of interventions. Using PAMIMs as part of a comprehensive intervention plan can facilitate active engagement and participation in occupational tasks and improve occupational performance (see Table 1 for case examples).

As part of the intervention plan, the therapeutic use of PAMIMs may be categorized as follows:

1. *Interventions to support occupations*—Occupational therapy practitioners administer PAMIMs to address barriers to body functions and structures prior to engagement in occupation. For example, a practitioner may apply thermal modalities on a client's hands and wrists to increase tissue extensibility and alleviate pain prior to engaging in cooking activities.
2. *Concurrent to therapeutic occupation or purposeful activities*—Occupational therapy practitioners may administer PAMIMs to reduce the impact of impairment on body functions and structures while the client is engaged in occupation to improve performance. For example, a practitioner may apply FES on the client's affected wrist extensors and flexors during a morning grooming routine to facilitate grasp and release.
3. *As a necessary component of a person's occupational routine*—Occupational therapy practitioners may recommend and train a client to self-administer PAMIMs as part of their health management and maintenance. For example, a practitioner may teach a client how to perform manual lymph drainage massage, use an intermittent pneumatic compression device, and properly apply compression garments to abate the effects of lymphedema on occupational performance.

Outcomes

Outcomes are related to intervention implementation and are established during the evaluation process (AOTA, 2020c). An occupational therapy practitioner may choose to utilize PAMIMs as an intervention if it is thought to support occupational engagement. In collaboration with the client, occupational therapy practitioners determine the target outcomes and monitor the client's progress over time and the progress made as the result of PAMIMs and associated interventions. Under the supervision of the occupational therapist, an occupational therapy assistant may administer an outcome measure, which is then analyzed to determine the need for continuation or discontinuation of services or modification of the intervention plan.

Conclusion

The use of physical agent, mechanical, and instrument-assisted modalities may be an integral part of an occupational therapy intervention that supports or enhances a client's occupational performance, health and wellness, participation, and quality of life (AOTA, 2020c). While an entry-level preparation for occupational therapist and occupational therapy assistant indicates knowledge and practice preparation in the use of select therapeutic modalities (ACOTE, 2018), occupational therapy practitioners should strive to maintain their service competency in these modalities within the parameters of practice established by their state regulatory boards, payors, and institutional policies.

Table 1

Case Study 1: Certified Nursing Assistant with Adhesive Capsulitis

A 52-year-old certified nursing assistant (she/her/hers) has adhesive capsulitis, or frozen shoulder, after a fall 3 months ago. She works full-time and cares for her elderly mother at home.

Research Evidence and Related Resources Guiding Practice

- Post, R., & Nolan, T. P. (2016). Electromagnetic waves: Laser, diathermy, and pulsed electromagnetic fields. In J. W. Bellew, S. L. Michlovitz, & T. P. Nolan (Eds.), *Modalities for therapeutic intervention* (6th ed., pp. 167–210). Philadelphia: F. A. Davis.
- Sung, J.-H., Lee, J.-M., & Kim, J.-H. (2022). The effectiveness of ultrasound deep heat therapy for adhesive capsulitis: A systematic review and meta-analysis. *International Journal of Environmental Research and Public Health*, *19*(3), 1859. https://doi.org/10.3390/ijerph19031859

Evaluation and Goal Setting	Occupational Therapy Intervention	Outcomes
Evaluation summary: At evaluation in an outpatient occupational therapy clinic, the client presented significant shoulder pain and loss of shoulder ROM, which limits her ability to reach above her head (reaching into the linen closet at work or into cabinets at home) and behind her back (to don/doff her bra or toilet hygiene). She is able to lift and carry light objects over a limited range. Prolonged holding positions (e.g., holding a steering wheel, shaving under the involved arm, assisting with client bed mobility at work) are difficult to maintain and cause discomfort. The client's mother requires physical assistance for bathroom transfers, meal preparation and cleanup, dressing, and hair care. The client states that using the curling iron with her involved arm on her mother causes an increase in pain and discomfort.	*PAMIMs used as an intervention to support occupation:* Although the client's desire to continue to work full-time and keep her mother in the home are a strength, impairments in client factors (e.g., pain and limited ROM) impact her ability to achieve goals. The client wants to be independent to get dressed and prepare meals without pain. The OT assesses pain and limited ROM as barriers to occupational performance and establishes an intervention plan that incorporates therapeutic occupations and activities with the use of thermal modalities like moist heat, ultrasound, or diathermy to increase ROM while decreasing pain. The OTA can use these PAMIMs as interventions to support occupation prior to occupation-based and relevant functional activities that support the client's goals.	Through collaboration with the OT practitioners, the client learned adaptive strategies to improve her ability to get dressed and prepare meals. The client also learned self-management strategies and a home exercise program that includes the use of superficial heat to reduce her pain and maintain her ROM. The OT also discussed the client's progress with the referring physician for concurrent medical management for adhesive capsulitis. Given the protracted nature of the condition, the client initially began with modified duty at work and eventually was able to resume full duty as her symptoms improved.

Occupational Goals: The client desires to continue to work and care for herself and her mother in the home.		

Note. OT = occupational therapist; OTA = occupational therapy assistant; PAMIMs = physical agent, mechanical, and instrument-assisted modalities; ROM = range of motion.

Case Study 2: HVAC Technician With Bilateral Lateral Epicondylitis

A 47-year-old self-employed HVAC technician (she/her/hers) presented with bilateral arm pain that has progressively worsened since its onset 6 months ago. The client was diagnosed with bilateral lateral epicondylitis, was initially prescribed with forearm counterforce braces, and received cortisone injections on both sides.

Research Evidence and Related Resources Guiding Practice

- Chys, M., De Meulemeester, K., De Greef, I., Murillo, C., Kindt, W., Kouzouz, Y., Lescroart, B., & Cagnie, B. (2023). Clinical effectiveness of dry needling in patients with musculoskeletal pain—An umbrella review. *Journal of Clinical Medicine*, *12*(3), 1205. https://doi.org/10.3390/jcm12031205
- Sánchez-Infante, J., Navarro-Santana, M. J., Bravo-Sánchez, A., Jiménez-Diaz, F., & Abián-Vicén, J. (2021). Is dry needling applied by physical therapists effective for pain in musculoskeletal conditions? A Systematic review and meta-analysis. *Physical Therapy*, *101*(3), pzab070. https://doi.org/10.1093/ptj/pzab070
- Uygur, E., Aktaş, B., & Yilmazoglu, E. G. (2021). The use of dry needling vs. corticosteroid injection to treat lateral epicondylitis: A prospective, randomized, controlled study. *Journal of Shoulder and Elbow Surgery*, *30*(1), 134–139. https://doi.org/10.1016/j.jse.2020.08.044

Evaluation and Goal Setting	Occupational Therapy Intervention	Outcomes
Evaluation Summary: After experiencing initial relief with the cortisone injections and counterforce bracing, the client noted worsening of pain and sought outpatient occupational therapy services. At initial evaluation, there was notable weakness and pain with grip and persistent lateral elbow pain that was further magnified and	*PAMIMs used as an intervention to support occupation:* Based on the relative acuity of the client's condition, the occupational therapist (OT) approached the intervention process more conservatively, which included a focus on activity modification (e.g., reduce gripping, modify lifting technique, etc.), gentle stretching and exercises, compressive sleeves and soft hand orthoses, and superficial thermal modalities. The client noted gradual	With the introduction of dry needling to standard of care, the client experienced noticeable pain relief over the course of 3–4 weeks. Orthopedic screening tests indicate that the client still had a positive response, but the pain that is reproduced is substantially less intense. The OT initiated a progressive strengthening program for another 4 weeks that also included simulated work tasks and

reproduced using orthopedic screening tests. The client also has active signs of tissue irritation, as noted by intermittent swelling and myofascial trigger points around the area of inflammation. The client, who is self-employed, has not been able to take on new jobs and expressed concerns about her financial status. *Occupational Goals:* The client would like to have significant pain reduction, improve arm and grip strength, and resume work.	improvement in swelling, point tenderness, and movement, but while reduced, the pain continues to impede her ability to execute her occupational routine. The OT recommended the addition of dry needling with kinesiotaping to the intervention plan. The OT explained the benefits of using kinesiotape and instructed the client on how to self apply the tape. The OT explained the therapeutic mechanisms of dry needling and obtained an additional release secondary to the more invasive nature of the procedure.	an ongoing monitoring of acute exacerbation. The OT also collaborated with the client on a gradual return to work schedule.

Note. OT = occupational therapist; PAMIMs = physical agent, mechanical, and instrument-assisted modalities.

Case Study 3: Older Adult With Right-side Hemiparesis

A 61-year-old older adult (he/him/his) with right-sided hemiparesis presented to a community based occupational therapy clinic for uninsured clients with decreased arm function on his dominant side.

Research Evidence and Related Resources Guiding Practice

- Eraifej, J., Clark, W., France, B., Desando, S., & Moore, D. (2017). Effectiveness of upper limb functional electrical stimulation after stroke for the improvement of activities of daily living and motor function: A systematic review and meta-analysis. *Systematic Reviews*, *6*(1), 40. https://doi.org/10.1186/s13643-017-0435-5
- Knutson, J. S., Fu, M. J., Sheffler, L. R., & Chae, J. (2015). Neuromuscular electrical stimulation for motor restoration in hemiplegia. *Physical Medicine and Rehabilitation Clinics of North America*, *26*(4), 729–745. https://doi.org/10.1016/j.pmr.2015.06.002

Evaluation and Goal Setting	Occupational Therapy Intervention	Outcomes
Evaluation summary: The client's community based occupational therapy evaluation indicates weakness of the wrist and finger extension and grip, which makes grasping and releasing objects difficult. He is motivated to return to work and his daily activities that includes, yardwork and	*PAMIMs as an intervention to support occupation and purposeful activities:* The occupational therapist (OT) assessed that the client has potential to regain motor function with the help of task-oriented training combined with electrical stimulation to augment lack of motor activation of key muscle groups. The OT provided training and a home program to enable the client to be	After 10 weeks of participation in a home task-oriented intervention and weekly OT visits, the client demonstrated improvement in UE function, according to standardized measures. Although the client learned adaptive strategies that incorporated the use of both hands, he had hoped for greater fine motor control for more intricate tasks involved with

vegetable gardening. The client had a stroke approximately 2 months ago. He received acute care and 2 weeks of inpatient rehabilitation from his city's public hospital. He was referred to occupational therapy by his pro-bono community based primary physician. He was working full-time as a janitor when he had his stroke. *Occupational Goals:* The client would like to improve arm and hand function and return to work until he qualifies for Medicare.	able to reach and manipulate work tools and garden tools. Because of an unstable grip, the OT trialed the use of functional electrical stimulation (FES) to support the wrist extensors as the client attempts to sustain his grip with positive results. A home FES unit was given to the client by a family member and the OT set the device to the appropriate parameters. The unit was used to assist with hand opening during pre-grasp practice with various objects while at mid-reach. Subsequently, the OT recommended ongoing training with the use of a home FES unit along with a task-oriented training program.	gardening. In collaboration with the OT, the client was able to ease his way back into work with part-time status due to issues of fatigue. The OT advised that the client continue to engage in a home program with a battery of task-oriented activities to maximize hand use and maintain his functional gains. The OT assisted the client to coordinate a follow-up with the referring pro bono physician in 6 months and a subsequent OT re-evaluation to determine the need for continuing services and/or revision of the client's home program.

Note. FES = functional electrical stimulation; OT = occupational therapist; PAMIMs = physical agent, mechanical, and instrument-assisted modalities; UE = upper extremity.

Case Study 4: Computer Engineer With Elbow Fracture and Wrist Sprain

A 26-year-old computer engineer (they/them/theirs) presents with severe pain in their dominant upper extremity after a fall 4 months ago that resulted in an elbow fracture and wrist sprain. They have 9/10 pain with all grasping, lifting, and carrying and they have developed complex regional pain syndrome.

Research Evidence and Related Resources Guiding Practice

- Moretti, A., Gimigliano, F., Paoletta, M., Liguori, S., Toro, G., Aulicino, M., Iolascon, G., … (2021). Efficacy and effectiveness of physical agent modalities in complex regional pain syndrome type I: A scoping review. *Applied Sciences*, *11*(4), 1857. http://dx.doi.org/10.3390/app11041857
- Bellew, J. W. (2016). Foundations of clinical electrotherapy. In J. W. Bellew, S. L. Michlovitz, & T. P. Nolan (Eds.), *Michlovitz's modalities for therapeutic intervention* (6th ed.), pp. 253–285). Philadelphia: F. A. Davis.

Evaluation and Goal Setting	Occupational Therapy Intervention	Outcomes
Evaluation summary: The client has limited grip strength and therefore limited function. They work full-time and have a 1-year-old child at home. They are having difficulty with activities involving lifting and	*PAMIMs as a component of the client's occupational routine:* In collaboration with the client, the OT provided strategies to manage their CRPS through activity modifications and the use of TENS. Prior to recommending a TENS unit, the OT evaluated key areas	The client became independent in the use of TENS in the treatment of pain due to complex regional pain syndrome. The client required a few additional sessions to develop an occupational routine that they could incorporate stress-management

carrying, childcare, and meal preparation and reports that they have increased pain while typing on the computer for work-related tasks. *Occupational Goals:* The client would like to be able to better manage pain as they resume their usual occupations in the home and work setting.	of pain that may benefit from TENS and the client's level of tolerance to stimulation. The OT educated the client on proper application and scheduling of TENS use and then trialed and assessed their ability to use a home TENS unit to manage pain at work and at home during activity to decrease pain and support improved function. The OT used a time log to gain an understanding of the client's experience of pain linked to daily activities, and the use of the TENS unit was incorporated into their daily routine based on the information gleaned from the log. In addition to the modality, the OT educated the client on stress management techniques and self-monitoring of physiologic signs.	techniques, including mindfulness and low-impact aerobics.

Note. CRPS = complex regional pain syndrome; OT = occupational therapist; PAMIMs = physical agent, mechanical, and instrument-assisted modalities; TENS = transcutaneous electrical nerve stimulation.

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American Occupational Therapy Association

MODEL OCCUPATIONAL THERAPY PRACTICE ACT

The Model Occupational Therapy Practice Act (Model Practice Act) has been developed by the State Affairs Group of the American Occupational Therapy Association, in collaboration with the Commission on Practice for use by state occupational therapy associations or state regulatory boards interested in developing or revising legislation to regulate the practice of Occupational Therapy. The Model Practice Act also includes the definition of Occupational Therapy, which is approved by the Representative Assembly Coordinating Committee (RACC) on behalf of the Representative Assembly (RA) and is included in the Scope of Practice Official Document[1]. The current definition was approved in 2021.

The Model Practice Act must be reviewed and carefully adapted to comply with a state's legislative requirements and practices. It must also be adapted to reflect a state's administrative and regulatory laws and other legal procedures. The Model Practice Act leaves blanks or indicates alternatives in brackets when further detail needs to be considered or when adaptions are especially necessary. The term "state" is used throughout the document for ease of reading. Other jurisdictions, such as the District of Columbia and Puerto Rico, will need to modify the language accordingly.

[1] American Occupational Therapy Association. (2021). Occupational therapy scope of practice. *American Journal of Occupational Therapy, 75*(Suppl. 3), 7513410030. https://doi.org/10.5014/ajot.2021.75S3005

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Article I. General Provisions

1.01 Title [Title should conform to state requirements. The following is suggested for appropriate adaptation.]

An Act providing for the licensure of Occupational Therapists and Occupational Therapy Assistants; for a Board of Occupational Therapy practice and its powers and duties; and for related purposes.

1.02 Short Title

This Act shall be known and may be cited as the "Occupational Therapy Practice Act."

1.03 Legislative Intent and Purpose

The Legislature finds and declares that the Occupational Therapy Practice Act is enacted to safeguard public health, safety, and welfare; to protect the public from incompetent, unethical, or unauthorized persons; to assure a high level of professional conduct on the part of Occupational Therapists and Occupational Therapy Assistants; and to assure the availability of high quality Occupational Therapy services to persons in need of such services. It is the purpose of this Act to provide for the regulation of persons representing themselves as Occupational Therapists or as Occupational Therapy Assistants, or performing services that constitute Occupational Therapy.

1.04 Definitions

(1) "Act" means the Occupational Therapy Practice Act.
(2) "Aide" means a person who is not licensed by the Board and who provides supportive services to Occupational Therapists and Occupational Therapy Assistants. An Aide shall function only under the guidance, responsibility, and supervision of the licensed Occupational Therapist or an Occupational Therapy Assistant who is appropriately supervised by an Occupational Therapist. An Aide does not provide occupational therapy services. An Aide must first demonstrate competence before performing assigned, delegated, client related and non–client related tasks.
(3) "Association" means the _____ State Occupational Therapy Association.
(4) "Board" means the _____ State Board of Occupational Therapy.
(5) "Good Standing" means the individual's license is not currently suspended or revoked by any State regulatory entity.
(6) "Continuing Competence" means the process in which an occupational therapist or occupational therapy assistant develops and maintains the knowledge, critical reasoning, interpersonal skills, performance skills, and ethical practice necessary to perform their occupational therapy responsibilities.
(7) "The Practice of Occupational Therapy" means the therapeutic use of everyday life occupations with persons, groups, or populations (clients) to support occupational performance and participation. Occupational therapy practice includes clinical reasoning and professional judgment to evaluate, analyze, and diagnose occupational challenges (e.g., issues with client factors, performance patterns, and performance skills) and provide occupation-based interventions to address them. Occupational therapy services include habilitation, rehabilitation, and the promotion of physical and mental health and wellness for clients with all levels of ability-related needs. These services are provided for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Through the provision of skilled services and engagement in everyday activities, occupational therapy promotes physical and mental health and well-being by supporting occupational performance in people with, or at risk of experiencing, a range of developmental,

physical, and mental health disorders. The practice of occupational therapy includes the following components:

a) Evaluation of factors affecting activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation, including
    1. Context (environmental and personal factors) and occupational and activity demands that affect performance
    2. Performance patterns including habits, routines, roles, and rituals
    3. Performance skills, including motor skills (e.g., moving oneself or moving and interacting with objects), process skills (e.g., actions related to selecting, interacting with, and using tangible task objects), and social interaction skills (e.g., using verbal and nonverbal skills to communicate)
    4. Client factors, including body functions (e.g., neuromuscular, sensory, visual, mental, psychosocial, cognitive, pain factors), body structures (e.g., cardiovascular, digestive, nervous, integumentary, and genitourinary systems; structures related to movement), values, and spirituality
b) Methods or approaches to identify and select interventions, such as
    1. Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline
    2. Compensation, modification, or adaptation of occupations, activities, and contexts to improve or enhance performance
    3. Maintenance of capabilities to prevent decline in performance in everyday life occupations
    4. Health promotion and wellness to enable or enhance performance in everyday life activities and quality of life
    5. Prevention of occurrence or emergence of barriers to performance and participation, including injury and disability prevention
c) Interventions and procedures to promote or enhance safety and performance in ADLs, IADLs, health management, rest and sleep, education, work, play, leisure, and social participation, for example:
    1. Therapeutic use of occupations and activities
    2. Training in self-care, self-management, health management (e.g., medication management, health routines), home management, community/work integration, school activities, and work performance
    3. Identification, development, remediation, or compensation of physical, neuromusculoskeletal, sensory–perceptual, emotional regulation, visual, mental, and cognitive functions; pain tolerance and management; praxis; developmental skills; and behavioral skills
    4. Education and training of persons, including family members, caregivers, groups, populations, and others
    5. Care coordination, case management, and transition services
    6. Consultative services to persons, groups, populations, programs, organizations, and communities
    7. Virtual interventions (e.g., simulated, real-time, and near-time technologies, including telehealth and mobile technology)
    8. Modification of contexts (environmental and personal factors in settings such as home, work, school, and community) and adaptation of processes, including the application of ergonomic principles

9. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices
10. Assessment, recommendation, and training in techniques to enhance functional mobility, including fitting and management of wheelchairs and other mobility devices
11. Exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation
12. Remediation of and compensation for visual deficits, including low vision rehabilitation
13. Driver rehabilitation and community mobility
14. Management of feeding, eating, and swallowing to enable eating and feeding performance
15. Application of physical agent and mechanical modalities and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, motor, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills
16. Facilitating the occupational participation of persons, groups, or populations through modification of contexts (environmental and personal) and adaptation of processes
17. Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their everyday life occupations
18. Group interventions (e.g., use of dynamics of group and social interaction to facilitate learning and skill acquisition across the life course).

(8) "Occupational Therapist" means a person licensed to practice Occupational Therapy under this Act. The Occupational Therapist is responsible for and directs the evaluation process, develops the intervention plan, and provides occupational therapy services.

(9) "Occupational Therapy Assistant" means a person licensed to assist in the practice of Occupational Therapy under this Act and who shall work under the appropriate supervision of and in partnership with an Occupational Therapist.

(10) "Person" means any individual, partnership, unincorporated organization, limited liability entity, or corporate body, except that only an individual may be licensed under this Act.

(11) "Supervision" means a collaborative process for responsible, periodic review and inspection of all aspects of occupational therapy services. The Occupational Therapist is accountable for occupational therapy services provided by the Occupational Therapy Assistant and the Aide. In addition, the Occupational Therapy Assistant is accountable for occupational therapy services they provide. Within the scope of occupational therapy practice, supervision is aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and development.

(12) "Telehealth" means the application of evaluation, consultative, preventative, and therapeutic services delivered through information and communication technology.

Article II. Board of Occupational Therapy

2.01 Board Created

There is hereby established the _____ Board of Occupational Therapy hereafter referred to as the Board, which shall be responsible for the implementation and enforcement of this Act.

2.02 Board Composition

(1) The Board shall be composed of at least five individuals appointed by the Governor.
(2) At least two members shall be licensed as Occupational Therapists in this state.
(3) At least one member shall be an Occupational Therapy Assistant licensed in this state.
(4) At least two members shall be representatives of the public with an interest in the rights of consumers of health and wellness services (public member) and a representative of healthcare or education (consumer member).

2.03 Qualifications

(1) Public and Consumer Members must reside in this state for at least 5 years immediately preceding their appointment. Public members and consumer members shall understand or be willing to learn the specific responsibilities of the Board; be willing to learn about and develop contacts with major community service, civic, consumer, public service, religious, and other organizations in their state that have an interest in health care delivery and health care policy, including organizations that represent disadvantaged communities, rural, and non-English speaking populations; and have a track record of advocacy related to furthering consumer interests, especially in the area of health care. Public and consumer members may not be or have ever been Occupational Therapists or Occupational Therapy Assistants or in training to become an Occupational Therapist or Occupational Therapy Assistant. Public and consumer members may not be related to or have a household member who is an Occupational Therapist or an Occupational Therapy Assistant. The consumer member shall have knowledge of the profession of occupational therapy through personal experience. The public member shall have knowledge of the profession of occupational therapy through professional experience in health care reimbursement, regulatory, or policy arenas.
(2) Occupational Therapy and Occupational Therapy Assistant members must be licensed consistent with state law and reside in the state for at least 5 years, or have a privilege to practice through the Occupational Therapy Licensure Compact, and have been engaged in: rendering occupational therapy services to the public; teaching; consultation; or research in occupational therapy for at least 5 years, including the 3 years immediately preceding their appointment.
(3) No member shall be a current officer, Board member, or employee of a statewide organization established for the purpose of advocating for the interests of persons licensed under this Act.

2.04 Appointments

(1) Within 90 days after the enactment of this Act, the first Board shall be appointed by the Governor from a list of names submitted by the State Occupational Therapy Association and from nominations submitted by interested organizations or persons in the state.
(2) Each subsequent appointment shall be made from recommendations submitted by the State Occupational Therapy Association or from recommendations submitted by other interested organizations or persons in the state.

2.05 Terms

(1) Appointments to the Board shall be for a period of 3 years, except for the initial appointments which shall be staggered terms of 1, 2, and 3 years. Members shall serve until the expiration of the term for which they have been appointed or until their successors have been appointed to serve on the Board. No member may serve more than two consecutive 3-year terms or for six consecutive years.

(2) Terms shall begin on the first day of the calendar year and end on the last day of the calendar year or until successors are appointed, except for the first appointed members who shall serve through the last calendar day of the year in which they are appointed, before commencing the terms prescribed by this section.

2.06 Vacancies

In the event of a vacancy in the office of a member of the Board other than by expiration of a term, the Governor shall appoint a qualified person to fill the vacancy for the unexpired term.

2.07 Removal of Board Members

The Governor or the Board may remove a member of the Board for incompetence, professional misconduct, conflict of interest, or neglect of duty after written notice and opportunity for a hearing. The Board shall be responsible for defining the standards for removal for regulation.

2.08 Compensation of Board Members

Members of the Board shall receive no compensation for their services, but shall be entitled to reasonable reimbursement for travel and other expenses incurred in the execution of their powers and duties.

2.09 Administrative Provisions

(1) The Board may employ and discharge an Administrator and such officers and employees as it deems necessary, and shall determine their duties in accordance with [applicable State statute].
(2) [This subsection should be used to include administrative detail covering revenues and expenditures, authentication and preservation of documents, promulgation of rules and regulations, etc., in accordance with prevailing state practice, and to the extent that such detail is not already taken care of in state laws of general applicability.]

2.10 Meetings

(1) The Board shall, at the first meeting of each calendar year, select a Chairperson and conduct other appropriate business.
(2) At least three additional meetings shall be held before the end of each calendar year.
(3) Other meetings, including telecommunication conference meetings, may be convened at the call of the Chairperson or the written request of two of more Board members.
(4) A majority of the members of the Board shall constitute a quorum for all purposes. The quorum must include at least one Occupational Therapist.
(5) The Board shall conduct its meetings and keep records of its proceedings in accordance with the provisions of the Administrative Procedure Act of this state.
(6) All Board meetings and hearings shall be open to the public. The Board may, in its discretion and according to the state's Administrative Procedures Act [or other comparable statute], conduct any portion of its meetings or hearings in executive session, closed to the public.
(7) The Board shall develop and implement policies that provide the public with a reasonable opportunity to appear before the Board and to speak on any issue under Board jurisdiction.

2.11 Powers and Duties

(1) The Board shall, in accordance with the Administrative Procedures Act, perform all lawful functions consistent with this Act, or otherwise authorized by state law including that it shall:
    a. Administer, coordinate, and enforce the provisions of this Act;
    b. Evaluate applicants' qualifications for licensure in a timely manner;
    c. Establish licensure fees and issue, renew, or deny licenses;
    d. Issue subpoenas, examine witnesses, and administer oaths;
    e. Investigate allegations of practices violating the provisions of this Act;
    f. Make, adopt, amend, and repeal such rules as may be deemed necessary by the Board from time to time for the proper administration and enforcement of this Act;
    g. Conduct hearings and keep records and minutes;
    h. Establish a system for giving the public, including its regulated profession, reasonable advance notice of all open Board and committee meetings. Emergency meetings, including telephone or other telecommunication conference meetings, shall be held in accordance with applicable Administrative Procedures Act provisions;
    i. Communicate disciplinary actions to relevant state and federal authorities, the National Board for Certification in Occupational Therapy (NBCOT), the American Occupational Therapy Association (AOTA) Ethics Commission, and to other State OT licensing authorities;
    j. Publish at least annually Board rulings, opinions, and interpretations of statutes or rules in order to guide persons regulated by this Act; and
    k. Establish a system for tracking the amount of time the Board takes to issue an initial license or licensure renewal to an applicant.
(2) No member of the Board shall be civilly liable for any act or failure to act performed in good faith in the performance of his or her duties as prescribed by law.

2.12 Training of New Members

The Board shall conduct and new members shall attend a training program designed to familiarize new members with their duties. A training program for new members shall be held as needed.

Article III. Licensing and Examination

3.01 Requirements for Licensure

An applicant applying for a license as an Occupational Therapist or as an Occupational Therapy Assistant shall file a written application provided by the Board, demonstrating to the satisfaction of the Board that the applicant

(1) Is in good standing as defined in Section 1.04;
(2) Has successfully completed the minimum academic requirements of an educational program for Occupational Therapists or Occupational Therapy Assistants that is accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education (ACOTE) or predecessor organizations;
(3) Has successfully completed a minimum period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements described in Section 3.03 (2); and
(4) Has passed an examination administered by the National Board for Certification in Occupational Therapy (NBCOT), a predecessor organization, or another nationally recognized credentialing body as approved by the Board.

3.02 Internationally Educated Applicants

An Occupational Therapist who is a graduate of a school of occupational therapy that is located outside of the United States and its territories shall:

(1) Complete occupational therapy education programs (including fieldwork requirements) that are deemed comparable by the credentialing body recognized by the state occupational therapy regulatory board or agency to entry-level occupational therapy education programs in the United States.
(2) Fulfill examination requirement described in section 3.01(4).

3.03 Limited Permit

(1) A limited permit to practice occupational therapy may be granted to a person who has completed the academic and fieldwork requirements for Occupational Therapist of this Act and has not yet taken or received the results of the entry-level certification examination. This permit shall be valid for __ months and shall allow the person to practice occupational therapy under the direction and appropriate supervision of an Occupational Therapist licensed under this Act. This permit shall expire when the person is issued a license under Section 3.01or if the person is notified that they did not pass the examination. The limited permit may not be renewed.
(2) A limited permit to assist in the practice of occupational therapy may be granted to a person who has completed the academic and fieldwork requirements of Occupational Therapy Assistant of this Act and has not yet taken or received the results of the entry-level certification examination. This permit shall be valid for __ months and shall allow the person to practice occupational therapy under the direction and appropriate supervision of an Occupational Therapist licensed under this Act. This permit shall expire when the person is issued a license under Section 3.01 or if the person is notified that they did not pass the examination. The limited permit may not be renewed.

3.04 Temporary License

An applicant who is currently licensed and in good standing to practice in another jurisdiction and meets the requirements for licensure by endorsement may obtain a temporary license while the application is being processed by the Board.

3.05 Issuance of License

The Board shall issue a license to any person who meets the requirements of this Act, as described in sections 3.01 or 3.02, upon payment of the prescribed license fee as described in Section 3.09.

3.06 Renewal of License

(1) Any license issued under this Act shall be subject to annual [biennial] renewal and shall expire unless renewed in the manner prescribed by the rules and regulations of the Board.
(2) The Board shall prescribe by rule continuing competence requirements as a condition for renewal of licensure.
(3) The Board may provide late renewal of a license upon the payment of a late fee in accordance with its rules and regulations.
(4) Licensees are granted a grace period of 30 days after the expiration of their licenses in which to renew retroactively if they meet statutory requirements for renewal and pay to the Board the renewal fee and any late fee set by the Board.

(5) A suspended license is subject to expiration and may be renewed as provided in this Act, but such renewal shall not entitle the licensee, while the license remains suspended and until it is reinstated, to engage in the licensed activity, or in any other conduct or activity in violation of the order of judgement by which the license was suspended.
(6) A license revoked on disciplinary grounds may not be renewed or restored.

3.07 Inactive License

(1) Upon request, the Board shall grant inactive status to a licensee who is in good standing and maintains continuing competence requirements established by the Board, and
    a. Does not practice during such "inactive" period as an Occupational Therapist or an Occupational Therapy Assistant, and
    b. Does not during such "inactive" period hold themselves out as an Occupational Therapist or an Occupational Therapy Assistant.

3.08 Re-entry

(1) Reentering Occupational Therapists and Occupational Therapy Assistants are individuals who have previously practiced in the field of occupational therapy and have not engaged in the practice of occupational therapy for a minimum of 24 months.
(2) Occupational Therapists and Occupational Therapy Assistants who are seeking re-entry must fulfill re-entry requirements as prescribed by the Board in regulations.

3.09 Fees

(1) Consistent with the Administrative Procedures Act, the Board shall prescribe, and publish in the manner established by its rules, fees in amounts determined by the Board for the following:
    a. Initial license fee
    b. Renewal of license fee
    c. Late renewal fee
    d. Limited permit fee
    e. Temporary license fee
    f. Any other fees it determines appropriate.
(2) These fees shall be set in such an amount as to reimburse the state, to the extent feasible, for the cost of the services rendered.

Article IV. Regulation of Practice

4.01 Unlawful Practice

(1) No person shall practice occupational therapy or assist in the practice of occupational therapy or provide occupational therapy services or hold themselves as an Occupational Therapist or Occupational Therapy Assistant, or as being able to practice occupational therapy or assist in the practice of occupational therapy or provide occupational therapy services in this state unless they are licensed under the provisions of this Act.
(2) It is unlawful for any person not licensed as an Occupational Therapist in this state or whose license is suspended or revoked to use in connection with their name or place of business in this state, the words "Occupational Therapist," "licensed Occupational Therapist," "Doctor of Occupational Therapy," or the professional abbreviations "O.T.," "O.T.L.," "M.O.T.," "O.T.D.," "M.O.T./L.," "O.T.D./L." or any word, title, letters, or designation that implies that the person practices or is authorized to practice occupational therapy.

(3) It is unlawful for any person not licensed as an Occupational Therapy Assistant in this state or whose license is suspended or revoked to use in connection with their name or place of business in this state, the words “Occupational Therapy Assistant,” “licensed Occupational Therapy Assistant,” or the professional abbreviations “O.T.A.” or “O.T.A./L.,” or use any word, title, letters, or designation that implies that the person assists in, or is authorized to assist in, the practice of occupational therapy as an Occupational Therapy Assistant.

4.02 Exemptions

This Act does not prevent or restrict the practice, service, or activities of:

(1) Any person licensed or otherwise regulated in this state by any other law from engaging in their profession or occupation as defined in the Practice Act under which they are licensed.
(2) Any person pursuing a course of study leading to a degree in occupational therapy at an accredited educational program, if that person is designated by a title that clearly indicates their status as a student and if they act under appropriate instruction and supervision.
(3) Any person fulfilling the supervised fieldwork experience requirements of Section 3.01 of this Act, if the experience constitutes a part of the experience necessary to meet the requirement of that section and they act under appropriate supervision.
(4) Any person fulfilling a supervised or mentored occupational therapy doctoral capstone experience.
(5) An Occupational Therapist or Occupational Therapy Assistant who is authorized to practice occupational therapy in any jurisdiction, if they practice occupational therapy in this state for the purpose of education, consulting, or training, for the duration of the purpose, as preapproved by the Board;

4.03 Titles and Designations

(1) A licensed Occupational Therapist may use the words “occupational therapist,” “licensed occupational therapist,” or any words, title, letters, or other appropriate designation that indicates licensure, including but not limited to OT or OT/L, MOT/L, MSOT/L, and OTD/L that identifies the person as a licensed Occupational Therapist in connection with:
    a. Their name or place of business; and
    b. Any activity, practice, or service, so long as they are at all times in conformance with the requirements of this Act when providing occupational therapy services.
(2) A licensed Occupational Therapy Assistant may use the words “occupational therapy assistant,” “licensed occupational therapy assistant,” or any word, title, letters, or other appropriate designation that indicates licensure including, but not limited to OTA or OTA/L that identifies the person as a licensed Occupational Therapy Assistant in connection with:
    a. Their name or place of business; and
    b. Any activity, practice, or service, so long as they are at all times in conformance with the requirements of this Act when providing occupational therapy services.

4.04 Grounds for Disciplinary Action

The Board may take action against a licensee as described in Section 4.08 for unprofessional conduct including:

(1) Obtaining a license by means of fraud, misrepresentation, or concealment of material facts.

(2) Being guilty of unprofessional conduct as defined by the rules established by the Board, or violating the Code of Ethics adopted and published by the Board.
(3) Being convicted of a crime in any court except for minor offenses.
(4) Violating any lawful order, rule, or regulation rendered or adopted by the Board.
(5) Violating any provision of this Act (or regulations pursuant to this Act).
(6) Practicing beyond the scope of the practice of occupational therapy.
(7) Providing substandard care as an Occupational Therapist due to a deliberate or negligent act or failure to act regardless of whether actual injury to the client is established.
(8) Providing substandard care as an Occupational Therapy Assistant, including exceeding the authority to perform components of intervention selected and delegated by the supervising Occupational Therapist regardless of whether actual injury to the client is established.
(9) Knowingly delegating responsibilities to an individual who does not have the knowledge, skills, or abilities to perform those responsibilities.
(10) Failing to provide appropriate supervision to an Occupational Therapy Assistant or Aide in accordance with this Act and Board rules.
(11) Practicing as an Occupational Therapist or Occupational Therapy Assistant when competent services to recipients may not be provided due to the practitioner's own physical or mental impairment.
(12) Having had an Occupational Therapist or Occupational Therapy Assistant license revoked or suspended, other disciplinary action taken, or an application for licensure reused, revoked, or suspended by the proper authorities of another state, territory, or country, irrespective of intervening appeals and stays.
(13) Engaging in sexual misconduct. For the purposes of this paragraph, sexual misconduct includes:
    a. Engaging in or soliciting a sexual relationship, whether consensual or non-consensual, while an Occupational Therapist or Occupational Therapy Assistant/client relationship exists with that person.
    b. Making sexual advances, requesting sexual favors, or engaging in physical contact of a sexual nature with patients or clients.
(14) Aiding or abetting a person who is not licensed as an Occupational Therapist or Occupational Therapy Assistant in this state and who directly or indirectly performs activities requiring a license.
(15) Abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care.

4.05 Complaints

(1) Any individual, group, or entity may file a complaint with the Board against any licensed Occupational Therapist or licensed Occupational Therapy Assistant in the state charging that person with having violated the provisions of this Act.
(2) The complaint shall specify charges in sufficient detail so as to disclose to the accused fully and completely the alleged acts of misconduct for which they are charged.
    a. "Sufficient Detail" is defined as a complainant's full name and contact information, respondent's full name and contact information when available, alleged violations of Standards of Conduct from the Code, signature or e-signature, and supporting documentation.
(3) Upon receiving a complaint, the Board shall notify the licensee of the complaint and request a written response from the licensee.

(4) The Board shall keep an information file about each complaint filed with the Board. The information in each complaint file shall contain complete, current, and accurate information including, but not limited to:
    a. All persons contacted in relation to the complaint;
    b. A summary of findings made at each step of the complaint process;
    c. An explanation of the legal basis and reason for the complaint that is dismissed; and
    d. Other relevant information.

4.06 Due Process

(1) Before the Board imposes disciplinary actions, it shall give the individual against whom the action is contemplated an opportunity for a hearing before the Board.
(2) The Board shall give notice and hold a hearing in accordance with the state's Administrative Procedures Act [or other comparable statute].
(3) The individual shall be entitled to be heard in their defense, alone or with counsel, and may produce testimony and testify on their own behalf, and present witnesses, within reasonable time limits.
(4) Any person aggrieved by a final decision of the Board may appeal in accordance with the Administrative Procedures Act [or other comparable statute].

4.07 Investigation

To enforce this Act, the Board is authorized to:

(1) Receive complaints filed against licensees and conduct a timely investigation.
(2) Conduct an investigation at any time and on its own initiative without receipt of a written complaint if the Board has reason to believe that there may be a violation of this Act.
(3) Issue subpoenas to compel the attendance of any witness or the production of any documentation relative to a case.
(4) For good cause, take emergency action ordering the summary suspension of a license or the restriction of the licensee's practice or employment pending proceedings by the Board.
(5) Appoint hearing officers authorized to conduct hearings. Hearing officers shall prepare and submit to the Board findings of fact, conclusions of law, and an order that shall be reviewed and voted on by the Board.
(6) Require a licensee to be examined in order to determine the licensee's professional competence or resolve any other material issue arising from a proceeding.
(7) Take the following actions if the Board finds that the information received in a complaint or an investigation is not of sufficient seriousness to merit disciplinary action against a licensee:
    a. Dismiss the complaint if the Board believes the information or complaint is without merit or not within the purview of the Board. The record of the complaint shall be expunged from the licensee's record.
    b. Issue a confidential advisory letter to the licensee. An advisory letter is non-disciplinary and notifies a licensee that, while there is insufficient evidence to begin disciplinary action, the Board believes that the licensee should be aware of an issue.
(8) Take other lawful and appropriate actions within its scope of functions and implementation of this Act.

The licensee shall comply with a lawful investigation conducted by the Board.

4.08 Penalties

(1) Consistent with the Administrative Procedures Act, the Board may impose separately, or in combination, any of the following disciplinary actions on a licensee as provided in this Act:
    a. Refuse to issue or renew a license;
    b. Suspend or revoke a license;
    c. Impose probationary conditions;
    d. Issue a letter of reprimand, concern, public order, or censure;
    e. Require restitution of fees;
    f. Impose a fine not to exceed $____, which deprives the licensee of any economic advantage gained by the violation and which reimburses the Board for costs of the investigation and proceeding;
    g. Impose practice and/or supervision requirements;
    h. Require licensees to participate in continuing competence activities specified by the Board;
    i. Accept a voluntary surrendering of a license; or
    j. Take other appropriate corrective actions including advising other parties as needed to protect their legitimate interests and to protect the public.

(2) If the Board imposes suspension or revocation of license, application may be made to the Board for reinstatement, subject to the limits of section 3.06. The Board shall have the discretion to accept or reject an application for reinstatement and may require an examination or other satisfactory proof of eligibility for reinstatement.

(3) If a licensee is placed on probation, the Board may require the license holder to:
    a. Report regularly to the Board on matters that are the basis of probation;
    b. Limit practice to the areas prescribed by the Board;
    c. Continue to review continuing competence activities until the license holder attains a degree of skill satisfactory to the Board in those areas that are the basis of the probation;
    d. Provide other relevant information to the Board.

4.09 Injunction

(1) The Board is empowered to apply for relief by injunction, without bond, to restrain any person, partnership, or corporation from any threatened or actual act or practice that constitutes an offense against this Act. It shall not be necessary for the Board to allege and prove that there is no adequate remedy at law in order to obtain the relief requested. The members of the Board shall not be individually liable for applying for such relief.

(2) If a person other than a licensed Occupational Therapist or Occupational Therapy Assistant threatens to engage in or has engaged in any act or practice that constitutes an offense under this Act, a district court of any county on application of the Board may issue an injunction or other appropriate order restraining such conduct.

4.10 Duty to Refer

(1) An Occupational Therapist may evaluate, initiate, and provide occupational therapy treatment for a client without a referral from other health service providers.

(2) An Occupational Therapist shall refer recipients to other service providers or consult with other service providers when additional knowledge and expertise are required or when this would further the client's care needs and health outcomes.

4.11 Telehealth

A licensee may provide occupational therapy services to a client utilizing a telehealth visit if the occupational therapy services are provided in accordance with all requirements of this Act.

(1) "Telehealth Visit" means the provision of occupational therapy services by a licensee to a client using technology where the licensee and client are not in the same physical location for the occupational therapy service.
(2) A licensee engaged in a telehealth visit shall utilize technology that is secure and compliant with state and federal law.
(3) A licensee engaged in a telehealth visit shall be held to the same standard of care as a licensee who provides in-person occupational therapy. A licensee shall not utilize a telehealth visit if the standard of care for the particular occupational therapy services cannot be met using technology.
(4) Occupational therapy services provided by telehealth can be synchronous or asynchronous.
    a. "Asynchronous" means using any transmission to another site for review at a later time that uses a camera or other technology to capture images or data to be recorded.
    b. "Synchronous" means real-time interactive technology.
(5) Supervision of Occupational Therapy Assistants, Aides, and students using telehealth technologies must follow existing state law and guidelines regarding supervision, regardless of the method of supervision.

Article V. Other

5.01 Severability

(1) If a part of this Act is held unconstitutional or invalid, all valid parts that are severable from the invalid or unconstitutional part shall remain in effect.
(2) If a part of this Act is held unconstitutional or invalid in one or more of its applications, the part shall remain in effect in all constitutional and valid applications that are severable from the invalid applications.

5.02 Effective Date

(1) The Act, except for Section 3.01, shall take effect ninety (90) days after enactment [unless State practice or requirements require another effective date].
(2) Section 3.01 of this Act shall take effect 180 days after enactment.

Occupational Therapy Practice Framework: Domain and Process Fourth Edition

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Preface

The fourth edition of the *Occupational Therapy Practice Framework: Domain and Process* (hereinafter referred to as the *OTPF–4*), is an official document of the American Occupational Therapy Association (AOTA). Intended for occupational therapy practitioners and students, other health care professionals, educators, researchers, payers, policymakers, and consumers, the *OTPF–4* presents a summary of interrelated constructs that describe occupational therapy practice.

Definitions

Within the *OTPF–4, occupational therapy* is defined as the therapeutic use of everyday life occupations with persons, groups, or populations (i.e., the client) for the purpose of enhancing or enabling participation. Occupational therapy practitioners use their knowledge of the transactional relationship among the client, the client's engagement in valuable occupations, and the context to design occupation-based intervention plans. Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non–disability-related needs. These services include acquisition and preservation of occupational identity for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction (AOTA, 2011; see the glossary in Appendix A for additional definitions).

When the term *occupational therapy practitioners* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2015b). Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process.

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Occupational therapy assistants deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2020a).

The clients of occupational therapy are typically classified as *persons* (including those involved in care of a client), *groups* (collections of individuals having shared characteristics or a common or shared purpose; e.g., family members, workers, students, people with similar interests or occupational challenges), and *populations* (aggregates of people with common attributes such as contexts, characteristics, or concerns, including health risks; Scaffa & Reitz, 2014). People may also consider themselves as part of a *community,* such as the Deaf community or the disability community; a *community* is a collection of populations that is changeable and diverse and includes various people, groups, networks, and organizations (Scaffa, 2019; World Federation of Occupational Therapists [WFOT], 2019). It is important to consider the community or communities with which a client identifies throughout the occupational therapy process.

Whether the client is a person, group, or population, information about the client's wants, needs, strengths, contexts, limitations, and occupational risks is gathered, synthesized, and framed from an occupational perspective. Throughout the *OTPF–4,* the term *client* is used broadly to refer to persons, groups, and populations unless otherwise specified. In the *OTPF–4*, "group" as a client is distinct from "group" as an intervention approach. For examples of clients, see Table 1 (all tables are placed together at the end of this document). The glossary in Appendix A provides definitions of other terms used in this document.

Evolution of This Document

The *Occupational Therapy Practice Framework* was originally developed to articulate occupational therapy's distinct perspective and contribution to promoting the health and participation of persons, groups, and populations through engagement in occupation. The first edition of the *OTPF* emerged from an examination of documents related to the *Occupational Therapy Product Output Reporting System and Uniform Terminology for Reporting Occupational Therapy Services* (AOTA, 1979). Originally a document that responded to a federal requirement to develop a uniform reporting system, this text gradually shifted to describing and outlining the domains of concern of occupational therapy.

The second edition of *Uniform Terminology for Occupational Therapy* (AOTA, 1989) was adopted by the AOTA Representative Assembly (RA) and published in 1989. The document focused on delineating and defining only the occupational performance areas and occupational performance components that are addressed in occupational therapy direct services. The third and final edition of *Uniform Terminology for Occupational Therapy* (*UT–III;* AOTA, 1994) was adopted by the RA in 1994 and was "expanded to reflect current practice and to incorporate contextual aspects of performance" (p. 1047). Each revision

reflected changes in practice and provided consistent terminology for use by the profession.

In fall 1998, the AOTA Commission on Practice (COP) embarked on the journey that culminated in the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002a). At that time, AOTA also published *The Guide to Occupational Therapy Practice* (Moyers, 1999), which outlined contemporary practice for the profession. Using this document and the feedback received during the review process for the *UT–III,* the COP proceeded to develop a document that more fully articulated occupational therapy.

The *OTPF* is an ever-evolving document. As an official AOTA document, it is reviewed on a 5-year cycle for usefulness and the potential need for further refinements or changes. During the review period, the COP collects feedback from AOTA members, scholars, authors, practitioners, AOTA volunteer leadership and staff, and other stakeholders. The revision process ensures that the *OTPF* maintains its integrity while responding to internal and external influences that should be reflected in emerging concepts and advances in occupational therapy.

The *OTPF* was first revised and approved by the RA in 2008. Changes to the document included refinement of the writing and the addition of emerging concepts and changes in occupational therapy. The rationale for specific changes can be found in Table 11 of the *OTPF–2* (AOTA, 2008, pp. 665–667).

In 2012, the process of review and revision of the *OTPF* was initiated again, and several changes were made. The rationale for specific changes can be found on page S2 of the *OTPF–3* (AOTA, 2014).

In 2018, the process to revise the *OTPF* began again. After member review and feedback, several modifications were made and are reflected in this document:

- The focus on group and population clients is increased, and examples are provided for both.
- Cornerstones of occupational therapy practice are identified and described as foundational to the success of occupational therapy practitioners.
- *Occupational science* is more explicitly described and defined.
- The terms *occupation* and *activity* are more clearly defined.
- For occupations, the definition of *sexual activity* as an activity of daily living is revised, *health management* is added as a general occupation category, and *intimate partner* is added in the social participation category (see Table 2).
- The *contexts and environments* aspect of the occupational therapy domain is changed to *context* on the basis of the World Health Organization (WHO; 2008) taxonomy from the *International Classification of Functioning, Disability and Health (ICF)* in an effort to adopt standard, well-accepted definitions (see Table 4).
- For the client factors category of body functions, *gender identity* is now included under "experience of self and time," the definition of *psychosocial* is expanded to match the *ICF* description, and *interoception* is added under sensory functions.
- For types of intervention, "preparatory methods and tasks" has been changed to "interventions to support occupations" (see Table 12).
- For outcomes, transitions and discontinuation are discussed as conclusions to occupational therapy services, and patient-reported outcomes are addressed (see Table 14).
- Five new tables are added to expand on and clarify concepts:
  - Table 1. Examples of Clients: Persons, Groups, and Populations
  - Table 3. Examples of Occupations for Persons, Groups, and Populations
  - Table 7. Performance Skills for Persons (includes examples of effective and ineffective performance skills)
  - Table 8. Performance Skills for Groups (includes examples of the impact of ineffective individual performance skills on group collective outcome)
  - Table 10. Occupational Therapy Process for Persons, Groups, and Populations.
- Throughout, the use of *OTPF* rather than *Framework* acknowledges the current requirements for a unique

identifier to maximize digital discoverability and to promote brevity in social media communications. It also reflects the longstanding use of the acronym in academic teaching and clinical practice.

- Figure 1 has been revised to provide a simplified visual depiction of the domain and process of occupational therapy.

Vision for This Work

Although this edition of the *OTPF* represents the latest in the profession's efforts to clearly articulate the occupational therapy domain and process, it builds on a set of values that the profession has held since its founding in 1917. The original vision had at its center a profound belief in the value of therapeutic occupations as a way to remediate illness and maintain health (Slagle, 1924). The founders emphasized the importance of establishing a therapeutic relationship with each client and designing a treatment plan based on knowledge about the client's environment, values, goals, and desires (Meyer, 1922). They advocated for scientific practice based on systematic observation and treatment (Dunton, 1934). Paraphrased using today's lexicon, the founders proposed a vision that was occupation based, client centered, contextual, and evidence based—the vision articulated in the *OTPF–4*.

Introduction

The purpose of a framework is to provide a structure or base on which to build a system or a concept ("Framework," 2020). The *OTPF* describes the central concepts that ground occupational therapy practice and builds a common understanding of the basic tenets and vision of the profession. The *OTPF–4* does not serve as a taxonomy, theory, or model of occupational therapy. By design, the *OTPF–4* must be used to guide occupational therapy practice in conjunction with the knowledge and evidence relevant to occupation and occupational therapy within the identified areas of practice and with the appropriate clients. In addition, the *OTPF–4* is intended to be a valuable tool in the academic preparation of students, communication with the public and policymakers, and provision of language that can shape and be shaped by research.

Occupation and Occupational Science

Embedded in this document is the occupational therapy profession's core belief in the positive relationship between occupation and health and its view of people as occupational beings. Occupational therapy practice emphasizes the occupational nature of humans and the importance of occupational identity (Unruh, 2004) to healthful, productive, and satisfying living. As Hooper and Wood (2019) stated,

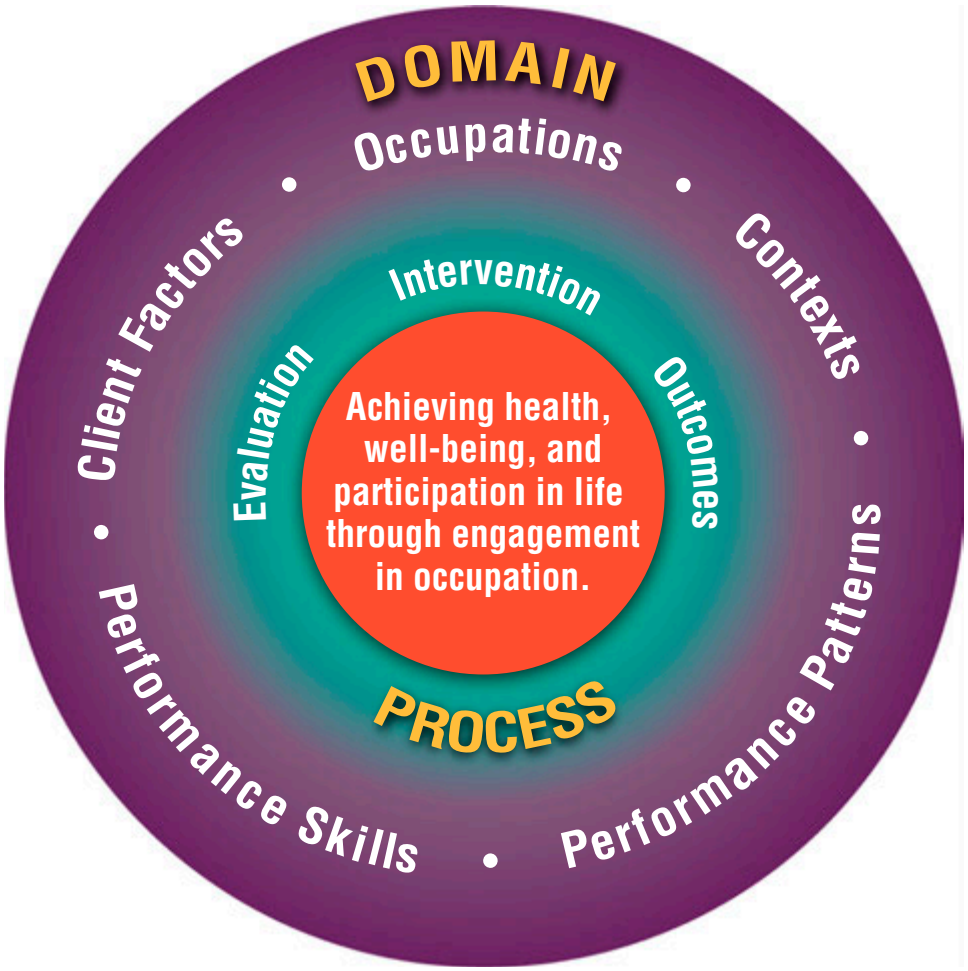
> A core philosophical assumption of the profession, therefore, is that by virtue of our biological endowment, people of all ages and abilities require occupation to grow and thrive; in pursuing occupation, humans express the totality of their being, a mind–body–spirit union. Because human existence could not otherwise be, humankind is, in essence, occupational by nature. (p. 46)

Occupational science is important to the practice of occupational therapy and "provides a way of thinking that enables an understanding of occupation, the occupational nature of humans, the relationship between occupation, health and well-being, and the influences that shape occupation" (WFOT, 2012b, p. 2). Many of its concepts are emphasized throughout the *OTPF–4,* including occupational justice and injustice, identity, time use, satisfaction, engagement, and performance.

OTPF *Organization*

The *OTPF–4* is divided into two major sections: (1) the *domain,* which outlines the profession's purview and the areas in which its members have an established body of knowledge and expertise, and (2) the *process,* which describes the actions practitioners take when providing services that are client centered and focused on engagement in occupations. The profession's understanding of the domain and process of occupational therapy guides practitioners as they seek to support clients' participation in daily living, which results from the dynamic intersection of clients, their desired engagements, and their contexts (including environmental and personal factors;

Figure 1. Occupational Therapy Domain and Process



Christiansen & Baum, 1997; Christiansen et al., 2005; Law et al., 2005).

"Achieving health, well-being, and participation in life through engagement in occupation" is the overarching statement that describes the domain and process of occupational therapy in its fullest sense. This statement acknowledges the profession's belief that active engagement in occupation promotes, facilitates, supports, and maintains health and participation. These interrelated concepts include

- *Health*—"a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO, 2006, p. 1).
- *Well-being*—"a general term encompassing the total universe of human life domains, including physical, mental, and social aspects, that make up what can be called a 'good life'" (WHO, 2006, p. 211).
- *Participation*—"involvement in a life situation" (WHO, 2008, p. 10). Participation occurs naturally when clients are actively involved in carrying out occupations or daily life activities they find purposeful and meaningful. More specific outcomes of occupational therapy intervention are multidimensional and support the end result of participation.
- *Engagement in occupation*—performance of occupations as the result of choice, motivation, and meaning within a supportive context (including

environmental and personal factors). Engagement includes objective and subjective aspects of clients' experiences and involves the transactional interaction of the mind, body, and spirit. Occupational therapy intervention focuses on creating or facilitating opportunities to engage in occupations that lead to participation in desired life situations (AOTA, 2008).

Although the domain and process are described separately, in actuality they are linked inextricably in a transactional relationship. The aspects that constitute the domain and those that constitute the process exist in constant interaction with one another during the delivery of occupational therapy services. Figure 1 represents aspects of the domain and process and the overarching goal of the profession as achieving health, well-being, and participation in life through engagement in occupation. Although the figure illustrates these two elements in distinct spaces, in reality the domain and process interact in complex and dynamic ways as described throughout this document. The nature of the interactions is impossible to capture in a static one-dimensional image.

Cornerstones of Occupational Therapy Practice

The transactional relationship between the domain and process is facilitated by the occupational therapy practitioner. Occupational therapy practitioners have distinct knowledge, skills, and qualities that contribute to the success of the occupational therapy process, described in this document as "cornerstones." A *cornerstone* can be defined as something of great importance on which everything else depends ("Cornerstone," n.d.), and the following cornerstones of occupational therapy help distinguish it from other professions:

- Core values and beliefs rooted in occupation (Cohn, 2019; Hinojosa et al., 2017)
- Knowledge of and expertise in the therapeutic use of occupation (Gillen, 2013; Gillen et al., 2019)
- Professional behaviors and dispositions (AOTA 2015a, 2015c)
- Therapeutic use of self (AOTA, 2015c; Taylor, 2020).

These cornerstones are not hierarchical; instead, each concept influences the others.

Occupational therapy cornerstones provide a fundamental foundation for practitioners from which to view clients and their occupations and facilitate the occupational therapy process. Practitioners develop the cornerstones over time through education, mentorship, and experience. In addition, the cornerstones are ever evolving, reflecting developments in occupational therapy practice and occupational science.

Many contributors influence each cornerstone. Like the cornerstones, the contributors are complementary and interact to provide a foundation for practitioners. The contributors include, but are not limited to, the following:

- Client-centered practice
- Clinical and professional reasoning
- Competencies for practice
- Cultural humility
- Ethics
- Evidence-informed practice
- Inter- and intraprofessional collaborations
- Leadership
- Lifelong learning
- Micro and macro systems knowledge
- Occupation-based practice
- Professionalism
- Professional advocacy
- Self-advocacy
- Self-reflection
- Theory-based practice.

Domain

Exhibit 1 identifies the aspects of the occupational therapy domain: occupations, contexts, performance patterns, performance skills, and client factors. All aspects of the domain have a dynamic interrelatedness. All aspects are of equal value and together interact to affect occupational identity, health, well-being, and participation in life.

Occupational therapists are skilled in evaluating all aspects of the domain, the interrelationships among the aspects, and the client within context. Occupational therapy practitioners recognize the importance and

Exhibit 1. Aspects of the Occupational Therapy Domain
All aspects of the occupational therapy domain transact to support engagement, participation, and health. This exhibit does not imply a hierarchy.

Occupations	Contexts	Performance Patterns	Performance Skills	Client Factors
Activities of daily living (ADLs) Instrumental activities of daily living (IADLs) Health management Rest and sleep Education Work Play Leisure Social participation	Environmental factors Personal factors	Habits Routines Roles Rituals	Motor skills Process skills Social interaction skills	Values, beliefs, and spirituality Body functions Body structures

impact of the mind–body–spirit connection on engagement and participation in daily life. Knowledge of the transactional relationship and the significance of meaningful and productive occupations forms the basis for the use of occupations as both the means and the ends of interventions (Trombly, 1995). This knowledge sets occupational therapy apart as a distinct and valuable service (Hildenbrand & Lamb, 2013) for which a focus on the whole is considered stronger than a focus on isolated aspects of human functioning.

The discussion that follows provides a brief explanation of each aspect of the domain. Tables included at the end of the document provide additional descriptions and definitions of terms.

Occupations

Occupations are central to a client's (person's, group's, or population's) health, identity, and sense of competence and have particular meaning and value to that client. "In occupational therapy, *occupations* refer to the everyday activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do" (WFOT, 2012a, para. 2).

In the *OTPF–4,* the term *occupation* denotes personalized and meaningful engagement in daily life events by a specific client. Conversely, the term *activity* denotes a form of action that is objective and not related to a specific client's engagement or context (Schell et al., 2019) and, therefore, can be selected and designed to enhance occupational engagement by supporting the development of performance skills and performance patterns. Both occupations and activities are used as interventions by practitioners. For example, a practitioner may use the activity of chopping vegetables during an intervention to address fine motor skills with the ultimate goal of improving motor skills for the occupation of preparing a favorite meal. Participation in occupations is considered both the means and the end in the occupational therapy process.

Occupations occur in contexts and are influenced by the interplay among performance patterns, performance skills, and client factors. Occupations occur over time; have purpose, meaning, and perceived utility to the client; and can be observed by others (e.g., preparing a meal) or be known only to the person involved (e.g., learning through reading a textbook). Occupations can involve the execution of multiple activities for completion and can result in various outcomes.

The *OTPF–4* identifies a broad range of occupations categorized as activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation (Table 2). Within each of these nine broad categories of occupation are many specific occupations. For example, the broad category of IADLs has specific

occupations that include grocery shopping and money management.

When occupational therapy practitioners work with clients, they identify the types of occupations clients engage in individually or with others. Differences among clients and the occupations they engage in are complex and multidimensional. The client's perspective on how an occupation is categorized varies depending on that client's needs, interests, and contexts. Moreover, values attached to occupations are dependent on cultural and sociopolitical determinants (Wilcock & Townsend, 2019). For example, one person may perceive gardening as leisure, whereas another person, who relies on the food produced from that garden to feed their family or community, may perceive it as work. Additional examples of occupations for persons, groups, and populations can be found in Table 3.

The ways in which clients prioritize engagement in selected occupations may vary at different times. For example, clients in a community psychiatric rehabilitation setting may prioritize registering to vote during an election season and food preparation during holidays. The unique features of occupations are noted and analyzed by occupational therapy practitioners, who consider all components of the engagement and use them effectively as both a therapeutic tool and a way to achieve the targeted outcomes of intervention.

The extent to which a client is engaged in a particular occupation is also important. Occupational therapy practitioners assess the client's ability to engage in *occupational performance,* defined as the accomplishment of the selected occupation resulting from the dynamic transaction among the client, their contexts, and the occupation. Occupations can contribute to a well-balanced and fully functional lifestyle or to a lifestyle that is out of balance and characterized by occupational dysfunction. For example, excessive work without sufficient regard for other aspects of life, such as sleep or relationships, places clients at risk for health problems. External factors, including war, natural disasters, or extreme poverty, may hinder a client's ability to create balance or engage in certain occupations (AOTA, 2017b; McElroy et al., 2012).

Because occupational performance does not exist in a vacuum, context must always be considered. For example, for a client who lives in food desert, lack of access to a grocery store may limit their ability to have balance in their performance of IADLs such as cooking and grocery shopping or to follow medical advice from health care professionals on health management and preparation of nutritious meals. For this client, the limitation is not caused by impaired client factors or performance skills but rather is shaped by the context in which the client functions. This context may include policies that resulted in the decline of commercial properties in the area, a socioeconomic status that does not enable the client to live in an area with access to a grocery store, and a social environment in which lack of access to fresh food is weighed as less important than the social supports the community provides.

Occupational therapy practitioners recognize that health is supported and maintained when clients are able to engage in home, school, workplace, and community life. Thus, practitioners are concerned not only with occupations but also with the variety of factors that disrupt or empower those occupations and influence clients' engagement and participation in positive health-promoting occupations (Wilcock & Townsend, 2019).

Although engagement in occupations is generally considered a positive outcome of the occupational therapy process, it is important to consider that a client's history might include negative, traumatic, or unhealthy occupational participation (Robinson Johnson & Dickie, 2019). For example, a person who has experienced a traumatic sexual encounter might negatively perceive and react to engagement in sexual intimacy. A person with an eating disorder might engage in eating in a maladaptive way, deterring health management and physical health.

In addition, some occupations that are meaningful to a client might also hinder performance in other occupations or negatively affect health. For example, a person who spends a disproportionate amount of time playing video games may develop a repetitive stress injury and may have less balance in their time spent on IADLs and other forms of social participation. A client engaging in the recreational use of prescription pain medications may experience barriers to participation in previously

important occupations such as work or spending time with family.

Occupations have the capacity to support or promote other occupations. For example, children engage in play to develop the performance skills that later facilitate engagement in leisure and work. Adults may engage in social participation and leisure with an intimate partner that may improve satisfaction with sexual activity. The goal of engagement in sleep and health management includes maintaining or improving performance of work, leisure, social participation, and other occupations.

Occupations are often shared and done with others. Those that implicitly involve two or more individuals are termed *co-occupations* (Zemke & Clark, 1996). Co-occupations are the most interactive of all social occupations. Central to the concept of co-occupation is that two or more individuals share a high level of physicality, emotionality, and intentionality (Pickens & Pizur-Barnekow, 2009). In addition, co-occupations can be parallel (different occupations in close proximity to others; e.g., reading while others listen to music when relaxing at home) and shared (same occupation but different activities; e.g., preparing different dishes for a meal; Zemke & Clark, 1996).

Caregiving is a co-occupation that requires active participation by both the caregiver and the recipient of care. For the co-occupations required during parenting, the socially interactive routines of eating, feeding, and comforting may involve the parent, a partner, the child, and significant others (Olson, 2004). The specific occupations inherent in this social interaction are reciprocal, interactive, and nested (Dunlea, 1996; Esdaile & Olson, 2004). Consideration of co-occupations by practitioners supports an integrated view of the client's engagement in the context of relationship to significant others.

Occupational participation can be considered independent whether it occurs individually or with others. It is important to acknowledge that clients can be independent in living regardless of the amount of assistance they receive while completing occupations. Clients may be considered independent even when they direct others (e.g., caregivers) in performing the actions necessary to participate, regardless of the amount or kind of assistance required, if clients are satisfied with their performance. In contrast to definitions of independence that imply direct physical interaction with the environment or objects within the environment, occupational therapy practitioners consider clients to be independent whether they perform the specific occupations by themselves, in an adapted or modified environment, with the use of various devices or alternative strategies, or while overseeing activity completion by others (AOTA, 2002b). For example, a person with spinal cord injury who directs a personal care assistant to assist them with ADLs is demonstrating independence in this essential aspect of their life.

It is also important to acknowledge that not all clients view success as independence. *Interdependence,* or co-occupational performance, can also be an indicator of personal success. How a client views success may be influenced by their client factors, including their culture.

Contexts

Context is a broad construct defined as the environmental and personal factors specific to each client (person, group, population) that influence engagement and participation in occupations. Context affects clients' access to occupations and the quality of and satisfaction with performance (WHO, 2008). Practitioners recognize that for people to truly achieve full participation, meaning, and purpose, they must not only function but also engage comfortably within their own distinct combination of contexts.

In the literature, the terms *environment* and *context* often are used interchangeably, but this may result in confusion when describing aspects of situations in which occupational engagement takes place. Understanding the contexts in which occupations can and do occur provides practitioners with insights into the overarching, underlying, and embedded influences of environmental factors and personal factors on engagement in occupations.

Environmental Factors

Environmental factors are aspects of the physical, social, and attitudinal surroundings in which people live and

conduct their lives (Table 4). Environmental factors influence functioning and disability and have positive aspects (facilitators) or negative aspects (barriers or hindrances; WHO, 2008). Environmental factors include

- *Natural environment and human-made changes to the environment:* Animate and inanimate elements of the natural or physical environment and components of that environment that have been modified by people, as well as characteristics of human populations within that environment. Engagement in human occupation influences the sustainability of the natural environment, and changes to human behavior can have a positive impact on the environment (Dennis et al., 2015).
- *Products and technology:* Natural or human-made products or systems of products, equipment, and technology that are gathered, created, produced, or manufactured.
- *Support and relationships:* People or animals that provide practical physical or emotional support, nurturing, protection, assistance, and connections to other persons in the home, workplace, or school or at play or in other aspects of daily occupations.
- *Attitudes:* Observable evidence of customs, practices, ideologies, values, norms, factual beliefs, and religious beliefs held by people other than the client.
- *Services, systems, and policies:* Benefits, structured programs, and regulations for operations provided by institutions in various sectors of society designed to meet the needs of persons, groups, and populations.

When people interact with the world around them, environmental factors can either enable or restrict participation in meaningful occupations and can present barriers to or supports and resources for service delivery. Examples of environmental barriers that restrict participation include the following:

- For persons, doorway widths that do not allow for wheelchair passage
- For groups, absence of healthy social opportunities for those abstaining from alcohol use
- For populations, businesses that are not welcoming to people who identify as LGBTQ+. (*Note:* In this document, *LGBTQ+* is used to represent the large and diverse communities and individuals with nonmajority sexual orientations and gender identities.)

Addressing these barriers, such as by widening a doorway to allow access, results in environmental supports that enable participation. A client who has difficulty performing effectively in one context may be successful when the natural environment has human-made modifications or if the client uses applicable products and technology. In addition, occupational therapy practitioners must be aware of norms related to, for example, eating or deference to medical professionals when working with someone from a culture or socioeconomic status that differs from their own.

Personal Factors

Personal factors are the unique features of a person that are not part of a health condition or health state and that constitute the particular background of the person's life and living (Table 5). Personal factors are internal influences affecting functioning and disability and are not considered positive or negative but rather reflect the essence of the person—"who they are." When clients provide demographic information, they are typically describing personal factors. Personal factors also include customs, beliefs, activity patterns, behavioral standards, and expectations accepted by the society or cultural group of which a person is a member.

Personal factors are generally considered to be enduring, stable attributes of the person, although some personal factors change over time. They include, but are not limited to, the following:

- Chronological age
- Sexual orientation (sexual preference, sexual identity)
- Gender identity
- Race and ethnicity
- Cultural identification and attitudes

- Social background, social status, and socioeconomic status
- Upbringing and life experiences
- Habits and past and current behavioral patterns
- Psychological assets, temperament, unique character traits, and coping styles
- Education
- Profession and professional identity
- Lifestyle
- Health conditions and fitness status (that may affect the person's occupations but are not the primary concern of the occupational therapy encounter).

For example, siblings share personal factors of race and age, yet for those separated at birth, environmental differences may result in divergent personal factors in terms of cultural identification, upbringing, and life experiences, producing different contexts for their individual occupational engagement. Whether separated or raised together, as siblings move through life, they may develop differences in sexual orientation, life experience, habits, education, profession, and lifestyle.

Groups and populations are often formed or identified on the basis of shared or similar personal factors that make possible occupational therapy assessment and intervention. Of course, individual members of a group or population differ in other personal factors. For example, a group of fifth graders in a community public school are likely to share age and, perhaps, socioeconomic status. Yet race, fitness, habits, and coping styles make each group member unlike the others. Similarly, a population of older adults living in an urban low-income housing community may have few personal factors in common other than age and current socioeconomic status.

Application of Context to Occupational Justice

Interwoven throughout the concept of context is that of *occupational justice,* defined as "a justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences" (Nilsson & Townsend, 2010, p. 58). Occupational therapy's focus on engagement in occupations and occupational justice complements WHO's (2008) perspective on health. To broaden the understanding of the effects of disease and disability on health, WHO emphasized that health can be affected by the inability to carry out occupations and activities and participate in life situations caused by contextual barriers and by problems that exist in body structures and body functions. The *OTPF–4* identifies occupational justice as both an aspect of contexts and an outcome of intervention.

Occupational justice involves the concern that occupational therapy practitioners have with respect, fairness, and impartiality and equitable opportunities when considering the contexts of persons, groups, and populations (AOTA, 2015a). As part of the occupational therapy domain, practitioners consider how these aspects can affect the implementation of occupational therapy and the target outcome of participation. Practitioners recognize that for individuals to truly achieve full participation, meaning, and purpose, they must not only function but also engage comfortably within their own distinct combination of contexts (both environmental factors and personal factors).

Examples of contexts that can present occupational justice issues include the following:

- An alternative school placement for children with mental health and behavioral disabilities that provides academic support and counseling but limited opportunities for participation in sports, music programs, and organized social activities
- A residential facility for older adults that offers safety and medical support but provides little opportunity for engagement in the role-related occupations that were once a source of meaning
- A community that lacks accessible and inclusive physical environments and provides limited services and supports, making participation difficult or even dangerous for people who have disabilities (e.g., lack of screening facilities and services resulting in higher rates of breast cancer among community members)
- A community that lacks financial and other necessary resources, resulting in an adverse and

disproportionate impact of natural disasters and severe weather events on vulnerable populations.

Occupational therapy practitioners recognize areas of occupational injustice and work to support policies, actions, and laws that allow people to engage in occupations that provide purpose and meaning in their lives. By understanding and addressing the specific justice issues in contexts such as an individual's home, a group's shared job site, or a population's community center, practitioners promote occupational therapy outcomes that address empowerment and self-advocacy.

Performance Patterns

Performance patterns are the acquired habits, routines, roles, and rituals used in the process of engaging consistently in occupations and can support or hinder occupational performance (Table 6). Performance patterns help establish lifestyles (Uyeshiro Simon & Collins, 2017) and occupational balance (e.g., proportion of time spent in productive, restorative, and leisure occupations; Eklund et al., 2017; Wagman et al., 2015) and are shaped, in part, by context (e.g., consistency, work hours, social calendars) and cultural norms (Eklund et al., 2017; Larson & Zemke, 2003).

Time provides an organizational structure or rhythm for performance patterns (Larson & Zemke, 2003); for example, an adult goes to work every morning, a child completes homework every day after school, or an organization hosts a fundraiser every spring. The manner in which people think about and use time is influenced by biological rhythms (e.g., sleep–wake cycles), family of origin (e.g., amount of time a person is socialized to believe should be spent in productive occupations), work and social schedules (e.g., religious services held on the same day each week), and cyclic cultural patterns (e.g., birthday celebration with cake every year, annual cultural festival; Larson & Zemke, 2003). Other temporal factors influencing performance patterns are time management and time use. *Time management* is the manner in which a person, group, or population organizes, schedules, and prioritizes certain activities (Uyeshiro Simon & Collins, 2017). *Time use* is the manner in which a person manages their activity levels; adapts to changes in routines; and organizes their days, weeks, and years (Edgelow & Krupa, 2011).

Habits are specific, automatic adaptive or maladaptive behaviors. Habits may be healthy or unhealthy (e.g., exercising on a daily basis vs. smoking during every lunch break), efficient or inefficient (e.g., completing homework after school vs. in the few minutes before the school bus arrives), and supportive or harmful (e.g., setting an alarm clock before going to bed vs. not doing so; Clark, 2000; Dunn, 2000; Matuska & Barrett, 2019).

Routines are established sequences of occupations or activities that provide a structure for daily life; they can also promote or damage health (Fiese, 2007; Koome et al., 2012; Segal, 2004). Shared routines involve two or more people and take place in a similar manner regardless of the individuals involved (e.g., routines shared by parents to promote the health of their children; routines shared by coworkers to sort the mail; Primeau, 2000). Shared routines can be nested in co-occupations. For example, a young child's occupation of completing oral hygiene with the assistance of an adult is a part of the child's daily routine, and the adult who provides the assistance may also view helping the young child with oral hygiene as a part of the adult's own daily routine.

Roles have historically been defined as sets of behaviors expected by society and shaped by culture and context; they may be further conceptualized and defined by a person, group, or population (Kielhofner, 2008; Taylor, 2017). Roles are an aspect of occupational identity—that is, they help define who a person, group, or population believes themselves to be on the basis of their occupational history and desires for the future. Certain roles are often associated with specific activities and occupations; for example, the role of parent is associated with feeding children (Kielhofner, 2008; Taylor, 2017). When exploring roles, occupational therapy practitioners consider the complexity of identity and the limitations associated with assigning stereotypical occupations to specific roles (e.g., on the basis of gender). Practitioners also consider how clients construct their occupations and establish efficient and supportive habits and routines to achieve health outcomes, fulfill their perceived roles and

identity, and determine whether their roles reinforce their values and beliefs.

Rituals are symbolic actions with spiritual, cultural, or social meaning. Rituals contribute to a client's identity and reinforce the client's values and beliefs (Fiese, 2007; Segal, 2004). Some rituals (e.g., those associated with certain holidays) are associated with different seasons or times of the year (e.g., New Year's Eve, Independence Day), whereas others are associated with times of the day or days of the week (e.g., daily prayers, weekly family dinners).

Performance patterns are influenced by all other aspects of the occupational therapy domain and develop over time. Occupational therapy practitioners who consider clients' past and present behavioral and performance patterns are better able to understand the frequency and manner in which performance skills and healthy and unhealthy occupations are, or have been, integrated into clients' lives. Although clients may have the ability to engage in skilled performance, if they do not embed essential skills in a productive set of engagement patterns, their health, well-being, and participation may be negatively affected. For example, a person may have skills associated with proficient health literacy but not embed them into consistent routines (e.g., a dietitian who consistently chooses to eat fast food rather than prepare a healthy meal) or struggle with modifying daily performance patterns to access health systems effectively (e.g., a nurse who struggles to modify work hours to get a routine mammogram).

Performance Skills

Performance skills are observable, goal-directed actions and consist of motor skills, process skills, and social interaction skills (Fisher & Griswold, 2019; Table 7). The occupational therapist evaluates and analyzes performance skills during actual performance to understand a client's ability to perform an activity (i.e., smaller aspect of the larger occupation) in natural contexts (Fisher & Marterella, 2019). This evaluation requires analysis of the quality of the individual actions (performance skills) during actual performance. Regardless of the client population, the performance skills defined in this document are universal and provide the foundation for understanding performance (Fisher & Marterella, 2019).

Performance skills can be analyzed for all occupations with clients of any age and level of ability, regardless of the setting in which occupational therapy services are provided (Fisher & Marterella, 2019). Motor and process skills are seen during performance of an activity that involves the use of tangible objects, and social interaction skills are seen in any situation in which a person is interacting with others:

- *Motor skills* refer to how effectively a person moves self or interacts with objects, including positioning the body, obtaining and holding objects, moving self and objects, and sustaining performance.
- *Process skills* refer to how effectively a person organizes objects, time, and space, including sustaining performance, applying knowledge, organizing timing, organizing space and objects, and adapting performance.
- *Social interaction skills* refer to how effectively a person uses both verbal and nonverbal skills to communicate, including initiating and terminating, producing, physically supporting, shaping content of, maintaining flow of, verbally supporting, and adapting social interaction.

For example, when a client catches a ball, the practitioner can analyze how effectively they bend and reach for and then grasp the ball (motor skills). When a client cooks a meal, the practitioner can analyze how effectively they initiate and sequence the steps to complete the recipe in a logical order to prepare the meal in a timely and well-organized manner (process skills). Or when a client interacts with a friend at work, the practitioner can analyze the manner in which the client smiles, gestures, turns toward the friend, and responds to questions (social interaction skills). In these examples, many other motor skills, process skills, and social interaction skills are also used by the client.

By analyzing the client's performance within an occupation at the level of performance skills, the occupational therapist identifies effective and ineffective use of skills (Fisher & Marterella, 2019). The result of this

analysis indicates not only whether the person is able to complete an activity safely and independently but also the amount of physical effort and efficiency the client demonstrates in activities.

After the quality of occupational performance skills has been analyzed, the practitioner speculates about the reasons for decreased quality of occupational performance and determines the need to evaluate potential underlying causes (e.g., occupational demands, environmental factors, client factors; Fisher & Griswold, 2019). Performance skills are different from client factors (see the "Client Factors" section that follows), which include values, beliefs, and spirituality and body structures and functions (e.g., memory, strength) that reside within the person. Occupational therapy practitioners analyze performance skills as a client performs an activity, whereas client factors cannot be directly viewed during the performance of occupations. For example, the occupational therapy practitioner cannot directly view the client factors of cognitive ability or memory when a client is engaged in cooking but rather notes ineffective use of performance skills when the person hesitates to start a step or performs steps in an illogical order. The practitioner may then infer that a possible reason for the client's hesitation may be diminished memory and elect to further assess the client factor of cognition.

Similarly, context influences the quality of a client's occupational performance. After analyzing the client's performance skills while completing an activity, the practitioner can hypothesize how the client factors and context might have influenced the client's performance. Thus, client factors and contexts converge and may support or limit a person's quality of occupational performance.

Application of Performance Skills With Persons

When completing the analysis of occupational performance (described in the "Evaluation" section later in this document), the practitioner analyzes the client's challenges in performance and generates a hypothesis about gaps between current performance and effective performance and the need for occupational therapy services. To plan appropriate interventions, the practitioner considers the underlying reasons for the gaps, which may involve performance skills, performance patterns, and client factors. The hypothesis is generated on the basis of what the practitioner analyzes when the client is actually performing occupations.

Regardless of the client population, the universal performance skills defined in this section provide the foundations for understanding performance (Fisher & Marterella, 2019). The following example crosses many client populations. The practitioner observes as a client rushes through the steps of an activity toward completion. On the basis of what the client does, the practitioner may interpret this rushing as resulting from a lack of impulse control. This limitation may be seen in clients living with anxiety, attention deficit hyperactivity disorder, dementia, traumatic brain injury, and other clinical conditions. The behavior of rushing may be captured in motor performance skills of *manipulates, coordinates,* or *calibrates;* in process performance skills of *paces, initiates, continues,* or *organizes;* or in social interaction performance skills of *takes turn, transitions, times response,* or *times duration*. Understanding the client's specific occupational challenges enables the practitioner to determine the suitable intervention to address impulsivity to facilitate greater occupational performance. Clinical interventions then address the skills required for the client's specific occupational demands on the basis of their alignment with the universal performance skills (Fisher & Marterella, 2019). Thus, the application of universal performance skills guides practitioners in developing the intervention plan for specific clients to address the specific concerns occurring in the specific practice setting.

Application of Performance Skills With Groups

Analysis of performance skills is always focused on individuals (Fisher & Marterella, 2019). Thus, when analyzing performance skills with a group client, the occupational therapist always focuses on one individual at a time (Table 8). The therapist may choose to analyze some or all members of the group engaging in relevant group occupations over time as the group members contribute to the collective actions of the group.

If all members demonstrate effective performance skills, then the group client may achieve its collective outcomes. If one or more group members demonstrate ineffective performance skills, the collective outcomes may be diminished. Only in cases in which group members demonstrate ongoing limitations in performance skills that hinder the collective outcomes of the group would the practitioner recommend interventions for individual group members. Interventions would then be directed at those members demonstrating diminished performance skills to facilitate their contributions to the collective group outcomes.

Application of Performance Skills With Populations

Using an occupation-based approach to population health, occupational therapy addresses the needs of populations by enhancing occupational performance and participation for communities of people (see "Service Delivery" in the "Process" section). Service delivery to populations focuses on aggregates of people rather than on intervention for persons or groups; thus, it is not relevant to analyze performance skills at the person level in service delivery to populations.

Client Factors

Client factors are specific capacities, characteristics, or beliefs that reside within the person, group, or population and influence performance in occupations (Table 9). Client factors are affected by the presence or absence of illness, disease, deprivation, and disability, as well as by life stages and experiences. These factors can affect performance skills (e.g., a client may have weakness in the right arm [a client factor], affecting their ability to manipulate a button [a motor and process skill] to button a shirt; a child in a classroom may be nearsighted [a client factor], affecting their ability to copy from a chalkboard [a motor and process skill]).

In addition, client factors are affected by occupations, contexts, performance patterns, and performance skills. For example, a client in a controlled and calm environment might be able to problem solve to complete an occupation or activity, but when they are in a louder, more chaotic environment, their ability to process and plan may be adversely affected. It is through this interactive relationship that occupations and interventions to support occupations can be used to address client factors and vice versa.

Values, beliefs, and spirituality influence clients' motivation to engage in occupations and give their life or existence meaning. *Values* are principles, standards, or qualities considered worthwhile by the client who holds them. A *belief* is "something that is accepted, considered to be true, or held as an opinion" ("Belief," 2020). *Spirituality* is "a deep experience of meaning brought about by engaging in occupations that involve the enacting of personal values and beliefs, reflection, and intention within a supportive contextual environment" (Billock, 2005, p. 887). It is important to recognize spirituality "as dynamic and often evolving" (Humbert, 2016, p. 12).

Body functions and *body structures* refer to the "physiological function of body systems (including psychological functions) and anatomical parts of the body such as organs, limbs, and their components," respectively (WHO, 2008, p. 10). Examples of body functions include sensory, musculoskeletal, mental (affective, cognitive, perceptual), cardiovascular, respiratory, and endocrine functions. Examples of body structures include the heart and blood vessels that support cardiovascular function. Body structures and body functions are interrelated, and occupational therapy practitioners consider them when seeking to promote clients' ability to engage in desired occupations.

Occupational therapy practitioners understand that the presence, absence, or limitation of specific body functions and body structures does not necessarily determine a client's success or difficulty with daily life occupations. Occupational performance and client factors may benefit from supports in the physical, social, or attitudinal contexts that enhance or allow participation. It is through the process of assessing clients as they engage in occupations that practitioners are able to determine the transaction between client factors and performance skills; to create adaptations, modifications, and remediation; and to select occupation-based interventions that best promote enhanced participation.

Exhibit 2. Operationalizing the Occupational Therapy Process
Ongoing interaction among evaluation, intervention, and outcomes occurs throughout the occupational therapy process.

Evaluation
Occupational Profile • Identify the following: ◦ Why is the client seeking services, and what are the client's current concerns relative to engaging in occupations and in daily life activities? ◦ In what occupations does the client feel successful, and what barriers are affecting their success in desired occupations? ◦ What is the client's occupational history (i.e., life experiences)? ◦ What are the client's values and interests? ◦ What aspects of their contexts (environmental and personal factors) does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement? ◦ How are the client's performance patterns supporting or limiting occupational performance and engagement? ◦ What are the client's patterns of engagement in occupations, and how have they changed over time? ◦ What client factors does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement (e.g., pain, active symptoms)? ◦ What are the client's priorities and desired targeted outcomes related to occupational performance, prevention, health and wellness, quality of life, participation, role competence, well-being, and occupational justice? Analysis of Occupational Performance • The analysis of occupational performance involves one or more of the following: ◦ Synthesizing information from the occupational profile to determine specific occupations and contexts that need to be addressed ◦ Completing an occupational or activity analysis to identify the demands of occupations and activities on the client ◦ Selecting and using specific assessments to measure the quality of the client's performance or performance deficits while completing occupations or activities relevant to desired occupations, noting the effectiveness of performance skills and performance patterns ◦ Selecting and using specific assessments to measure client factors that influence performance skills and performance patterns ◦ Selecting and administering assessments to identify and measure more specifically the client's contexts and their impact on occupational performance. Synthesis of Evaluation Process • This synthesis may include the following: ◦ Determining the client's values and priorities for occupational participation ◦ Interpreting the assessment data to identify supports and hindrances to occupational performance ◦ Developing and refining hypotheses about the client's occupational performance strengths and deficits ◦ Considering existing support systems and contexts and their ability to support the intervention process ◦ Determining desired outcomes of the intervention ◦ Creating goals in collaboration with the client that address the desired outcomes ◦ Selecting outcome measures and determining procedures to measure progress toward the goals of intervention, which may include repeating assessments used in the evaluation process.
Intervention
Intervention Plan • Develop the plan, which involves selecting ◦ Objective and measurable occupation-based goals and related time frames; ◦ Occupational therapy intervention approach or approaches, such as create or promote, establish or restore, maintain, modify, or prevent; and ◦ Methods for service delivery, including what types of intervention will be provided, who will provide the interventions, and which service delivery approaches will be used. • Consider potential discharge needs and plans. • Make recommendations or referrals to other professionals as needed.

(Continued)

Exhibit 2. Operationalizing the Occupational Therapy Process *(cont'd)*

Intervention Implementation
- Select and carry out the intervention or interventions, which may include the following:
  - Therapeutic use of occupations and activities
  - Interventions to support occupations
  - Education
  - Training
  - Advocacy
  - Self-advocacy
  - Group intervention
  - Virtual interventions.
- Monitor the client's response through ongoing evaluation and reevaluation.

Intervention Review
- Reevaluate the plan and how it is implemented relative to achieving outcomes.
- Modify the plan as needed.
- Determine the need for continuation or discontinuation of services and for referral to other services.

Outcomes

Outcomes
- Select outcome measures early in the occupational therapy process (see the "Evaluation" section of this table) on the basis of their properties:
  - Valid, reliable, and appropriately sensitive to change in clients' occupational performance
  - Consistent with targeted outcomes
  - Congruent with the client's goals
  - Able to predict future outcomes.
- Use outcome measures to measure progress and adjust goals and interventions by
  - Comparing progress toward goal achievement with outcomes throughout the intervention process and
  - Assessing outcome use and results to make decisions about the future direction of intervention (e.g., continue, modify, transition, discontinue, provide follow-up, refer for other service).

Client factors can also be understood as pertaining to group and population clients and may be used to help define the group or population. Although client factors may be described differently when applied to a group or population, the underlying principles do not change substantively. Client factors of a group or population are explored by performing needs assessments, and interventions might include program development and strategic planning to help the members engage in occupations.

Process

This section operationalizes the process undertaken by occupational therapy practitioners when providing services to clients. Exhibit 2 summarizes the aspects of the occupational therapy process.

The *occupational therapy process* is the client-centered delivery of occupational therapy services. The three-part process includes (1) evaluation and (2) intervention to achieve (3) targeted outcomes and occurs within the purview of the occupational therapy domain (Table 10). The process is facilitated by the distinct perspective of occupational therapy practitioners engaging in professional reasoning, analyzing occupations and activities, and collaborating with clients. The cornerstones of occupational therapy practice underpin the process of service delivery.

Overview of the Occupational Therapy Process

Many professions use a similar process of evaluating, intervening, and targeting outcomes. However, only occupational therapy practitioners focus on the therapeutic use of occupations to promote health, well-

being, and participation in life. Practitioners use professional reasoning to select occupations as primary methods of intervention throughout the process. To help clients achieve desired outcomes, practitioners facilitate interactions among the clients, their contexts, and the occupations in which they engage. This perspective is based on the theories, knowledge, and skills generated and used by the profession and informed by available evidence.

Analyzing occupational performance requires an understanding of the complex and dynamic interaction among the demands of the occupation and the client's contexts, performance patterns, performance skills, and client factors. Occupational therapy practitioners fully consider each aspect of the domain and gauge the influence of each on the others, individually and collectively. By understanding how these aspects influence one another, practitioners can better evaluate how each aspect contributes to clients' participation and performance-related concerns and potentially to interventions that support occupational performance and participation.

The occupational therapy process is fluid and dynamic, allowing practitioners and clients to maintain their focus on the identified outcomes while continually reflecting on and changing the overall plan to accommodate new developments and insights along the way, including information gained from inter- and intraprofessional collaborations. The process may be influenced by the context of service delivery (e.g., setting, payer requirements); however, the primary focus is always on occupation.

Service Delivery Approaches

Various service delivery approaches are used when providing skilled occupational therapy services, of which intra- and interprofessional collaborations are a key component. It is imperative to communicate with all relevant providers and stakeholders to ensure a collaborative approach to the occupational therapy process. These providers and stakeholders can be within the profession (e.g., occupational therapist and occupational therapy assistant collaborating to work with a student in a school, a group of practitioners collaborating to develop community-based mental health programming in their region) or outside the profession (e.g., a team of rehabilitation and medical professionals on an inpatient hospital unit; a group of employees, human resources staff, and health and safety professionals in a large organization working with an occupational therapy practitioner on workplace wellness initiatives).

Regardless of the service delivery approach, the individual client may not be the exclusive focus of the occupational therapy process. For example, the needs of an at-risk infant may be the initial impetus for intervention, but the concerns and priorities of the parents, extended family, and funding agencies are also considered. Occupational therapy practitioners understand and focus intervention to include the issues and concerns surrounding the complex dynamics among the client, caregiver, family, and community. Similarly, services addressing independent living skills for adults coping with serious mental illness or chronic health conditions may also address the needs and expectations of state and local service agencies and of potential employers.

Direct Services. Services are provided directly to clients using a collaborative approach in settings such as hospitals, clinics, industry, schools, homes, and communities. Direct services include interventions completed when in direct contact with the client through various mechanisms such as meeting in person, leading a group session, and interacting with clients and families through telehealth systems (AOTA, 2018c).

Examples of person-level direct service delivery include working with an adult on an inpatient rehabilitation unit, working with a child in the classroom while collaborating with the teacher to address identified goals, and working with an adolescent in an outpatient setting. Direct group interventions include working with a cooking group in a skilled nursing facility, working with an outpatient feeding group, and working with a handwriting group in a school. Examples of population-level direct services include implementing a large-scale healthy lifestyle or safe driver initiative in the community and

delivering a training program for brain injury treatment facilities regarding safely accessing public transportation. An occupational therapy approach to population health focuses on aggregates or communities of people and the many factors that influence their health and well-being: "Occupational therapy practitioners develop and implement occupation-based health approaches to enhance occupational performance and participation, [quality of life], and occupational justice for populations" (AOTA, 2020b, p. 3).

Indirect Services. When providing services to clients indirectly on their behalf, occupational therapy practitioners provide consultation to entities such as teachers, multidisciplinary teams, and community planning agencies. For example, a practitioner may consult with a group of elementary school teachers and administrators about opportunities for play during recess to promote health and well-being. A practitioner may also provide consultation on inclusive design to a park district or civic organization to address how the built and natural environments can support occupational performance and engagement. In addition, a practitioner may consult with a business regarding the work environment, ergonomic modifications, and compliance with the Americans With Disabilities Act of 1990 (Pub. L. 101-336).

Occupational therapy practitioners can advocate indirectly on behalf of their clients at the person, group, and population levels to ensure their occupational needs are met. For example, an occupational therapy practitioner may advocate for funding to support the costs of training a service animal for an individual client. A practitioner working with a group client may advocate for meeting space in the community for a peer support group of transgender youth. Examples of population-level advocacy include talking with legislators about improving transportation for older adults, developing services for people with disabilities to support their living and working in the community of their choice, establishing meaningful civic engagement opportunities for underserved youth, and assisting in the development of policies that address inequities in access to health care.

Additional Approaches. Occupational therapy practitioners use additional approaches that may also be classified as direct or indirect for persons, groups, and populations. Examples include, but are not limited to, case management (AOTA, 2018b), telehealth (AOTA, 2018c), episodic care (Centers for Medicare & Medicaid Services, 2019), and family-centered care approaches (Hanna & Rodger, 2002).

Practice Within Organizations and Systems

Organization- or systems-level practice is a valid and important part of occupational therapy for several reasons. First, organizations serve as a mechanism through which occupational therapy practitioners provide interventions to support participation of people who are members of or served by the organization (e.g., falls prevention programming in a skilled nursing facility, ergonomic changes to an assembly line to reduce musculoskeletal disorders). Second, organizations support occupational therapy practice and practitioners as stakeholders in carrying out the mission of the organization. Practitioners have the responsibility to ensure that services provided to organizational stakeholders (e.g., third-party payers, employers) are of high quality and delivered in an ethical, efficient, and efficacious manner.

Finally, organizations employ occupational therapy practitioners in roles in which they use their knowledge of occupation and the profession of occupational therapy indirectly. For example, practitioners can serve in positions such as dean, administrator, and corporate leader (e.g., CEO, business owner). In these positions, practitioners support and enhance the organization but do not provide occupational therapy services in the traditional sense. Occupational therapy practitioners can also serve organizations in roles such as client advocate, program coordinator, transition manager, service or care coordinator, health and wellness coach, and community integration specialist.

Occupational and Activity Analysis

Occupational therapy practitioners are skilled in the analysis of occupations and activities and apply this important skill throughout the occupational therapy

process. Occupational analysis is performed with an understanding of "the specific situation of the client and therefore . . . the specific occupations the client wants or needs to do in the actual context in which these occupations are performed" (Schell et al., 2019, p. 322). In contrast, activity analysis is generic and decontextualized in its purpose and serves to develop an understanding of typical activity demands within a given culture. Many professions use activity analysis, whereas occupational analysis requires the understanding of occupation as distinct from activity and brings an occupational therapy perspective to the analysis process (Schell et al., 2019).

Occupational therapy practitioners analyze the demands of an occupation or activity to understand the performance patterns, performance skills, and client factors that are required to perform it (Table 11). Depending on the purpose of the analysis, the meaning ascribed to and the contexts for performance of and engagement in the occupation or activity are considered either from a client-specific subjective perspective (occupational analysis) or a general perspective within a given culture (activity analysis).

Therapeutic Use of Self

An integral part of the occupational therapy process is *therapeutic use of self,* in which occupational therapy practitioners develop and manage their therapeutic relationship with clients by using professional reasoning, empathy, and a client-centered, collaborative approach to service delivery (Taylor & Van Puymbrouck, 2013). Occupational therapy practitioners use professional reasoning to help clients make sense of the information they are receiving in the intervention process, discover meaning, and build hope (Taylor, 2019; Taylor & Van Puymbrouck, 2013). *Empathy* is the emotional exchange between occupational therapy practitioners and clients that allows more open communication, ensuring that practitioners connect with clients at an emotional level to assist them with their current life situation.

Practitioners develop a collaborative relationship with clients to understand their experiences and desires for intervention. The collaborative approach used throughout the process honors the contributions of clients along with practitioners. Through the use of interpersonal communication skills, practitioners shift the power of the relationship to allow clients more control in decision making and problem solving, which is essential to effective intervention. Clients have identified the therapeutic relationship as critical to the outcome of occupational therapy intervention (Cole & McLean, 2003).

Clients bring to the occupational therapy process their knowledge about their life experiences and their hopes and dreams for the future. They identify and share their needs and priorities. Occupational therapy practitioners must create an inclusive, supportive environment to enable clients to feel safe in expressing themselves authentically. To build an inclusive environment, practitioners can take actions such as pursuing education on gender-affirming care, acknowledging systemic issues affecting underrepresented groups, and using a lens of cultural humility throughout the occupational therapy process (AOTA, 2020c; Hammell, 2013).

Occupational therapy practitioners bring to the therapeutic relationship their knowledge about how engagement in occupation affects health, well-being, and participation; they use this information, coupled with theoretical perspectives and professional reasoning, to critically evaluate, analyze, describe, and interpret human performance. Practitioners and clients, together with caregivers, family members, community members, and other stakeholders (as appropriate), identify and prioritize the focus of the intervention plan.

Clinical and Professional Reasoning

Throughout the occupational therapy process, practitioners are continually engaged in clinical and professional reasoning about a client's occupational performance. The term *professional reasoning* is used throughout this document as a broad term to encompass reasoning that occurs in all settings (Schell, 2019). Professional reasoning enables practitioners to

- Identify the multiple demands, required skills, and potential meanings of the activities and occupations and
- Gain a deeper understanding of the interrelationships among aspects of the domain that affect performance and that support client-centered interventions and outcomes.

Occupational therapy practitioners use theoretical principles and models, knowledge about the effects of conditions on participation, and available evidence on the effectiveness of interventions to guide their reasoning. Professional reasoning ensures the accurate selection and application of client-centered evaluation methods, interventions, and outcome measures. Practitioners also apply their knowledge and skills to enhance clients' participation in occupations and promote their health and well-being regardless of the effects of disease, disability, and occupational disruption or deprivation.

Evaluation

The evaluation process is focused on finding out what the client wants and needs to do; determining what the client can do and has done; and identifying supports and barriers to health, well-being, and participation. Evaluation occurs during the initial and all subsequent interactions with a client. The type and focus of the evaluation differ depending on the practice setting; however, all evaluations should assess the complex and multifaceted needs of each client.

The evaluation consists of the occupational profile and the analysis of occupational performance, which are synthesized to inform the intervention plan (Hinojosa et al., 2014). Although it is the responsibility of the occupational therapist to initiate the evaluation process, both occupational therapists and occupational therapy assistants may contribute to the evaluation, following which the occupational therapist completes the analysis and synthesis of information for the development of the intervention plan (AOTA, 2020a). The occupational profile includes information about the client's needs, problems, and concerns about performance in occupations. The analysis of occupational performance focuses on collecting and interpreting information specifically to identify supports and barriers related to occupational performance and establish targeted outcomes.

Although the *OTPF–4* describes the components of the evaluation process separately and sequentially, the exact manner in which occupational therapy practitioners collect client information is influenced by client needs, practice settings, and frames of reference or practice models. The evaluation process for groups and populations mirrors that for individual clients.

In some settings, the occupational therapist first completes a screening or consultation to determine the appropriateness of a full occupational therapy evaluation (Hinojosa et al., 2014). This process may include

- Review of client history (e.g., medical, health, social, or academic records),
- Consultation with an interprofessional or referring team, and
- Use of standardized or structured screening instruments.

The screening or consultation process may result in the development of a brief occupational profile and recommendations for full occupational therapy evaluation and intervention (Hinojosa et al., 2014).

Occupational Profile

The *occupational profile* is a summary of a client's (person's, group's, or population's) occupational history and experiences, patterns of daily living, interests, values, needs, and relevant contexts (AOTA, 2017a). Developing the occupational profile provides the occupational therapy practitioner with an understanding of the client's perspective and background.

Using a client-centered approach, the occupational therapy practitioner gathers information to understand what is currently important and meaningful to the client (i.e., what the client wants and needs to do) and to identify past experiences and interests that may assist in the understanding of current issues and problems. During the process of collecting this information, the client, with the assistance of the practitioner, identifies priorities and desired

targeted outcomes that will lead to the client's engagement in occupations that support participation in daily life. Only clients can identify the occupations that give meaning to their lives and select the goals and priorities that are important to them. By valuing and respecting clients' input, practitioners help foster their involvement and can more effectively guide interventions.

Occupational therapy practitioners collect information for the occupational profile at the beginning of contact with clients to establish client-centered outcomes. Over time, practitioners collect additional information, refine the profile, and ensure that the additional information is reflected in changes subsequently made to targeted outcomes. The process of completing and refining the occupational profile varies by setting and client and may occur continuously throughout the occupational therapy process.

Information gathering for the occupational profile may be completed in one session or over a longer period while working with the client. For clients who are unable to participate in this process, their profile may be compiled through interaction with family members or other significant people in their lives. Information for the occupational profile may also be gathered from available and relevant records.

Obtaining information for the occupational profile through both formal and informal interview techniques and conversation is a way to establish a therapeutic relationship with clients and their support network. Techniques used should be appropriate and reflective of clients' preferred method and style of communication (e.g., use of a communication board, translation services). Practitioners may use AOTA's Occupational Profile Template as a guide to completing the occupational profile (AOTA, 2017a). The information obtained through the occupational profile contributes to an individualized approach in the evaluation, intervention planning, and intervention implementation stages. Information is collected in the following areas:

- Why is the client seeking services, and what are the client's current concerns relative to engaging in occupations and in daily life activities?
- In what occupations does the client feel successful, and what barriers are affecting their success in desired occupations?
- What is the client's occupational history (i.e., life experiences)?
- What are the client's values and interests?
- What aspects of their contexts (environmental and personal factors) does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement?
- How are the client's performance patterns supporting or limiting occupational performance and engagement?
- What are the client's patterns of engagement in occupations, and how have they changed over time?
- What client factors does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement (e.g., pain, active symptoms)?
- What are the client's priorities and desired targeted outcomes related to occupational performance, prevention, health and wellness, quality of life, participation, role competence, well-being, and occupational justice?

After the practitioner collects profile data, the occupational therapist views the information and develops a working hypothesis regarding possible reasons for the identified problems and concerns. Reasons could include impairments in performance skills, performance patterns, or client factors or barriers within relevant contexts. In addition, the therapist notes the client's strengths and supports in all areas because these can inform the intervention plan and affect targeted outcomes.

Analysis of Occupational Performance

Occupational performance is the accomplishment of the selected occupation resulting from the dynamic transaction among the client, their contexts, and the occupation. In the *analysis of occupational performance,* the practitioner identifies the client's ability to effectively complete desired occupations. The client's assets and limitations or potential problems are more specifically determined through

assessment tools designed to analyze, measure, and inquire about factors that support or hinder occupational performance.

Multiple methods often are used during the evaluation process to assess the client, contexts, occupations, and occupational performance. Methods may include observation and analysis of the client's performance of specific occupations and assessment of specific aspects of the client or their performance. The approach to the analysis of occupational performance is determined by the information gathered through the occupational profile and influenced by models of practice and frames of reference appropriate to the client and setting. The analysis of occupational performance involves one or more of the following:

- Synthesizing information from the occupational profile to determine specific occupations and contexts that need to be addressed
- Completing an occupational or activity analysis to identify the demands of occupations and activities on the client
- Selecting and using specific assessments to measure the quality of the client's performance or performance deficits while completing occupations or activities relevant to desired occupations, noting the effectiveness of performance skills and performance patterns
- Selecting and using specific assessments to measure client factors that influence performance skills and performance patterns
- Selecting and administering assessments to identify and measure more specifically the client's contexts and their impact on occupational performance.

Occupational performance may be measured through standardized, formal, and structured assessment tools, and when necessary informal approaches may also be used (Asher, 2014). Standardized assessments are preferred, when available, to provide objective data about various aspects of the domain influencing engagement and performance. The use of valid and reliable assessments for obtaining trustworthy information can also help support and justify the need for occupational therapy services (Doucet & Gutman, 2013; Hinojosa & Kramer, 2014). In addition, the use of standardized outcome performance measures and outcome tools assists in establishing a baseline of occupational performance to allow for objective measurement of progress after intervention.

Synthesis of the Evaluation Process

The occupational therapist synthesizes the information gathered through the occupational profile and analysis of occupational performance. This process may include the following:

- Determining the client's values and priorities for occupational participation
- Interpreting the assessment data to identify supports and hindrances to occupational performance
- Developing and refining hypotheses about the client's occupational performance strengths and deficits
- Considering existing support systems and contexts and their ability to support the intervention process
- Determining desired outcomes of the intervention
- Creating goals in collaboration with the client that address the desired outcomes
- Selecting outcome measures and determining procedures to measure progress toward the goals of intervention, which may include repeating assessments used in the evaluation process.

Any outcome assessment used by occupational therapy practitioners must be consistent with clients' belief systems and underlying assumptions regarding their desired occupational performance. Occupational therapy practitioners select outcome assessments pertinent to clients' needs and goals, congruent with the practitioner's theoretical model of practice. Assessment selection is also based on the practitioner's knowledge of and available evidence for the psychometric properties of standardized measures or the rationale and protocols for nonstandardized structured measures. In addition, clients' perception of success in engaging in desired occupations is a vital part of outcome assessment (Bandura, 1986). The occupational therapist uses the synthesis and summary of information from the

evaluation and established targeted outcomes to guide the intervention process.

Intervention

The intervention process consists of services provided by occupational therapy practitioners in collaboration with clients to facilitate engagement in occupation related to health, well-being, and achievement of established goals consistent with the various service delivery models. Practitioners use the information about clients gathered during the evaluation and theoretical principles to select and provide occupation-based interventions to assist clients in achieving physical, mental, and social well-being; identifying and realizing aspirations; satisfying needs; and changing or coping with contextual factors.

Types of occupational therapy interventions are categorized as occupations and activities, interventions to support occupations, education and training, advocacy, group interventions, and virtual interventions (Table 12). Approaches to intervention include create or promote, establish or restore, maintain, modify, and prevent (Table 13). Across all types of and approaches to interventions, it is imperative that occupational therapy practitioners maintain an understanding of the *Occupational Therapy Code of Ethics* (AOTA, 2015a) and the *Standards of Practice for Occupational Therapy* (AOTA, 2015c).

Intervention is intended to promote health, well-being, and participation. *Health promotion* is "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986). Wilcock (2006) stated,

> Following an occupation-based health promotion approach to well-being embraces a belief that the potential range of what people can do, be, and strive to become is the primary concern, and that health is a by-product. A varied and full occupational lifestyle will coincidentally maintain and improve health and well-being if it enables people to be creative and adventurous physically, mentally, and socially. (p. 315)

Interventions vary depending on the client—person, group, or population—and the context of service delivery. The actual term used for clients or groups of clients receiving occupational therapy varies among practice settings and delivery models. For example, when working in a hospital, the person or group might be referred to as a *patient* or *patients,* and in a school, the clients might be *students.* Early intervention requires practitioners to work with the family system as their clients. When practitioners provide consultation to an organization, clients may be called *consumers* or *members.* Terms used for others who may help or be served indirectly include, but are not limited to, *caregiver, teacher, parent, employer,* or *spouse*.

Intervention can also be in the form of collective services to groups and populations. Such intervention can occur as direct service provision or consultation. When consulting with an organization, occupational therapy practitioners may use strategic planning, change agent plans, and other program development approaches. Practitioners addressing the needs of a population direct their interventions toward current or potential diseases or conditions with the goal of enhancing the health, well-being, and participation of all members collectively. With groups and populations, the intervention focus is often on health promotion, prevention, and screening. Interventions may include (but are not limited to) self-management training, educational services, and environmental modification. For instance, occupational therapy practitioners may provide education on falls prevention and the impact of fear of falling to residents in an assisted living center or training to people facing a mental health challenge in use of the internet to identify and coordinate community resources that meet their needs.

Occupational therapy practitioners work with a wide variety of populations experiencing difficulty in accessing and engaging in healthy occupations because of factors such as poverty, homelessness, displacement, and discrimination. For example, practitioners can work with organizations providing services to refugees and asylum seekers to identify opportunities to reestablish occupational roles and enhance well-being and quality of life.

The intervention process is divided into three components: (1) intervention plan, (2) intervention implementation, and (3) intervention review. During the intervention process, the occupational therapy practitioner integrates information from the evaluation with theory,

practice models, frames of reference, and research evidence on interventions, including those that support occupations. This information guides the practitioner's professional reasoning in intervention planning, implementation, and review. Because evaluation is ongoing, revision may occur at any point during the intervention process.

Intervention Plan

The *intervention plan,* which directs the actions of occupational therapy practitioners, describes the occupational therapy approaches and types of interventions selected for use in reaching clients' targeted outcomes. The intervention plan is developed collaboratively with clients or their proxies and is directed by

- Client goals, values, beliefs, and occupational needs and
- Client health and well-being,

as well as by the practitioners' evaluation of

- Client occupational performance needs;
- Collective influence of the contexts, occupational or activity demands, and client factors on the client;
- Client performance skills and performance patterns;
- Context of service delivery in which the intervention is provided; and
- Best available evidence.

The occupational therapist designs the intervention plan on the basis of established treatment goals, addressing the client's current and potential situation related to engagement in occupations or activities. The intervention plan should reflect the priorities of the client, information on occupational performance gathered through the evaluation process, and targeted outcomes of the intervention. Intervention planning includes the following steps:

1. Developing the plan, which involves selecting
   - Objective and measurable occupation-based goals and related time frames;
   - Occupational therapy intervention approach or approaches; and
   - Methods for service delivery, including what types of interventions will be provided, who will provide the interventions, and which service delivery approaches will be used;
2. Considering potential discharge needs and plans; and
3. Making recommendations or referrals to other professionals as needed.

Steps 2 and 3 are discussed in the Outcomes section.

Intervention Implementation

Intervention implementation is the process of putting the intervention plan into action and occurs after the initial evaluation process and development of the intervention plan. Interventions may focus on a single aspect of the occupational therapy domain, such as a specific occupation, or on several aspects of the domain, such as contexts, performance patterns, and performance skills, as components of one or more occupations. Intervention implementation must always reflect the occupational therapy scope of practice; occupational practitioners should not perform interventions that do not use purposeful and occupation-based approaches (Gillen et al., 2019).

Intervention implementation includes the following steps (see Table 12):

- Select and carry out the intervention or interventions, which may include the following:
  - Therapeutic use of occupations and activities
  - Interventions to support occupations
  - Education
  - Training
  - Advocacy
  - Self-advocacy
  - Group intervention
  - Virtual interventions.
- Monitor the client's response through ongoing evaluation and reevaluation.

Given that aspects of the domain are interrelated and influence one another in a continuous, dynamic process, occupational therapy practitioners expect that a client's ability to adapt, change, and develop in one area will affect other areas. Because of this dynamic interrelationship, evaluation, including analysis of occupational performance, and intervention planning continue throughout the implementation process. In addition, intervention implementation includes monitoring of the client's response to specific interventions and progress toward goals.

Intervention Review

Intervention review is the continuous process of reevaluating and reviewing the intervention plan, the effectiveness of its delivery, and progress toward outcomes. As during intervention planning, this process includes collaboration with the client to identify progress toward goals and outcomes. Reevaluation and review may lead to change in the intervention plan. Practitioners should review best practices for using process indicators and, as appropriate, modify the intervention plan and monitor progress using outcome performance measures and outcome tools. Intervention review includes the following steps:

1. Reevaluating the plan and how it is implemented relative to achieving outcomes
2. Modifying the plan as needed
3. Determining the need for continuation or discontinuation of occupational therapy services and for referral to other services.

Outcomes

Outcomes emerge from the occupational therapy process and describe the results clients can achieve through occupational therapy intervention (Table 14). The outcomes of occupational therapy are multifaceted and may occur in all aspects of the domain of concern. Outcomes should be measured with the same methods used at evaluation and determined through comparison of the client's status at evaluation with the client's status at discharge or transition. Results of occupational therapy services are established using outcome performance measures and outcome tools.

Outcomes are directly related to the interventions provided and to the targeted occupations, performance patterns, performance skills, client factors, and contexts. Outcomes may be traced to improvement in areas of the domain, such as performance skills and client factors, but should ultimately be reflected in clients' ability to engage in their desired occupations. Outcomes targeted in occupational therapy can be summarized as

- Occupational performance,
- Prevention,
- Health and wellness,
- Quality of life,
- Participation,
- Role competence,
- Well-being, and
- Occupational justice.

Occupational adaptation, or the client's effective and efficient response to occupational and contextual demands (Grajo, 2019), is interwoven through all of these outcomes.

The impact of outcomes and the way they are defined are specific to clients (persons, groups, or populations) and to other stakeholders such as payers and regulators. Outcomes and their documentation vary by practice setting and are influenced by the stakeholders in each setting (AOTA, 2018a).

The focus on outcomes is woven throughout the process of occupational therapy. During evaluation, occupational therapy practitioners and clients (and often others, such as parents and caregivers) collaborate to identify targeted outcomes related to engagement in valued occupations or daily life activities. These outcomes are the basis for development of the intervention plan. During intervention implementation and review, clients and practitioners may modify targeted outcomes to accommodate changing needs, contexts, and performance abilities. Ultimately, the intervention process should result in the achievement of outcomes related to

health, well-being, and participation in life through engagement in occupation.

Outcome Measurement

Objective outcomes are measurable and tangible aspects of improved performance. Outcome measurement is sometimes derived from standardized assessments, with results reflected in numerical data following specific scoring instructions. These data quantify a client's response to intervention in a way that can be used by all relevant stakeholders. Objective outcome measures are selected early in the occupational therapy process on the basis of properties showing that they are

- Valid, reliable, and appropriately sensitive to change in the client's occupational performance,
- Consistent with targeted outcomes,
- Congruent with the client's goals, and
- Able to predict future outcomes.

Practitioners use objective outcome measures to measure progress and adjust goals and interventions by

- Comparing progress toward goal achievement with outcomes throughout the intervention process and
- Measuring and assessing results to make decisions about the future direction of intervention (e.g., continue, modify, transition, discontinue, provide follow-up, refer for other service).

In some settings, the focus is on *patient-reported outcomes* (PROs), which have been defined as "any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else" (National Quality Forum, n.d., para. 1). PROs can be used as subjective measures of improved outlook, confidence, hope, playfulness, self-efficacy, sustainability of valued occupations, pain reduction, resilience, and perceived well-being. An example of a PRO is parents' greater perceived efficacy in parenting through a new understanding of their child's behavior (Cohn, 2001; Cohn et al., 2000; Graham et al., 2013). Another example is a report by an outpatient client with a hand injury of a reduction in pain during the IADL of doing laundry. "PRO tools measure what patients are able to do and how they feel by asking questions. These tools enable assessment of patient-reported health status for physical, mental, and social well-being" (National Quality Forum, n.d., para. 1).

Outcomes can also be designed for caregivers—for example, improved quality of life for both care recipient and caregiver. Studies of caregivers of people with dementia who received a home environmental intervention found fewer declines in occupational performance, enhanced mastery and skill, improved sense of self-efficacy and well-being, and less need for help with care recipients (Gitlin & Corcoran, 2005; Gitlin et al., 2001, 2003, 2008; Graff et al., 2007; Piersol et al., 2017).

Outcomes for groups that receive an educational intervention may include improved social interaction, increased self-awareness through peer support, a larger social network, or improved employee health and productivity. For example, education interventions for groups of employees on safety and workplace wellness have been shown to decrease work injuries and increase workplace productivity and satisfaction (Snodgrass & Amini, 2017).

Outcomes for populations may address health promotion, occupational justice and self-advocacy, health literacy, community integration, community living, and access to services. As with other occupational therapy clients, outcomes for populations are focused on occupational performance, engagement, and participation. For example, outcomes at the population level as a result of advocacy interventions include construction of accessible playground facilities, improved accessibility for polling places, and reconstruction of a school after a natural disaster.

Transition and Discontinuation

Transition is movement from one life role or experience to another. Transitions in services, like all life transitions, may require preparation, new knowledge, and time to accommodate to the new situation (Orentlicher et al., 2015). Transition planning may be needed, for example, when a client moves from one setting to another along the care continuum (e.g., acute hospital to skilled nursing

facility) or ages out of one program and into a new one (e.g., early intervention to elementary school). Collaboration among practitioners is necessary to ensure safety, well-being, and optimal outcomes for clients (Joint Commission, 2012, 2013).

Transition planning may include a referral to a provider within occupational therapy with advanced knowledge and skill (e.g., vestibular rehabilitation, driver evaluation, hand therapy) or outside the profession (e.g., psychologist, optometrist). Transition planning for groups and populations may be needed for a transition from one stage to another (e.g., middle school students in a life skills program who transition to high school) or from one set of needs to another (e.g., older adults in a community falls prevention program who transition to a community exercise program).

Planning for discontinuation of occupational therapy services begins at initial evaluation. Discontinuation of care occurs when the client ends services after meeting short- and long-term goals or chooses to discontinue receiving services (consistent with client-centered care). Safe and effective discharge planning for a person may include education on the use of new equipment, adaptation of an occupation, caregiver training, environmental modification, or determination of the appropriate setting for transition of care. A key goal of discharge planning for individual clients is prevention of readmission (Rogers et al., 2017). Discontinuation of services for groups and populations occurs when goals are met and sustainability plans are implemented for long-term success.

Conclusion

The *OTPF–4* describes the central concepts that ground occupational therapy practice and builds a common understanding of the basic tenets and distinct contribution of the profession. The occupational therapy domain and process are linked inextricably in a transactional relationship. An understanding of this relationship supports and guides the complex decision making required in the daily practice of occupational therapy and enhances practitioners' ability to define the reasons for and justify the provision of services when communicating with clients, family members, team members, employers, payers, and policymakers.

This edition of the *OTPF* provides a broader view than previous editions of occupational therapy as related to groups and populations and current and future occupational needs of clients. It also presents and describes the cornerstones of occupational therapy practice, which are discrete and critical qualities of occupational therapy practitioners that provide them with a foundation for success in the occupational therapy process. The *OTPF–4* highlights the distinct value of occupation and occupational therapy in contributing to health, well-being, and participation in life for persons, groups, and populations. This document can be used to advocate for the importance of occupational therapy in meeting society's current and future needs, ultimately advancing the profession to ensure a sustainable future.

Table 1. Examples of Clients: Persons, Groups, and Populations

Person	Group	Population
Health Management		
Middle-school student with diabetes interested in developing self-management skills to test blood sugar levels	Group of students with diabetes interested in problem solving the school setting's support for management of their condition	All students in the school provided with access to food choices to meet varying dietary needs and desires
Feeding		
Family of an infant with a history of prematurity and difficulty accepting nutrition orally	Families with infants experiencing feeding challenges advocating for the local hospital's rehabilitation services to develop infant feeding classes	Families of infants advocating for research and development of alternative nipple and bottle designs to address feeding challenges
Community Mobility		
Person with stroke who wants to return to driving	Stroke support group talking with elected leaders about developing community mobility resources	Stroke survivors advocating for increased access to community mobility options for all persons living with mobility limitations
Social Participation		
Young adult with IDD interested in increasing social participation	Young adults with IDD in a transition program sponsoring leisure activities in which all may participate in valued social relationships	Young adults with IDD educating their community about their need for inclusion in community-based social and leisure activities
Home Establishment and Management		
Person living with SMI interested in developing skills for independent living	Support group for people living with SMI developing resources to foster independent living	People living with SMI in the same region advocating for increased housing options for independent living
Work Participation		
Older worker with difficulty performing some work tasks	Group of older workers in a factory advocating for modification of equipment to address discomfort when operating the same set of machines	Older workers in a national corporation advocating for company-wide wellness support programs

Note. IDD = intellectual and developmental disabilities; SMI = serious mental illness.

Table 2. Occupations

Occupations are "the everyday activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do" (World Federation of Occupational Therapists, 2012a, para. 2). Occupations are categorized as activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure, and social participation.

Occupation	Description
Activities of Daily Living (ADLs)—Activities oriented toward taking care of one's own body and completed on a routine basis (adapted from Rogers & Holm, 1994).	
Bathing, showering	Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; transferring to and from bathing positions
Toileting and toilet hygiene	Obtaining and using toileting supplies, managing clothing, maintaining toileting position, transferring to and from toileting position, cleaning body, caring for menstrual and continence needs (including catheter, colostomy, and suppository management), maintaining intentional control of bowel movements and urination and, if necessary, using equipment or agents for bladder control (Uniform Data System for Medical Rehabilitation, 1996, pp. III-20, III-24)
Dressing	Selecting clothing and accessories with consideration of time of day, weather, and desired presentation; obtaining clothing from storage area; dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; applying and removing personal devices, prosthetic devices, or splints
Eating and swallowing	Keeping and manipulating food or fluid in the mouth, swallowing it (i.e., moving it from the mouth to the stomach)
Feeding	Setting up, arranging, and bringing food or fluid from the vessel to the mouth (includes self-feeding and feeding others)
Functional mobility	Moving from one position or place to another (during performance of everyday activities), such as in-bed mobility, wheelchair mobility, and transfers (e.g., wheelchair, bed, car, shower, tub, toilet, chair, floor); includes functional ambulation and transportation of objects
Personal hygiene and grooming	Obtaining and using supplies; removing body hair (e.g., using a razor or tweezers); applying and removing cosmetics; washing, drying, combing, styling, brushing, and trimming hair; caring for nails (hands and feet); caring for skin, ears, eyes, and nose; applying deodorant; cleaning mouth; brushing and flossing teeth; removing, cleaning, and reinserting dental orthotics and prosthetics
Sexual activity	Engaging in the broad possibilities for sexual expression and experiences with self or others (e.g., hugging, kissing, foreplay, masturbation, oral sex, intercourse)
Instrumental Activities of Daily Living (IADLs)—Activities to support daily life within the home and community.	
Care of others (including selection and supervision of caregivers)	Providing care for others, arranging or supervising formal care (by paid caregivers) or informal care (by family or friends) for others

(Continued)

Table 2. Occupations *(cont'd)*

Occupation	Description
Care of pets and animals	Providing care for pets and service animals, arranging or supervising care for pets and service animals
Child rearing	Providing care and supervision to support the developmental and physiological needs of a child
Communication management	Sending, receiving, and interpreting information using systems and equipment such as writing tools, telephones (including smartphones), keyboards, audiovisual recorders, computers or tablets, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for deaf people, augmentative communication systems, and personal digital assistants
Driving and community mobility	Planning and moving around in the community using public or private transportation, such as driving, walking, bicycling, or accessing and riding in buses, taxi cabs, ride shares, or other transportation systems
Financial management	Using fiscal resources, including financial transaction methods (e.g., credit card, digital banking); planning and using finances with long-term and short-term goals
Home establishment and management	Obtaining and maintaining personal and household possessions and environments (e.g., home, yard, garden, houseplants, appliances, vehicles), including maintaining and repairing personal possessions (e.g., clothing, household items) and knowing how to seek help or whom to contact
Meal preparation and cleanup	Planning, preparing, and serving meals and cleaning up food and tools (e.g., utensils, pots, plates) after meals
Religious and spiritual expression	Engaging in religious or spiritual activities, organizations, and practices for self-fulfillment; finding meaning or religious or spiritual value; establishing connection with a divine power, such as is involved in attending a church, temple, mosque, or synagogue; praying or chanting for a religious purpose; engaging in spiritual contemplation (World Health Organization, 2008); may also include giving back to others, contributing to society or a cause, and contributing to a greater purpose
Safety and emergency maintenance	Evaluating situations in advance for potential safety risks; recognizing sudden, unexpected hazardous situations and initiating emergency action; reducing potential threats to health and safety, including ensuring safety when entering and exiting the home, identifying emergency contact numbers, and replacing items such as batteries in smoke alarms and light bulbs
Shopping	Preparing shopping lists (grocery and other); selecting, purchasing, and transporting items; selecting method of payment and completing payment transactions; managing internet shopping and related use of electronic devices such as computers, cell phones, and tablets

(Continued)

Table 2. Occupations *(cont'd)*

Occupation	Description
Health Management—Activities related to developing, managing, and maintaining health and wellness routines, including self-management, with the goal of improving or maintaining health to support participation in other occupations.	
Social and emotional health promotion and maintenance	Identifying personal strengths and assets, managing emotions, expressing needs effectively, seeking occupations and social engagement to support health and wellness, developing self-identity, making choices to improve quality of life in participation
Symptom and condition management	Managing physical and mental health needs, including using coping strategies for illness, trauma history, or societal stigma; managing pain; managing chronic disease; recognizing symptom changes and fluctuations; developing and using strategies for managing and regulating emotions; planning time and establishing behavioral patterns for restorative activities (e.g., meditation); using community and social supports; navigating and accessing the health care system
Communication with the health care system	Expressing and receiving verbal, written, and digital communication with health care and insurance providers, including understanding and advocating for self or others
Medication management	Communicating with the physician about prescriptions, filling prescriptions at the pharmacy, interpreting medication instructions, taking medications on a routine basis, refilling prescriptions in a timely manner (American Occupational Therapy Association, 2017c; Schwartz & Smith, 2017)
Physical activity	Completing cardiovascular exercise, strength training, and balance training to improve or maintain health and decrease risk of health episodes, such as by incorporating walks into daily routine
Nutrition management	Implementing and adhering to nutrition and hydration recommendations from the medical team, preparing meals to support health goals, participating in health-promoting diet routines
Personal care device management	Procuring, using, cleaning, and maintaining personal care devices, including hearing aids, contact lenses, glasses, orthotics, prosthetics, adaptive equipment, pessaries, glucometers, and contraceptive and sexual devices
Rest and Sleep—Activities related to obtaining restorative rest and sleep to support healthy, active engagement in other occupations.	
Rest	Identifying the need to relax and engaging in quiet and effortless actions that interrupt physical and mental activity (Nurit & Michal, 2003, p. 227); reducing involvement in taxing physical, mental, or social activities, resulting in a relaxed state; engaging in relaxation or other endeavors that restore energy and calm and renew interest in engagement
Sleep preparation	Engaging in routines that prepare the self for a comfortable rest, such as grooming and undressing, reading or listening to music, saying goodnight to others, and engaging in meditation or prayers; determining the time of day and length of time

(Continued)

Table 2. Occupations *(cont'd)*

Occupation	Description
	desired for sleeping and the time needed to wake; establishing sleep patterns that support growth and health (patterns are often personally and culturally determined); preparing the physical environment for periods of sleep, such as making the bed or space on which to sleep, ensuring warmth or coolness and protection, setting an alarm clock, securing the home (e.g., by locking doors or closing windows or curtains), setting up sleep-supporting equipment (e.g., CPAP machine), and turning off electronics and lights
Sleep participation	Taking care of personal needs for sleep, such as ceasing activities to ensure onset of sleep, napping, and dreaming; sustaining a sleep state without disruption; meeting nighttime toileting and hydration needs, including negotiating the needs of and interacting with others (e.g., children, partner) within the social environment, such as providing nighttime caregiving (e.g., breastfeeding) and monitoring comfort and safety of others who are sleeping
Education—Activities needed for learning and participating in the educational environment.	
Formal educational participation	Participating in academic (e.g., math, reading, degree coursework), nonacademic (e.g., recess, lunchroom, hallway), extracurricular (e.g., sports, band, cheerleading, dances), technological (e.g., online assignment completion, distance learning), and vocational (including prevocational) educational activities
Informal personal educational needs or interests exploration (beyond formal education)	Identifying topics and methods for obtaining topic-related information or skills
Informal educational participation	Participating in classes, programs, and activities that provide instruction or training outside of a structured curriculum in identified areas of interest
Work—Labor or exertion related to the development, production, delivery, or management of objects or services; benefits may be financial or nonfinancial (e.g., social connectedness, contributions to society, structure and routine to daily life; Christiansen & Townsend, 2010; Dorsey et al., 2019).	
Employment interests and pursuits	Identifying and selecting work opportunities consistent with personal assets, limitations, goals, and interests (adapted from Mosey, 1996, p. 342)
Employment seeking and acquisition	Advocating for oneself; completing, submitting, and reviewing application materials; preparing for interviews; participating in interviews and following up afterward; discussing job benefits; finalizing negotiations
Job performance and maintenance	Creating, producing, and distributing products and services; maintaining required work skills and patterns; managing time use; managing relationships with coworkers, managers, and customers; following and providing leadership and supervision; initiating, sustaining, and completing work; complying with work norms and procedures; seeking and responding to feedback on performance

(Continued)

Table 2. Occupations *(cont'd)*

Occupation	Description
Retirement preparation and adjustment	Determining aptitudes, developing interests and skills, selecting vocational pursuits, securing required resources, adjusting lifestyle in the absence of the worker role
Volunteer exploration	Identifying and learning about community causes, organizations, and opportunities for unpaid work consistent with personal skills, interests, location, and time available
Volunteer participation	Performing unpaid work activities for the benefit of selected people, causes, or organizations
Play—Activities that are intrinsically motivated, internally controlled, and freely chosen and that may include suspension of reality (e.g., fantasy; Skard & Bundy, 2008), exploration, humor, risk taking, contests, and celebrations (Eberle, 2014; Sutton-Smith, 2009). Play is a complex and multidimensional phenomenon that is shaped by sociocultural factors (Lynch et al., 2016).	
Play exploration	Identifying play activities, including exploration play, practice play, pretend play, games with rules, constructive play, and symbolic play (adapted from Bergen, 1988, pp. 64–65)
Play participation	Participating in play; maintaining a balance of play with other occupations; obtaining, using, and maintaining toys, equipment, and supplies
Leisure—"Nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep" (Parham & Fazio, 1997, p. 250).	
Leisure exploration	Identifying interests, skills, opportunities, and leisure activities
Leisure participation	Planning and participating in leisure activities; maintaining a balance of leisure activities with other occupations; obtaining, using, and maintaining equipment and supplies
Social Participation—Activities that involve social interaction with others, including family, friends, peers, and community members, and that support social interdependence (Bedell, 2012; Khetani & Coster, 2019; Magasi & Hammel, 2004).	
Community participation	Engaging in activities that result in successful interaction at the community level (e.g., neighborhood, organization, workplace, school, digital social network, religious or spiritual group)
Family participation	Engaging in activities that result in "interaction in specific required and/or desired familial roles" (Mosey, 1996, p. 340)
Friendships	Engaging in activities that support "a relationship between two people based on mutual liking in which partners provide support to each other in times of need" (Hall, 2017, para. 2)
Intimate partner relationships	Engaging in activities to initiate and maintain a close relationship, including giving and receiving affection and interacting in desired roles; intimate partners may or may not engage in sexual activity
Peer group participation	Engaging in activities with others who have similar interests, age, background, or social status

Note. CPAP = continuous positive airway pressure.

Table 3. Examples of Occupations for Persons, Groups, and Populations
Persons engage in occupations, and groups engage in shared occupations; populations as a whole do not engage in shared occupations, which happen at the person or group level. Occupational therapy practitioners provide interventions for persons, groups, and populations.

Occupation Category	Client Type	Example
Activities of daily living	Person	Older adult completing bathing with assistance from an adult child
	Group	Students eating lunch during a lunch break
Instrumental activities of daily living	Person	Parent using a phone app to pay a babysitter electronically
	Group	Club members using public transportation to arrive at a musical performance
Health management	Person	Patient scheduling an appointment with a specialist after referral by the primary care doctor
	Group	Parent association sharing preparation of healthy foods to serve at a school-sponsored festival
Rest and sleep	Person	Person turning off lights and adjusting the room temperature to 68° before sleep
	Group	Children engaging in nap time at a day care center
Education	Person	College student taking an African-American history class online
	Group	Students working on a collaborative science project on robotics
Work	Person	Electrician turning off power before working on a power line
	Group	Peers volunteering for a day of action at an animal shelter
Play	Person	Child playing superhero dress up
	Group	Class playing freeze tag during recess
Leisure	Person	Family member knitting a sweater for a new baby
	Group	Friends meeting for a craft circle
Social participation	Person	New mother going to lunch with friends
	Group	Older adults gathering at a community center to wrap holiday presents for charity distribution

Table 4. Context: Environmental Factors

Context is the broad construct that encompasses environmental factors and personal factors. *Environmental factors* are aspects of the physical, social, and attitudinal surroundings in which people live and conduct their lives.

Environmental Factor	Components	Examples
Natural environment and human-made changes to the environment: Animate and inanimate elements of the natural or physical environment and components of that environment that have been modified by people, as well as characteristics of human populations within the environment	Physical geography	• Raised flower beds in a backyard • Local stream cleanup by Boy Scouts during a community service day project • Highway expansion cutting through an established neighborhood
	Population: Groups of people living in a given environment who share the same pattern of environmental adaptation	• Universal access playground where children with mobility impairment can play • Hearing loop installed in a synagogue for congregation members with hearing aids • Tree-shaded, solid-surface walking path enjoyed by older adults in a senior living community
	Flora (plants) and fauna (animals)	• Nonshedding service dog • Family-owned herd of cattle • Community garden
	Climate: Meteorological features and events, such as weather	• Sunny day requiring use of sunglasses • Rain shower prompting a crew of road workers to don rain gear • Unusually high temperatures turning a community ice skating pond to slush
	Natural events: Regular or irregular geographic and atmospheric changes that cause disruption in the physical environment	• Barometric pressure causing a headache • Flood of a local creek damaging neighborhood homes • Hurricane devastating a low-lying region
	Human-caused events: Alterations or disturbances in the natural environment caused by humans that result in the disruption of day-to-day life	• High air pollution forcing a person with lung disease to stay indoors • Accessible dock at a local river park demolished to make way for a new bridge construction project • Derailment of a train loaded with highly combustible chemicals leading to the emergency total evacuation of a small town
	Light: Light intensity and quality	• Darkness requiring use of a reading lamp • Office with ample natural light • Street lamps
	Time-related changes: Natural, regularly occurring, or predictable change; rhythm and duration of activity; time of day, week, month, season, or year; day–night cycles; lunar cycles	• Jet lag • Quitting time at the end of a work shift • Summer solstice

(Continued)

Table 4. Context: Environmental Factors *(cont'd)*

Environmental Factor	Components	Examples
	Sound and vibration: Heard or felt phenomena that may provide useful or distracting information about the world	• Vibration of a cell phone indicating a text message • Bell signaling the start of the school day • Outdoor emergency warning system on a college campus
	Air quality: Characteristics of the atmosphere (outside buildings) or enclosed areas of air (inside buildings)	• Heavy perfume use by a family member causing an asthmatic reaction • Smoking area outside an office building • High incidence of respiratory diseases near an industrial district
Products and technology: Natural or human-made products or systems of products, equipment, and technology that are gathered, created, produced, or manufactured	Food, drugs, and other products or substances for personal consumption	• Preferred snack • Injectable hormones for a transgender man • Grade-school cafeteria lunch
	General products and technology for personal use in daily living (including assistive technology and products)	• Toothbrush • Household refrigerator • Shower in a fitness or exercise facility
	Personal indoor and outdoor mobility and transportation equipment used by people in activities requiring movement inside and outside of buildings	• Four-wheeled walker • Family car • Elevator in a multistory apartment building
	Communication: Activities involving sending and receiving information	• Hearing aid • Text chain via personal cell phones • Use of emergency response system to warn region of impending dangerous storms
	Education: Processes and methods for acquiring knowledge, expertise, or skill	• Textbook • Online course • Curriculum for workplace sexual harassment program
	Employment: Paid work activities	• Home office for remote work • Assembly factory • Internet connection for health care workers to access electronic medical records
	Cultural, recreational, and sporting activities	• Gaming console • Instruments for a university marching band • Soccer stadium
	Practice of religion and spirituality	• Prayer rug • Temple • Sunday church service television broadcast
	Indoor and outdoor human-made environments that are planned, designed, and constructed for public and private use	• Home bathroom with grab bars and raised toilet seat • Accessible playground at a city park • Zero-grade entry to a shopping mall

(Continued)

Table 4. Context: Environmental Factors *(cont'd)*

Environmental Factor	Components	Examples
	Assets for economic exchange, such as money, goods, property, and other valuables that an individual owns or has rights to use	• Pocket change • Household budget • Condominium association tax bill
	Virtual environments occurring in simulated, real-time, and near-time situations, absent of physical contact	• Personal cell phone • Synchronous video meeting of coworkers in distant locations • Open-source video gaming community
Support and relationships: People or animals that provide practical physical or emotional support, nurturing, protection, assistance, and relationships to other persons in the home, workplace, or school or at play or in other aspects of their daily activities	Immediate and extended family	• Spouses, partners, parents, siblings, foster parents, and adoptive grandparents • Biological families and found or constructed families
	Friends, acquaintances, peers, colleagues, neighbors, and community members	• Trusted best friend • Coworkers • Helpful next-door neighbor • Substance abuse recovery support group sponsor
	People in positions of authority and those in subordinate positions	• Teacher who offers extra tutoring • Legal guardian for a parentless minor • Female religious reporting to a sister superior • New employee being oriented to the job tasks by an assigned mentor
	Personal care providers and personal assistants providing support to individuals	Health care professionals and other professionals serving a community
	Domesticated animals	• Therapy dog program in a senior living community • Horse kept to draw a buggy for an Amish family's transportation
Attitudes: Observable evidence of customs, practices, ideologies, values, norms, factual beliefs, and religious beliefs held by people other than the client	Individual attitudes of immediate and extended family, friends and acquaintances, peers and colleagues, neighbors and community members, people in positions of authority and subordinate positions, personal care providers and personal assistants, strangers, and health care and other professionals	• Shared grief over the untimely death of a sibling • Automatic trust from a patient who knows one's father • Reliance among members of a faith community
	Societal attitudes, including discriminatory practices	• Failure to acknowledge a young person who wants to vote for the first time • Racial discrimination in job hiring processes
	Social norms, practices, and ideologies that marginalize specific populations	No time off work allowed to observe a religion's holy day
Services, systems, and policies: Benefits, structured programs, and regulations for operations, provided by institutions in	Services designed to meet the needs of persons, groups, and populations	• Economic services, including Social Security income and public assistance

(Continued)

Table 4. Context: Environmental Factors *(cont'd)*

Environmental Factor	Components	Examples
various sectors of society, designed to meet the needs of persons, groups, and populations		• Health services for preventing and treating health problems, providing medical rehabilitation, and promoting healthy lifestyles
	Systems established by governments at the local, regional, national, and international levels or by other recognized authorities	• Public utilities (e.g., water, electricity, sanitation) • Communications (transmission and exchange of information) • Transportation systems • Political systems related to voting, elections, and governance
	Policies constituted by rules, regulations, conventions, and standards established by governments at the local, regional, national, and international levels or by other recognized authorities	• Architecture, construction, open space use, and housing policies • Civil protection and legal services • Labor and employment policies related to finding suitable work, looking for different work, or seeking promotion

Table 5. Context: Personal Factors

Context is the broad construct that encompasses environmental factors and personal factors. *Personal factors* are the particular background of a person's life and living and consist of the unique features of the person that are not part of a health condition or health state.

Personal Factor	Person A	Person B
Age (chronological)	• 48 years old	• 14 years old
Sexual orientation	• Attracted to men	• Attracted to all genders
Gender identity	• Female	• Male
Race and ethnicity	• Black French Caribbean	• Southeast Asian Hmong
Cultural identification and cultural attitudes	• Urban Black • Feminist • Caribbean island identification	• Traditional clan structure • Elders who are decision makers for community
Social background, social status, and socioeconomic status	• Urban, upscale neighborhood • Friends in the professional workforce • Income that allows for luxury	• Family owns small home • Father with a stable job in light manufacturing • Mother who is a child care provider for neighborhood children
Upbringing and life experiences	• No siblings • Raised in household with grandmother as caregiver • Moved from California to Boston while an adolescent	• Traditional • Born in a refugee camp before parents emigrated • Youngest of five siblings • Lives in a small city in the Upper Midwest
Habits and past and current behavioral patterns	• Coffee before anything else • Meticulous about dress	• Organized and attentive to family • Never misses a family meal
Individual psychological assets, including temperament, character traits, and coping styles, for handling responsibilities, stress, crises, and other psychological demands (e.g., extroversion, agreeableness, conscientiousness, psychic stability, openness to experience, optimism, confidence)	• Anxious when not working • Extroverted • High level of confidence • Readily adapts approach to and interactions with those who are culturally different	• Known for being calm • Not outgoing but friendly to all • Does not speak up or complain at school during conflict
Education	• Master's degree in political science • Law degree	• High school freshman • Advanced skills in the sciences
Profession and professional identity	• Public interest lawyer	• Public high school student
Lifestyle	• High-rise apartment • Likes urban nightlife and casual dating • Works long hours	• Engaged in clan and community • Four older siblings who live nearby
Other health conditions and fitness	• Treated for anorexia nervosa while an adolescent • Occasional runner	• Wears eyeglasses for astigmatism • Sedentary at home except for assigned chores

Table 6. Performance Patterns

Performance patterns are the habits, routines, roles, and rituals that may be associated with different lifestyles and used in the process of engaging in occupations or activities. These patterns are influenced by context and time use and can support or hinder occupational performance.

Category	Description	Examples
Person		
Habits	"Specific, automatic behaviors performed repeatedly, relatively automatically, and with little variation" (Matuska & Barrett, 2019, p. 214). Habits can be healthy or unhealthy, efficient or inefficient, and supportive or harmful (Dunn, 2000).	• Automatically puts car keys in the same place • Spontaneously looks both ways before crossing the street • Always turns off the stove burner before removing a cooking pot • Activates the alarm system before leaving the home • Always checks smartphone for emails or text messages on waking • Snacks when watching television
Routines	Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require delimited time commitment and are embedded in cultural and ecological contexts (Fiese, 2007; Segal, 2004).	• Follows a morning sequence to complete toileting, bathing, hygiene, and dressing • Follows the sequence of steps involved in meal preparation • Manages morning routine to drop children off at school and arrive at work on time
Roles	Aspects of identity shaped by culture and context that may be further conceptualized and defined by the client and the activities and occupations one engages in.	• Sibling in a family with three children • Retired military personnel • Volunteer at a local park district • Mother of an adolescent with developmental disabilities • Student with a learning disability studying computer technology • Corporate executive returning to part-time work after a stroke
Rituals	Symbolic actions with spiritual, cultural, or social meaning contributing to the client's identity and reinforcing values and beliefs. Rituals have a strong affective component and consist of a collection of events (Fiese, 2007; Fiese et al., 2002; Segal, 2004).	• Shares a highlight from the day during evening meals with family • Kisses a sacred book before opening the pages to read • Recites the Pledge of Allegiance before the start of the school day
Group and Population		
Routines	Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying, promoting, or damaging. Time provides an organizational structure or rhythm for routines (Larson & Zemke, 2003). Routines are embedded in cultural and ecological contexts (Segal, 2004).	*Group* • Workers attending weekly staff meetings • Students turning in homework assignments as they enter the classroom • Exercise class attendees setting up their mats and towels before class *Population* • Parents of young children following health practices such as yearly checkups and scheduled immunizations

(Continued)

Table 6. Performance Patterns *(cont'd)*

Category	Description	Examples
		• Corporations following business practices such as providing services for disadvantaged populations (e.g., loans to underrepresented groups) • School districts following legislative procedures such as those associated with the Individuals With Disabilities Education Improvement Act of 2004 (Pub. L. 108-446) or Medicare
Roles	Sets of behaviors by the group or population expected by society and shaped by culture and context that may be further conceptualized and defined by the group or population.	*Group* • Nonprofit civic group providing housing for people living with mental illness • Humanitarian group distributing food and clothing donations to refugees • Student organization in a university educating elementary school children about preventing bullying *Population* • Parents providing care for children until they become adults • Grandparents or older community members being consulted before decisions are made
Rituals	Shared social actions with traditional, emotional, purposive, and technological meaning contributing to values and beliefs within the group or population.	*Group* • Employees of a company attending an annual holiday celebration • Members of a community agency hosting a fundraiser every spring *Population* • Citizens of a country suspending work activities in observance of a national holiday

Table 7. Performance Skills for Persons

Performance skills are observable, goal-directed actions that result in a client's quality of performing desired occupations. Skills are supported by the context in which the performance occurs, including environmental and client factors (Fisher & Marterella, 2019). Effective use of motor and process performance skills is demonstrated when the client carries out an activity efficiently, safely, with ease, or without assistance. Effective use of social interaction performance skills is demonstrated when the client completes interactions in a manner that matches the demands of the social situation. Ineffective use of performance skills is demonstrated when the client routinely requires assistance or support to perform activities or engage in social interactions.

The examples in this table are limited to descriptions of the client's ability to use each performance skill in an effective or ineffective manner. A client who demonstrates ineffective use of performance skills may be able to successfully complete the entire occupation with the use of occupational or environmental adaptations. Successful occupational performance by the client may be achieved when such adaptions are used.

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Motor Skills—*"Motor skills* are the group of performance skills that represent small, observable actions related to moving oneself or moving and interacting with tangible task objects (e.g., tools, utensils, clothing, food or other supplies, digital devices, plant life) in the context of performing a personally and ecologically relevant daily life task" (Fisher & Marterella, 2019, p. 331).		
Positioning the body	**Washing dishes at the kitchen sink**	
Stabilizes—Moves through task environment and interacts with task objects without momentary propping or loss of balance	Person moves through the kitchen without propping or loss of balance.	Person momentarily props on the counter to stabilize body while standing at the sink and washing dishes.
Aligns—Interacts with task objects without evidence of persistent propping or leaning	Person washes dishes without using the counter for support.	Person persistently leans on the counter, resulting in ineffective performance when washing dishes.
Positions—Positions self an effective distance from task objects and without evidence of awkward arm or body positions	Person places body or wheelchair at an effective distance for washing dishes.	Person positions body or wheelchair too far from the sink, resulting in difficulty reaching for dishes in the sink.
Obtaining and holding objects	**Acquiring a game from a cabinet in preparation for a family activity**	
Reaches—Effectively extends arm and, when appropriate, bends trunk to effectively grasp or place task objects that are out of reach	Person reaches without effort for the game box.	Person reaches with excessive physical effort for the game box.
Bends—Flexes or rotates trunk as appropriate when sitting down or when bending to grasp or place task objects that are out of reach	Person bends without effort when reaching for the game box.	Person demonstrates excessive stiffness when bending to reach for the game box.
Grips—Effectively pinches or grasps task objects such that the objects do not slip (e.g., from between fingers, from between teeth, from between hand and supporting surface)	Person grips the game box and game pieces, and they do not slip from the hand.	Person grips the game box ineffectively, and the box slips from the hand so that game pieces spill.
Manipulates—Uses dexterous finger movements, without evidence of fumbling, when manipulating task objects	Person readily manipulates the game pieces with fingers while setting up and playing the game.	Person fumbles the game pieces so that some pieces fall off the game board.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Motor Skills *(cont'd)*		
Moving self and objects	**Completing janitorial tasks at a factory site**	
Coordinates—Uses two or more body parts together to manipulate and hold task objects without evidence of fumbling or task objects slipping from the grasp	Person uses both hands to shuffle the game cards without fumbling them, and the cards do not slip from the hands.	Person uses both hands to shuffle the cards but fumbles the deck, and the cards slip out of the hands.
Moves—Effectively pushes or pulls task objects along a supporting surface, pulls to open or pushes to close doors and drawers, or pushes on wheels to propel a wheelchair	Person moves the broom easily, pushing and pulling it across the floor.	Person demonstrates excessive effort to move the broom across the floor when sweeping.
Lifts—Effectively raises or lifts task objects without evidence of excessive physical effort	Person easily lifts cleaning supplies out of the cart.	Person needs to use both hands to lift small lightweight containers of cleaning supplies out of the cart.
Walks—During task performance, ambulates on level surfaces without shuffling feet, becoming unstable, propping, or using assistive devices	Person walks steadily through the factory.	Person demonstrates unstable walking while performing janitorial duties or walks while supporting self on the cart.
Transports—Carries task objects from one place to another while walking or moving in a wheelchair	Person carries cleaning supplies from one factory location to another, either by walking or using a wheelchair, without effort.	Person is unstable when transporting cleaning supplies throughout the factory.
Calibrates—Uses movements of appropriate force, speed, or extent when interacting with task objects (e.g., does not crush task objects, pushes a door with enough force to close it without a bang)	Person uses an appropriate amount of force to squeeze liquid soap onto a cleaning cloth.	Person applies too little force to squeeze soap out of the container onto the cleaning cloth.
Flows—Uses smooth and fluid arm and wrist movements when interacting with task objects	Person demonstrates fluid arm and wrist movements when wiping tables.	Person demonstrates stiff and jerky arm and wrist movements when wiping tables.
Sustaining performance	**Bathing an older parent as caregiver**	
Endures—Persists and completes the task without demonstrating physical fatigue, pausing to rest, or stopping to catch breath	Person completes bathing of parent without evidence of physical fatigue.	Person stops to rest, interrupting the task of bathing the parent.
Paces—Maintains a consistent and effective rate or tempo of performance throughout the entire task performance	Person uses an appropriate tempo when bathing the parent.	Person sometimes rushes or delays actions when bathing the parent.
Process Skills—*"Process skills* are the group of performance skills that represent small, observable actions related to selecting, interacting with, and using tangible task objects (e.g., tools, utensils, clothing, food or other supplies, digital devices, plant life); carrying out individual actions and steps; and preventing problems of occupational performance from occurring or reoccurring in the context of performing a personally and ecologically relevant daily life task" (Fisher & Marterella, 2019, pp. 336–337).		

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Process Skills *(cont'd)*		
Sustaining performance	**Writing sentences for a school assignment**	
Paces—Maintains a consistent and effective rate or tempo of performance throughout the entire task performance	Person uses a consistent and even tempo when writing sentences.	Person rushes writing sentences, resulting in incorrectly formed letters or misspelled words.
Attends—Does not look away from task performance, maintaining the ongoing task progression	Person maintains gaze on the assignment and continues writing sentences without pause.	Person looks toward another student and pauses when writing sentences.
Heeds—Carries out and completes the task originally agreed on or specified by another person	Person completes the assignment, writing the number of sentences required.	Person writes fewer sentences than required, not completing the assignment.
Applying knowledge	**Taking prescribed medications**	
Chooses—Selects necessary and appropriate type and number of objects for the task, including the task objects that one chooses or is directed to use (e.g., by a teacher)	Person chooses specified medicine bottles appropriate for the specific timed dose.	Person chooses an incorrect medicine bottle for the specific timed dose.
Uses—Applies task objects as they are intended (e.g., using a pencil sharpener to sharpen a pencil but not a crayon) and in a hygienic fashion	Person uses a medicine spoon to take a dose of liquid medicine.	Person uses a tablespoon to take a 1-teaspoon dose of liquid medicine.
Handles—Supports or stabilizes task objects appropriately, protecting them from being damaged, slipping, moving, or falling	Person supports the medicine bottle, keeping it upright without the bottle tipping or falling.	Person allows the medicine bottle to tip, and pills spill from the bottle.
Inquires—(1) Seeks needed verbal or written information by asking questions or reading directions or labels and (2) does not ask for information when fully oriented to the task and environment and recently aware of the answer	Person reads the label on the medicine bottle before taking the medication.	Person asks the care provider what dose to take having already read the dose on the label.
Organizing timing	**Using an ATM to get cash to pay a babysitter**	
Initiates—Starts or begins the next task action or task step without any hesitation	Person begins each step of ATM use without hesitation.	Person pauses before entering the PIN into the ATM.
Continues—Performs single actions or steps without any interruptions so that once an action or task step is initiated, performance continues without pauses or delays until the action or step is completed	Person completes each step of ATM use without delays.	Person starts to enter the PIN, pauses, and then continues entering the PIN.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Process Skills *(cont'd)*		
Sequences—Performs steps in an effective or logical order and with an absence of randomness in the ordering or inappropriate repetition of steps	Person completes each step of ATM use in logical order.	Person attempts to enter the PIN before inserting the bank card into the card reader.
Terminates—Brings to completion single actions or single steps without inappropriate persistence or premature cessation	Person completes each step of ATM use in the appropriate length of time.	Person persists in entering numbers after completing the four-digit PIN.
Organizing space and objects	**Managing clerical duties for a large company**	
Searches/locates—Looks for and locates task objects in a logical manner	Person readily locates needed office supplies from shelves and drawers.	Person searches a shelf a second time to locate needed clerical supplies.
Gathers—Collects related task objects into the same work space and regathers task objects that have spilled, fallen, or been misplaced	Person gathers required clerical tools and supplies in the assigned work space.	Person places required paper and pen in different work spaces and then must move them to the same work space.
Organizes—Logically positions or spatially arranges task objects in an orderly fashion within a single work space or between multiple appropriate work spaces such that the work space is not too spread out or too crowded	Person organizes required clerical tools and supplies within the work space so all are within reach.	Person places books on top of papers, resulting in a crowded work space.
Restores—Puts away task objects in appropriate places and ensures that the immediate work space is restored to its original condition	Person returns clerical tools and supplies to their original storage location.	Person puts pens and extra paper in a different storage closet from where originally found.
Navigates—Moves body or wheelchair without bumping into obstacles when moving through the task environment or interacting with task objects	Person moves through the office space without bumping into office furniture or machines.	Person bumps hand into the edge of the desk when reaching for a pen from the pen holder.
Adapting performance	**Preparing a green salad for a family meal**	
Notices/responds—Responds appropriately to (1) nonverbal task-related cues (e.g., heat, movement), (2) the spatial arrangement and alignment of task objects to one another, and (3) cupboard doors or drawers that have been left open during task performance	Person notices the carrot rolling off the cutting board and catches it before it rolls onto the floor.	Person delays noticing a rolling carrot, and it rolls off the cutting board onto the floor.
Adjusts—Overcomes problems with ongoing task performance effectively by (1) going to a new workspace; (2) moving task objects out of the current workspace; or (3) adjusting knobs, dials, switches, or water taps	Person readily adjusts the flow of water from the tap when washing vegetables.	Person delays turning off the water tap after washing the vegetables.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	**Ineffective Performance[b]**
Performance Skills: Process Skills *(cont'd)*		
Accommodates—Prevents ineffective performance of all other motor and process skills and asks for assistance only when appropriate or needed	Person prevents problems from occurring during the salad preparation.	Person does not prevent problems from occurring, such as carrots rolling off the cutting board and onto the floor.
Benefits—Prevents ineffective performance of all other motor and process skills from recurring or persisting	Person prevents problems from continuing or reoccurring during the salad preparation.	Person retrieves the carrot from the floor and puts it back on the cutting board, and the carrot rolls off the board again.
Social Interaction Skills—*"Social interaction skills* are the group of performance skills that represent small, observable actions related to communicating and interacting with others in the context of engaging in a personally and ecologically relevant daily life task performance that involves social interaction with others" (Fisher & Marterella, 2019, p. 342).		
Initiating and terminating social interaction	**Participating in a community support group**	
Approaches/starts—Approaches or initiates interaction with the social partner in a manner that is socially appropriate	Person politely begins interactions with support group members.	Person begins interactions with support group members by yelling at them from across the room.
Concludes/disengages—Effectively terminates the conversation or social interaction, brings to closure the topic under discussion, and disengages or says goodbye	Person politely ends a conversation with a support group member.	Person abruptly ends interaction with the support group by walking out of the room.
Producing social interaction	**Child playing in the sandbox with others to build roads for cars and trucks**	
Produces speech—Produces spoken, signed, or augmentative (i.e., computer-generated) messages that are audible and clearly articulated	Person produces clear verbal, signed, or augmentative messages to communicate with other children playing in the sandbox.	Person mumbles when interacting with other children playing in the sandbox, and the other children do not understand the message.
Gesticulates—Uses socially appropriate gestures to communicate or support a message	Person gestures by waving or pointing while communicating with other children playing in the sandbox.	Person uses aggressive gestures when interacting with other children playing in the sandbox.
Speaks fluently—Speaks in a fluent and continuous manner, with an even pace (not too fast, not too slow) and without pauses or delays, while sending a message	Person speaks, without pausing, stuttering, or hesitating, when engaging with other children playing in the sandbox.	Person hesitates or pauses when talking with other children playing in the sandbox.
Physically supporting social interaction	**Older adult in a senior residence talking with other residents during a shared mealtime**	
Turns toward—Actively positions or turns body and face toward the social partner or the person who is speaking	Person turns body and face toward other residents while interacting during the meal.	Person turns face away from other residents while interacting during the meal.
Looks—Makes eye contact with the social partner	Person makes eye contact with other residents while interacting during the meal.	Person looks down at own plate while interacting during the meal.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Social Interaction Skills *(cont'd)*		
Places self—Positions self at an appropriate distance from the social partner	Person sits an appropriate distance from other residents at the table.	Person sits too far from other residents, interfering with interactions.
Touches—Responds to and uses touch or bodily contact with the social partner in a socially appropriate manner	Person touches other residents appropriately during the meal.	Person reaches out, grasps another resident's shirt, and abruptly pulls on it during the meal.
Regulates—Does not demonstrate irrelevant, repetitive, or impulsive behaviors during social interaction	Person avoids demonstrating irrelevant, repetitive, or impulsive behaviors while interacting during the meal.	Person repeatedly taps the fork on the plate while interacting during the meal.
Shaping content of social interaction	**Serving ice cream to customers in an ice cream shop**	
Questions—Requests relevant facts and information and asks questions that support the intended purpose of the social interaction	Person asks customers for their choice of ice cream flavor.	Person asks customers for their choice of ice cream flavor and then repeats the question after they respond.
Replies—Keeps conversation going by replying appropriately to suggestions, opinions, questions, and comments	Person readily replies with relevant answers to customers' questions about ice cream products.	Person delays in replying to customers' questions or provides irrelevant information.
Discloses—Reveals opinions, feelings, and private information about self or others in a socially appropriate manner	Person discloses no personal information about self or others to customers.	Person reveals socially inappropriate details about own family.
Expresses emotions—Displays affect and emotions in a socially appropriate manner	Person displays socially appropriate emotions when sending messages to customers.	Person uses a sarcastic tone of voice when describing ice cream flavor options.
Disagrees—Expresses differences of opinion in a socially appropriate manner	Person expresses a difference of opinion about ice cream products in a polite way.	Person becomes argumentative when a customer requests a flavor that is not available.
Thanks—Uses appropriate words and gestures to acknowledge receipt of services, gifts, or compliments	Person thanks the customers for purchasing ice cream.	Person fails to say thank you after customers purchase ice cream.
Maintaining flow of social interaction	**Sharing suggestions with others in a support group for persons experiencing mental health challenges**	
Transitions—Handles transitions in the conversation or changes the topic without disrupting the ongoing conversation	Person offers comments or suggestions that relate to the topic of mental health challenges, smoothly moving the topic in a relevant direction.	Person abruptly changes the topic of conversation to planning social activities during a discussion of mental health challenges.
Times response—Replies to social messages without delay or hesitation and without interrupting the social partner	Person replies to another group member's question about community supports for mental health challenges after briefly considering how best to respond.	Person replies to another group member's question about community supports for mental health challenges before the other person finishes asking the question.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Social Interaction Skills *(cont'd)*		
Times duration—Speaks for a reasonable length of time given the complexity of the message	Person sends messages about mental health challenges of an appropriate length.	Person sends prolonged messages containing extraneous details.
Takes turns—Speaks in turn and gives the social partner the freedom to take their turn	Person engages in back-and-forth conversation with others in the group.	Person does not respond to comments from others during the group discussion.
Verbally supporting social interaction	**Visiting a Social Security office to obtain information relative to potential benefits**	
Matches language—Uses a tone of voice, dialect, and level of language that are socially appropriate and matched to the social partner's abilities and level of understanding	Person uses a tone of voice and vocabulary that match those of the Social Security agent.	Person uses a loud voice and slang when interacting with the Social Security agent.
Clarifies—Responds to gestures or verbal messages from the social partner signaling that the social partner does not comprehend or understand a message and ensures that the social partner is following the conversation	Person rephrases the initial question when the Social Security agent requests clarification.	Person asks an unrelated question when the Social Security agent requests clarification of the initial question.
Acknowledges and encourages—Acknowledges receipt of messages, encourages the social partner to continue the social interaction, and encourages all social partners to participate in the interaction	Person nods to indicate understanding of the information shared by the Social Security agent.	Person does not nod or use words to acknowledge receipt of messages sent by the Social Security agent.
Empathizes—Expresses a supportive attitude toward the social partner by agreeing with, empathizing with, or expressing understanding of the social partner's feelings and experiences	Person shows empathy when the Social Security agent expresses frustration with the slow computer system.	Person shows impatience when the Social Security agent expresses frustration with the slow computer system.
Adapting social interaction	**Deciding which restaurant to go to with a group of friends**	
Heeds—Uses goal-directed social interactions focused on carrying out and completing the intended purpose of the social interaction	Person maintains focus on deciding which restaurant to go to.	Person makes comments unrelated to choosing a restaurant, disrupting the group decision making.
Accommodates—Prevents ineffective or socially inappropriate social interaction	Person avoids making ineffective responses to others about restaurant choice.	Person asks a question that is irrelevant to choosing a restaurant.
Benefits—Prevents problems with ineffective or socially inappropriate social interaction from recurring or persisting	Person avoids making reoccurring ineffective comments during the decision making.	Person persists in asking questions irrelevant to choosing a restaurant.

Note. ATM = automated teller machine; PIN = personal identification number.

[a]Effective use of motor and process performance skills is demonstrated when the client carries out an activity efficiently, safely, with ease, or without assistance. Effective use of social interaction performance skills is demonstrated when the client completes interactions in a manner that matches the demands of the social situation. [b]Ineffective performance skills are demonstrated when the client routinely requires assistance or support to perform activities or engage in social interaction. Ineffective use of social interaction performance skills is demonstrated when the client engages in social interactions in a manner that does not appropriately meet the demands of the social situation.

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Table 8. Performance Skills for Groups

To address performance skills for a group client, occupational therapy practitioners analyze the motor, process, and social interaction skills of individual group members to identify whether ineffective performance skills may limit the group's collective outcome. Italicized words in the middle column are specific performance skills defined in Table 7.

Performance Skill Category	Ineffective Performance by an Individual Group Member	Impact on Group Collective Outcome
Group collective outcome: Religious organization committee furnishing spaces for a preschool for member families		
Motor—Obtaining and holding objects	• Member *reaches* with excessive effort for chairs stored in closet. • Member *bends* with stiffness or excessive effort when reaching for the chairs. • Member fumbles when *gripping* writing materials in preparation for recording committee decisions for planning. • Member demonstrates limited finger dexterity to *manipulate* tools for assembling storage units for toys. • Member is unable to *coordinate* one hand and trunk to stabilize self while gripping and loading toys onto shelves.	Other members may need to take responsibility for obtaining and holding objects to accommodate the member's ineffective motor performance skills during the process of furnishing preschool spaces.
Process—Organizing space and objects	• Member repeatedly asks for help when *searching* for needed furniture or *locating* play equipment that is organized logically in near and distant places within the building. • Member does not effectively *gather* required play activity materials in the designated play spaces. • Member has difficulty *organizing* toys or play equipment within the various play spaces in a logical and orderly fashion. • Member does not *restore* toys or play equipment to storage spaces to return the preschool space to an effective order. • Member bumps into play furniture when *navigating* spaces to set up furniture to meet the needs of families or groups.	The group may need to accommodate the member's limitations in effectively organizing space and objects by adjusting the timing of the outcome to allow greater time to complete furnishing the preschool spaces.
Social interaction—Producing social interaction	• Member communicates in whispers when *producing speech* to communicate with other members about decisions for placing play equipment. • Member delays in *gesticulating* so other members do not receive effective messages while arranging toys and play equipment. • Member *speaks fluently* but too quickly when communicating to friends, resulting in challenges for other members in decision making for furnishing the preschool.	The group decision-making process may be hindered by the member's difficulty in producing social interactions. Limited communication during the tasks of placing furniture in preschool spaces may cause confusion among group members.

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Table 9. Client Factors

Client factors include (1) values, beliefs, and spirituality; (2) body functions; and (3) body structures. Client factors reside within the client and influence the client's performance in occupations.

Category	Examples Relevant to Occupational Therapy Practice
Values, Beliefs, and Spirituality—Client's (person's, group's, or population's) perceptions, motivations, and related meaning that influence or are influenced by engagement in occupations.	
Values—Acquired beliefs and commitments, derived from culture, about what is good, right, and important to do (Kielhofner, 2008)	*Person* • Honesty with self and others • Commitment to family *Group* • Obligation to provide a service • Fairness • Inclusion *Population* • Freedom of speech • Equal opportunities for all • Tolerance toward others
Beliefs—"Something that is accepted, considered to be true, or held as an opinion" ("Belief," 2020).	*Person* • One is powerless to influence others. • Hard work pays off. *Group* • Teaching others how to garden decreases their reliance on grocery stores. • Writing letters as part of a neighborhood group can support the creation of a community park. *Population* • Some personal rights are worth fighting for. • A new health care policy, as yet untried, will positively affect society.
Spirituality—"A deep experience of meaning brought about by engaging in occupations that involve the enacting of personal values and beliefs, reflection, and intention within a supportive contextual environment" (Billock, 2005, p. 887). It is important to recognize spirituality "as dynamic and often evolving" (Humbert, 2016, p. 12).	*Person* • Personal search for purpose and meaning in life • Guidance of actions by a sense of value beyond the acquisition of wealth or fame *Group* • Study of religious texts together • Attendance at a religious service *Population* • Common search for purpose and meaning in life • Guidance of actions by values agreed on by the collective
Body Functions—"The physiological functions of body systems (including psychological functions)" (WHO, 2001, p. 10). This section of the table is organized according to the classifications of the *ICF;* for fuller descriptions and definitions, refer to WHO (2001). This list is not all inclusive.	

(Continued)

Table 9. Client Factors *(cont'd)*

Category	Examples Relevant to Occupational Therapy Practice
Body Functions *(cont'd)*	
Mental functions	
Specific mental functions	
Higher level cognitive	Judgment, concept formation, metacognition, executive functions, praxis, cognitive flexibility, insight
Attention	Sustained shifting and divided attention, concentration, distractibility
Memory	Short-term, long-term, and working memory
Perception	Discrimination of sensations (e.g., auditory, tactile, visual, olfactory, gustatory, vestibular, proprioceptive)
Thought	Control and content of thought, awareness of reality vs. delusions, logical and coherent thought
Mental functions of sequencing complex movement	Mental functions that regulate the speed, response, quality, and time of motor production, such as restlessness, toe tapping, or hand wringing, in response to inner tension
Emotional	Regulation and range of emotions; appropriateness of emotions, including anger, love, tension, and anxiety; lability of emotions
Experience of self and time	Awareness of one's identity (including gender identity), body, and position in the reality of one's environment and of time
Global mental functions	
Consciousness	State of awareness and alertness, including the clarity and continuity of the wakeful state
Orientation	Orientation to person, place, time, self, and others
Psychosocial	General mental functions, as they develop over the life span, required to understand and constructively integrate the mental functions that lead to the formation of the personal and interpersonal skills needed to establish reciprocal social interactions, in terms of both meaning and purpose
Temperament and personality	Extroversion, introversion, agreeableness, conscientiousness, emotional stability, openness to experience, self-control, self-expression, confidence, motivation, impulse control, appetite
Energy	Energy level, motivation, appetite, craving, impulse
Sleep	Physiological process, quality of sleep
Sensory functions	
Visual functions	Quality of vision, visual acuity, visual stability, and visual field functions to promote visual awareness of environment at various distances for functioning
Hearing functions	Sound detection and discrimination; awareness of location and distance of sounds
Vestibular functions	Sensation related to position, balance, and secure movement against gravity
Taste functions	Association of taste qualities of bitterness, sweetness, sourness, and saltiness
Smell functions	Sensing of odors and smells
Proprioceptive functions	Awareness of body position and space

(Continued)

Table 9. Client Factors *(cont'd)*

Category	Examples Relevant to Occupational Therapy Practice
Body Functions *(cont'd)*	
Touch functions	Feeling of being touched by others or touching various textures, such as those of food; presence of numbness, paresthesia, hyperesthesia
Interoception	Internal detection of changes in one's internal organs through specific sensory receptors (e.g., awareness of hunger, thirst, digestion, state of alertness)
Pain	Unpleasant feeling indicating potential or actual damage to some body structure; sensations of generalized or localized pain (e.g., diffuse, dull, sharp, phantom)
Sensitivity to temperature and pressure	Thermal awareness (hot and cold), sense of force applied to skin (thermoreception)
Neuromusculoskeletal and movement-related functions	
Functions of joints and bones	
Joint mobility	Joint range of motion
Joint stability	Maintenance of structural integrity of joints throughout the body; physiological stability of joints related to structural integrity
Muscle functions	
Muscle power	Strength
Muscle tone	Degree of muscle tension (e.g., flaccidity, spasticity, fluctuation)
Muscle endurance	Sustainability of muscle contraction
Movement functions	
Motor reflexes	Involuntary contraction of muscles automatically induced by specific stimuli (e.g., stretch, asymmetrical tonic neck, symmetrical tonic neck)
Involuntary movement reactions	Postural reactions, body adjustment reactions, supporting reactions
Control of voluntary movement	Eye–hand and eye–foot coordination, bilateral integration, crossing of the midline, fine and gross motor control, oculomotor function (e.g., saccades, pursuits, accommodation, binocularity)
Gait patterns	Gait and mobility in relation to engagement in daily life activities (e.g., walking patterns and impairments, asymmetric gait, stiff gait)
Cardiovascular, hematological, immune, and respiratory system functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Cardiovascular system functions	Maintenance of blood pressure functions (hypertension, hypotension, postural hypotension), heart rate and rhythm
Hematological and immune system functions	Protection against foreign substances, including infection, allergic reactions
Respiratory system functions	Rate, rhythm, and depth of respiration
Additional functions and sensations of the cardiovascular and respiratory systems	Physical endurance, aerobic capacity, stamina, fatigability

(Continued)

Table 9. Client Factors *(cont'd)*

Category	Examples Relevant to Occupational Therapy Practice
Voice and speech functions; digestive, metabolic, and endocrine system functions; genitourinary and reproductive functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Voice and speech functions	Fluency and rhythm, alternative vocalization functions
Digestive, metabolic, and endocrine system functions	Digestive system functions, metabolic system, and endocrine system functions
Genitourinary and reproductive functions	Genitourinary and reproductive functions
Skin and related structure functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Skin functions Hair and nail functions	Protection (presence or absence of wounds, cuts, or abrasions), repair (wound healing)
Body Structures—"Anatomical parts of the body, such as organs, limbs, and their components" that support body function (WHO, 2001, p. 10). This section of the table is organized according to the *ICF* classifications; for fuller descriptions and definitions, refer to WHO (2001).	
Structure of the nervous system Structures related to the eyes and ears Structures involved in voice and speech Structures of the cardiovascular, immunological, and respiratory systems Structures related to the digestive, metabolic, and endocrine systems Structures related to the genitourinary and reproductive systems Structures related to movement	Occupational therapy practitioners have knowledge of body structures and understand broadly the interaction that occurs between these structures to support health, well-being, and participation in life through engagement in occupation.

Note. The categorization of body functions and body structures is based on the *ICF* (WHO, 2001). The classification was selected because it has received wide exposure and presents a language that is understood by external audiences. *ICF* = *International Classification of Function, Disability and Health;* WHO = World Health Organization.

Table 10. Occupational Therapy Process for Persons, Groups, and Populations
The occupational therapy process applies to work with persons, groups, and populations. The process for groups and populations mirrors that for persons. The process for populations includes public health approaches, and the process for groups may include both person and population methods to address occupational performance (Scaffa & Reitz, 2014).

Process Component	Process Step		
	Person	**Group**	**Population**
Evaluation	*Consultation and screening:* • Review client history • Consult with interprofessional team • Administer standardized screening tools	*Consultation and screening, environmental scan:* • Identify collective need on the basis of available data • For each individual in the group, ◦ Review history ◦ Administer standardized screening tools ◦ Consult with interprofessional team	*Environmental scan, trend analysis, preplanning:* • Collect data to inform design of intervention program by identifying information needs • Identify health trends in targeted population and potential positive and negative impacts on occupational performance
	Occupational profile: • Interview client and caregiver	*Occupational profile or community profile:* • Interview persons who make up the group • Engage with persons in the group to determine their interests, needs, and priorities	*Needs assessment, community profile:* • Engage with persons within the population to determine their interests and needs and opportunities for collaboration • Identify priorities through ◦ Surveys ◦ Interviews ◦ Group discussions or forums
	Analysis of occupational performance: • Assess occupational performance • Conduct occupational and activity analysis • Assess contexts • Assess performance skills and patterns • Assess client factors	*Analysis of occupational performance:* • Conduct occupational and activity analysis • Assess group context • Assess the following for individual group members: ◦ Occupational performance ◦ Performance skills and patterns ◦ Client factors • Analyze impact of individual performance on the group	*Needs assessment, review of secondary data:* • Evaluate existing quantitative data, which may include ◦ Public health records ◦ Prevalence of disease or disability ◦ Demographic data ◦ Economic data
	Synthesis of evaluation process: • Review and consolidate information to select occupational outcomes and determine impact of performance patterns and client factors on occupation	*Synthesis of evaluation process:* • Review and consolidate information to select collective occupational outcomes • Review and consolidate information regarding each member's performance and its impact on the group and the group's occupational performance as a whole	*Data analysis and interpretation:* • Review and consolidate information to support need for the program and identify any missing data
Intervention	*Development of the intervention plan:* • Identify client goals • Identify intervention outcomes • Select outcome measures	*Development of the intervention plan or program:* • Identify collective group goals	*Program planning:* • Identify short-term program objectives • Identify long-term program goals

(Continued)

Table 10. Occupational Therapy Process for Persons, Groups, and Populations *(cont'd)*

Process Component	Process Step		
	Person	**Group**	**Population**
	• Select methods for service delivery, including theoretical framework	• Identify intervention outcomes for the group • Select outcome measures • Select methods for service delivery, including theoretical framework	• Select outcome measures to be used in program evaluation • Select strategies for service delivery, including theoretical framework
	Intervention implementation: • Carry out occupational therapy intervention to address specific occupations, contexts, and performance patterns and skills affecting performance	*Intervention or program implementation:* • Carry out occupational therapy intervention or program to address the group's specific occupations, contexts, and performance patterns and skills affecting group performance	*Program implementation:* • Carry out program or advocacy action to address identified occupational needs
	Intervention review: • Reevaluate and review client's response to intervention • Review progress toward goals and outcomes • Modify plan as needed	*Intervention review or program evaluation:* • Reevaluate and review individual members' and the group's response to intervention • Review progress toward goals and outcomes • Modify plan as needed • Evaluate efficiency of program • Evaluate achievement of determined objectives	*Program evaluation:* • Gather information on program implementation • Measure the impact of the program • Evaluate efficiency of program • Evaluate achievement of determined objectives
Outcomes	*Outcomes:* • Use measures to assess progress toward outcomes • Identify change in occupational participation	*Outcomes:* • Use measures to assess progress toward outcomes • Identify change in occupational performance of individual members and the group as a whole	*Outcomes:* • Use measures to assess progress toward long-term program goals • Identify change in occupational performance of targeted population
	Transition: • Facilitate client's move from one life role or experience to another, such as ◦ Moving to a new level of care ◦ Transitioning between providers ◦ Moving into a new setting or program	*Transition:* • Facilitate group members' move from one life role or experience to another, such as ◦ Moving to a new level of care ◦ Transitioning between providers ◦ Moving into a new setting or program	*Sustainability plan:* • Develop action plan to maintain program • Identify sources of funding • Build community capacity and support relationships to continue program
	Discontinuation: • Discontinue care after short- and long-term goals have been achieved or client chooses to no longer participate • Implement discharge plan to support performance after discontinuation of services	*Discontinuation:* • Discontinue care after the group's short- and long-term goals have been achieved • Implement discharge plan to support performance after discontinuation of services	*Dissemination plan:* • Share results with participants, stakeholders, and community members • Implement sustainability plan

Table 11. Occupation and Activity Demands

Occupation and activity demands are the components of occupations and activities that occupational therapy practitioners consider in their professional and clinical reasoning process. *Activity demands* are what is typically required to carry out the activity regardless of client and context. *Occupation demands* are what is required by the specific client (person, group, or population) to carry out an occupation. Depending on the context and needs of the client, occupation and activity demands can act as barriers to or supports for participation. Specific knowledge about activity demands assists practitioners in selecting occupations for therapeutic purposes.

Type of Demand	Activity Demands: Typically Required to Carry Out the Activity	Occupational Demands: Required by the Client (Person, Group, or Population) to Carry Out the Occupation
Relevance and importance	General meaning of the activity within the given culture	Meaning the client derives from the occupation, which may be subjective and personally constructed; symbolic, unconscious, and metaphorical; and aligned with the client's goals, values, beliefs, and needs and perceived utility
	Person: Knitting clothing items for personal use, for income from sale, or as a leisure activity	*Person:* Knitting as a way to practice mindfulness strategies for coping with anxiety
	Group: Cooking to provide nutrition, fulfill a family role, or engage in a leisure activity	*Group:* Preparation of a holiday meal with family to connect members to each other and to their culture and traditions
	Population: Presence of accessible restrooms in public spaces in compliance with federal law	*Population:* Creation of new accessible and all-gender restrooms to symbolize a community's commitment to safety and inclusion of members with disabilities and LGBTQ+ members
Objects used and their properties: Tools (e.g., scissors, dishes, shoes, volleyball), supplies (e.g., paints, milk, lipstick), equipment (e.g., workbench, stove, basketball hoop), and resources (e.g., money, transportation) required in the process of carrying out the activity or occupation and their inherent properties (e.g., heavy, rough, sharp, colorful, loud, bitter tasting)	*Person:* Computer workstation that includes a computer, keyboard, mouse, desk, and chair	
	Group: Financial and transportation resources for a group of friends to attend a concert	
	Population: Tools, supplies, and equipment for flood relief efforts to ensure safety of people with disabilities	
Space demands: Physical environment requirements of the occupation or activity (e.g., size, arrangement, surface, lighting, temperature, noise, humidity, ventilation)	*Person:* Desk arrangement in an elementary school classroom	
	Group: Accessible meeting space to run a fall prevention workshop	
	Population: Noise, lighting, arrangement, and temperature controls for a sensory-friendly museum	
Social demands: Elements of the social and attitudinal environments required for the occupation or activity	*Person:* Rules of engagement for a child at recess	
	Group: Expectations of travelers in an airport (e.g., waiting in line, following cues from staff and others, asking questions when needed)	
	Population: Understanding of the social and political climate of the geographic region	

(Continued)

Table 11. Occupation and Activity Demands *(cont'd)*

Type of Demand	Activity Demands: Typically Required to Carry Out the Activity	Occupational Demands: Required by the Client (Person, Group, or Population) to Carry Out the Occupation
Sequencing and timing demands: Temporal process required to carry out the activity or occupation (e.g., specific steps, sequence of steps, timing requirements)	*Person:* Preferred sequence and timing of a client's morning routine to affirm social, cultural, and gender identity	
	Group: Steps a class of students takes in preparation to start the school day	
	Population: Public train schedules	
Required actions and performance skills: Actions and performance skills (motor, process, and social interaction) that are an inherent part of the activity or occupation	*Person:* Body movements required to drive a car	
	Group and population: See "Performance Skills" section for discussion related to groups and population	
Required body functions: "Physiological functions of body systems (including psychological functions)" (WHO, 2001, p. 10) required to support the actions used to perform the activity or occupation	*Person:* Cognitive level required for a child to play a game	
	Group and population: See "Client Factors" section for discussion of required body functions related to groups and populations	
Required body structures: "Anatomical parts of the body such as organs, limbs, and their components" that support body functions (WHO, 2001, p. 10) and are required to perform the activity or occupation	*Person:* Presence of upper limbs to play catch	
	Group and population: See "Client Factors" section for discussion of required body structures related to groups and populations	

Note. WHO = World Health Organization.

Table 12. Types of Occupational Therapy Interventions

Occupational therapy intervention types include occupations and activities, interventions to support occupations, education and training, advocacy, group interventions, and virtual interventions. Occupational therapy interventions facilitate engagement in occupation to enable persons, groups, and populations to achieve health, well-being, and participation in life. The examples provided illustrate the types of interventions that clients engage in (denoted as "client") and that occupational therapy practitioners provide (denoted as "practitioner") and are not intended to be all-inclusive.

Intervention Type	Description	Examples
Occupations and Activities—Occupations and activities selected as interventions for specific clients are designed to meet therapeutic goals and address the underlying needs of the client's mind, body, and spirit. To use occupations and activities therapeutically, the practitioner considers activity demands and client factors in relation to the client's therapeutic goals and contexts.		
Occupations	Broad and specific daily life events that are personalized and meaningful to the client	*Person* Client completes morning dressing and hygiene using adaptive devices. *Group* Client plays a group game of tag on the playground to improve social participation. *Population* Practitioner creates an app to improve access for people with autism spectrum disorder using metropolitan paratransit systems.
Activities	Components of occupations that are objective and separate from the client's engagement or contexts. Activities as interventions are selected and designed to support the development of performance skills and performance patterns to enhance occupational engagement.	*Person* Client selects clothing and manipulates clothing fasteners in advance of dressing. *Group* Group members separate into two teams for a game of tag. *Population* Client establishes parent volunteer committees at their children's school.
Interventions to Support Occupations—Methods and tasks that prepare the client for occupational performance are used as part of a treatment session in preparation for or concurrently with occupations and activities or provided to a client as a home-based engagement to support daily occupational performance.		
PAMs and mechanical modalities	Modalities, devices, and techniques to prepare the client for occupational performance. Such approaches should be part of a broader plan and not used exclusively.	*Person* Practitioner administers PAMs to decrease pain, assist with wound healing or edema control, or prepare muscles for movement to enhance occupational performance. *Group* Practitioner develops a reference manual on postmastectomy manual lymphatic drainage techniques for implementation at an outpatient facility.

(Continued)

Table 12. Types of Occupational Therapy Interventions *(cont'd)*

Intervention Type	Description	Examples
Orthotics and prosthetics	Construction of devices to mobilize, immobilize, or support body structures to enhance participation in occupations	*Person* Practitioner fabricates and issues a wrist orthosis to facilitate movement and enhance participation in household activities. *Group* Group members participate in a basketball game with veterans using prosthetics after amputation.
Assistive technology and environmental modifications	Assessment, selection, provision, and education and training in use of high- and low-tech assistive technology; application of universal design principles; and recommendations for changes to the environment or activity to support the client's ability to engage in occupations	*Person* Practitioner recommends using a visual support (e.g., social story) to guide behavior. *Group* Practitioner uses a smart board with speaker system during a social skills group session to improve participants' attention. *Population* Practitioner recommends that a large health care organization paint exits in their facilities to resemble bookshelves to deter patients with dementia from eloping.
Wheeled mobility	Products and technologies that facilitate a client's ability to maneuver through space, including seating and positioning; improve mobility to enhance participation in desired daily occupations; and reduce risk for complications such as skin breakdown or limb contractures	*Person* Practitioner recommends, in conjunction with the wheelchair team, a sip-and-puff switch to allow the client to maneuver the power wheelchair independently and interface with an environmental control unit in the home. *Group* Group of wheelchair users in the same town host an educational peer support event.
Self-regulation	Actions the client performs to target specific client factors or performance skills. Intervention approaches may address sensory processing to promote emotional stability in preparation for social participation or work or leisure activities or executive functioning to support engagement in occupation and meaningful activities. Such approaches involve active participation of the client and sometimes use of materials to simulate components of occupations.	*Person* Client participates in a fabricated sensory environment (e.g., through movement, tactile sensations, scents) to promote alertness before engaging in a school-based activity. *Group* Practitioner instructs a classroom teacher to implement mindfulness techniques, visual imagery, and rhythmic breathing after recess to enhance students' success in classroom activities. *Population* Practitioner consults with businesses and community sites to establish sensory-friendly environments for people with sensory processing deficits.

(Continued)

Table 12. Types of Occupational Therapy Interventions *(cont'd)*

Intervention Type	Description	Examples
Education and Training		
Education	Imparting of knowledge and information about occupation, health, well-being, and participation to enable the client to acquire helpful behaviors, habits, and routines	*Person* Practitioner provides education regarding home and activity modifications to the spouse or family member of a person with dementia to support maximum independence. *Group* Practitioner participates in a team care planning meeting to educate the family and team members on a patient's condition and level of function and establish a plan of care. *Population* Practitioner educates town officials about the value of and strategies for constructing walking and biking paths accessible to people who use mobility devices.
Training	Facilitation of the acquisition of concrete skills for meeting specific goals in a real-life, applied situation. In this case, *skills* refers to measurable components of function that enable mastery. Training is differentiated from education by its goal of enhanced performance as opposed to enhanced understanding, although these goals often go hand in hand (Collins & O'Brien, 2003).	*Person* Practitioner instructs the client in the use of coping skills such as deep breathing to address anxiety symptoms before engaging in social interaction. *Group* Practitioner provides an in-service on applying new reimbursement and practice standards adopted by a facility. *Population* Practitioner develops a training program to support practice guidelines addressing occupational deprivation and cultural competence for practitioners working with refugees.
Advocacy—Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to support health, well-being, and occupational participation.		
Advocacy	Advocacy efforts undertaken by the practitioner	*Person* Practitioner collaborates with a client to procure reasonable accommodations at a work site. *Group* Practitioner collaborates with and educates teachers in an elementary school about inclusive classroom design. *Population* Practitioner serves on the policy board of an organization to procure supportive housing accommodations for people with disabilities.

(Continued)

Table 12. Types of Occupational Therapy Interventions *(cont'd)*

Intervention Type	Description	Examples
Self-advocacy	Advocacy efforts undertaken by the client with support by the practitioner	*Person* Client requests reasonable accommodations, such as audio textbooks, to support their learning disability. *Group* Client participates in an employee meeting to request and procure adjustable chairs to improve comfort at computer workstations. *Population* Client participates on a student committee partnering with school administration to develop cyberbullying prevention programs in their district.
Group Interventions—Use of distinct knowledge of the dynamics of group and social interaction and leadership techniques to facilitate learning and skill acquisition across the lifespan. Groups are used as a method of service delivery.		
Functional groups, activity groups, task groups, social groups, and other groups	Groups used in health care settings, within the community, or within organizations that allow clients to explore and develop skills for participation, including basic social interaction skills and tools for self-regulation, goal setting, and positive choice making	*Person* Client participates in a group for adults with traumatic brain injury focused on individual goals for reentering the community after inpatient treatment. *Group* Group of older adults participates in volunteer days to maintain participation in the community through shared goals. *Population* Practitioner works with middle school teachers in a district on approaches to address issues of self-efficacy and self-esteem as the basis for creating resiliency in children at risk for being bullied.
Virtual Interventions—Use of simulated, real-time, and near-time technologies for service delivery absent of physical contact, such as telehealth or mHealth.		
Telehealth (telecommunication and information technology) and mHealth (mobile telephone application technology)	Use of technology such as video conferencing, teleconferencing, or mobile telephone application technology to plan, implement, and evaluate occupational therapy intervention, education, and consultation	*Person* Practitioner performs a telehealth therapy session with a client living in a rural area. *Group* Client participates in an initial online support group session to establish group protocols, procedures, and roles. *Population* Practitioner develops methods and standards for mHealth in community occupational therapy practice.

Note. mHealth = mobile health; PAMs = physical agent modalities.

Table 13. Approaches to Intervention
Approaches to intervention are specific strategies selected to direct the evaluation and intervention processes on the basis of the client's desired outcomes, evaluation data, and research evidence. Approaches inform the selection of practice models, frames of references, and treatment theories.

Approach	Description	Examples
Create, promote (health promotion)	An intervention approach that does not assume a disability is present or that any aspect would interfere with performance. This approach is designed to provide enriched contextual and activity experiences that will enhance performance for all people in the natural contexts of life (adapted from Dunn et al., 1998, p. 534).	*Person* Develop a fatigue management program for a client recently diagnosed with multiple sclerosis *Group* Create a resource list of developmentally appropriate toys to be distributed by staff at a day care program *Population* Develop a falls prevention curriculum for older adults for trainings at senior centers and day centers
Establish, restore (remediation, restoration)	Approach designed to change client variables to establish a skill or ability that has not yet developed or to restore a skill or ability that has been impaired (adapted from Dunn et al., 1998, p. 533)	*Person* Restore a client's upper extremity movement to enable transfer of dishes from the dishwasher into the upper kitchen cabinets Collaborate with a client to help establish morning routines needed to arrive at school or work on time *Group* Educate staff of a group home for clients with serious mental illness to develop a structured schedule, chunking tasks to decrease residents' risk of being overwhelmed by the many responsibilities of daily life roles *Population* Restore access ramps to a church entrance after a hurricane
Maintain	Approach designed to provide supports that will allow clients to preserve the performance capabilities that they have regained and that continue to meet their occupational needs. The assumption is that without continued maintenance intervention, performance would decrease and occupational needs would not be met, thereby affecting health, well-being, and quality of life.	*Person* Provide ongoing intervention for a client with amyotrophic lateral sclerosis to address participation in desired occupations through provision of assistive technology *Group* Maintain environmental modifications at a group home for young adults with physical disabilities for continued safety and engagement with housemates

(Continued)

Table 13. Approaches to Intervention *(cont'd)*

Approach	Description	Examples
		Population Maintain safe and independent access for people with low vision by increasing hallway lighting in a community center
Modify (compensation, adaptation)	Approach directed at "finding ways to revise the current context or activity demands to support performance in the natural setting, [including] compensatory techniques . . . [such as] enhancing some features to provide cues or reducing other features to reduce distractibility" (Dunn et al., 1998, p. 533)	*Person* Simplify task sequence to help a person with cognitive impairments complete a morning self-care routine *Group* Modify a college campus housing building to accommodate a group of students with mobility impairments *Population* Consult with architects and builders to design homes that will support aging in place and use universal design principles
Prevent (disability prevention)	Approach designed to address the needs of clients with or without a disability who are at risk for occupational performance problems. This approach is designed to prevent the occurrence or evolution of barriers to performance in context. Interventions may be directed at client, context, or activity variables (adapted from Dunn et al., 1998, p. 534).	*Person* Aid in the prevention of illicit substance use by introducing self-initiated routine strategies that support drug-free behavior *Group* Prevent social isolation of employees by promoting participation in after-work group activities *Population* Consult with a hotel chain to provide an ergonomics educational program designed to prevent back injuries in housekeeping staff

Table 14. Outcomes

Outcomes are the end result of the occupational therapy process; they describe what clients can achieve through occupational therapy intervention. Some outcomes are measurable and are used for intervention planning and review and discharge planning. These outcomes reflect the attainment of treatment goals that relate to engagement in occupation. Other outcomes are experienced by clients when they have realized the effects of engagement in occupation and are able to return to desired habits, routines, roles, and rituals.

Adaptation is embedded in all categories of outcomes. The examples listed specify how the broad outcome of health and participation in life may be operationalized.

Outcome Category	Description	Examples
Occupational performance	Act of doing and accomplishing a selected action (performance skill), activity, or occupation (Fisher, 2009; Fisher & Griswold, 2019; Kielhofner, 2008) that results from the dynamic transaction among the client, the context, and the activity. Improving or enhancing skills and patterns in occupational performance leads to engagement in occupations or activities (adapted in part from Law et al., 1996, p. 16).	*Person* A patient with hip precautions showers safely with modified independence using a tub transfer bench and a long-handled sponge. *Group* A group of older adults cooks a holiday meal during their stay in a skilled nursing facility with minimal assistance from staff. *Population* A community welcomes children with spina bifida in public settings after a news story featuring occupational therapy practitioners.
Improvement	Increased occupational performance through adaptation when a performance limitation is present	*Person* A child with autism plays interactively with a peer. An older adult returns home from a skilled nursing facility as desired. *Group* Back strain in nursing personnel decreases as a result of an in-service education program on body mechanics for job duties that require bending and lifting. *Population* Accessible playground facilities for all children are constructed in city parks.
Enhancement	Development of performance skills and performance patterns that augment existing performance of life occupations when a performance limitation is not present	*Person* A teenage mother experiences increased confidence and competence in parenting as a result of structured social groups and child development classes. *Group* Membership in the local senior citizen center increases as a result of expanded social wellness and exercise programs. School staff have increased ability to address and manage school-age youth violence as a result of conflict resolution training to address bullying. *Population* Older adults have increased opportunities to participate in community activities through ride-share programs.

(Continued)

Table 14. Outcomes *(cont'd)*

Outcome Category	Description	Examples
Prevention	Education or health promotion efforts designed to identify, reduce, or stop the onset and reduce the incidence of unhealthy conditions, risk factors, diseases, or injuries. Occupational therapy promotes a healthy lifestyle at the individual, group, population (societal), and government or policy level (adapted from AOTA, 2020b).	*Person* A child with orthopedic impairments is provided with appropriate seating and a play area. *Group* A program of leisure and educational activities is implemented at a drop-in center for adults with serious mental illness. *Population* Access to occupational therapy services is provided in underserved areas where residents typically receive other services.
Health and wellness	*Health:* State of physical, mental, and social well-being, as well as a positive concept emphasizing social and personal resources and physical capacities (WHO, 1986). Health for groups and populations also includes social responsibility of members to the group or population as a whole. *Wellness:* "Active process through which individuals [or groups or populations] become aware of and make choices toward a more successful existence" (Hettler, 1984, p. 1117). Wellness is more than a lack of disease symptoms; it is a state of mental and physical balance and fitness (adapted from "Wellness," 1997, p. 2110)	*Person* A person with a mental health challenge participates in an empowerment and advocacy group to improve services in the community. A person with attention deficit hyperactivity disorder demonstrates self-management through the ability to manage the various aspects of their life. *Group* A company-wide program for employees is implemented to identify problems and solutions regarding the balance among work, leisure, and family life. *Population* The incidence of childhood obesity decreases.
Quality of life	Dynamic appraisal of the client's life satisfaction (perceptions of progress toward goals), hope (real or perceived belief that one can move toward a goal through selected pathways), self-concept (composite of beliefs and feelings about oneself), health and functioning (e.g., health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income; adapted from Radomski, 1995)	*Person* A deaf child from a hearing family participates fully and actively during a recreational activity. *Group* A facility experiences increased participation of residents during outings and independent travel as a result of independent living skills training for care providers. *Population* A lobby is formed to support opportunities for social networking, advocacy activities, and sharing of scientific information for stroke survivors and their families.

(Continued)

Table 14. Outcomes *(cont'd)*

Outcome Category	Description	Examples
Participation	Engagement in desired occupations in ways that are personally satisfying and congruent with expectations within the culture	*Person* A person recovers the ability to perform the essential duties of his or her job after a flexor tendon laceration. *Group* A family enjoys a vacation spent traveling cross-country in their adapted van. *Population* All children within a state have access to school sports programs.
Role competence	Ability to effectively meet the demands of the roles in which one engages	*Person* A person with cerebral palsy is able to take notes and type papers to meet the demands of the student role. *Group* A factory implements job rotation to allow sharing of higher demand tasks so employees can meet the demands of the worker role. *Population* Accessibility of polling places is improved, enabling all people with disabilities in the community to meet the demands of the citizen role.
Well-being	Contentment with one's health, self-esteem, sense of belonging, security, and opportunities for self-determination, meaning, roles, and helping others (Hammell, 2009). *Well-being* is "a general term encompassing the total universe of human life domains, including physical, mental, and social aspects, that make up what can be called a 'good life'" (WHO, 2006, p. 211).	*Person* A person with amyotrophic lateral sclerosis achieves contentment with their ability to find meaning in fulfilling the role of parent through compensatory strategies and environmental modifications. *Group* Members of an outpatient depression and anxiety support group feel secure in their sense of group belonging and ability to help other members. *Population* Residents of a town celebrate the groundbreaking for a school being reconstructed after a natural disaster.

(Continued)

Table 14. Outcomes *(cont'd)*

Outcome Category	Description	Examples
Occupational justice	Access to and participation in the full range of meaningful and enriching occupations afforded to others, including opportunities for social inclusion and resources to participate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004)	*Person* An individual with intellectual and developmental disabilities serves on an advisory board to establish programs to be offered by a community recreation center. *Group* Workers have enough break time to eat lunch with their young children in the day care center. *Group and Population* People with persistent mental illness experience an increased sense of empowerment and self-advocacy skills, enabling them to develop an antistigma campaign promoting engagement in the civic arena (group) and alternative adapted housing options for older adults to age in place (population).

Note. AOTA = American Occupational Therapy Association; WHO = World Health Organization.

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Appendix A. Glossary

A

Activities
Actions designed and selected to support the development of performance skills and performance patterns to enhance occupational engagement.

Activities of daily living (ADLs)
Activities that are oriented toward taking care of one's own body (adapted from Rogers & Holm, 1994) and are completed on a daily basis. These activities are "fundamental to living in a social world; they enable basic survival and well-being" (Christiansen & Hammecker, 2001, p. 156; see Table 2).

Activity analysis
Generic and decontextualized analysis that seeks to develop an understanding of typical activity demands within a given culture.

Activity demands
Aspects of an activity needed to carry it out, including relevance and importance to the client, objects used and their properties, space demands, social demands, sequencing and timing, required actions and performance skills, and required underlying body functions and body structures (see Table 11).

Adaptation
Effective and efficient response by the client to occupational and contextual demands (Grajo, 2019).

Advocacy
Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their daily life occupations. Efforts undertaken by the practitioner are considered advocacy, and those undertaken by the client are considered self-advocacy and can be promoted and supported by the practitioner (see Table 12).

Analysis of occupational performance
The step in the evaluation process in which the client's assets and limitations or potential problems are more specifically determined through assessment tools designed to analyze, measure, and inquire about factors that support or hinder occupational performance (see Exhibit 2).

Assessment
"A specific tool, instrument, or systematic interaction . . . used to understand a client's occupational profile, client factors, performance skills, performance patterns, and contextual and environmental factors, as well as activity demands that influence occupational performance" (Hinojosa et al., 2014, pp. 3–4).

B

Belief

Something that is accepted, considered to be true, or held as an opinion ("Belief," 2020).

Body functions

"Physiological functions of body systems (including psychological functions)" (World Health Organization, 2001, p. 10; see Table 9).

Body structures

"Anatomical parts of the body, such as organs, limbs, and their components" that support body functions (World Health Organization, 2001, p. 10; see Table 9).

C

Client

Person (including one involved in the care of a client), *group* (collection of individuals having shared characteristics or common or shared purpose, e.g., family members, workers, students, and those with similar interests or occupational challenges), or *population* (aggregate of people with common attributes such as contexts, characteristics, or concerns, including health risks; Scaffa & Reitz, 2014).

Client-centered care (client-centered practice)

Approach to service that incorporates respect for and partnership with clients as active participants in the therapy process. This approach emphasizes clients' knowledge and experience, strengths, capacity for choice, and overall autonomy (Schell & Gillen, 2019, p. 1194).

Client factors

Specific capacities, characteristics, or beliefs that reside within the person and that influence performance in occupations. Client factors include values, beliefs, and spirituality; body functions; and body structures (see Table 9).

Clinical reasoning

See *Professional reasoning*

Collaboration

"The complex interpretative acts in which the practitioners must understand the meanings of the interventions, the meanings of illness or disability in a person and family's life, and the feelings that accompany these experiences" (Lawlor & Mattingly, 2019, p. 201).

Community

Collection of populations that is changeable and diverse and includes various people, groups, networks, and organizations (Scaffa, 2019; World Federation of Occupational Therapists, 2019).

Context

Construct that constitutes the complete makeup of a person's life as well as the common and divergent factors that characterize groups and populations. Context includes environmental factors and personal factors (see Tables 4 and 5).

Co-occupation

Occupation that implicitly involves two or more individuals (Schell & Gillen, 2019, p. 1195) and includes aspects of physicality, emotionality, and intentionality (Pickens & Pizur-Barnekow, 2009).

Cornerstone

Something of significance on which everything else depends.

D

Domain

Profession's purview and areas in which its members have an established body of knowledge and expertise.

E

Education

As an occupation: Activities involved in learning and participating in the educational environment (see Table 2).
As an environmental factor of context: Processes and methods for acquisition of knowledge, expertise, or skills (see Table 4).
As an intervention: Activities that impart knowledge and information about occupation, health, well-being, and participation, resulting in acquisition by the client of helpful behaviors, habits, and routines that may or may not require application at the time of the intervention session (see Table 12).

Empathy

Emotional exchange between occupational therapy practitioners and clients that allows more open communication, ensuring that practitioners connect with clients at an emotional level to assist them with their current life situation.

Engagement in occupation

Performance of occupations as the result of choice, motivation, and meaning within a supportive context.

Environmental factors

Aspects of the physical, social, and attitudinal surroundings in which people live and conduct their lives.

Evaluation

"The comprehensive process of obtaining and interpreting the data necessary to understand the person, system, or situation. . . . Evaluation requires synthesis of all data obtained, analytic interpretation of that data, reflective clinical reasoning, and consideration of occupational performance and contextual factors" (Hinojosa et al., 2014, p. 3).

G

Goal

Measurable and meaningful, occupation-based, long-term or short-term aim directly related to the client's ability and need to engage in desired occupations (AOTA, 2018a, p. 4).

Group

Collection of individuals having shared characteristics or a common or shared purpose (e.g., family members, workers, students, others with similar occupational interests or occupational challenges).

Group intervention

Use of distinct knowledge and leadership techniques to facilitate learning and skill acquisition across the lifespan through the dynamics of group and social interaction. Groups may be used as a method of service delivery (see Table 12).

H

Habilitation

Health care services that help a person keep, learn, or improve skills and functioning for daily living (e.g., therapy for a child who does not walk or talk at the expected age). These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and outpatient settings ("Provision of EHB," 2015).

Habits

"Specific, automatic behaviors performed repeatedly, relatively automatically, and with little variation" (Matuska & Barrett, 2019, p. 214). Habits can be healthy or unhealthy, efficient or inefficient, and supportive or harmful (Dunn, 2000).

Health

"State of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organization, 2006, p. 1).

Health management

Occupation focused on developing, managing, and maintaining routines for health and wellness by engaging in self-care with the goal of improving or maintaining health, including self-management, to allow for participation in other occupations (see Table 2).

Health promotion

"Process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment" (World Health Organization, 1986).

Hope

Real or perceived belief that one can move toward a goal through selected pathways.

I

Independence

"Self-directed state of being characterized by an individual's ability to participate in necessary and preferred occupations in a satisfying manner irrespective of the amount or kind of external assistance desired or required" (AOTA, 2002a, p. 660).

Instrumental activities of daily living (IADLs)

Activities that support daily life within the home and community and that often require more complex interactions than those used in ADLs (see Table 2).

Interdependence

"Reliance that people have on one another as a natural consequence of group living" (Christiansen & Townsend, 2010, p. 419). "Interdependence engenders a spirit of social inclusion, mutual aid, and a moral commitment and responsibility to recognize and support difference" (Christiansen & Townsend, 2010, p. 187).

Interests

"What one finds enjoyable or satisfying to do" (Kielhofner, 2008, p. 42).

Intervention

"Process and skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation related to health and participation. The intervention process includes the plan, implementation, and review" (AOTA, 2015c, p. 2).

Intervention approaches

Specific strategies selected to direct the process of interventions on the basis of the client's desired outcomes, evaluation data, and evidence (see Table 13).

Interventions to support occupations

Methods and tasks that prepare the client for occupational performance, used as part of a treatment session in preparation for or concurrently with occupations and activities or provided to a client as a home-based engagement to support daily occupational performance (see Table 12).

L

Leisure

"Nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep" (Parham & Fazio, 1997, p. 250; see Table 2).

M

Motor skills

The "group of performance skills that represent small, observable actions related to moving oneself or moving and interacting with tangible task objects (e.g., tools, utensils, clothing, food or other supplies, digital devices, plant life) in the context of performing a personally and ecologically relevant daily life task. They are commonly named in terms of type of task being performed (e.g., [activity of daily living] motor skills, school motor skills, work motor skills)" (Fisher & Marterella, 2019, p. 331; see Table 7).

O

Occupation

Everyday personalized activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations can involve the execution of multiple activities for completion and can result in various outcomes. The broad range of occupations is categorized as activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure, and social participation (see Table 2).

Occupation-based

Characteristic of the best practice method used in occupational therapy, in which the practitioner uses an evaluation process and types of interventions that actively engage the client in occupation (Fisher & Marterella, 2019).

Occupational analysis

Analysis that is performed with an understanding of "the specific situation of the client and therefore [of] the specific occupations the client wants or needs to do in the actual context in which these occupations are performed" (Schell et al., 2019, p. 322).

Occupational demands

Aspects of an activity needed to carry it out, including relevance and importance to the client, objects used and their properties, space demands, social demands, sequencing and timing, required actions and performance skills, and required underlying body functions and body structures (see Table 10).

Occupational identity

"Composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation" (Schell & Gillen, 2019, p. 1205).

Occupational justice

"A justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences" (Nilsson & Townsend, 2010, p. 58). Occupational justice includes access to and participation in the full range of meaningful and enriching occupations afforded to others, including opportunities for social inclusion and the resources to participate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004).

Occupational performance

Accomplishment of the selected occupation resulting from the dynamic transaction among the client, their context, and the occupation.

Occupational profile

Summary of the client's occupational history and experiences, patterns of daily living, interests, values, needs, and relevant contexts (see Exhibit 2).

Occupational science

"Way of thinking that enables an understanding of occupation, the occupational nature of humans, the relationship between occupation, health and wellbeing, and the influences that shape occupation" (World Federation of Occupational Therapists, 2012b, p. 2).

Occupational therapy

Therapeutic use of everyday life occupations with persons, groups, or populations (i.e., clients) for the purpose of enhancing or enabling participation. Occupational therapy practitioners use their knowledge of the transactional relationship among the person, their engagement in valued occupations, and the context to design occupation-based intervention plans. Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non-disability-related needs. Services promote acquisition and preservation of occupational identity for those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction (adapted from American Occupational Therapy Association, 2011).

Organization

Entity composed of individuals with a common purpose or enterprise, such as a business, industry, or agency.

Outcome

Result clients can achieve through the occupational therapy process (see Table 14).

P

Participation

"Involvement in a life situation" (World Health Organization, 2001, p. 10).

Performance patterns

Habits, routines, roles, and rituals that may be associated with different lifestyles and used in the process of engaging in occupations or activities. These patterns are influenced by context and time and can support or hinder occupational performance (see Table 6).

Performance skills

Observable, goal-directed actions that result in a client's quality of performing desired occupations. Skills are supported by the context in which the performance occurred and by underlying client factors (Fisher & Marterella, 2019).

Person

Individual, including family member, caregiver, teacher, employee, or relevant other.

Personal factors

Unique features of the person reflecting the particular background of their life and living that are not part of a health condition or health state. Personal factors are generally considered to be enduring, stable attributes of the person, although some personal factors may change over time (see Table 5).

Play

Active engagement in an activity that is intrinsically motivated, internally controlled, and freely chosen and that may include the suspension of reality (Skard & Bundy, 2008). Play includes participation in a broad range of experiences including but not limited to exploration, humor, fantasy, risk, contest, and celebrations (Eberle, 2014; Sutton-Smith, 2009). Play is a complex and multidimensional phenomenon that is shaped by sociocultural factors (Lynch et al., 2016; see Table 2).

Population

Aggregate of people with common attributes such as contexts, characteristics, or concerns, including health risks.

Prevention

Education or health promotion efforts designed to identify, reduce, or prevent the onset and decrease the incidence of unhealthy conditions, risk factors, diseases, or injuries (American Occupational Therapy Association, 2020a).

Process

Series of steps occupational therapy practitioners use to operationalize their expertise in providing services to clients. The occupational therapy process includes evaluation, intervention, and outcomes; occurs within the purview of the occupational therapy domain; and involves collaboration among the occupational therapist, occupational therapy assistant, and client.

Process skills

The "group of performance skills that represent small, observable actions related to selecting, interacting with, and using tangible task objects (e.g., tools, utensils, clothing, food or other supplies, digital devices, plant life); carrying out individual actions and steps; and preventing problems of occupational performance from occurring or reoccurring in the context of performing a personally and ecologically relevant daily life task. They are commonly named in terms of type of task being performed (e.g., [activity of daily living] process skills, school process skills, work process skills)" (Fisher & Marterella, 2019, pp. 336–337; see Table 7).

Professional reasoning

"Process that practitioners use to plan, direct, perform, and reflect on client care" (Schell, 2019, p. 482).

Q

Quality of life

Dynamic appraisal of life satisfaction (perception of progress toward identifying goals), self-concept (beliefs and feelings about oneself), health and functioning (e.g., health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income; adapted from Radomski, 1995).

R

Reevaluation

Reappraisal of the client's performance and goals to determine the type and amount of change that has taken place.

Rehabilitation

Services provided to persons experiencing deficits in key areas of physical and other types of function or limitations in participation in daily life activities. Interventions are designed to enable the achievement and maintenance of optimal physical, sensory, intellectual, psychological, and social functional levels. Rehabilitation services provide tools and techniques clients need to attain desired levels of independence and self-determination.

Rituals

For persons: Sets of symbolic actions with spiritual, cultural, or social meaning contributing to the client's identity and reinforcing values and beliefs. Rituals have a strong affective component (Fiese, 2007; Fiese et al., 2002; Segal, 2004; see Table 6).

For groups and populations: Shared social actions with traditional, emotional, purposive, and technological meaning contributing to values and beliefs within the group or population (see Table 6).

Roles

For persons: Sets of behaviors expected by society and shaped by culture and context that may be further conceptualized and defined by the client (see Table 6).

For groups and populations: Sets of behaviors by the group or population expected by society and shaped by culture and context that may be further conceptualized and defined by the group or population (see Table 6).

Routines

For persons, groups, and populations: Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying and promoting or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Fiese et al., 2002; Segal, 2004; see Table 6).

S

Screening

"Process of reviewing available data, observing a client, or administering screening instruments to identify a person's (or a population's) potential strengths and limitations and the need for further assessment" (Hinojosa et al., 2014, p. 3).

Self-advocacy

Advocacy for oneself, including making one's own decisions about life, learning how to obtain information to gain an understanding about issues of personal interest or importance, developing a network of support, knowing one's rights and responsibilities, reaching out to others when in need of assistance, and learning about self-determination.

Service delivery

Set of approaches and methods for providing services to or on behalf of clients.

Skilled services

To be covered as skilled therapy, services must require the skills of a qualified occupational therapy practitioner and must be reasonable and necessary for the treatment of the patient's condition, illness, or injury. Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. Practitioners should check their payer policies to ensure they meet payer definitions and comply with payer requirements.

Social interaction skills

The "group of performance skills that represent small, observable actions related to communicating and interacting with others in the context of engaging in a personally and ecologically relevant daily life task performance that involves social interaction with others" (Fisher & Marterella, 2019, p. 342).

Social participation

"Interweaving of occupations to support desired engagement in community and family activities as well as those involving peers and friends" (Schell & Gillen, 2019, p. 711) involvement in a subset of activities that incorporate social situations with others (Bedell, 2012) and that support social interdependence (Magasi & Hammel, 2004; see Table 2).

Spirituality

"Deep experience of meaning brought about by engaging in occupations that involve the enacting of personal values and beliefs, reflection, and intention within a supportive contextual environment" (Billock, 2005, p. 887). It is important to recognize spirituality "as dynamic and often evolving" (Humbert, 2016, p. 12).

T

Time management

Manner in which a person, group, or population organizes, schedules, and prioritizes certain activities.

Transaction

Process that involves two or more individuals or elements that reciprocally and continually influence and affect one another through the ongoing relationship (Dickie et al., 2006).

V

Values

Acquired beliefs and commitments, derived from culture, about what is good, right, and important to do (Kielhofner, 2008).

W

Well-being

"General term encompassing the total universe of human life domains, including physical, mental, and social aspects, that make up what can be called a 'good life'" (World Health Organization, 2006, p. 211).

Wellness

"The individual's perception of and responsibility for psychological and physical well-being as these contribute to overall satisfaction with one's life situation" (Schell & Gillen, 2019, p. 1215).

Work

Labor or exertion related to the development, production, delivery, or management of objects or services; benefits may be financial or nonfinancial (e.g., social connectedness, contributions to society, adding structure and routine to daily life; Christiansen & Townsend, 2010; Dorsey et al., 2019).

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Occupational Therapy Scope of Practice

Statement of Purpose

The purpose of this document is to

A. Define the scope of practice in occupational therapy by
   1. Delineating the domain of occupational therapy practice and services provided by occupational therapists and occupational therapy assistants,
   2. Delineating the dynamic process of occupational therapy evaluation and intervention services used to achieve outcomes that support the participation of clients[1] in everyday life occupations, and
   3. Describing the education and certification requirements needed to practice as an occupational therapist and occupational therapy assistant;
B. Provide a model definition of occupational therapy to promote uniform standards and professional mobility across state occupational therapy statutes and regulations; and
C. Inform consumers, health care providers, educators, the community, funding agencies, payers, referral sources, and policymakers regarding the scope of occupational therapy.

Introduction

The occupational therapy scope of practice is based on the American Occupational Therapy Association (AOTA) documents *Occupational Therapy Practice Framework: Domain and Process* (4th ed.; AOTA, 2020c) and the *Philosophical Base of Occupational Therapy* (AOTA, 2017), which states that "the use of occupation to promote individual, family, community, and population health is the core of occupational therapy practice, education, research, and advocacy" (p. 1). Occupational therapy is a dynamic and evolving profession that is responsive to consumer and societal needs, to system changes, and to emerging knowledge and research.

Although this document may be a resource to use with state statutes and regulations that govern the practice of occupational therapy, it does not supersede existing laws and other regulatory requirements.

[1]"The clients of occupational therapy are typically classified as persons (including those involved in care of a client), groups (collections of individuals having shared characteristics or a common or shared purpose; e.g., family members, workers, students, people with similar interests or occupational challenges), and populations (aggregates of people with common attributes such as contexts, characteristics, or concerns, including health risks)"; Scaffa & Reitz, 2014, as quoted in AOTA, 2020c, p. 2).

Occupational therapists and occupational therapy assistants are required to abide by relevant statutes and regulations when providing occupational therapy services. State statutes and other regulatory requirements typically include statements about educational requirements to be eligible for licensure as an occupational therapy practitioner, procedures to practice occupational therapy legally within the defined area of jurisdiction, the definition and scope of occupational therapy practice, and supervision requirements for occupational therapy assistants.

It is the position of AOTA that a referral is not required for the provision of occupational therapy services; however, laws and payment policies generally affect referrals for such services. AOTA's position is also that "an occupational therapist accepts and responds to referrals in compliance with state or federal laws, other regulatory and payer requirements, and AOTA documents" (AOTA, 2015b, Standard II.2, p. 3). State laws and other regulatory requirements should be viewed as minimum criteria to practice occupational therapy. A *Code of Ethics* and related standards of conduct ensure safe and effective delivery of occupational therapy services (AOTA, 2020a). Policies of payers such as public and private insurance companies also must be followed.

Occupational therapy services may be provided by two levels of practitioners: (1) the occupational therapist and (2) the occupational therapy assistant, as well as by occupational therapy students under appropriate supervision (AOTA, 2018). Occupational therapists function as autonomous practitioners, are responsible for all aspects of occupational therapy service delivery, and are accountable for the safety and effectiveness of the occupational therapy service delivery process.

The occupational therapy assistant delivers occupational therapy services only under the supervision of and in partnership with the occupational therapist (AOTA, 2020b). When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2015a).

Definition of Occupational Therapy

The *Occupational Therapy Practice Framework: Domain and Process* (4th ed.; AOTA, 2020c) defines *occupational therapy* as

> therapeutic use of everyday life occupations with persons, groups, or populations (i.e., clients) for the purpose of enhancing or enabling participation. Occupational therapy practitioners use their knowledge of the transactional relationship among the client, their engagement in valuable occupations, and the context to design occupation-based intervention plans. Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non–disability-related needs. Services promote acquisition and preservation of occupational identity for those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. (p. 80)

Exhibit 1 contains the model definition of occupational therapy for the AOTA (2021) Model Occupational Therapy Practice Act in a format that will be used to assert the scope of practice of occupational therapy for state regulation. States are encouraged to adopt this language in their practice acts because it reflects the contemporary occupational therapy scope of practice.

Scope of Practice: Domain and Process

The scope of practice includes the domain and process of occupational therapy services. These two concepts are intertwined, with the *domain* (Exhibit 2) defining the focus of occupational therapy and the *process* (Exhibit 3) defining the delivery of occupational therapy.

The *domain* of occupational therapy includes the everyday life occupations that people find meaningful and purposeful; aspects of the domain are presented in Exhibit 2. Within this domain, occupational therapy services enable clients to participate in their everyday life occupations in their desired roles, contexts, and life situations.

Clients may be persons, groups, or populations. The domain of occupational therapy consists of the following occupations in which clients engage throughout the life course (AOTA, 2020c, pp. 30–34, Table 2):

- ADLs (activities oriented toward taking care of one's own body and completed on a routine basis; e.g., bathing, feeding, dressing)
- IADLs (activities to support daily life within the home and community that often require complex interactions; e.g., household management, financial management, child care)
- Health management (activities related to developing, managing, and maintaining health and wellness routines, including self-management, with the goal of improving or maintaining health to support participation in other occupations; e.g., medication management, social and emotional health promotion and maintenance)
- Rest and sleep (activities relating to obtaining restorative rest and sleep, including identifying the need for rest and sleep, preparing for sleep, and participating in rest and sleep)
- Education (activities needed for learning and participating in the educational environment)
- Work (activities for engaging in employment or volunteer activities with financial and nonfinancial benefits)
- Play (activities that are intrinsically motivated, internally controlled, and freely chosen)
- Leisure (nonobligatory and intrinsically motivated activities during discretionary time)
- Social participation (activities that involve social interaction with others and support social interdependence).

Within their domain of practice, occupational therapists and occupational therapy assistants consider the repertoire of occupations in which the client engages, the contexts influencing engagement, the performance patterns and skills the client uses, the demands of the occupation, and the client's body functions and structures. Occupational therapy practitioners use their knowledge and skills, including therapeutic use of self, to help clients conduct or resume daily life occupations that support function and health throughout the lifespan. Participation in occupations that are meaningful to the client involves emotional, psychosocial, cognitive, and physical aspects of performance. Participation in meaningful occupations enhances health, well-being, and life satisfaction.

The domain of occupational therapy practice complements the World Health Organization's (2008) conceptualization of *participation* and *health* articulated in the *International Classification of Functioning, Disability and Health* (*ICF*). Occupational therapy incorporates the basic constructs of the *ICF,* including context, participation, activities, and body structures and functions, in interventions to enable full participation in occupations and maximize occupational engagement.

The *process* of occupational therapy refers to the delivery of services and includes evaluating, intervening, and targeting of outcomes, as detailed in Exhibit 3. Occupation remains central to the occupational therapy process, which is client centered, involving collaboration with the client throughout each aspect of service delivery. There are many service delivery approaches, including direct (e.g., providing individual services in person, leading a group session, interacting with clients and families through telehealth systems) and indirect (services on the client's behalf; e.g., consultation to teachers, multidisciplinary teams, and community planning agencies), and services can be delivered at the person, group, or population level. This process includes the following key components:

- Evaluation and intervention may address one or more aspects of the domain that influence occupational performance.
- During the evaluation, the occupational therapist develops an occupational profile; analyzes the client's ability to carry out everyday life activities; and determines the client's occupational needs, strengths, barriers to participation, and priorities for intervention.
- Intervention includes planning and implementing occupational therapy services, including education and training, advocacy, group interventions, and virtual interventions. The occupational therapist and occupational therapy assistant in partnership with the client use occupation-based theories, frames of reference, evidence, and clinical reasoning to guide the intervention (AOTA, 2020c).

Exhibit 1. Definition of Occupational Therapy for Use in State Regulations

The practice of occupational therapy means the therapeutic use of everyday life occupations with persons, groups, or populations (clients) to support occupational performance and participation. Occupational therapy practice includes clinical reasoning and professional judgment to evaluate, analyze, and diagnose occupational challenges (e.g., issues with client factors, performance patterns, and performance skills) and provide occupation-based interventions to address them. Occupational therapy services include habilitation, rehabilitation, and the promotion of physical and mental health and wellness for clients with all levels of ability-related needs. These services are provided for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Through the provision of skilled services and engagement in everyday activities, occupational therapy promotes physical and mental health and well-being by supporting occupational performance in people with, or at risk of experiencing, a range of developmental, physical, and mental health disorders.

The practice of occupational therapy includes the following components:

A. Evaluation of factors affecting activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation, including
   1. Contexts (environmental and personal factors) and occupational and activity demands that affect performance
   2. Performance patterns, including habits, routines, roles, and rituals
   3. Performance skills, including motor skills (e.g., moving oneself or moving and interacting with objects), process skills (e.g., actions related to selecting, interacting with, and using tangible task objects), and social interaction skills (e.g., using verbal and nonverbal skills to communicate)
   4. Client factors, including body functions (e.g., neuromuscular, sensory, visual, mental, psychosocial, cognitive, pain factors), body structures (e.g., cardiovascular, digestive, nervous, integumentary, genitourinary systems; structures related to movement), values, beliefs, and spirituality.

B. Methods or approaches to identify and select interventions, such as
   1. Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline
   2. Compensation, modification, or adaptation of occupations, activities, and contexts to improve or enhance performance
   3. Maintenance of capabilities to prevent decline in performance in everyday life occupations
   4. Health promotion and wellness to enable or enhance performance in everyday life activities and quality of life
   5. Prevention of occurrence or emergence of barriers to performance and participation, including injury and disability prevention

C. Interventions and procedures to promote or enhance safety and performance in ADLs, IADLs, health management, rest and sleep, education, work, play, leisure, and social participation, for example,
   1. Therapeutic use of occupations and activities
   2. Training in self-care, self-management, health management (e.g., medication management, health routines), home management, community and work integration, school activities and work performance
   3. Identification, development, remediation, or compensation of physical, neuromusculoskeletal, sensory–perceptual, emotional regulation, visual, mental, and cognitive functions; pain tolerance and management; praxis; developmental skills; and behavioral skills
   4. Education and training of persons, including family members, caregivers, groups, populations, and others
   5. Care coordination, case management, and transition services
   6. Consultative services to persons, groups, populations, programs, organizations, and communities
   7. Virtual interventions (e.g., simulated, real-time, and near-time technologies, including telehealth and mobile technology)
   8. Modification of contexts (environmental and personal factors in settings such as home, work, school, and community) and adaptation of processes, including the application of ergonomic principles
   9. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices
   10. Assessment, recommendation, and training in techniques to enhance functional mobility, including fitting and management of wheelchairs and other mobility devices
   11. Exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation
   12. Remediation of and compensation for visual deficits, including low vision rehabilitation
   13. Driver rehabilitation and community mobility
   14. Management of feeding, eating, and swallowing to enable eating and feeding performance

(*Continued*)

Exhibit 1. Definition of Occupational Therapy for Use in State Regulations (*cont'd*)

15. Application of physical agent and mechanical modalities and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, motor, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills
16. Facilitating the occupational participation of persons, groups, or populations through modification of contexts (environmental and personal) and adaptation of processes
17. Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their everyday life occupations
18. Group interventions (e.g., use of dynamics of group and social interaction to facilitate learning and skill acquisition across the life course).

Source. From American Occupational Therapy Association. (2021). *Definition of occupational therapy practice for the AOTA Model Practice Act*, p. 1. Available at https://www.aota.org/Advocacy-Policy/State-Policy/Resource-Factsheets.aspx

- The outcomes of occupational therapy intervention are directed toward "achieving health, well-being, and participation in life through engagement in occupations" (AOTA, 2020c, p. 5). Outcomes of the intervention determine future actions with the client and include occupational performance, improvement, enhancement, prevention (of risk factors, disease, and disability), health and wellness, quality of life, participation, role competence, well-being, and occupational justice (AOTA, 2020c). "*Occupational adaptation*, or the client's effective and efficient response to occupational and contextual demands, is interwoven through all of these outcomes" (AOTA, 2020c, p. 26).

Sites of Intervention and Areas of Focus

Occupational therapy services are provided to clients across the life course. Practitioners work in collaboration with clients to address occupational needs and issues in areas such as mental health; work and industry; participation in education; rehabilitation, disability, and participation; productive aging; and health and wellness.

Along the continuum of service, occupational therapy services are provided to clients in a variety of settings, such as

- Institutional (inpatient) settings (e.g., acute care, rehabilitation facilities, psychiatric hospitals, community and specialty-focused hospitals, nursing facilities, prisons),

Exhibit 2. Aspects of the Domain of Occupational Therapy
All aspects of the occupational therapy domain transact to support engagement, participation, and health. This exhibit does not imply a hierarchy.

Occupations	Contexts	Performance Patterns	Performance Skills	Client Factors
Activities of daily living (ADLs) Instrumental activities of daily living (IADLs) Health management Rest and sleep Education Work Play Leisure Social participation	Environmental factors Personal factors	Habits Routines Roles Rituals	Motor skills Process skills Social interaction skills	Values, beliefs, and spirituality Body functions Body structures

Source. From American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2), 7412410010, p. 7. https://doi.org/10.5014/ajot.2020.74S2001

Exhibit 3. Operationalizing the Occupational Therapy Process

Ongoing interaction among evaluation, intervention, and outcomes occurs throughout the occupational therapy process.

Evaluation
Occupational Profile • Identify the following: ◦ Why is the client seeking services, and what are the client's current concerns relative to engaging in occupations and in daily life activities? ◦ In what occupations does the client feel successful, and what barriers are affecting their success in desired occupations? ◦ What is the client's occupational history (i.e., life experiences)? ◦ What are the client's values and interests? ◦ What aspects of their contexts (environmental and personal factors) does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement? ◦ How are the client's performance patterns supporting or limiting occupational performance and engagement? ◦ What are the client's patterns of engagement in occupations, and how have they changed over time? ◦ What client factors does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement (e.g., pain, active symptoms)? ◦ What are the client's priorities and desired targeted outcomes related to occupational performance, prevention, health and wellness, quality of life, participation, role competence, well-being, and occupational justice? Analysis of Occupational Performance • The analysis of occupational performance involves one or more of the following: ◦ Synthesizing information from the occupational profile to determine specific occupations and contexts that need to be addressed ◦ Completing an occupational or activity analysis to identify the demands of occupations and activities on the client ◦ Selecting and using specific assessments to measure the quality of the client's performance or performance deficits while completing occupations or activities relevant to desired occupations, noting the effectiveness of performance skills and performance patterns ◦ Selecting and using specific assessments to measure client factors that influence performance skills and performance patterns ◦ Selecting and administering assessments to identify and measure more specifically the client's contexts and their impact on occupational performance. Synthesis of Evaluation Process • This synthesis may include the following: ◦ Determining the client's values and priorities for occupational participation ◦ Interpreting the assessment data to identify supports and hindrances to occupational performance ◦ Developing and refining hypotheses about the client's occupational performance strengths and deficits ◦ Considering existing support systems and contexts and their ability to support the intervention process ◦ Determining desired outcomes of the intervention ◦ Creating goals in collaboration with the client that address the desired outcomes ◦ Selecting outcome measures and determining procedures to measure progress toward the goals of intervention, which may include repeating assessments used in the evaluation process.
Intervention
Intervention Plan • Develop the plan, which involves selecting ◦ Objective and measurable occupation-based goals and related time frames; ◦ Occupational therapy intervention approach or approaches, such as create or promote, establish or restore, maintain, modify, or prevent; and ◦ Methods for service delivery, including what types of intervention will be provided, who will provide the interventions, and which service delivery approaches will be used.

(*Continued*)

Exhibit 3. Operationalizing the Occupational Therapy Process (*cont'd*)

Evaluation
• Consider potential discharge needs and plans. • Make recommendations or referrals to other professionals as needed. Intervention Implementation • Select and carry out the intervention or interventions, which may include the following: ◦ Therapeutic use of occupations and activities ◦ Interventions to support occupations ◦ Education ◦ Training ◦ Advocacy ◦ Self-advocacy ◦ Group intervention ◦ Virtual interventions. • Monitor the client's response through ongoing evaluation and reevaluation. Intervention Review • Reevaluate the plan and how it is implemented relative to achieving outcomes. • Modify the plan as needed. • Determine the need for continuation or discontinuation of services and for referral to other services.
Outcomes
Outcomes • Select outcome measures early in the occupational therapy process (see the "Evaluation" section of this table) on the basis of theirproperties: ◦ Valid, reliable, and appropriately sensitive to change in clients' occupational performance ◦ Consistent with targeted outcomes ◦ Congruent with the client's goals ◦ Able to predict future outcomes. • Use outcome measures to measure progress and adjust goals and interventions by ◦ Comparing progress toward goal achievement with outcomes throughout the intervention process and ◦ Assessing outcome use and results to make decisions about the future direction of intervention (e.g., continue, modify, transition, discontinue, provide follow-up, refer for other service).

Source. From American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2), 7412410010, p. 16. https://doi.org/10.5014/ajot.2020.74S2001

- Outpatient settings (e.g., hospitals, clinics, medical and therapy offices),
- Home and community settings (e.g., residences, group homes, assisted living, schools, early intervention centers, day care centers, industry and business, hospice, homeless shelters, transitional living facilities, wellness and fitness centers, community mental health facilities, public and private transportation agencies, park districts, work sites), and
- Research facilities.

Education and Certification Requirements

To practice as an occupational therapist, the individual trained in the United States

- Has graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE®; 2018) or predecessor organizations;

- Has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE or predecessor organizations;
- Has passed a nationally recognized entry-level examination for occupational therapists; and
- Fulfills state requirements for licensure, certification, or registration.

To practice as an occupational therapy assistant, the individual trained in the United States

- Has graduated from an occupational therapy assistant program accredited by ACOTE or predecessor organizations;
- Has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapy assistants that is accredited by ACOTE or predecessor organizations;
- Has passed a nationally recognized entry-level examination for occupational therapy assistants; and
- Fulfills state requirements for licensure, certification, or registration.

AOTA supports licensure of qualified occupational therapists and occupational therapy assistants (AOTA, 2016). State and other legislative or regulatory agencies may impose additional requirements to practice as occupational therapists and occupational therapy assistants in their area of jurisdiction.

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

Adopted by the Representative Assembly Coordinating Council (RACC) for the Representative Assembly, 2021

Note. This document replaces the 2014 document *Scope of Practice*, previously published and copyrighted in 2014 by the American Occupational Therapy Association in the *American Journal of Occupational Therapy, 68*(Suppl. 3), S34–S40. https://doi.org/10.5014/ajot.2014.686S04

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American Occupational Therapy Association

MODEL OCCUPATIONAL THERAPY PRACTICE ACT

The Model Occupational Therapy Practice Act (Model Practice Act) has been developed by the State Affairs Group of the American Occupational Therapy Association, in collaboration with the Commission on Practice for use by state occupational therapy associations or state regulatory boards interested in developing or revising legislation to regulate the practice of Occupational Therapy. The Model Practice Act also includes the definition of Occupational Therapy, which is approved by the Representative Assembly Coordinating Committee (RACC) on behalf of the Representative Assembly (RA) and is included in the Scope of Practice Official Document[1]. The current definition was approved in 2021.

The Model Practice Act must be reviewed and carefully adapted to comply with a state's legislative requirements and practices. It must also be adapted to reflect a state's administrative and regulatory laws and other legal procedures. The Model Practice Act leaves blanks or indicates alternatives in brackets when further detail needs to be considered or when adaptions are especially necessary. The term "state" is used throughout the document for ease of reading. Other jurisdictions, such as the District of Columbia and Puerto Rico, will need to modify the language accordingly.

[1] American Occupational Therapy Association. (2021). Occupational therapy scope of practice. *American Journal of Occupational Therapy, 75*(Suppl. 3), 7513410030. https://doi.org/10.5014/ajot.2021.75S3005

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Article I. General Provisions

1.01 Title [Title should conform to state requirements. The following is suggested for appropriate adaptation.]

An Act providing for the licensure of Occupational Therapists and Occupational Therapy Assistants; for a Board of Occupational Therapy practice and its powers and duties; and for related purposes.

1.02 Short Title

This Act shall be known and may be cited as the "Occupational Therapy Practice Act."

1.03 Legislative Intent and Purpose

The Legislature finds and declares that the Occupational Therapy Practice Act is enacted to safeguard public health, safety, and welfare; to protect the public from incompetent, unethical, or unauthorized persons; to assure a high level of professional conduct on the part of Occupational Therapists and Occupational Therapy Assistants; and to assure the availability of high quality Occupational Therapy services to persons in need of such services. It is the purpose of this Act to provide for the regulation of persons representing themselves as Occupational Therapists or as Occupational Therapy Assistants, or performing services that constitute Occupational Therapy.

1.04 Definitions

(1) "Act" means the Occupational Therapy Practice Act.
(2) "Aide" means a person who is not licensed by the Board and who provides supportive services to Occupational Therapists and Occupational Therapy Assistants. An Aide shall function only under the guidance, responsibility, and supervision of the licensed Occupational Therapist or an Occupational Therapy Assistant who is appropriately supervised by an Occupational Therapist. An Aide does not provide occupational therapy services. An Aide must first demonstrate competence before performing assigned, delegated, client related and non–client related tasks.
(3) "Association" means the _____ State Occupational Therapy Association.
(4) "Board" means the _____ State Board of Occupational Therapy.
(5) "Good Standing" means the individual's license is not currently suspended or revoked by any State regulatory entity.
(6) "Continuing Competence" means the process in which an occupational therapist or occupational therapy assistant develops and maintains the knowledge, critical reasoning, interpersonal skills, performance skills, and ethical practice necessary to perform their occupational therapy responsibilities.
(7) "The Practice of Occupational Therapy" means the therapeutic use of everyday life occupations with persons, groups, or populations (clients) to support occupational performance and participation. Occupational therapy practice includes clinical reasoning and professional judgment to evaluate, analyze, and diagnose occupational challenges (e.g., issues with client factors, performance patterns, and performance skills) and provide occupation-based interventions to address them. Occupational therapy services include habilitation, rehabilitation, and the promotion of physical and mental health and wellness for clients with all levels of ability-related needs. These services are provided for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Through the provision of skilled services and engagement in everyday activities, occupational therapy promotes physical and mental health and well-being by supporting occupational performance in people with, or at risk of experiencing, a range of developmental,

physical, and mental health disorders. The practice of occupational therapy includes the following components:

a) Evaluation of factors affecting activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation, including
    1. Context (environmental and personal factors) and occupational and activity demands that affect performance
    2. Performance patterns including habits, routines, roles, and rituals
    3. Performance skills, including motor skills (e.g., moving oneself or moving and interacting with objects), process skills (e.g., actions related to selecting, interacting with, and using tangible task objects), and social interaction skills (e.g., using verbal and nonverbal skills to communicate)
    4. Client factors, including body functions (e.g., neuromuscular, sensory, visual, mental, psychosocial, cognitive, pain factors), body structures (e.g., cardiovascular, digestive, nervous, integumentary, and genitourinary systems; structures related to movement), values, and spirituality
b) Methods or approaches to identify and select interventions, such as
    1. Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline
    2. Compensation, modification, or adaptation of occupations, activities, and contexts to improve or enhance performance
    3. Maintenance of capabilities to prevent decline in performance in everyday life occupations
    4. Health promotion and wellness to enable or enhance performance in everyday life activities and quality of life
    5. Prevention of occurrence or emergence of barriers to performance and participation, including injury and disability prevention
c) Interventions and procedures to promote or enhance safety and performance in ADLs, IADLs, health management, rest and sleep, education, work, play, leisure, and social participation, for example:
    1. Therapeutic use of occupations and activities
    2. Training in self-care, self-management, health management (e.g., medication management, health routines), home management, community/work integration, school activities, and work performance
    3. Identification, development, remediation, or compensation of physical, neuromusculoskeletal, sensory–perceptual, emotional regulation, visual, mental, and cognitive functions; pain tolerance and management; praxis; developmental skills; and behavioral skills
    4. Education and training of persons, including family members, caregivers, groups, populations, and others
    5. Care coordination, case management, and transition services
    6. Consultative services to persons, groups, populations, programs, organizations, and communities
    7. Virtual interventions (e.g., simulated, real-time, and near-time technologies, including telehealth and mobile technology)
    8. Modification of contexts (environmental and personal factors in settings such as home, work, school, and community) and adaptation of processes, including the application of ergonomic principles

9. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices
10. Assessment, recommendation, and training in techniques to enhance functional mobility, including fitting and management of wheelchairs and other mobility devices
11. Exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation
12. Remediation of and compensation for visual deficits, including low vision rehabilitation
13. Driver rehabilitation and community mobility
14. Management of feeding, eating, and swallowing to enable eating and feeding performance
15. Application of physical agent and mechanical modalities and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, motor, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills
16. Facilitating the occupational participation of persons, groups, or populations through modification of contexts (environmental and personal) and adaptation of processes
17. Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their everyday life occupations
18. Group interventions (e.g., use of dynamics of group and social interaction to facilitate learning and skill acquisition across the life course).

(8) "Occupational Therapist" means a person licensed to practice Occupational Therapy under this Act. The Occupational Therapist is responsible for and directs the evaluation process, develops the intervention plan, and provides occupational therapy services.

(9) "Occupational Therapy Assistant" means a person licensed to assist in the practice of Occupational Therapy under this Act and who shall work under the appropriate supervision of and in partnership with an Occupational Therapist.

(10) "Person" means any individual, partnership, unincorporated organization, limited liability entity, or corporate body, except that only an individual may be licensed under this Act.

(11) "Supervision" means a collaborative process for responsible, periodic review and inspection of all aspects of occupational therapy services. The Occupational Therapist is accountable for occupational therapy services provided by the Occupational Therapy Assistant and the Aide. In addition, the Occupational Therapy Assistant is accountable for occupational therapy services they provide. Within the scope of occupational therapy practice, supervision is aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and development.

(12) "Telehealth" means the application of evaluation, consultative, preventative, and therapeutic services delivered through information and communication technology.

Article II. Board of Occupational Therapy

2.01 Board Created

There is hereby established the _____ Board of Occupational Therapy hereafter referred to as the Board, which shall be responsible for the implementation and enforcement of this Act.

2.02 Board Composition

(1) The Board shall be composed of at least five individuals appointed by the Governor.
(2) At least two members shall be licensed as Occupational Therapists in this state.
(3) At least one member shall be an Occupational Therapy Assistant licensed in this state.
(4) At least two members shall be representatives of the public with an interest in the rights of consumers of health and wellness services (public member) and a representative of healthcare or education (consumer member).

2.03 Qualifications

(1) Public and Consumer Members must reside in this state for at least 5 years immediately preceding their appointment. Public members and consumer members shall understand or be willing to learn the specific responsibilities of the Board; be willing to learn about and develop contacts with major community service, civic, consumer, public service, religious, and other organizations in their state that have an interest in health care delivery and health care policy, including organizations that represent disadvantaged communities, rural, and non-English speaking populations; and have a track record of advocacy related to furthering consumer interests, especially in the area of health care. Public and consumer members may not be or have ever been Occupational Therapists or Occupational Therapy Assistants or in training to become an Occupational Therapist or Occupational Therapy Assistant. Public and consumer members may not be related to or have a household member who is an Occupational Therapist or an Occupational Therapy Assistant. The consumer member shall have knowledge of the profession of occupational therapy through personal experience. The public member shall have knowledge of the profession of occupational therapy through professional experience in health care reimbursement, regulatory, or policy arenas.
(2) Occupational Therapy and Occupational Therapy Assistant members must be licensed consistent with state law and reside in the state for at least 5 years, or have a privilege to practice through the Occupational Therapy Licensure Compact, and have been engaged in: rendering occupational therapy services to the public; teaching; consultation; or research in occupational therapy for at least 5 years, including the 3 years immediately preceding their appointment.
(3) No member shall be a current officer, Board member, or employee of a statewide organization established for the purpose of advocating for the interests of persons licensed under this Act.

2.04 Appointments

(1) Within 90 days after the enactment of this Act, the first Board shall be appointed by the Governor from a list of names submitted by the State Occupational Therapy Association and from nominations submitted by interested organizations or persons in the state.
(2) Each subsequent appointment shall be made from recommendations submitted by the State Occupational Therapy Association or from recommendations submitted by other interested organizations or persons in the state.

2.05 Terms

(1) Appointments to the Board shall be for a period of 3 years, except for the initial appointments which shall be staggered terms of 1, 2, and 3 years. Members shall serve until the expiration of the term for which they have been appointed or until their successors have been appointed to serve on the Board. No member may serve more than two consecutive 3-year terms or for six consecutive years.

(2) Terms shall begin on the first day of the calendar year and end on the last day of the calendar year or until successors are appointed, except for the first appointed members who shall serve through the last calendar day of the year in which they are appointed, before commencing the terms prescribed by this section.

2.06 Vacancies

In the event of a vacancy in the office of a member of the Board other than by expiration of a term, the Governor shall appoint a qualified person to fill the vacancy for the unexpired term.

2.07 Removal of Board Members

The Governor or the Board may remove a member of the Board for incompetence, professional misconduct, conflict of interest, or neglect of duty after written notice and opportunity for a hearing. The Board shall be responsible for defining the standards for removal for regulation.

2.08 Compensation of Board Members

Members of the Board shall receive no compensation for their services, but shall be entitled to reasonable reimbursement for travel and other expenses incurred in the execution of their powers and duties.

2.09 Administrative Provisions

(1) The Board may employ and discharge an Administrator and such officers and employees as it deems necessary, and shall determine their duties in accordance with [applicable State statute].
(2) [This subsection should be used to include administrative detail covering revenues and expenditures, authentication and preservation of documents, promulgation of rules and regulations, etc., in accordance with prevailing state practice, and to the extent that such detail is not already taken care of in state laws of general applicability.]

2.10 Meetings

(1) The Board shall, at the first meeting of each calendar year, select a Chairperson and conduct other appropriate business.
(2) At least three additional meetings shall be held before the end of each calendar year.
(3) Other meetings, including telecommunication conference meetings, may be convened at the call of the Chairperson or the written request of two of more Board members.
(4) A majority of the members of the Board shall constitute a quorum for all purposes. The quorum must include at least one Occupational Therapist.
(5) The Board shall conduct its meetings and keep records of its proceedings in accordance with the provisions of the Administrative Procedure Act of this state.
(6) All Board meetings and hearings shall be open to the public. The Board may, in its discretion and according to the state's Administrative Procedures Act [or other comparable statute], conduct any portion of its meetings or hearings in executive session, closed to the public.
(7) The Board shall develop and implement policies that provide the public with a reasonable opportunity to appear before the Board and to speak on any issue under Board jurisdiction.

2.11 Powers and Duties

(1) The Board shall, in accordance with the Administrative Procedures Act, perform all lawful functions consistent with this Act, or otherwise authorized by state law including that it shall:
    a. Administer, coordinate, and enforce the provisions of this Act;
    b. Evaluate applicants' qualifications for licensure in a timely manner;
    c. Establish licensure fees and issue, renew, or deny licenses;
    d. Issue subpoenas, examine witnesses, and administer oaths;
    e. Investigate allegations of practices violating the provisions of this Act;
    f. Make, adopt, amend, and repeal such rules as may be deemed necessary by the Board from time to time for the proper administration and enforcement of this Act;
    g. Conduct hearings and keep records and minutes;
    h. Establish a system for giving the public, including its regulated profession, reasonable advance notice of all open Board and committee meetings. Emergency meetings, including telephone or other telecommunication conference meetings, shall be held in accordance with applicable Administrative Procedures Act provisions;
    i. Communicate disciplinary actions to relevant state and federal authorities, the National Board for Certification in Occupational Therapy (NBCOT), the American Occupational Therapy Association (AOTA) Ethics Commission, and to other State OT licensing authorities;
    j. Publish at least annually Board rulings, opinions, and interpretations of statutes or rules in order to guide persons regulated by this Act; and
    k. Establish a system for tracking the amount of time the Board takes to issue an initial license or licensure renewal to an applicant.
(2) No member of the Board shall be civilly liable for any act or failure to act performed in good faith in the performance of his or her duties as prescribed by law.

2.12 Training of New Members

The Board shall conduct and new members shall attend a training program designed to familiarize new members with their duties. A training program for new members shall be held as needed.

Article III. Licensing and Examination

3.01 Requirements for Licensure

An applicant applying for a license as an Occupational Therapist or as an Occupational Therapy Assistant shall file a written application provided by the Board, demonstrating to the satisfaction of the Board that the applicant

(1) Is in good standing as defined in Section 1.04;
(2) Has successfully completed the minimum academic requirements of an educational program for Occupational Therapists or Occupational Therapy Assistants that is accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education (ACOTE) or predecessor organizations;
(3) Has successfully completed a minimum period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements described in Section 3.03 (2); and
(4) Has passed an examination administered by the National Board for Certification in Occupational Therapy (NBCOT), a predecessor organization, or another nationally recognized credentialing body as approved by the Board.

3.02 Internationally Educated Applicants

An Occupational Therapist who is a graduate of a school of occupational therapy that is located outside of the United States and its territories shall:

(1) Complete occupational therapy education programs (including fieldwork requirements) that are deemed comparable by the credentialing body recognized by the state occupational therapy regulatory board or agency to entry-level occupational therapy education programs in the United States.
(2) Fulfill examination requirement described in section 3.01(4).

3.03 Limited Permit

(1) A limited permit to practice occupational therapy may be granted to a person who has completed the academic and fieldwork requirements for Occupational Therapist of this Act and has not yet taken or received the results of the entry-level certification examination. This permit shall be valid for __ months and shall allow the person to practice occupational therapy under the direction and appropriate supervision of an Occupational Therapist licensed under this Act. This permit shall expire when the person is issued a license under Section 3.01or if the person is notified that they did not pass the examination. The limited permit may not be renewed.
(2) A limited permit to assist in the practice of occupational therapy may be granted to a person who has completed the academic and fieldwork requirements of Occupational Therapy Assistant of this Act and has not yet taken or received the results of the entry-level certification examination. This permit shall be valid for __ months and shall allow the person to practice occupational therapy under the direction and appropriate supervision of an Occupational Therapist licensed under this Act. This permit shall expire when the person is issued a license under Section 3.01 or if the person is notified that they did not pass the examination. The limited permit may not be renewed.

3.04 Temporary License

An applicant who is currently licensed and in good standing to practice in another jurisdiction and meets the requirements for licensure by endorsement may obtain a temporary license while the application is being processed by the Board.

3.05 Issuance of License

The Board shall issue a license to any person who meets the requirements of this Act, as described in sections 3.01 or 3.02, upon payment of the prescribed license fee as described in Section 3.09.

3.06 Renewal of License

(1) Any license issued under this Act shall be subject to annual [biennial] renewal and shall expire unless renewed in the manner prescribed by the rules and regulations of the Board.
(2) The Board shall prescribe by rule continuing competence requirements as a condition for renewal of licensure.
(3) The Board may provide late renewal of a license upon the payment of a late fee in accordance with its rules and regulations.
(4) Licensees are granted a grace period of 30 days after the expiration of their licenses in which to renew retroactively if they meet statutory requirements for renewal and pay to the Board the renewal fee and any late fee set by the Board.

(5) A suspended license is subject to expiration and may be renewed as provided in this Act, but such renewal shall not entitle the licensee, while the license remains suspended and until it is reinstated, to engage in the licensed activity, or in any other conduct or activity in violation of the order of judgement by which the license was suspended.
(6) A license revoked on disciplinary grounds may not be renewed or restored.

3.07 Inactive License

(1) Upon request, the Board shall grant inactive status to a licensee who is in good standing and maintains continuing competence requirements established by the Board, and
    a. Does not practice during such "inactive" period as an Occupational Therapist or an Occupational Therapy Assistant, and
    b. Does not during such "inactive" period hold themselves out as an Occupational Therapist or an Occupational Therapy Assistant.

3.08 Re-entry

(1) Reentering Occupational Therapists and Occupational Therapy Assistants are individuals who have previously practiced in the field of occupational therapy and have not engaged in the practice of occupational therapy for a minimum of 24 months.
(2) Occupational Therapists and Occupational Therapy Assistants who are seeking re-entry must fulfill re-entry requirements as prescribed by the Board in regulations.

3.09 Fees

(1) Consistent with the Administrative Procedures Act, the Board shall prescribe, and publish in the manner established by its rules, fees in amounts determined by the Board for the following:
    a. Initial license fee
    b. Renewal of license fee
    c. Late renewal fee
    d. Limited permit fee
    e. Temporary license fee
    f. Any other fees it determines appropriate.
(2) These fees shall be set in such an amount as to reimburse the state, to the extent feasible, for the cost of the services rendered.

Article IV. Regulation of Practice

4.01 Unlawful Practice

(1) No person shall practice occupational therapy or assist in the practice of occupational therapy or provide occupational therapy services or hold themselves as an Occupational Therapist or Occupational Therapy Assistant, or as being able to practice occupational therapy or assist in the practice of occupational therapy or provide occupational therapy services in this state unless they are licensed under the provisions of this Act.
(2) It is unlawful for any person not licensed as an Occupational Therapist in this state or whose license is suspended or revoked to use in connection with their name or place of business in this state, the words "Occupational Therapist," "licensed Occupational Therapist," "Doctor of Occupational Therapy," or the professional abbreviations "O.T.," "O.T.L.," "M.O.T.," "O.T.D.," "M.O.T./L.," "O.T.D./L." or any word, title, letters, or designation that implies that the person practices or is authorized to practice occupational therapy.

(3) It is unlawful for any person not licensed as an Occupational Therapy Assistant in this state or whose license is suspended or revoked to use in connection with their name or place of business in this state, the words “Occupational Therapy Assistant,” “licensed Occupational Therapy Assistant,” or the professional abbreviations “O.T.A.” or “O.T.A./L.,” or use any word, title, letters, or designation that implies that the person assists in, or is authorized to assist in, the practice of occupational therapy as an Occupational Therapy Assistant.

4.02 Exemptions

This Act does not prevent or restrict the practice, service, or activities of:

(1) Any person licensed or otherwise regulated in this state by any other law from engaging in their profession or occupation as defined in the Practice Act under which they are licensed.
(2) Any person pursuing a course of study leading to a degree in occupational therapy at an accredited educational program, if that person is designated by a title that clearly indicates their status as a student and if they act under appropriate instruction and supervision.
(3) Any person fulfilling the supervised fieldwork experience requirements of Section 3.01 of this Act, if the experience constitutes a part of the experience necessary to meet the requirement of that section and they act under appropriate supervision.
(4) Any person fulfilling a supervised or mentored occupational therapy doctoral capstone experience.
(5) An Occupational Therapist or Occupational Therapy Assistant who is authorized to practice occupational therapy in any jurisdiction, if they practice occupational therapy in this state for the purpose of education, consulting, or training, for the duration of the purpose, as preapproved by the Board;

4.03 Titles and Designations

(1) A licensed Occupational Therapist may use the words “occupational therapist,” “licensed occupational therapist,” or any words, title, letters, or other appropriate designation that indicates licensure, including but not limited to OT or OT/L, MOT/L, MSOT/L, and OTD/L that identifies the person as a licensed Occupational Therapist in connection with:
    a. Their name or place of business; and
    b. Any activity, practice, or service, so long as they are at all times in conformance with the requirements of this Act when providing occupational therapy services.
(2) A licensed Occupational Therapy Assistant may use the words “occupational therapy assistant,” “licensed occupational therapy assistant,” or any word, title, letters, or other appropriate designation that indicates licensure including, but not limited to OTA or OTA/L that identifies the person as a licensed Occupational Therapy Assistant in connection with:
    a. Their name or place of business; and
    b. Any activity, practice, or service, so long as they are at all times in conformance with the requirements of this Act when providing occupational therapy services.

4.04 Grounds for Disciplinary Action

The Board may take action against a licensee as described in Section 4.08 for unprofessional conduct including:

(1) Obtaining a license by means of fraud, misrepresentation, or concealment of material facts.

(2) Being guilty of unprofessional conduct as defined by the rules established by the Board, or violating the Code of Ethics adopted and published by the Board.
(3) Being convicted of a crime in any court except for minor offenses.
(4) Violating any lawful order, rule, or regulation rendered or adopted by the Board.
(5) Violating any provision of this Act (or regulations pursuant to this Act).
(6) Practicing beyond the scope of the practice of occupational therapy.
(7) Providing substandard care as an Occupational Therapist due to a deliberate or negligent act or failure to act regardless of whether actual injury to the client is established.
(8) Providing substandard care as an Occupational Therapy Assistant, including exceeding the authority to perform components of intervention selected and delegated by the supervising Occupational Therapist regardless of whether actual injury to the client is established.
(9) Knowingly delegating responsibilities to an individual who does not have the knowledge, skills, or abilities to perform those responsibilities.
(10) Failing to provide appropriate supervision to an Occupational Therapy Assistant or Aide in accordance with this Act and Board rules.
(11) Practicing as an Occupational Therapist or Occupational Therapy Assistant when competent services to recipients may not be provided due to the practitioner's own physical or mental impairment.
(12) Having had an Occupational Therapist or Occupational Therapy Assistant license revoked or suspended, other disciplinary action taken, or an application for licensure reused, revoked, or suspended by the proper authorities of another state, territory, or country, irrespective of intervening appeals and stays.
(13) Engaging in sexual misconduct. For the purposes of this paragraph, sexual misconduct includes:
    a. Engaging in or soliciting a sexual relationship, whether consensual or non-consensual, while an Occupational Therapist or Occupational Therapy Assistant/client relationship exists with that person.
    b. Making sexual advances, requesting sexual favors, or engaging in physical contact of a sexual nature with patients or clients.
(14) Aiding or abetting a person who is not licensed as an Occupational Therapist or Occupational Therapy Assistant in this state and who directly or indirectly performs activities requiring a license.
(15) Abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care.

4.05 Complaints

(1) Any individual, group, or entity may file a complaint with the Board against any licensed Occupational Therapist or licensed Occupational Therapy Assistant in the state charging that person with having violated the provisions of this Act.
(2) The complaint shall specify charges in sufficient detail so as to disclose to the accused fully and completely the alleged acts of misconduct for which they are charged.
    a. "Sufficient Detail" is defined as a complainant's full name and contact information, respondent's full name and contact information when available, alleged violations of Standards of Conduct from the Code, signature or e-signature, and supporting documentation.
(3) Upon receiving a complaint, the Board shall notify the licensee of the complaint and request a written response from the licensee.

(4) The Board shall keep an information file about each complaint filed with the Board. The information in each complaint file shall contain complete, current, and accurate information including, but not limited to:
    a. All persons contacted in relation to the complaint;
    b. A summary of findings made at each step of the complaint process;
    c. An explanation of the legal basis and reason for the complaint that is dismissed; and
    d. Other relevant information.

4.06 Due Process

(1) Before the Board imposes disciplinary actions, it shall give the individual against whom the action is contemplated an opportunity for a hearing before the Board.
(2) The Board shall give notice and hold a hearing in accordance with the state's Administrative Procedures Act [or other comparable statute].
(3) The individual shall be entitled to be heard in their defense, alone or with counsel, and may produce testimony and testify on their own behalf, and present witnesses, within reasonable time limits.
(4) Any person aggrieved by a final decision of the Board may appeal in accordance with the Administrative Procedures Act [or other comparable statute].

4.07 Investigation

To enforce this Act, the Board is authorized to:

(1) Receive complaints filed against licensees and conduct a timely investigation.
(2) Conduct an investigation at any time and on its own initiative without receipt of a written complaint if the Board has reason to believe that there may be a violation of this Act.
(3) Issue subpoenas to compel the attendance of any witness or the production of any documentation relative to a case.
(4) For good cause, take emergency action ordering the summary suspension of a license or the restriction of the licensee's practice or employment pending proceedings by the Board.
(5) Appoint hearing officers authorized to conduct hearings. Hearing officers shall prepare and submit to the Board findings of fact, conclusions of law, and an order that shall be reviewed and voted on by the Board.
(6) Require a licensee to be examined in order to determine the licensee's professional competence or resolve any other material issue arising from a proceeding.
(7) Take the following actions if the Board finds that the information received in a complaint or an investigation is not of sufficient seriousness to merit disciplinary action against a licensee:
    a. Dismiss the complaint if the Board believes the information or complaint is without merit or not within the purview of the Board. The record of the complaint shall be expunged from the licensee's record.
    b. Issue a confidential advisory letter to the licensee. An advisory letter is non-disciplinary and notifies a licensee that, while there is insufficient evidence to begin disciplinary action, the Board believes that the licensee should be aware of an issue.
(8) Take other lawful and appropriate actions within its scope of functions and implementation of this Act.

The licensee shall comply with a lawful investigation conducted by the Board.

4.08 Penalties

(1) Consistent with the Administrative Procedures Act, the Board may impose separately, or in combination, any of the following disciplinary actions on a licensee as provided in this Act:
    a. Refuse to issue or renew a license;
    b. Suspend or revoke a license;
    c. Impose probationary conditions;
    d. Issue a letter of reprimand, concern, public order, or censure;
    e. Require restitution of fees;
    f. Impose a fine not to exceed $____, which deprives the licensee of any economic advantage gained by the violation and which reimburses the Board for costs of the investigation and proceeding;
    g. Impose practice and/or supervision requirements;
    h. Require licensees to participate in continuing competence activities specified by the Board;
    i. Accept a voluntary surrendering of a license; or
    j. Take other appropriate corrective actions including advising other parties as needed to protect their legitimate interests and to protect the public.

(2) If the Board imposes suspension or revocation of license, application may be made to the Board for reinstatement, subject to the limits of section 3.06. The Board shall have the discretion to accept or reject an application for reinstatement and may require an examination or other satisfactory proof of eligibility for reinstatement.

(3) If a licensee is placed on probation, the Board may require the license holder to:
    a. Report regularly to the Board on matters that are the basis of probation;
    b. Limit practice to the areas prescribed by the Board;
    c. Continue to review continuing competence activities until the license holder attains a degree of skill satisfactory to the Board in those areas that are the basis of the probation;
    d. Provide other relevant information to the Board.

4.09 Injunction

(1) The Board is empowered to apply for relief by injunction, without bond, to restrain any person, partnership, or corporation from any threatened or actual act or practice that constitutes an offense against this Act. It shall not be necessary for the Board to allege and prove that there is no adequate remedy at law in order to obtain the relief requested. The members of the Board shall not be individually liable for applying for such relief.

(2) If a person other than a licensed Occupational Therapist or Occupational Therapy Assistant threatens to engage in or has engaged in any act or practice that constitutes an offense under this Act, a district court of any county on application of the Board may issue an injunction or other appropriate order restraining such conduct.

4.10 Duty to Refer

(1) An Occupational Therapist may evaluate, initiate, and provide occupational therapy treatment for a client without a referral from other health service providers.

(2) An Occupational Therapist shall refer recipients to other service providers or consult with other service providers when additional knowledge and expertise are required or when this would further the client's care needs and health outcomes.

4.11 Telehealth

A licensee may provide occupational therapy services to a client utilizing a telehealth visit if the occupational therapy services are provided in accordance with all requirements of this Act.

(1) "Telehealth Visit" means the provision of occupational therapy services by a licensee to a client using technology where the licensee and client are not in the same physical location for the occupational therapy service.
(2) A licensee engaged in a telehealth visit shall utilize technology that is secure and compliant with state and federal law.
(3) A licensee engaged in a telehealth visit shall be held to the same standard of care as a licensee who provides in-person occupational therapy. A licensee shall not utilize a telehealth visit if the standard of care for the particular occupational therapy services cannot be met using technology.
(4) Occupational therapy services provided by telehealth can be synchronous or asynchronous.
    a. "Asynchronous" means using any transmission to another site for review at a later time that uses a camera or other technology to capture images or data to be recorded.
    b. "Synchronous" means real-time interactive technology.
(5) Supervision of Occupational Therapy Assistants, Aides, and students using telehealth technologies must follow existing state law and guidelines regarding supervision, regardless of the method of supervision.

Article V. Other

5.01 Severability

(1) If a part of this Act is held unconstitutional or invalid, all valid parts that are severable from the invalid or unconstitutional part shall remain in effect.
(2) If a part of this Act is held unconstitutional or invalid in one or more of its applications, the part shall remain in effect in all constitutional and valid applications that are severable from the invalid applications.

5.02 Effective Date

(1) The Act, except for Section 3.01, shall take effect ninety (90) days after enactment [unless State practice or requirements require another effective date].
(2) Section 3.01 of this Act shall take effect 180 days after enactment.

Occupational Therapy Profession—Scope of Practice Definitions

State	Scope of Practice[1]
Alabama	**Statute: Alabama Code §34-39-3** **(4) OCCUPATIONAL THERAPY.** a. The practice of occupational therapy means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life. The practice of occupational therapy includes: 1. Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation including all of the following: (i) Client factors, including body functions, such as neuromusculoskeletal, sensory-perceptual, visual, mental, cognitive, and pain factors; body structures such as cardiovascular, digestive, nervous, integumentary, genitourinary systems, and structures related to movement; values, beliefs, and spirituality. (ii) Habits, routines, roles, rituals, and behavior patterns. Pen (iii) Physical and social environments, cultural, personal, temporal, and virtual contexts, and activity demands that affect performance. (iv) Performance skills, including motor and praxis, sensory-perceptual, emotional regulation, cognitive, communication, and social skills. 2. Methods or approaches selected to direct the process of interventions such as: (i) Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline. (ii) Compensation, modification, or adaptation of activity or environment to enhance performance, or to prevent injuries, disorders, or other conditions. (iii) Retention and enhancement of skills or abilities without which performance in everyday life activities would decline (iv) Promotion of health and wellness, including the use of self-management strategies, to enable or enhance performance in everyday life activities. (v) Prevention of barriers to performance and participation, including injury and disability prevention. 3. Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation including all of the following: (i) Therapeutic use of occupations, exercises, and activities. (ii) Training in self-care, self-management, health management and maintenance, home management, community/work reintegration, and school activities and work performance. (iii) Development, remediation, or compensation of neuromusculoskeletal, sensory-perceptual, visual, mental, and cognitive functions, pain tolerance and management, and behavioral skills. (iv) Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process. (v) Education and training of individuals, including family members, caregivers, groups, populations, and others.

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	(vi) Care coordination, case management, and transition services. (vii) Consultative services to groups, programs, organizations, or communities. (viii) Modification of environments, including home, work, school, or community, and adaptation of processes, including the application of ergonomic principles. (ix) Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, training in the use of prosthetic devices, orthotic devices, and the design, fabrication and application of selected splints or orthotics. (x) Assessment, recommendation, and training in techniques to enhance functional mobility, including management of wheelchairs and other mobility devices. (xi) Low vision rehabilitation when the patient or client is referred by a licensed optometrist, a licensed ophthalmologist, a licensed physician, a licensed assistant to physician acting pursuant to a valid supervisory agreement, or a licensed certified registered nurse practitioner in a collaborative practice agreement with a licensed physician. (xii) Driver rehabilitation and community mobility. (xiii) Management of feeding, eating, and swallowing to enable eating and feeding performance. (xiv) Application of physical agent modalities, and use of a range of specific therapeutic procedures such as wound care management, interventions to enhance sensory-perceptual and cognitive processing, and manual therapy, all to enhance performance skills. (xv) Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and the adaptation of processes. b. An occupational therapist or occupational therapy assistant is qualified to perform the above activities for which they have received training and any other activities for which appropriate training or education, or both, has been received. Notwithstanding any other provision of this chapter, no occupational therapy treatment programs to be rendered by an occupational therapist, occupational therapy assistant, or occupational therapy aide shall be initiated without the referral of a licensed physician, a licensed chiropractor, a licensed optometrist, a licensed assistant to a physician acting pursuant to a valid supervisory agreement, a licensed certified registered nurse practitioner in a collaborative practice agreement with a licensed physician, a licensed psychologist, or a licensed dentist who shall establish a diagnosis of the condition for which the individual will receive occupational therapy services. In cases of long-term or chronic disease, disability, or dysfunction, or any combination of the foregoing, requiring continued occupational therapy services, the person receiving occupational therapy services shall be reevaluated by a licensed physician, a licensed chiropractor, a licensed optometrist, a licensed assistant to a physician acting pursuant to a valid supervisory agreement, a licensed certified registered nurse practitioner in a collaborative practice agreement with a licensed physician, a licensed psychologist, or a licensed dentist at least annually for confirmation or modification of the diagnosis. Occupational therapists performing services that are not related to injury, disease, or illness that are performed in a wellness or community setting for the purposes of enhancing performance in everyday activities are exempt from this referral requirement. Occupational therapists employed by state agencies and those employed by the public schools and colleges of this state who provide screening and rehabilitation services for the educationally related needs of the students are exempt from this referral requirement. c. Nothing in this chapter shall be construed as giving occupational therapists the authority to examine or diagnose patients or clients for departures from the normal of human eyes, visual systems or their adjacent structures, or to prescribe or modify ophthalmic materials including, but not limited to, spectacles, contacts, or spectacle-mounted low vision devices.
Alaska	**Statute: Alaska Statutes 08.84.190** (3) “occupational therapy” means, for compensation, the use of purposeful activity, evaluation, treatment, and consultation with human beings whose ability to cope with the tasks of daily living are threatened with, or impaired by developmental deficits, learning disabilities, aging, poverty, cultural differences, physical injury or illness, or psychological and social disabilities to maximize independence, prevent disability, and maintain health; “occupational therapy” includes

	(A) developing daily living, play, leisure, social, and developmental skills; (B) facilitating perceptual-motor and sensory integrative functioning; (C) enhancing functional performance, prevocational skills, and work capabilities using specifically designed exercises, therapeutic activities and measure, manual intervention, and appliances; (D) design, fabrication, and application of splints or selective adaptive equipment; (E) administering and interpreting standardized and nonstandardized assessments, including sensory, manual muscle, and range of motion assessments, necessary for planning effective treatment; and (F) adapting environments for the disabled;
Arizona	**Statute: Arizona Revised Statutes §32-3401** 6. "Occupational therapy" means the use of therapeutic activities or modalities to promote engagement in activities with individuals who are limited by physical or cognitive injury or illness, psychosocial dysfunction, developmental or learning disabilities, sensory processing or modulation deficits or the aging process in order to achieve optimum functional performance, maximize independence, prevent disability and maintain health. Occupational therapy includes evaluation, treatment and consultation based on the client's temporal, spiritual and cultural values and needs. 8. "Occupational therapy services" includes the following: (a) Developing an intervention and training plan that is based on the occupational therapist's evaluation of the client's occupational history and experiences, including the client's daily living activities, development, activity demands, values and needs. (b) Evaluating and facilitating developmental, perceptual-motor, communication, neuromuscular and sensory processing function, psychosocial skills and systemic functioning, including wound, lymphatic and cardiac functioning. (c) Enhancing functional achievement, prevocational skills and work capabilities through the use of therapeutic activities and modalities that are based on anatomy, physiology and kinesiology, growth and development, disabilities, technology and analysis of human behavioral and occupational performance. (d) Evaluating, designing, fabricating and training the individual in the use of selective orthotics, prosthetics, adaptive devices, assistive technology and durable medical equipment as appropriate. (e) Administering and interpreting standardized and nonstandardized tests that are performed within the practice of occupational therapy, including manual muscle, sensory processing, range of motion, cognition, developmental and psychosocial tests. (f) Assessing and adapting environments for individuals with disabilities or who are at risk for dysfunction.
Arkansas	**Statute: Arkansas Code §17-88-102** (5) (A) “Occupational therapy” means the evaluation and treatment of individuals whose ability to cope with the tasks of living is threatened or impaired by developmental deficits, the aging process, poverty or cultural differences, environmental or sensory deprivation, physical injury or illness, or psychological and social disability. (B) The treatment utilizes task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual so that he or she might perform tasks normally performed at his or her stage of development. (C) Specific occupational therapy techniques include, but are not limited to: (i) Instruction in activities of daily living, design, fabrication, application, recommendation, and instruction in the use of selected orthotic or prosthetic devices and other adaptive equipment; (ii) Perceptual-motor and sensory integrative activities; (iii) The use of specifically designed crafts; (iv) Exercises to enhance functional performance; and (v) Prevocational evaluation and treatment.

	(D) The techniques are applied in the treatment of individual patients or clients, in groups, or through social systems;
California	**Statute: California Business & Professions Code §2570.2 & 2570.3** **§2570.2** (j) "Occupational therapy services" means the services of an occupational therapist or the services of an occupational therapy assistant under the appropriate supervision of an occupational therapist. (l) "Occupational therapy" means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) with individuals, groups, populations, or organizations, to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness for clients with disability- and nondisability-related needs or to those who have, or are at risk of developing, health conditions that limit activity or cause participation restrictions. Occupational therapy services encompass occupational therapy assessment, treatment, education, and consultation. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perception and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life. 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. Through engagement in everyday activities, occupational therapy promotes mental health by supporting occupational performance in people with, or at risk of experiencing, a range of physical and mental health disorders. Occupational therapy techniques that are used for treatment involve teaching activities of daily living (excluding speech-language skills); designing or fabricating 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, in groups, or populations. (m) "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. (n) "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. **2570.3.** (d) An occupational therapist may provide advanced practices if the therapist has the knowledge, skill, and ability to do so and has demonstrated to the satisfaction of the board that he or she has met educational training and competency requirements. These advanced practices include the following: (1) Hand therapy. (2) The use of physical agent modalities. (3) Swallowing assessment, evaluation, or intervention. (e) An occupational therapist providing hand therapy services shall demonstrate to the satisfaction of the board that he or she has completed education and training in all of the following areas: (1) Anatomy of the upper extremity and how it is altered by pathology.

	(2) Histology as it relates to tissue healing and the effects of immobilization and mobilization on connective tissue. (3) Muscle, sensory, vascular, and connective tissue physiology. (4) Kinesiology of the upper extremity, such as biomechanical principles of pulleys, intrinsic and extrinsic muscle function, internal forces of muscles, and the effects of external forces. (5) The effects of temperature and electrical currents on nerve and connective tissue. (6) Surgical procedures of the upper extremity and their postoperative course. (f) An occupational therapist using physical agent modalities shall demonstrate to the satisfaction of the board that he or she has completed education and training in all of the following areas: (1) Anatomy and physiology of muscle, sensory, vascular, and connective tissue in response to the application of physical agent modalities. (2) Principles of chemistry and physics related to the selected modality. (3) Physiological, neurophysiological, and electrophysiological changes that occur as a result of the application of a modality. (4) Guidelines for the preparation of the client, including education about the process and possible outcomes of treatment. (5) Safety rules and precautions related to the selected modality. (6) Methods for documenting immediate and long-term effects of treatment. (7) Characteristics of the equipment, including safe operation, adjustment, indications of malfunction, and care.
Colorado	**Statute: Colorado Revised Statutes §12-270-104. Definitions** (1) "Activities of daily living" means activities that are oriented toward taking care of one's own body, such as bathing, showering, bowel and bladder management, dressing, eating, feeding, functional mobility, personal device care, personal hygiene and grooming, sexual activity, sleep, rest, and toilet hygiene. (3) "Instrumental activities of daily living" means activities that are oriented toward interacting with the environment and that may be complex. These activities are generally optional in nature and may be delegated to another person. "Instrumental activities of daily living" include care of others, care of pets, child-rearing, communication device use, community mobility, financial management, health management and maintenance, home establishment and management, meal preparation and cleanup, safety procedures and emergency responses, and shopping. (4) "Low vision rehabilitation services" means the evaluation, diagnosis, management, and care of the low vision patient in visual acuity and visual field as it affects the patient's occupational performance, including low vision rehabilitation therapy, education, and interdisciplinary consultation. (6) "Occupational therapy" means the therapeutic use of everyday life activities with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. The practice of occupational therapy includes: (a) Methods or strategies selected to direct the process of interventions such as: (I) Establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired; (II) Compensation, modification, or adaptation of an activity or environment to enhance performance; (III) Maintenance and enhancement of capabilities without which performance of everyday life activities would decline; (IV) Promotion of health and wellness to enable or enhance performance in everyday life activities; and (V) Prevention of barriers to performance, including disability prevention; (b) Evaluation of factors affecting activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation, including: (I) Client factors, including body functions such as neuromuscular, sensory, visual, perceptual, and cognitive functions, and body structures such as cardiovascular, digestive, integumentary, and genitourinary systems; (II) Habits, routines, roles, and behavior patterns; (III) Cultural, physical, environmental, social, and spiritual contexts and activity demands that affect performance; and

	(IV) Performance skills, including motor, process, and communication and interaction skills; (c) Interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation, including: (I) Therapeutic use of occupations, exercises, and activities; (II) Training in self-care, self-management, home management, and community and work reintegration; (III) Identification, development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions, sensory processing, and behavioral skills; (IV) Therapeutic use of self, including a person's personality, insights, perceptions, and judgments, as part of the therapeutic process; (V) Education and training of individuals, including family members, caregivers, and others; (VI) Care coordination, case management, and transition services; (VII) Consultative services to groups, programs, organizations, or communities; (VIII) Modification of environments such as home, work, school, or community and adaptation of processes, including the application of ergonomic principles; (IX) Assessment, design, fabrication, application, fitting, and training in assistive technology and adaptive and orthotic devices and training in the use of prosthetic devices, excluding glasses, contact lenses, or other prescriptive devices to correct vision unless prescribed by an optometrist; (X) Assessment, recommendation, and training in techniques to enhance functional mobility, including wheelchair management; (XI) Driver rehabilitation and community mobility; (XII) Management of feeding, eating, and swallowing to enable eating and feeding performance; (XIII) Application of physical agent modalities and therapeutic procedures such as wound management; techniques to enhance sensory, perceptual, and cognitive processing; and manual techniques to enhance performance skills; and (XIV) The use of telehealth pursuant to rules as may be adopted by the director. (9) "Vision therapy services" means the assessment, diagnosis, treatment, and management of a patient with vision therapy, visual training, visual rehabilitation, orthoptics, or eye exercises.
Connecticut	**Statute: Connecticut General Statutes §376a, Sec.20-74a, Definitions** As used in this chapter: (1) "Occupational therapy" means the evaluation, planning, and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities, or anticipated dysfunction, using (A) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual, (B) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped, (C) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities.

	Such techniques are applied in the treatment of individual patients or clients, in groups, or through social systems. Occupational therapy also includes the establishment and modification of peer review.
Delaware	**Statute: Delaware Code Title 24, Chapter 20, Subtitle I, §2002** (9) a. "Occupational therapy services" includes any of the following: 1. The assessment, treatment, and education of or consultation with an individual, family, or other persons. 2. Interventions directed toward developing, improving, or restoring daily living skills, work readiness or work performance,play skills, or leisure capacities, or enhancing educational performance skills. 3. Providing for the development, improvement, or restoration of sensorimotor, oralmotor, perceptual or neuromuscular functioning, or emotional, motivational, cognitive, or psychosocial components of performance. b. "Occupational therapy services" or "practice of occupational therapy" may require assessment of the need for use of interventions such as the design, development, adaptation, application, or training in the use of assistive technology devices; the design, fabrication, or application of rehabilitative technology such as selected orthotic devices; training in the use of assistive technology, orthotic or prosthetic devices; the application of thermal agent modalities, including paraffin, hot and cold packs, and fluido therapy, as an adjunct to, or in preparation for, purposeful activity; the use of ergonomic principles; the adaptation of environments and processes to enhance functional performance; or the promotion of health and wellness. c. "Occupational therapy services" or "practice of occupational therapy" may be provided through the use of telemedicine in a manner deemed appropriate by regulation and may include participation in telehealth as further defined in regulation. Telemedicine or telehealth regulations may not require the use of technology permitting visual communication. (12) "Practice of occupational therapy" means the use of goal-directed activities with individuals who are limited by physical limitations due to injury or illness, psychiatric and emotional disorders, developmental or learning disabilities, poverty and cultural differences, or the aging process, in order to maximize independence, prevent disability, and maintain health.
District of Columbia	**Statute: Code of DC, §3-1201.02** (9) (A) “Practice of occupational therapy” means: (i) The therapeutic use of everyday life activities and the use of other occupational therapy techniques to engage clients who have disability- or non-disability-related needs in everyday life occupations to enable participation in activities at home, school, the workplace, or other community settings to promote habilitation, rehabilitation, and health and wellness, with or without compensation. (ii) Addressing the physical, cognitive, psycho-social, sensory, or other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life; (iii) The education and training of persons in the direct care of clients through the use of occupational therapy; and (iv) The education and training of persons in the field of occupational therapy. **Regulation: DC Municipal Regulations §17-6305. Scope of practice for occupational therapists.** ***§6305.1.*** An occupational therapist shall exercise sound judgment and provide adequate care within the practice when using methods that include but are not exclusive of the following American Occupational Therapy Association (AOTA) standards for the scope of practice: (a) Establishment, remediation or restoration of skill or ability in a client; (b) Compensation, modification, or adaptation of activity or environment to enhance performance; (c) Maintenance and enhancement of capabilities without which performance in everyday life would decline; (d) Health and wellness promotion to enable or enhance performance in everyday life activities; and (e) Prevention of barriers to performance, including disability prevention.

	§6305.2. An occupational therapist shall exercise sound judgment when evaluating factors affecting activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation. These factors may include: (a) Body functions and body structures; (b) Habits, routines, roles, and behavior patterns; (c) Cultural, physical, environmental, social, and spiritual contexts and activity demands that affect performance; and (d) Performance skills including motor, process, and communication or interaction skills. ***§6305.3.*** An occupational therapist shall exercise sound judgment and provide adequate care to a client when administering interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation, which may include the following: (a) Therapeutic use of occupations, exercises, and activities; (b) Training in self-care, self-management, home management, and community work reintegration; (c) Development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions, and behavioral skills; (d) Therapeutic use of self including one's personality, insights, perceptions, and judgments as part of the therapeutic process (e) Education and training of individuals, involved in the care of the client; (f) Care coordination, case management, and transition services; (g) Consultative services to groups, programs, organizations, or communities; (h) Modification of environments and adaptation of processes, including the application of ergonomic principles; (i) Assessment, design, fabrication, application, fitting and training in assistive technology, adaptive devices and orthotic devices, and training in the use of prosthetic devices; (j) Assessment, recommendation, and training in techniques to enhance mobility including wheelchair management; (k) Driver rehabilitation and community mobility; (l) Management of feeding, eating, and swallowing to enable eating and feeding performance; and (m) Application of physical agent modalities, and use of a range of specific therapeutic procedures to enhance performance skills. **Regulation: DC Municipal Regulations §17-7313. Responsibilities (Occupational therapy assistants)** **7313.1.** An occupational therapy assistant shall exercise sound judgment and provide adequate care in the performance of duties in accordance with nationally recognized standards of practice while treating patients or supervising the treatment of patients. **7313.2.** An occupational therapy assistant supervising a student, an occupational therapy aide, or a person authorized to practice under supervision shall be responsible for all of the student's, aide's, or authorized person's actions performed within the scope of practice during the time of supervision and shall be subject to disciplinary action for any violation of the Act or this chapter by the person supervised. **7313.3.** An occupational therapist supervising an occupational therapy assistant who supervises a student, an occupational therapy aide, or a person authorized to practice under supervision shall be responsible for the actions of all supervised persons.
Florida	**Statute: Florida Statutes Title XXXII, Chapter 468, Part III, Section 468.203, Definitions.** (4) "Occupational therapy" means the therapeutic use of occupations through habilitation, rehabilitation, and the promotion of health and wellness with individuals, groups, or populations, along with their families or organizations, to support participation, performance, and function in the home, at school, in the workplace, in the community, and in other settings for clients who have, or who have been identified as being at risk of developing, an illness, an injury, a disease, a disorder, a condition, an impairment, a disability, an activity limitation, or a participation restriction. (a) For the purposes of this subsection:

	1. “Activities of daily living” means functions and tasks for self-care which are performed on a daily or routine basis, including functional mobility, bathing, dressing, eating and swallowing, personal hygiene and grooming, toileting, and other similar tasks 2. “Assessment” means the use of skilled observation or the administration and interpretation of standardized or nonstandardized tests and measurements to identify areas for occupational therapy services. 3. “Health management” means therapeutic services designed to develop, manage, and maintain health and wellness routines, including self-management, performed with the goal of improving or maintaining health to support participation in occupations. 4. “Instrumental activities of daily living” means daily or routine activities a person must perform to live independently within the home and community. 5. “Occupational performance” means the ability to perceive, desire, recall, plan, and carry out roles, routines, tasks, and subtasks for the purpose of self-maintenance, self-preservation, productivity, leisure, and rest, for oneself or for others, in response to internal or external demands of occupations and contexts. 6. “Occupational therapy services in mental health” means occupation-based interventions and services for individuals, groups, populations, families, or communities to improve participation in daily occupations for individuals who are experiencing, are in recovery from, or are identified as being at risk of developing mental health conditions. 7. “Occupations” means meaningful and purposeful everyday activities performed and engaged in by individuals, groups, populations, families, or communities which occur in contexts and over time, such as activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure, and social participation. The term includes more specific occupations and the execution of multiple activities that are influenced by performance patterns, performance skills, and client factors, and that result in varied outcomes. (b) The practice of occupational therapy includes, but is not limited to, the following services: 1. Assessment, treatment, and education of or consultation with individuals, groups, and populations whose abilities to participate safely in occupations, including activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation, are impaired or have been identified as being at risk of impairment due to issues related to, but not limited to, developmental deficiencies, the aging process, learning disabilities, physical environment and sociocultural context, physical injury or disease, cognitive impairments, or psychological and social disabilities. 2. Methods or approaches used to determine abilities and limitations related to performance of occupations, including, but not limited to, the identification of physical, sensory, cognitive, emotional, or social deficiencies. 3. Specific occupational therapy techniques used for treatment which include, but are not limited to, training in activities of daily living; environmental modification; assessment of the need for the use of interventions such as the design, fabrication, and application of orthotics or orthotic devices; selecting, applying, and training in the use of assistive technology and adaptive devices; sensory, motor, and cognitive activities; therapeutic exercises; manual techniques; physical agent modalities; and occupational therapy services in mental health. (c) The use of devices subject to 21 C.F.R. s. 801.109 and identified by the board is expressly prohibited except by an occupational therapist or occupational therapy assistant who has received training as specified by the board. The board shall adopt rules to carry out the purpose of this provision.
Georgia	**<u>Statute:</u> Georgia Code §43-28-3, Definitions.** (4) "Occupations" means activities of daily living in which people engage. (6) "Occupational therapy" means the therapeutic use of occupations with individuals, groups, populations, or organizations to support participation, performance, and function in life roles. Occupational therapy is provided for habilitation, rehabilitation, and the promotion of health

	and wellness to those who have or are at risk for developing activity limitation or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations promoting health, well-being, and quality of life. The practice of occupational therapy, including that which may be provided through telehealth, includes, but is not limited to, the following: (A) Evaluation, treatment, education of, and consultation with, individuals, groups, and populations whose abilities to participate safely in occupations, including activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation, are impaired or at risk for impairment due to issues related, but not limited to, developmental deficiencies, the aging process, learning disabilities, physical environment and sociocultural context, physical injury or disease, cognitive impairments, and psychological and social disabilities; (B) Evaluation to determine abilities and limitations related to performance of occupations, including the identification of physical, sensory, cognitive, emotional, or social deficiencies. Treatment based on such evaluation utilizes task oriented, purposeful, and meaningful goal directed activities to prevent, correct, minimize, or compensate for deficiencies to maximize independence in daily life and promote overall health and wellbeing; and (C) Specific occupational therapy techniques used for treatment that involve, but are not limited to, training in activities of daily living; environmental modification; the designing, fabrication, and application of orthotic or orthotic devices; selecting, applying, and training in the use of assistive technology and adaptive devices; sensory, motor, and cognitive activities; therapeutic exercises; manual therapy techniques that do not include adjustment or manipulation of the articulations of the human body; and physical agent modalities. Such techniques are applied in the treatment of individuals, groups, or through organizational-level practices to enhance physical functional performance, work capacities, and community participation. (10) "Orthotic" or "orthotic device" means a rigid or semi-rigid device or splint used to support a weak or deformed body part. An orthotic may be used to restrict, eliminate, or enhance motion; to support a healing body part; or to substitute for lost function or motion and can be custom fabricated, custom fitted, or prefabricated. (12) "Physical agent modalities" means occupational therapy treatment techniques, both superficial and deep tissue, which may, but are not required to utilize the following agents: thermal, mechanical, electromagnetic, water, and light for a specific therapeutic effect to promote functional outcomes.
Guam	**Statute: Guam Code Annotated Title 10, Chapter 12, Article 14 Occupational Therapy.** **§121401 Definitions.** For the purposes of this Article, the following words and phrases have been defined to mean: (b) Occupational therapy means the evaluation and treatment provided to people whose lives have been disrupted by physical injury, illness, developmental problems, the aging process, or psychosocial or cognitive difficulties. (1) Treatment entails the assessment, evaluation and treatment to assist each individual to achieve or return to an independent and productive life through techniques which prevent disability, assisting the individual in recovery from illness or accident and by promoting the development of functions which may have been impaired or delayed. (2) The treatment provided may include, but shall not be limited to, the adaptation of the environment and the selection, design and fabrication of assistive and orthotic devices, and other technology to facilitate development and promote the acquisition of functional skills through purposeful activity.

	§121409. Scope of practice; Occupational Therapist. (a) An occupational therapist may enter a case for the purposes of providing direct or indirect service, consulting, evaluating an individual as to the need for services, and other occupational therapy services for any individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, or other disorder or condition. It includes assessment by skilled observation or evaluation through the administration and interpretation of standardized or nonstandardized tests and measurements. Occupational therapy services include, but are not limited to, the following: (1) the assessment and provision of treatment in consultation with the individual, family or other appropriate persons; (2) interventions directed toward developing, improving, sustaining or restoring daily living skills, including self-care skills and activities that involve interactions with others and the environment, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills; (3) developing, improving, sustaining or restoring sensorimotor, oral-motor, perceptual or neuromuscular functioning, emotional, motivational, cognitive or psychosocial components of performance; and (4) education of the individual, family or other appropriate persons in carrying out appropriate interventions. (b) Services may encompass assessment of need and the design, development, adaptation, application or training in the use of assistive technology devices; the design, fabrication or application of rehabilitative technology, such as selected orthotic devices; training in the use of orthotic or prosthetic devices; the application of physical agent modalities as an adjunct to or in preparation for purposeful activity; the application of ergonomic principles; the adaptation of environments and processes to enhance functional performance; or the promotion of health and wellness. (c) Such evaluation shall be the occupational therapist's assessment of a patient's problem, and the therapist shall make an occupational therapy assessment and evaluation and treat accordingly. The therapist shall consult with an authorized health care practitioner if a patient's problem is outside the scope of occupational therapy. If, at any time, a patient requires further services of an authorized health care provider, a referral shall be made. **§ 121410. Scope of Practice; Occupational Therapy Assistant.** The occupational therapy assistant works under the supervision of the occupational therapist. The amount, degree and pattern of supervision a practitioner requires varies depending on the employment setting, method of service provision, the practitioner's competence and the demands of service. The occupational therapist is responsible for the evaluation of the client or patient. The treatment plan may be developed by the occupational therapist in collaboration with the occupational therapy assistant. Once the evaluation and treatment plans are established, the occupational therapy assistant may implement and modify various therapeutic interventions, as permitted by the Board under the supervision of the occupational therapist.
Hawaii	**<u>Statute:</u> Hawaii Revised Statutes §457G-1.5, Practice of occupational therapy.** (a) The practice of occupational therapy is the therapeutic use of everyday life activities with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. It includes: (1) Evaluation of factors affecting activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation, including: (A) Client factors, including body functions, such as neuromusculoskeletal, sensory-perceptual, visual, mental, cognitive, and pain factors; body structures, such as cardiovascular, digestive, nervous, integumentary, genitourinary systems, and structures related to movement, values, beliefs, and spirituality; (B) Habits, routines, roles, rituals, and behavior patterns; (C) Occupational and social environments, cultural, personal, temporal, and virtual contexts and activity demands that affect performance; and

	(D) Performance skills, including motor and praxis, sensory-perceptual, emotional regulation, cognitive, communication, and social skills; (2) Methods or approaches selected to direct the process of interventions, including: (A) Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline; (B) Compensation, modification, or adaptation of activity or environment to enhance performance or prevent injuries, disorders, or other conditions; (C) Retention and enhancement of skills or abilities without which performance in everyday life activities would decline; (D) Promotion of health and wellness, including the use of self-management strategies, to enable or enhance performance in everyday life activities; and (E) Prevention of barriers to performance and participation, including injury and disability prevention; and (3) Interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation, including: (A) Therapeutic use of occupations, exercises, and activities; (B) Training in self-care, self-management, health management and maintenance, home management, community reintegration, work reintegration, school activities, and work performance; (C) Development, remediation, or compensation of neuromusculoskeletal, sensory-perceptual, visual, mental, and cognitive functions; pain tolerance and management; and behavioral skills; (D) Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process; (E) Education and training of individuals, including family members, caregivers, groups, populations, and others; (F) Care coordination, case management, and transition services; (G) Consultative services to groups, programs, organizations, or communities; (H) Modification of environments, such as home, work, school, or community, and adaptation of processes, including the application of ergonomic principles; (I) Assessment, design, fabrication, application, fitting, and training in seating and positioning; assistive technology; adaptive evices; orthotic devices; and training in the use of prosthetic devices; (J) Assessment, recommendation, and training in techniques to enhance functional mobility, including management of wheelchairs and other mobility devices; (K) Low vision rehabilitation; (L) Driver rehabilitation and community mobility; (M) Management of feeding, eating, and swallowing to enable eating and feeding performance; (N) Application of physical agent modalities and use of a range of specific therapeutic procedures, such as wound care management, interventions to enhance sensory-perceptual and cognitive processing, and manual therapy, to enhance performance skills; and (O) Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and the adaptation of processes.
Idaho	**Statute: Idaho Code §54-3702** (10) "Occupational therapy" means the care and services provided by or under the direction and supervision of an occupational therapist. (13) "Practice of occupational therapy" means the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive,

	psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being and quality of life. The practice of occupational therapy includes: (a) Development of occupation-based plans, methods or strategies selected to direct the process of interventions such as: (i) Establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired. (ii) Compensation, modification, or adaptation of activity or environment to enhance performance. (iii) Maintenance and enhancement of capabilities without which performance in everyday life activities would decline. (iv) Health promotion and wellness to enable or enhance performance in everyday life activities. (v) Prevention of barriers to performance, including disability prevention. (b) Evaluation of factors affecting a client's occupational performance areas of activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation, including: (i) Client factors, including body functions (such as neuromuscular, sensory, visual, perceptual, cognitive), values, beliefs, and spirituality, and body structures (such as cardiovascular, digestive, integumentary, genitourinary systems). (ii) Performance patterns, including habits, routines, roles, and behavior patterns. (iii) Contexts and activity demands that affect performance, including cultural, physical, environmental, social, virtual and temporal. (iv) Performance skills, including sensory perceptual skills, motor and praxis skills, emotional regulation skills, cognitive skills, communication and social skills. (c) Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation, rest and sleep, including: (i) Therapeutic use of occupations, exercises, and activities. (ii) Training in self-care, self-management, home management, and community/work reintegration. (iii) Development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions and behavioral skills. (iv) Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process. (v) Education and training of individuals, including family members, caregivers, and others. (vi) Care coordination, case management, and transition services. (vii) Consultative services to groups, programs, organizations, or communities. (viii) Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles. (ix) Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, orthotic devices, and prosthetic devices. (x) Assessment, recommendation, and training in techniques to enhance functional mobility, including wheelchair management. (xi) Driver rehabilitation and community mobility. (xii) Management of feeding, eating, and swallowing to enable eating and feeding performance. (xiii) Application of superficial, thermal and mechanical physical agent modalities, and use of a range of specific therapeutic procedures (such as basic wound management; techniques to enhance sensory, perceptual, and cognitive processing; therapeutic exercise techniques to facilitate participation in occupations) to enhance performance skills. (xiv) Use of specialized knowledge and skills as attained through continuing education and experience for the application of deep thermal and electrotherapeutic modalities, therapeutic procedures specific to occupational therapy and wound care management for treatment to enhance participation in occupations as defined by rules adopted by the board.

	(d) Engaging in administration, consultation, testing, education and research as related to paragraphs (a), (b) and (c) of this subsection and further established in rule.
Illinois	**Statute: Illinois Compiled Statutes 225 ILCS 75/2** (6) "Occupational therapy" means the therapeutic use of everyday life occupations and activities with recipients , groups, or populations to support occupational performance and participation. “Occupational therapy practice” includes clinical reasoning and professional judgment to evaluate, analyze, and address occupational challenges, including issues with client factors, performance patterns, and performance skills and provide occupation-based interventions to address the challenges. Through the provision of skilled services and engagement in everyday activities, occupational therapy promotes physical and mental health and well-being by supporting occupational performance in people with, or are at risk of experiencing, a range of developmental, physical, and mental health disorders. Occupational therapy may be provided via technology or telecommunication methods, also known as telehealth, however the standard of care shall be the same whether a patient or recipient is seen in person, through telehealth, or other method of electronically enabled health care. Occupational therapy practice may include any of the following components: (a) evaluation of factors affecting activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure, and social participation; (b) methods or approaches to identify and select interventions; and (c) interventions and procedures including: (i) remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes; (ii) modification or adaptation of task, process, or the environment or the teaching of compensatory techniques in order to enhance performance; (iii) disability prevention methods and techniques that facilitate the development or safe application of performance skills; and (iv) health and wellness promotion strategies, including self-management strategies, and practices that enhance performance abilities. The licensed occupational therapist or licensed occupational therapy assistant may assume a variety of roles in the licensee’s career including, but not limited to, practitioner, supervisor of professional students and volunteers, researcher, scholar, consultant, administrator, faculty, clinical instructor, fieldwork educator, and educator of consumers, peers, family members, and care-partners. (7) "Occupational therapy services" means services that may be provided to individuals, groups, and populations, when provided to treat an occupational therapy need, including the following: (a) evaluating, developing, improving, sustaining, or restoring skills in self-care, self-management, health management, including medication-management, health routines, rest and sleep, home management, community and work integration, school activities, work performance, and play and leisure activities; (b) identification, development, and remediation or compensation for deficits in physical, neuromusculoskeletal, sensory-perceptual, emotional regulation, visual, mental, and cognitive functions; pain tolerance and management; praxis; developmental skills; and behavioral skills or psychosocial components of performance with considerations for cultural context and activity demands that affect performance; (c) assessing, designing, fabricating, applying, or training in the use of assistive technology, adaptive devices, seating and positioning, orthoses and training in the use of prostheses; (d) modification of contexts in settings, such as home, school, work, and community, and adaptation of processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles; (e) for the occupational therapist or occupational therapy assistant possessing advanced training, skill, and competency as demonstrated through criteria that shall be determined by the Department, applying physical agent modalities as an adjunct to or in preparation for engagement in occupations;

	(f) evaluating and providing intervention in collaboration with the recipient, family, caregiver, or others; (g) educating the recipient, family, caregiver, groups, populations, or others in carrying out appropriate nonskilled interventions; (h) consulting with groups, programs, organizations, or communities to provide population-based services; (i) assessing, recommending, and training in techniques to enhance functional mobility, including wheelchair fitting and management and other mobility devices; (j) driver rehabilitation and community mobility; (k) management of feeding, eating, and swallowing to enable or enhance performance of these tasks; (l) low vision rehabilitation; (m) lymphedema and wound care management; (n) pain management; (o) care coordination, case management, and transition services; (p) exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation; (q) virtual interventions, including simulated, real-time, and near-time technologies, consisting of telehealth and mobile technology; (r) evaluating and treating problems of rest and sleep; (s) group interventions, including the use of dynamics of group and social interaction to facilitate learning and skill acquisition across the life course; and (t) habilitation, rehabilitation, and the promotion of physical and mental health and wellness for clients with all levels of ability-related needs and for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, and activity limitation or participation restriction.
Indiana	**Statute: Indiana Code Title 25, Article 23.5, Chapter 1, Definitions.** **§25-23.5-1-5** Sec. 5. "Practice of occupational therapy" means the therapeutic use of everyday life occupations and occupational therapy services to: (1) aid individuals or groups to participate in meaningful roles and situations in the home, school, the workplace, the community, or other settings; (2) promote health and wellness through research and practice; and (3) serve individuals or groups who are well but have been or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. The practice of occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect a person's health, well-being, and quality of life throughout the person's life span. **§25-23.5-1-6.5** Sec. 6.5. “Occupational therapy services” means services that are provided to promote health and wellness, prevent disability, preserve functional capabilities, prevent barriers for occupational performance from occurring, and enable or improve performance in everyday activities, including services that do the following: (1) Establish, remediate, or restore a skill or ability that is impaired or not yet developed. Occupational therapy services include identifying speech, language, and hearing that are impaired or not yet developed, but does not include the remediation of speech, language, and hearing skills and abilities. (2) Modify or adapt a person or an activity or environment of a person or compensate for a loss of a person’s functions. (3) Evaluate factors that affect daily living activities, instrumental activities of daily living, and other activities relating to work, play, leisure, education, and social participation. These factors may include body functions, body structure, habits, routines, role

	performance, behavior patterns, sensory motor skills, cognitive skills, communication and interaction skills, and cultural, physical, psychosocial, spiritual, developmental, environmental, and socioeconomic contexts and activities that affect performance. (4) Perform interventions and procedures relating to the factors described in subdivision (3), including the following: (A) Task analysis and therapeutic use of occupations, exercises, and activities. (B) Education and training in self-care, self-management, home management, and community or work reintegration. (C) Care coordination, case management, transition, and consultative services. (D) Modification of environments and adaptation processes, including the application of ergonomic and safety principles. (E) Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices. However, this does not include the following: (i) Gait training. (ii) Training in the use of hearing aids, tracheoesophageal valves, speaking valves, or electrolarynx devices related to the oral production of language. (iii) Remediation of speech, language, and hearing disorders. (iv) Fabrication of shoe inserts. (F) Assessment, recommendation, and training in techniques to enhance safety, functional mobility, and community mobility, including wheelchair management and mobility. However, this does not include gait training. (G) Management of feeding, eating, and swallowing to enable eating and feeding performance. (H) Application of physical agent modalities and use of a range of specific therapeutic procedures used in preparation for or concurrently with purposeful and occupation based activities, including techniques to enhance sensory-motor, perceptual, and cognitive processing, manual therapy techniques, and adjunctive and preparatory activities for occupational performance. However, manual therapy does not include spinal manipulation, spinal adjustment, or grade 5 mobilization.
Iowa	**Statute: Iowa Code §148b.2** 3. "Occupational therapy" means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life. "Occupational therapy" includes but is not limited to providing assessment, design, fabrication, application, and fitting of selected orthotic devices and training in the use of prosthetic devices. **Regulation: Iowa Administrative Code Inspections and Appeals Department 481, Chapter 804, Licensure of Occupational Therapists and Occupational Therapy Assistants.** **481–804.1. Definitions.** For purposes of these rules, the following definitions shall apply: "Occupational therapy practice" means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations, to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life. The practice of occupational therapy includes:

	1. Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation, including: • Client factors, including body functions (such as neuromusculoskeletal, sensory-perceptual, visual, mental, cognitive, and pain factors) and body structures (such as cardiovascular, digestive, nervous, integumentary, genitourinary systems, and structures related to movement) and values, beliefs, and spirituality. • Habits, routines, roles, rituals, and behavior patterns. • Physical and social environments; cultural, personal, temporal and virtual contexts; and activity demands that affect performance. • Performance skills, including motor and praxis, sensory-perceptual, emotional regulation, cognitive, communication and social skills. 2. Methods or approaches selected to direct the process of interventions, including: • Establishment of a skill or ability that has not yet developed or remediation or restoration of a skill or ability that is impaired or is in decline.Ch 206, p.2 IAC • Compensation, modification, or adaptation of activity or environment to enhance performance or to prevent injuries, disorders, or other conditions. • Retention and enhancement of skills or abilities without which performance in everyday life activities would decline. • Promotion of health and wellness, including the use of self-management strategies, to enable or enhance performance in everyday life activities. • Prevention of barriers to performance and participation, including injury and disability prevention. 3. Interventions and procedures to promote or enhance safety and performance in ADL, IADL, rest and sleep, education, work, play, leisure, and social participation, including: • Therapeutic use of occupations, exercises, and activities. • Training in self-care, self-management, health management and maintenance, home management, community/work reintegration, and school activities and work performance. • Development, remediation, or compensation of neuromusculoskeletal, sensory-perceptual, visual, mental, and cognitive functions, pain tolerance and management, and behavioral skills. • Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process. • Education and training of individuals, including family members, caregivers, groups, populations, and others. • Care coordination, case management, and transition services. • Consultative services to groups, programs, organizations, or communities. • Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles. • Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices. • Assessment, recommendation, and training in techniques to enhance functional mobility, including management of wheelchairs and other mobility devices. • Low vision rehabilitation. • Driver rehabilitation and community mobility. • Management of feeding, eating, and swallowing to enable eating and feeding performance. • Application of physical agent modalities and use of a range of specific therapeutic procedures (such as wound care management, interventions to enhance sensory-perceptual and cognitive processing, and manual therapy) to enhance performance skills. • Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and the adaptation of processes.

	"Occupational therapy screening" means a brief process that is directed by an occupational therapist in order for the occupational therapist to render a decision as to whether the individual warrants further, in-depth evaluation and that includes: 1. Assessment of the medical and social history of an individual; 2. Observations related by that individual's caregivers; or 3. Observations or nonstandardized tests, or both, administered to an individual by the occupational therapist or an occupational therapy assistant under the direction of the occupational therapist. Nothing in this definition shall be construed to prohibit licensed occupational therapists and occupational therapy assistants who work in preschools or school settings from providing short-term interventions to children prior to an evaluation, not to exceed 16 sessions per concern per school year, in accordance with state and federal educational policy.
Kansas	**Statute: Kansas Statutes §65-5402** (b) "Practice of occupational therapy" means the therapeutic use of purposeful and meaningful occupations or goal-directed activities to evaluate and treat individuals who have a disease or disorder, impairment, activity limitation or participation restriction that interferes with their ability to function independently in daily life roles and to promote health and wellness. (1) Occupational therapy intervention may include: (A) Remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological or neurological cognitive processes; (B) adaptation of tasks, process, or the environment or the teaching of compensatory techniques in order to enhance performance; (C) disability prevention methods and techniques that facilitate the development or safe application of performance skills; and (D) health promotion strategies and practices that enhance performance abilities. (2) The "practice of occupational therapy" does not include the practice of any branch of the healing arts or making a medical diagnosis. (c) "Occupational therapy services" include, but are not limited to: (1) Evaluating, developing, improving, sustaining, or restoring skills in activities of daily living (ADL), work or productive activities, including instrumental activities of daily living (IADL) and play and leisure activities; (2) evaluating, developing, remediating, or restoring sensorimotor, cognitive or psychosocial components of performance; (3) designing, fabricating, applying, or training in the use of assistive technology or orthotic devices and training in the use of prosthetic devices; (4) adapting environments and processes, including the application of ergonomic principles, to enhance performance and safety indaily life roles; (5) applying physical agent modalities as an adjunct to or in preparation for engagement in occupations; (6) evaluating and providing intervention in collaboration with the client, family, caregiver or others; (7) educating the client, family, caregiver or others in carrying out appropriate nonskilled interventions; and (8) consulting with groups, programs, organizations or communities to provide population-based services.
Kentucky	**Statute: Kentucky Revised Statutes §319A.010** (2) "Practice of occupational therapy" means 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 that interferes with their ability to function independently in daily life roles, and to promote health and wellness. Occupational therapy intervention may include: (a) Remediation or restoration, through goal-directed activities, of those performance abilities that are limited due to impairment in biological, physiological, or neurological processes; (b) Adaptation of task, process, or the environment or the teaching of compensatory techniques to enhance performance;

(c) Disability prevention methods and techniques that facilitate the development or safe application of performance skills; and
(d) Health promotion strategies and practices that enhance performance abilities;
(6) "Occupational therapy services" include but are not limited to:
(a) Evaluating, developing, improving, sustaining, or restoring skills in basic and instrumental activities of daily living (BADLs and IADLs), work or productive activities, and play and leisure activities;
(b) Evaluating, developing, remediating, or restoring components of performance as they relate to sensorimotor, cognitive, or psychosocial aspects;
(c) Designing, fabricating, applying, and training in the use of assistive technology or orthotic devices and training in the use of prosthetic devices for functional mobility and activities of daily living;
(d) Adapting environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles;
(e) Applying superficial physical agent modalities as an adjunct to or in preparation for engagement in occupations;
(f) Applying deep physical agent modalities as an adjunct to or in preparation for engagement in occupations, in accordance with KRS 319A.080;
(g) Evaluating and providing intervention in collaboration with the client, family, caregiver, or others;
(h) Educating the client, family, caregiver, or others in carrying out appropriate nonskilled interventions; and
(i) Consulting with groups, programs, organizations, or communities to provide population based services;
(8) "Deep physical agent modalities" means any device that uses sound waves or agents which supply or induce an electric current through the body, which make the body a part of the circuit, including iontophoresis units with a physician's prescription, ultrasound, transcutaneous electrical nerve stimulation units and functional electrical stimulation, or microcurrent devices; and
(9) "Superficial physical agent modalities" means hot packs, cold packs, ice, fluidotherapy, paraffin, water, and other commercially available superficial heating and cooling devices.

Regulation: Kentucky Administrative Regulations 201 KAR 28:10
Section 1. Definitions.
(5) "Basic activities of daily living" means tasks or activities that are oriented toward taking care of one's own body; those tasks that are performed daily by an individual that pertain to and support one's self-care, mobility, and communication; and includes the following activities:
(a) Bathing and showering;
(b) Bowel and bladder management;
(c) Dressing;
(d) Swallowing, eating, and feeding;
(e) Functional mobility;
(f) Personal device care;
(g) Personal hygiene and grooming;
(h) Sexual activity;
(i) Sleep and rest; and
(j) Toileting and toilet hygiene
(7) "Components of performance" means activity and occupational demands, client factors, performance skills, context, and environment.
(10) "Functional mobility" means moving from one (1) position or place to another including in-bed mobility, wheelchair mobility, transportation of objects through space, and functional ambulating transfers, driving, and community mobility.
(12) "Instrumental activities of daily living" means complex tasks or activities that are oriented toward interacting with the environment and are essential to self-maintenance matters which extend beyond personal care, including:

(a) Care of others;
(b) Care of pets;
(c) Child rearing;
(d) Communication management;
(e) Financial management;
(f) Health management and maintenance;
(g) Home establishment, management, and maintenance;
(h) Meal preparation and cleanup;
(i) Safety and emergency maintenance;
(j) Shopping;
(k) Spiritual activities; and
(l) Selection and supervision of caregivers.

(14) "Occupations" means activities, tasks or roles that individuals engage in which provide intrinsic value and meaning for the individual, society, and culture.
(20) "Performance abilities" means the utilization of performance skills in the participation of active daily life.
(21) "Performance skills" means the observable actions of a person that have implicit functional purposes, including motor skills, processing skills, interaction skills, and communication skills.
(22) "Restoration" means to restore a performance skill or ability that has been impaired.

<u>Regulation:</u> Kentucky Administrative Regulations, 201 KAR 28:190
Section 1. Definitions.
(3) "Low-vision services" means occupational therapy services designed for the purpose of maximizing the use of residual vision in order to maintain or restore function in daily life roles and activities. Low-vision services include:
(a) Occupational profiling, analysis of occupational performance, and intervention planning that focuses on adapting or altering environments and processes and the implementation of the intervention plan; and
(b) Training in the use of assistive technology for the purpose of improving performance skills and performance abilities in basic and instrumental activities of daily living, work or productive activities, play, and leisure.

(5) "Visual-therapy services" means occupational therapy services designed for the purpose of maximizing visual perceptual components of performance in order to restore or maintain daily life roles and activities.
(6) "Visually related rehabilitative treatment plan" means a comprehensive vision plan of care for the rehabilitation and treatment of the visually-impaired or legally-blind individual which is developed by the optometrist, ophthalmologist, or physician after the evaluation and diagnosis of the individual client and which includes a general description of the low-vision services and the visual therapy services that are to be provided by the OT/L. A visually-related rehabilitative treatment plan is periodically reviewed by the optometrist, ophthalmologist, or physician.

Section 2. Provision of Low-vision and Visual-therapy Services.
(1) An OT/L shall not develop a visually-related rehabilitation plan, but an OT/L may provide low-vision or visual-therapy services to a client as prescribed in writing by an optometrist, ophthalmologist, or physician who has personally examined and evaluated the client for low vision rehabilitation services and who has referred the client to the OT/L.
(2) (a) The low-vision or visual-therapy services which an OT/L may provide shall include:
1. Adapting environments and processes; and
2. Training in the use of assistive technology for the purpose of improving performance skills and performance abilities in basic and instrumental activities of daily living, work or productive activities and play and leisure.

	(b) Low-vision and visual-therapy services shall not include independent diagnostic vision evaluations or the development of a comprehensive vision plan for the rehabilitation and treatment for individuals with visual impairments.
Louisiana	**Statute: Louisiana Revised Statutes §37:3003** (3) (a) "Occupational therapy" means the application of any activity in which one engages for the purposes of evaluation, interpretation, treatment planning, and treatment of problems interfering with functional performance in persons impaired by physical illness or injury, emotional disorders, congenital or developmental disabilities, or the aging process, in order to achieve optimum functioning and prevention and health maintenance. The occupational therapist may enter a case for the purposes of providing consultation and indirect services and evaluating an individual for the need of services. Prevention, wellness, and education related services shall not require a referral; however, in workers' compensation injuries preauthorization shall be required by the employer or workers' compensation insurer or provider. Implementation of direct occupational therapy to individuals for their specific medical condition or conditions shall be based on a referral or order from a physician, advanced practice registered nurse, dentist, podiatrist, or optometrist licensed to practice. Practice shall be in accordance with published standards of practice established by the American Occupational Therapy Association, Inc., and the essentials of accreditation established by the agencies recognized to accredit specific facilities and programs. (b) Specific occupational therapy services include, but are not limited to activities of daily living (ADL); the design, fabrication, and application of prescribed temporary splints; sensorimotor activities; the use of specifically designed crafts; guidance in the 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 persons with disabilities. These services are provided to individuals or groups through medical, health, educational, and social systems.
Maine	**Statute: Maine Revised Statutes, Title 32, Chapter 32, § 2272** **12-D. Occupational therapy.** "Occupational therapy" means the therapeutic use of everyday life activities and occupations with individuals or groups to enhance or enable participation, performance or function in roles and situations in home, school, workplace, community and other settings for the purpose of promoting health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory and other aspects of performance in a variety of contexts to support engagement in everyday occupations that affect physical and mental health, well-being and quality of life. "Occupational therapy" includes: A. Methods and strategies selected to direct the process of interventions such as: (1) Facilitating establishment, remediation or restoration of a skill or ability that has not yet developed, is impaired or is in decline; (2) Compensation, modification or adaptation of an activity or environment to enhance performance or to prevent injuries, disorders or other conditions; (3) Maintenance and enhancement of capabilities without which performance of everyday life activities would decline; (4) Health promotion and wellness to enable or enhance performance in everyday life activities; and (5) Prevention or remediation of barriers to performance, including disability prevention; B. Evaluation of client factors affecting activities of daily living, instrumental activities of daily living, education, work, play, leisure and social participation, including: (1) Body functions such as neuromuscular, sensory, visual, perceptual, mental and cognitive functions; pain factors; bodily systems such as cardiovascular, digestive, integumentary and genitourinary systems; and structures related to movement; (2) Habits, routines, roles and behavior patterns; (3) Cultural, physical, environmental, social and spiritual contexts and activity demands that affect performance; and (4) Performance skills, including motor, process, emotional regulation, cognitive, sensory perceptual, communication and social interaction skills; and

	C. Interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, education, work, play, leisure and social participation, including: (1) Therapeutic use of occupations, exercises and activities; (2) Training in self-care, self-management, home management, community and work integration and reintegration, school activities and work performance; (3) Development, remediation or compensation of physical, mental and cognitive functions, neuromuscular and sensory functions, pain tolerance and management, developmental skills and behavioral skills; (4) Therapeutic use of self, including one's personality, insights, perceptions and judgments, as part of the therapeutic process; (5) Education and training of other individuals, including family members and caregivers; (6) Care coordination, case management and transition services; (7) Consultative services to groups, programs, organizations and communities; (8) Modification of environments such as home, school, workplace and community settings and adaptation of processes, including the application of ergonomic principles; (9) Assessment, design, fabrication, application, fitting and training in assistive technology, adaptive devices and orthotic devices and training in the use of prosthetic devices; (10) Assessment, recommendation and training in techniques to enhance functional mobility, including seating and positioning and wheelchair management; (11) Driver rehabilitation and community mobility; (12) Management of feeding, eating and swallowing to enable eating and feeding performance; and (13) Application of physical agent modalities and use of a range of specific therapeutic procedures to enhance performance skills; techniques to enhance sensory, perceptual and cognitive processing; and manual therapy techniques.
Maryland	**Statute: Annotated Code of Maryland, Health Occupations Article § 10-101** (l) "Occupational therapy" means the therapeutic use of purposeful and meaningful goal–directed activities to evaluate, consult, and treat individuals who: (1) Have a disease or disorder, impairment, activity limitation, or participation restriction that interferes with their ability to function independently in daily life roles; or (2) Benefit from the prevention of impairments and activity limitations. (n) "Occupational therapy practice" or "limited occupational therapy practice" means to carry out a treatment program that applies the principles and procedures of occupational therapy. (o) "Occupational therapy principles" include: (1) The use of therapeutic activities that promote independence in daily life roles; (2) Remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes; (3) In order to enhance performance, the adaption of task, process, or the environment, or the teaching of compensatory techniques; (4) Methods and techniques for preventing disability that facilitate the development or safe application of performance skills; (5) Health promotion strategies and practices that enhance performance abilities; and (6) Education, instruction, and research in the practice of occupational therapy. (p) (1) "Occupational therapy procedures" include: (i) Developing, improving, sustaining, or restoring skills in activities of daily living, work, or productive activities, including: 1. Instrumental activities of daily activity; and 2. Play and leisure activities;

	(ii) Developing, remediating, or restoring sensorimotor, perceptual, cognitive, or psychological components of performance; (iii) Designing, fabricating, applying, or training in the use of assistive technology, splinting, or orthotic devices, including training in the use of prosthetic devices; (iv) Adapting environments and processes, including the application of ergonomic principles to enhance performance and safety in daily life roles; (v) Applying physical agent modalities as adjuncts to or in preparation for purposeful activity with appropriate training, as specified by the Board in regulations; (vi) Promoting safe, functional mobility in daily life tasks; (vii) Providing intervention in collaboration with the client, the client's family, the client's caregiver, or others; (viii) Educating the client, the client's family, the client's caregiver, or others in carrying out appropriate nonskilled interventions; and (ix) Consulting with groups, programs, organizations, and communities to provide population-based services. (2) "Occupational therapy procedures" do not include the adjustment or manipulation of any of the osseous structures of the body or spine.
Massachusetts	**Statute: Massachusetts General Laws Part 1, Title XVI, Chapter 112, Section 23a** "Occupational therapy", the application of principles, methods and procedures of evaluation, problem identification, treatment, education, and consultation which utilizes purposeful activity in order to maximize independence, prevent or correct disability, and maintain health. These services are used with individuals, throughout the life span, whose abilities to interact with their environment are limited by physical injury or illness, disabilities, poverty and cultural differences or the aging process. Occupational therapy includes but is not limited to: (1) administering and interpreting tests necessary for effective treatment planning; (2) developing daily living skills, perceptual motor skills, sensory integrative functioning, play skills and prevocational and vocational work capacities; (3) designing, fabricating or applying selected orthotic and prosthetic devices or selected adaptive equipment; (4) utilizing designated modalities, superficial heat and cold, and neuromuscular facilitation techniques to improve or enhance joint motion muscle function; (5) designing and applying specific therapeutic activities and exercises to enhance or monitor functional or motor performance and to reduce stress; and (6) adapting environments for the handicapped. These services are provided to individuals or groups through medical, health, educational, industrial or social systems. Occupational therapy shall also include delegating of selective forms of treatment to occupational therapy assistants and occupational therapy aides; provided, however, that the occupational therapist so delegating shall assume the responsibility for the care of the patient and the supervision of the occupational therapy assistant or the occupational therapy aide. **Regulation: Code of Massachusetts Regulations 259 CMR 3.01** Treatment. A treatment program shall be consistent with the statutory scope of practice and shall: (a) Include the therapeutic use of goal-directed activities, exercises and techniques and the use of group process to enhance occupational performance. Treatment also includes the use of therapeutic agents or techniques in preparation for, or as an adjunct to, purposeful activity to enhance occupational performance. Treatment is directed toward maximizing functional skill and task-related performance for the development of a client's vocational, avocational, daily living or related capacities. (b) Relate to physical, perceptual, sensory neuromuscular, sensory-integrative, cognitive or psychosocial skills. (c) Include, where appropriate for such purposes, and under appropriate conditions, therapeutic agents and techniques based on approaches taught in an occupational therapy curriculum, included in a program of professional education in occupational therapy,

	specific certification programs, continuing education or in-service education. Such continuing education or in-service education must include documented educational goals and objective testing (written examination, practical examination, and/or written simulation or case study) to ascertain a level of competence. Therapeutic procedures provided must be consistent with the individual's level of competence. (d) Require that appropriate supervision take place when an occupational therapist delegates treatment, including the employment of therapeutic agents and techniques to occupational therapy assistants, students, temporary license holders or occupational therapy aides, rehabilitation aides or persons known by other similar titles. (e) Require that the occupational therapist, occupational therapy assistant, occupational therapist student, and occupational therapy assistant student shall: 1. comply with federal and state laws and Board regulations; 2. comply with the AOTA Standards of Practice and Code of Ethics; and 3. provide only those services that are in the best interest of the client.
Michigan	**Statute: Michigan Compiled Laws, Public Health Code §333.18301** (c) "Occupational therapy services" means those services provided to promote health and wellness, prevent disability, preserve functional capabilities, prevent barriers, and enable or improve performance in everyday activities, including, but not limited to, the following: (i) Establishment, remediation, or restoration of a skill or ability that is impaired or not yet developed. (ii) Compensation, modification, or adaptation of a person, activity, or environment. (iii) Evaluation of factors that affect activities of daily living, instrumental activities of daily living, and other activities relating to education, work, play, leisure, and social participation. Those factors include, but are not limited to, body functions, body structure, habits, routines, role performance, behavior patterns, sensory motor skills, cognitive skills, communication and interaction skills, and cultural, physical, psychosocial, spiritual, developmental, environmental, and socioeconomic contexts and activities that affect performance. (iv) Interventions and procedures, including, but not limited to, any of the following: (A) Task analysis and therapeutic use of occupations, exercises, and activities. (B) Training in self-care, self-management, home management, and community or work reintegration. (C) Development remediation, or compensation of client factors such as body functions and body structure. (D) Education and training. (E) Care coordination, case management, transition, and consultative services. (F) Modification of environments and adaptation processes such as the application of ergonomic and safety principles. (G) Assessment, design, fabrication, application, fitting, and training in rehabilitative and assistive technology, adaptive devices, and low temperature orthotic devices, and training in the use of prosthetic devices. For the purposes of this sub-subparagraph, the design and fabrication of low temperature orthotic devices does not include permanent orthotics. (H) Assessment, recommendation, and training in techniques to enhance safety, functional mobility, and community mobility such as wheelchair management and mobility. (I) Management of feeding, eating, and swallowing. (J) Application of physical agent modalities and use of a range of specific therapeutic procedures, including, but not limited to, techniques to enhance sensory-motor, perceptual, and cognitive processing, manual therapy techniques, and adjunctive and preparatory activities. (K) Providing vision therapy services or low vision rehabilitation services, if those services are provided pursuant to a referral or prescription from, or under the supervision or comanagement of, a physician licensed under part 170 or 175 or an optometrist licensed under part 174.

	(e) "Practice of occupational therapy" means the therapeutic use of everyday life occupations and occupational therapy services to aid individuals or groups to participate in meaningful roles and situations in the home, school, workplace, community, and other settings, to promote health and wellness through research and practice, and to serve those individuals or groups who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. The practice of occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect a person's health, well-being, and quality of life throughout his or her life span. The practice of occupational therapy does not include any of the following: (i) The practice of medicine or osteopathic medicine and surgery or medical diagnosis or treatment. (ii) The practice of physical therapy. (iii) The practice of optometry.
Minnesota	**Statute: Minnesota Statutes Chapter 148, Occupational Therapists and Occupational Therapy Assistants** **148.6402 DEFINITIONS** Subd. 15. Occupational therapy. "Occupational therapy" means the use of purposeful activity to maximize the independence and the maintenance of health of an individual who is limited by a physical injury or illness, a cognitive impairment, a psychosocial dysfunction, a mental illness, a developmental or learning disability, or an adverse environmental condition. The practice encompasses evaluation, assessment, treatment, and consultation. Occupational therapy services may be provided individually, in groups, or through social systems. Occupational therapy includes those services described in section 148.6404. **148.6404 SCOPE OF PRACTICE.** (a) The practice of occupational therapy means the therapeutic use of everyday activities with individuals or groups for the purpose of enhancing or enabling participation. It is the promotion of health and well-being through the use of occupational therapy services that includes screening, evaluation, intervention, and consultation to develop, recover, and maintain a client's: (1) sensory integrative, neuromuscular, or motor, emotional, motivational, cognitive, or psychosocial components of performance; (2) daily living skills; (3) feeding and swallowing skills; (4) play and leisure skills; (5) educational participation skills; (6) functional performance and work participation skills; (7) community mobility; and (8) health and wellness. Occupational therapy services include, but are not limited to: (1) designing, fabricating, or applying rehabilitative technology, such as selected orthotic and prosthetic devices, and providing training in the functional use of these devices; (2) designing, fabricating, or adapting assistive technology and providing training in the functional use of assistive devices; (3) adapting environments using assistive technology such as environmental controls, wheelchair modifications, and positioning; and (4) employing physical agent modalities, in preparation for or as an adjunct to purposeful activity to meet established functional occupational therapy goals. (b) Occupational therapy services must be based on nationally established standards of practice.

Mississippi	**Statute: Mississippi Code §73-24-13** 7. Occupational therapy means the therapeutic use of purposeful and meaningful (goal-directed) activities and/or exercises to evaluate and treat an individual who has, or is at risk for, a disease or disorder, impairment, activity limitation or participation restriction which interferes with his ability to function independently in daily life roles and to promote health and wellness across his lifespan. 8. Occupational therapy intervention includes: a. remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological or neurological processes; b. adaptation of task, process or the environment, or the teaching of compensatory techniques in order to enhance functional performance; c. disability prevention methods and techniques which facilitate the development or safe application of functional performance skills; or d. health promotion strategies and practices which enhance functional performance abilities. 9. Occupational therapy service includes, but is not limited to: a. evaluating, developing, improving, sustaining or restoring skill in activities of daily living (ADLS), work or productive activities, including instrumental activities of daily living (IADLS), play and leisure activities; b. evaluating, developing, remediating or restoring physical, sensorimotor, cognitive or psycho social components of performance; c. designing, fabricating, applying or training in the use of assistive technology or orthotic devices, and training in the use of prosthetic devices; d. adaptation of environments and processes, including the application of ergonomic principles, to enhance functional performance and safety in daily life roles; e. application of physical agent modalities as an adjunct to or in preparation for engagement in an occupation or functional activity; f. evaluating and providing intervention in collaboration with the client, family, caregiver or other person responsible for the client; g. educating the client, family, caregiver or others in carrying out appropriate nonskilled interventions; h. consulting with groups, programs, organizations or communities to provide population-based services; or i. participation in administration, education, and research, including both clinical and academic environments.
Missouri	**Statute: Missouri Revised Statutes §324.050** (6) "Occupational therapy", 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. It shall include assessment by means of skill observation or evaluation through the administration and interpretation of standardized or nonstandardized tests and measurements. Occupational therapy services include, but are not limited to: (a) The assessment and provision of treatment in consultation with the individual, family or other appropriate persons; (b) Interventions directed toward developing, improving, sustaining or restoring daily living skills, including self-care skills and activities that involve interactions with others and the environment, work readiness or work performance, play skills or leisure capacities or enhancing educational performances skills; (c) Developing, improving, sustaining or restoring sensorimotor, oral-motor, perceptual or neuromuscular functioning; oremotional, motivational, cognitive or psychosocial components of performance; and (d) Education of the individual, family or other appropriate persons in carrying out appropriate interventions. Such services may encompass assessment of need and the design, development, adaptation, application or training in the use of assistive technology devices; the design, fabrication or application of rehabilitative technology such as selected orthotic devices, training in the use of orthotic or prosthetic devices; the application of ergonomic principles; the adaptation of environments and processes to enhance functional performance; or the promotion of health and wellness;

Montana	**Statute: Montana Code §37-24-103** (5) "Occupational therapy" means the therapeutic use of purposeful goal-directed activities and interventions to achieve functional outcomes to maximize the independence and the maintenance of health of an individual who is limited by disease or disorders, impairments, activity limitations, or participation restrictions that interfere with the individual's ability to function independently in daily life roles. The practice encompasses evaluation, assessment, treatment, consultation, remediation, and restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes. Occupational therapy services may be provided individually, in groups, or through social systems. Occupational therapy interventions include but are not limited to: (a) evaluating, developing, improving, sustaining, or restoring skills in activities of daily living, work or productive activities, including instrumental activities of daily living, and play and leisure activities; (b) developing perceptual-motor skills and sensory integrative functioning; (c) developing play skills and leisure capacities and enhancing educational performance skills; (d) designing, fabricating, or applying orthotic or prosthetic devices, applying and training in the use of assistive technology, and training in the use of orthotic and prosthetic devices; (e) providing for the development of emotional, motivational, cognitive, psychosocial, or physical components of performance; (f) providing assessment and evaluation, including the use of skilled observation or the administration and interpretation of standardized or nonstandardized tests and measurements to identify areas for occupational therapy services; (g) adaptation of task, process, or the environment, as well as teaching of compensatory techniques, in order to enhance performance; (h) developing feeding and swallowing skills; (i) enhancing and assessing work performance and work readiness through occupational therapy intervention, including education and instruction, activities to increase and improve general work behavior and skill, job site evaluation, on-the-job training and evaluation, development of work-related activities, and supported employment placement; (j) providing neuromuscular facilitation and inhibition, including the activation, facilitation, and inhibition of muscle action, both voluntary and involuntary, through the use of appropriate sensory stimulation, including vibration or brushing, to evoke a desired muscular response; (k) application of physical agent modalities, as defined in this section, as an adjunct to or in preparation for engagement in purposeful goal-directed activity; (l) promoting health and wellness; (m) evaluating and providing intervention in collaboration with the client, family, caregiver, or others; (n) educating the client, family, caregiver, or others in carrying out appropriate nonskilled interventions; (o) consulting with groups, programs, organizations, or communities to provide population-based services; and (p) use of prescribed topical medications. (8) "Physical agent modalities" means those modalities that produce a response in soft tissue through the use of light, water, temperature, sound, or electricity. Physical agent modalities are characterized as adjunctive methods used in conjunction with or in immediate preparation for patient involvement in purposeful activity. Superficial physical agent modalities include hot packs, cold packs, ice, fluidotherapy, paraffin, water, and other commercially available superficial heating and cooling devices. Use of superficial physical agent modalities is limited to the shoulder, arm, elbow, forearm, wrist, and hand and is subject to the provisions of 37-24-105. Use of sound and electrical physical agent modality devices is limited to the shoulder, arm, elbow, forearm, wrist, and hand and is subject to the provisions of 37-24-106.
Nebraska	**Statute: Nebraska Code §§38-2510 & 38-2526** **38-2510. Occupational therapy, defined.** (1) Occupational therapy means the use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process in order to maximize independent function, prevent further disability, and achieve and maintain health and productivity.

	(2) Occupational therapy encompasses evaluation, treatment, and consultation and may include (a) remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes, (b) adaptation of task, process, or the environment, or the teaching of compensatory techniques, in order to enhance performance, (c) disability prevention methods and techniques which facilitate the development or safe application of performance skills, and (d) health promotion strategies and practices which enhance performance abilities. **38-2526. Occupational therapist; services authorized.** Occupational therapy services mean an occupational therapist may perform the following services: 1. Evaluate, develop, improve, sustain, or restore skills in activities of daily living, work activities, or productive activities, including instrumental activities of daily living, and play and leisure activities; 2. Evaluate, develop, remediate, or restore sensorimotor, cognitive, or psychosocial components of performance; 3. Design, fabricate, apply, or train in the use of assistive technology or orthotic devices and train in the use of prosthetic devices; 4. Adapt environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles; 5. If certified pursuant to section 38-2530, apply physical agent modalities as an adjunct to or in preparation for engagement in occupations when applied by a practitioner who has documented evidence of possessing the theoretical background and technical skills for safe and competent use; 6. Evaluate and provide intervention in collaboration with the client, family, caregiver, or others; 7. Educate the client, family, caregiver, or others in carrying out appropriate nonskilled interventions; and 8. Consult with groups, programs, organizations, or communities to provide population-based services.
Nevada	**Statute: Nevada Revised Statutes §640A.050** "Occupational therapy" defined**.** "Occupational therapy" means the use of evaluations, teachings and interventions to facilitate the activities of daily living of a client in groups or on an individual basis to enable the client to participate in and perform activities of daily living in various settings, including, without limitation, at home, at school, in the workplace and in the community. The term includes: 1. Providing services for habilitation, rehabilitation and the promotion of health and wellness to a client; 2. Assisting a client in achieving the highest practicable physical, cognitive and psychosocial well-being to improve the physical and mental health of the client and the quality of life of the client; 3. Teaching a client skills for daily living; 4. Assisting a client in the development of cognitive and perceptual motor skills, and in the integration of sensory functions; 5. Assisting a client in learning to play and to use his or her leisure time constructively; 6. Assisting a client in developing functional skills necessary to be considered for employment; 7. Assessing the need for, designing, constructing and training a client in the use and application of selected orthotic devices and adaptive equipment; 8. Assessing the need for prosthetic devices for the upper body and training a client in the functional use of prosthetic devices; 9. Teaching a client crafts and exercises designed to enhance his or her ability to function normally; 10. Administering to a client manual tests of his or her muscles and range of motion, and interpreting the results of those tests; 11. Incorporating into the treatment of a client the safe and appropriate use of physical agent modalities and techniques which have been acquired through an appropriate program of education approved by the Board pursuant to subsection 2 of NRS 640A.120, or through a program of continuing education or higher education; and 12. Adapting the environment of a client to reduce the effects of handicaps.

New Hampshire	**Statute: New Hampshire Revised Statutes Title 30 §326-C:1** III. " Occupational therapy " means the therapeutic use of purposeful and meaningful occupations or 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. (a) Occupational therapy intervention may include: (1) Remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes. (2) Adaptation of task, process, or the environment, or the teaching of compensatory techniques, in order to enhance performance. (3) Disability prevention methods and techniques which facilitate the development or safe application of performance skills. (4) Health promotion strategies and practices which enhance performance abilities. (b) Occupational therapy services include, but are not limited to: (1) Evaluating, developing, improving, sustaining or restoring skills in activities of daily living, work or productive activities, including instrumental activities of daily living, and play and leisure activities. (2) Evaluating, developing, remediating, or restoring sensorimotor, cognitive, or psychosocial components of performance. (3) Designing, fabricating, applying, or training in the use of assistive technology or orthotic devices, and training in the use of prosthetic devices. (4) Adaptation of environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles. (5) Application of physical agent modalities as an adjunct to, or in preparation for, engagement in purposeful activities and occupations. (6) Evaluating and providing intervention in collaboration with the client, family, caregiver, or others. (7) Educating the client, family, caregiver, or others in carrying out appropriate non-skilled interventions. (8) Consulting with groups, programs, organizations, or communities to provide population-based services. **Statute: New Hampshire Revised Statutes Title 30 §326-C:1 (effective July 18, 2023)** IV. "Occupational therapy" means the care and services provided by an occupational therapist or occupational therapy assistant who are licensed pursuant to this chapter. Areas of occupation include but are not limited to: (a) Activities of daily living, which are the routine activities a person completes to meet their basic health and survival needs. (b) Instrumental activities of daily living, which are activities a person completes to live independently and participate in the community. (c) Health management. (d) Rest and sleep. (e) Education. (f) Work. (g) Play. (h) Leisure. (i) Social participation. V. "Practice of occupational therapy" means the therapeutic use of everyday life occupations and activities with persons, groups, or populations to support occupational performance across their lifespans. (a) Practice of occupational therapy includes but is not limited to: (1) Evaluation, analysis, and diagnosis of occupational performance, as well as interventions designed to address occupational performance and engagement in occupations.

(2) Assessment of occupations, occupational performance, and engagement which may include client performance skills (motor, process, social interaction), performance patterns (habits, roles, routines, rituals), contexts (environments and personal factors), and client factors (body functions and structures, values, beliefs, and spirituality).
(3) Identification, development, remediation, or compensation of physical, neuromusculoskeletal, sensory-perceptual, emotional regulation, social interaction, visual, mental, and behavioral skills; cognitive functions; pain and pain management; praxis and developmental skills to improve or enhance occupational performance and engagement.
(4) Compensation, modification, or adaptation of occupations, activities, performance patterns, and contexts, including the application of universal design and ergonomic principles to improve or enhance occupational performance and engagement.
(5) Habilitation, rehabilitation, and the promotion of physical and mental health and wellness for clients with all levels of ability-related needs. This includes occupational skills or performance abilities and patterns that are impaired, in decline, at risk of decline or impairment, or have not yet developed.
(6) Health promotion, injury and disease management, and disability prevention through the identification and remediation of client skills, habits, roles, routines as well as current or potential contextual barriers impacting occupational performance and engagement.
(7) Therapeutic exercises, including tasks and methods to increase motion, strength, endurance, and enhance healthy routines to support occupational performance and engagement.
(8) Assessment, design, fabrication, application, fitting and training in seating and positioning, assistive technology, adaptive devices and orthotic devices, and training in the use of prosthetic devices.
(9) Application of physical agent and mechanical modalities and use of a range specific therapeutic procedures (e.g. wound care management; techniques to enhance sensory, motor, perpetual, and cognitive processing; manual therapy techniques) to enhance occupational performance and engagement.
(10) Education and training of persons, including family members, caregivers, groups, populations to address occupational performance and engagement.
(11) Consultative services to persons, groups, populations, programs, organizations and communities to address occupational performance and engagement.
(12) Advocacy directed toward promoting opportunities for occupational performance and engagement that empower clients to seek and obtain resources to fully participate in their everyday life occupations.
(13) Care coordination, case management, and transition services.

VI. Occupational performance refers to the way occupations and related activities are completed in everyday life.

<u>Regulation:</u> New Hampshire Administrative Rules Chapter Occ 100, Organizational Rules, Part Occ 102 Definitions

Occ 102.03 “Occupational therapy” means “occupational therapy” as defined in RSA 326-C:1, III, namely the therapeutic use of purposeful and meaningful occupations or 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.

(a) Occupational therapy intervention may include:
(1) Remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes.
(2) Adaptation of task, process, or the environment, or the teaching of compensatory techniques, in order to enhance performance.
(3) Disability prevention methods and techniques which facilitate the development or safe application of performance skills.
(4) Health promotion strategies and practices which enhance performance abilities.

	(b) Occupational therapy services include, but are not limited to: (1) Work or productive activities, including instrumental activities of daily living, and play and leisure activities. (2) Evaluating, developing, remediating, or restoring sensorimotor, cognitive, or psychosocial components of performance. (3) Designing, fabricating, applying, or training in the use of assistive technology or orthotic devices, and training in the use of prosthetic devices. (4) Adaptation of environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles. (5) Application of physical agent modalities as an adjunct to, or in preparation for, engagement in purposeful activities and occupations. (6) Evaluating and providing intervention in collaboration with the client, family, caregiver, or others. (7) Educating the client, family, caregiver, or others in carrying out appropriate non-skilled interventions. (8) Consulting with groups, programs, organizations, or communities to provide population-based services.”
New Jersey	**Statute: New Jersey Revised Statutes § 45:9-37.53** "Occupational therapy" means the evaluation, planning, and implementation of a program of purposeful activities to develop or maintain functional skills necessary to achieve the maximal physical or mental functioning, or both, of the individual in the person's daily occupational performance. The tasks of daily living may be threatened or impaired by physical injury or illness, developmental disability, sensorimotor disability, psychological and social disability, the aging process, poverty, or cultural deprivation. Occupational therapy utilizes task oriented activities adapted to prevent or correct physical or emotional disabilities as well as to minimize the disabling effects of those disabilities on the life of the individual. Occupational therapy services include the use of specific techniques which enhance functional performance and include, but are not limited to, the evaluation and assessment of an individual's self-care, lifestyle performance patterns, work skills, performance related cognitive, sensory, motor, perceptual, affective, interpersonal and social functioning, vocational, and prevocational capacities, the design, fabrication, and application of adaptive equipment or prosthetic or orthotic devices, excluding dental devices, the administration of standardized and nonstandardized assessments, and consultation concerning the adaptation of physical environments for persons with disabilities. These services are provided to individuals or groups through medical, health, educational and social systems. "Purposeful activities" means acts and occupations of craftsmanship and workmanship, as well as creative, educational, or other activities, which in whole or in part are used to correct, compensate for or prevent dysfunction in the tasks and activities of everyday living, and which simultaneously incorporate personally and culturally relevant biological, psychological and social elements that produce positive adaptation and motivational behavior. **Regulations: New Jersey Administrative Code Title 13, Chapter 44K** **13:44K-1.2 DEFINITIONS** "Occupational therapy services" means the use of specific techniques which enhance the functional performance of a client, including the evaluation and assessment of a client's selfcare, lifestyle performance patterns, work skills, performance related cognitive, sensory, motor, perceptual, affective, interpersonal and social functioning, vocational and prevocational capacities. Occupational therapy services also includes the design, fabrication and application of adaptive equipment or prosthetic or orthotic devices, excluding dental devices, the utilization of physical agent modalities, the administration of standardized and non-standardized assessments and consultation, including recommendations for the adaptation of physical environments. **13:44K-5.1 SCOPE OF PRACTICE OF A LICENSED OCCUPATIONAL THERAPIST** a) The scope of practice of a licensed occupational therapist shall include:

	1) The provision of direct, indirect and/or consultative services to a client affected by physical, psycho-social, cognitive, congenital and/or developmental disorders or the aging process, to improve and/or prevent loss of physical or mental functioning and to promote wellness; 2) The administration of standardized and/or non-standardized assessments and/or the observation of a client and the environment to identify areas of functional abilities or deficits. Areas, which may be assessed shall include the performance of activities of daily living, including recreation, leisure or work related skills, which are affected by sensory, motor, developmental, perceptual, cognitive and/ or psycho-social abilities; 3) The interpretation of the results of the assessment process described in (a) 2 above, to determine the need for an intervention plan for the client. Such a plan shall be developed and administered by the occupational therapist in collaboration with the client, the client's family and related medical, health, educational or social agencies or professionals; 4) The development and utilization of, and education and training in, purposeful, task oriented activities for the client to improve, restore and/or maintain optimal performance of life skills, roles and functions including work, recreation, leisure skills and activities of daily living; 5) The design, fabrication, application and/or selection of adaptive equipment, prosthetics and/or orthotic devices, except dental devices; 6) Consultation concerning the adaptation of physical environments; and 7) The utilization of physical agent modalities, consistent with N.J.A.C. 13:44K-5.4, as an adjunct to, or in preparation for, purposeful activities to enhance occupational performance with which the licensee is familiar as a result of training and experience. **13:44K-5.2 SCOPE OF PRACTICE OF A LICENSED OCCUPATIONAL THERAPY ASSISTANT** a) The scope of practice of a licensed occupational therapy assistant, working under the supervision of a licensed occupational therapist as provided in N.J.A.C. 13:44K-6.1, shall include: 1) The provision of direct, indirect and/or consultative services to a client affected by physical, psycho-social, cognitive, congenital and/or developmental disorders or the aging process, to improve and/or prevent loss of physical or mental functioning and to promote wellness; 2) The administration of standardized and/or non-standardized assessments and/or the observation of a client and the environment to assist in the identification of functional abilities or deficits. Areas, which may be assessed shall include the performance of activities of daily living, including recreation, leisure or work related skills which are affected by sensory, motor, developmental, perceptual, cognitive and/or psycho-social abilities; 3) Assisting in the development and implementation of an intervention plan for the client; 4) The development and utilization of, and education and training in, purposeful, task oriented activities for the client to improve, restore and/or maintain optimal performance of life skills, roles and functions including work, recreation, leisure skills and the activities of daily living; 5) The design, fabrication, application and/or selection of adaptive equipment, prosthetics and/or orthotic devices, except dental devices; 6) Consultation concerning the adaptation of physical environments; and 7) The utilization of physical agent modalities, consistent with N.J.A.C. 13:44K-5.4, as an adjunct to, or in preparation for, purposeful activity to enhance occupational performance with which the licensee is familiar as a result of training and experience.
New Mexico	**<u>Statute:</u> New Mexico Revised Statutes §§61-12A-3 & 61-12A-4** **61-12A-3. Definitions.** F. "occupational therapy" means the therapeutic use of occupations, including everyday life activities with persons across the life span, including groups, populations or organizations, to enhance or enable participation, performance or function in roles, habits and routines in

home, school, workplace, community and other settings. Occupational therapy services are provided for habilitation, rehabilitation and the promotion of health and wellness to those clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation or participation restriction.

"Occupational therapy" includes addressing the physical, cognitive, psychosocial, sensory-perceptual and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being and quality of life. Occupational therapy uses everyday life activities to promote mental health and support functioning in people with or at risk of experiencing a range of mental health disorders, including psychiatric, behavioral, emotional and substance abuse disorders;

61-12A-4. Occupational therapy services.

The practice of occupational therapy includes the following processes and services:

A. evaluation of factors affecting all areas of occupation, including activities of daily living, instrumental activities of daily living, rest and sleep, education, work, productivity, play, leisure and social participation; including:

(1) client factors, including neuromuscular, sensory, visual, mental, cognitive and pain factors and body structures, including cardiovascular, digestive, integumentary and genitourinary systems and structures related to movement;

(2) habits, routines, roles and behavior patterns;

(3) cultural, physical, environmental, social and spiritual contexts and activity demands that affect performance; and

(4) performance skills, including motor process and communication and interaction skills;

B. activity analysis to determine activity demands of occupations performed;

C. design, implementation and modification of therapeutic interventions, including the following activities related to selection of intervention strategies to direct the process of interventions:

(1) establishment, remediation or restoration of a skill or ability that has not yet developed, is impaired or is in decline;

(2) compensation, modification or adaptation of activity or environment to enhance performance or to prevent injuries, disorders or other conditions;

(3) retention, maintenance and enhancement of skills and capabilities without which performance in everyday life activities would decline;

(4) promotion of health and wellness, including the use of self-management strategies to enable or enhance performance in everyday life activities;

(5) prevention of barriers to performance, including injury and disability prevention; and

(6) interventions and procedures to promote or enhance safety and performance in areas of occupation, including:

(a) therapeutic use of occupations, exercises and activities;

(b) training in self-care, self-management, health management and maintenance, home management, community-work reintegration, school activities and work performance;

(c) development, remediation or compensation of neuromusculoskeletal, sensory-perceptual, sensory-integrative and modulation, visual, mental and cognitive functions, pain tolerance and management, developmental skills and behavioral skills;

(d) therapeutic use of self, including one's personality, insights, perceptions and judgments, as part of the therapeutic process;

(e) education and training of persons, including family members, caregivers, groups, populations and others;

(f) care coordination, case management and transition services;

(g) consultative services to groups, programs, organizations or communities;

(h) modification of home, work, school and community environments and adaptation of processes, including the application of ergonomic principles;

(i) assessment, design, fabrication, application, fitting and training in seating and positioning, assistive technology, adaptive devices and orthotic devices and training in the use of prosthetic devices;

	(j) assessment, recommendation and training in techniques to enhance functional mobility, including management of wheelchairs and other mobility devices; (k) low-vision rehabilitation; (l) driver rehabilitation and community mobility; (m) management of feeding, eating and swallowing; (n) application of physical agent modalities and use of a range of specific therapeutic procedures such as wound care management; techniques to enhance sensory, perceptual and cognitive processing; and manual therapy techniques to enhance performance skills; (o) facilitating the occupational performance of groups, populations or organizations; and (p) management of a client's mental health, functioning and performance; and D. use of means to measure the outcomes and effects of interventions to reflect the attainment of treatment goals, including: (1) improved quality of life; (2) the degree of participation; (3) role competence; (4) well-being; (5) improved life function; (6) enhanced performance; and (7) prevention criteria.
New York	**Statute: New York Education Law Title 8, Article 156, §7901, Definition.** The practice of the profession of occupational therapy is defined as the functional evaluation of the client, the planning and utilization of a program of purposeful activities, the development and utilization of a treatment program, and/or consultation with the client, family, caregiver or organization in order to restore, develop or maintain adaptive skills, and/or performance abilities designed to achieve maximal physical, cognitive and mental functioning of the client associated with his or her activities of daily living and daily life tasks. A treatment program designed to restore function, shall be rendered on the prescription or referral of a physician, nurse practitioner or other health care provider acting within his or her scope of practice pursuant to this title. However, nothing contained in this article shall be construed to permit any licensee hereunder to practice medicine or psychology, including psychotherapy or to otherwise expand such licensee's scope of practice beyond what is authorized by this chapter. **Regulation: New York Codes, Rules and Regulations, Title 8 Education Department, Chapter II, Subchapter B, Part 76** **§76.5 Definition of occupational therapy practice.** a. A functional evaluation within the meaning of Education Law, section 7901 may include screening, observing, consulting, administering and/or interpreting standardized and non-standardized assessment tools, and simulating and analyzing activities or environments for the purpose of: 1. assessing levels of functional abilities and deficits resulting from developmental deficit, injury, disease or any limiting condition; and/or 2. identifying areas of function and dysfunction in daily life tasks; and/or 3. determining the need for and the types of initial and/or subsequent occupational therapy. b. Purposeful activity is defined as goal-directed behavior aimed at the development of functional daily living skills in the categories of self-care, work, homemaking or play/leisure. c. A treatment program within the meaning of Education Law, section 7901 shall be consistent with the statutory scope of practice and may:

1. Include the therapeutic use of goal-directed activities, exercises, or techniques to maximize the client's physical and/or mental functioning in life tasks. Treatment is directed toward maximizing functional skill and task-related performance for the development of a client's vocational, avocational, daily living or related capacities.
2. Relate to physical, perceptual, sensory, neuromuscular, sensory-integrative, cognitive or psychosocial skills.
3. Include, where appropriate for such purposes, and under appropriate conditions, modalities and techniques based on approaches taught in an occupational therapy curriculum and included in a program of professional education in occupational therapy registered by the department, and consistent with areas of individual competence. These approaches are based on:

i. The neurological and physiological sciences as taught in a registered occupational therapy professional education program. Modalities and techniques may be based on, but not limited to, any one or more of the following:

a. sensory integrative approaches;
b. developmental approaches;
c. sensorimotor approaches;
d. neurophysiological treatment approaches;
e. muscle reeducation;
f. superficial heat and cold; or
g. cognitive and perceptual remediation.

ii. The behavioral and social sciences as taught in a registered occupational therapy professional education program. Modalities and techniques may be based on, but not limited to, any one or more of the following:

a. behavioral principles;
b. work-related programs and simulation;
c. group dynamics and process; or
d. leisure/avocational activities.

iii. The biomechanical sciences as taught in a registered occupational therapy professional education program. Modalities and techniques may be based on, but not limited to, any one or more of the following:

a. passive, active assistive, and active range of motion;
b. muscle strengthening and conditioning;
c. positioning;
d. participation in design, fabrication, and/or application, and patient education related to orthotics and adaptive equipment;
e. evaluation of appropriateness, participation in design concept, application and patient education related to prosthetics;
f. daily life tasks;
g. adapting the client's environment; or
h. work-related programs.

d. Any treatment program described in this regulation shall be rendered on the prescription or referral of a physician. In accordance with section 7901 and articles 131 and 153 of the Education Law, nothing contained in this regulation shall be construed to permit any licensee hereunder to engage in the practice of medicine or psychology, including psychotherapy.

§76.6 Definition of occupational therapy assistant practice and the use of the title occupational therapy assistant.

a. An occupational therapy assistant shall mean a person licensed or otherwise authorized in accordance with this Part who provides occupational therapy services under the direction and supervision of an occupational therapist or licensed physician and performs client related activities assigned by the supervising occupational therapist or licensed physician. Only a person licensed or otherwise authorized under this

	Part shall participate in the practice of occupational therapy as an occupational therapy assistant, and only a person licensed or otherwise authorized under this Part shall use the title occupational therapy assistant. b. As used in this section, client related activities shall mean: 1. contributing to the evaluation of a client by gathering data, reporting observations and implementing assessments delegated by the supervising occupational therapist or licensed physician; 2. consulting with the supervising occupational therapist or licensed physician in order to assist him or her in making determinations related to the treatment plan, modification of client programs or termination of a client's treatment; 3. the utilization of a program of purposeful activities, a treatment program, and/or consultation with the client, family, caregiver, or other health care or education providers, in keeping with the treatment plan and under the direction of the supervising occupational therapist or licensed physician; 4. the use of treatment modalities and techniques that are based on approaches taught in an occupational therapy assistant educational program registered by the department or accredited by a national accreditation agency which is satisfactory to the department, and that the occupational therapy assistant has demonstrated to the occupational therapist or licensed physician that he or she is competent to use; or 5. the immediate suspension of any treatment intervention that appears harmful to the client and immediate notification of the occupational therapist or licensed physician.
North Carolina	**Statute: North Carolina General Statutes §90-270.67** 4. “Occupational therapy” means a health care profession providing evaluation, treatment and consultation to help individuals achieve a maximum level of independence by developing skills and abilities interfered with by disease, emotional disorder, physical injury, the aging process, or impaired development. Occupational therapists use purposeful activities and specially designed orthotic and prosthetic devices to reduce specific impairments and to help individuals achieve independence at home and in the work place. **Regulation: 21 NCAC §38.0103** (12) "Occupational Therapy", as defined in G.S. 90-270.67(4), may include evaluation of activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation. (13) "Occupational Therapy evaluation, treatment, and consultation" include the following: (a) remediation or restitution of performance abilities that are limited due to impairment in biological, physiological, psychosocial, and developmental process; (b) adaptation of skills, process or environment, or the teachings of compensatory techniques in order to enhance performance; (c) disability prevention methods and techniques that facilitate the development or safe application of performance skills; (d) promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction; and (e) interpretation of the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life. (15) "Occupational therapy services" include the following: (a) Methods or strategies selected to direct the process of interventions such as: (i) Establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired; (ii) Compensation, modification, or adaptation of activity or environment to enhance performance; (iii) Maintenance and enhancement of capabilities without which performance in everyday life activities would decline; (iv) Health promotion and wellness to enable or enhance performance in everyday life activities; and (v) Prevention of barriers to performance, including disability prevention.

	(b) Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation, including: (i) Client factors, including body functions (such as neuromuscular, sensory, visual, perceptual, cognitive) and body structures (such as cardiovascular, digestive, integumentary, genitourinary systems); (ii) Habits, routines, roles, and behavior patterns; (iii) Cultural, physical, environmental, social, and spiritual contexts and activity demands that affect performance; and (iv) Performance skills, including motor, process, and communication/interaction skills. (c) Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure and social participation, including: (i) Therapeutic use of occupations, exercises, and activities; (ii) Training in self-care, self-management, home management, and community or work reintegration; (iii) Development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions and behavioral skills; (iv) Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process; (v) Education and training of individuals, including family members, caregivers, and others; (vi) Care coordination, case management, and transition services; (vii) Consultative services to groups, programs, organizations, or communities; (viii) Modification of home, work, school, or community environments and adaptation of processes, including the application of ergonomic principles; (ix) Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices; (x) Assessment, recommendation, and training in techniques to enhance functional mobility, including wheelchair management; (xi) Driver rehabilitation and community mobility; (xii) Management of feeding, eating, and swallowing to enable eating and feeding performance; and (xiii) Application of physical agent modalities and use of a range of specific therapeutic procedures to enhance performance skills.
North Dakota	**Statute: North Dakota Century Code §43-40** 5. "Occupational therapy practice" means the use of occupation and purposeful activity or intervention designed to achieve functional outcomes that 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 occupational therapy education. Occupational therapy encompasses evaluation, treatment, consultation, research, and education. Occupational therapy practice includes evaluation by skilled observation, administration, and interpretation of standardized and nonstandardized tests and measurements. The occupational therapy practitioner designs and implements interventions directed toward developing, improving, sustaining, and restoring sensorimotor, neuromuscular, emotional, cognitive, or psychosocial performance components. Interventions include activities that contribute to optimal occupational performance including self-care; daily living skills; skills essential for productivity, functional communication and mobility; positioning; social integration; cognitive mechanisms; enhancing play and leisure skills; and the design, provision, and training in the use of assistive technology, devices, orthotics, or prosthetics or environmental adaptations to accommodate for loss of occupational performance. Therapy may be provided individually or in groups to prevent secondary conditions, promote community integration, and support the individual's health and well-being within the social and cultural contexts of the individual's natural environment.

Regulation: **North Dakota Administrative Code, Chapter 55.5-03-01, Scope of Practice**

55.5-03-01-03. Specific occupational therapy services.

The "Occupational Therapy Practice Framework: Domain and Process" (4th edition 2020) describes the practice of occupational therapy. The practice of occupational therapy means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness, including methods delivered via telerehabilitation to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being, and quality of life.

55.5-03-01-04. Occupational therapy evaluation.

Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), health maintenance, rest and sleep, education, work, play, leisure, and social participation, includes:

1. Client factors, including body functions (mental functions, sensory functions, neuromusculoskeletal, immunological, and respiratory system functions, voice and speech functions, skin and related structure functions)) and body structures, values, beliefs, and spirituality.
2. Performance patterns, including habits, routines, roles, and rituals.
3. Context is the environmental and personal factors specific to each client (person, group, population) that influences engagement and participation in occupations. Examples include physical and social environments, cultural, personal, temporal, and virtual contexts and activity demands.
4. Performance skills, including motor, cognitive, communication and social skills, process skills, and social interaction skills.

55.5-03-01-05. Occupational therapy intervention.

1. Methods or approaches selected to direct the process of interventions include:
   a. Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or in decline.
   b. Compensation, modification, or adaptation of activity or environment to enhance performance or to prevent injuries, disorders, or other conditions.
   c. Maintenance, retention, and enhancement of skills or abilities without which performance in everyday life activities would decline.
   d. Creation, promotion of health and wellness, including the use of self-management strategies, to enable or enhance performance in everyday life activities.
   e. Prevention of barriers to performance and participation, including injury and disability prevention.
2. Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), health maintenance, rest and sleep, education, work, play, leisure, and social participation, including:
   a. Therapeutic use of occupations, exercises, and activities.
   b. Training in self-care, self-management, health management and maintenance, home management, community or work reintegration, and school activities and work performance.
   c. Development, remediation, or compensation of neuromusculoskeletal, sensory-perceptual, visual, mental, and cognitive functions, pain tolerance and management, and behavioral skills.
   d. Therapeutic use of self, including one's personality, insights, perceptions, and judgements, as part of the therapeutic process.
   e. Education and training of individuals, including family members, caregivers, groups, populations, and others.
   f. Care coordination, case management, and transition services.

	g. Consultative services to groups, programs, organizations, or communities. h. Modification of home, work, school, or community environments and adaptation of processes, including the application of ergonomic principles. h. Modification of home, work, school, or community environments and adaptation of processes, including the application of ergonomic principles. i. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices. j. Assessment, recommendations, and training in techniques to enhance functional mobility, including management of wheelchairs and other mobility devices. k. Low vision rehabilitation. l. Driver rehabilitation and community mobility. m. Management of feeding, eating, and swallowing to enable eating and feeding performance. n. Application of physical agent modalities, and use of a range of specific therapeutic procedures (such as wound care management, interventions to enhance sensory-perceptual and cognitive processing, and manual therapy) to enhance performance skills. An occupational therapist may purchase, store, and administer topical medications, including aerosol medications, as part of the practice of occupational therapy, but shall not dispense or sell any of the medications to patients. An occupational therapist shall comply with any protocols of the United States pharmacopoeia for storage of medications. A valid order or prescription for medication classified as a legend drug is needed before administration to a patient. Occupational therapy facilities must work with a pharmacist to assist with proper protocols for storage of medications. A record of dosage, for, quantity, and strength of medication administered to each patient is required in the medical record. o. Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and the adaptation of processes. p. Advocacy in promoting and empowering clients to seek and obtain resources.
Ohio	**Statute: Ohio Revised Code §4755.04, Occupational therapist definitions.** (A) "Occupational therapy" means the therapeutic use of everyday life activities or occupations with individuals or groups for the purpose of participation in roles and situations in the home, school, workplace, community, and other settings. The practice of occupational therapy includes all of the following: (1) Methods or strategies selected to direct the process of interventions, including, but not limited to, establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired and compensation, modification, or adaptation of activity or environment to enhance performance; (2) Evaluation of factors affecting activities of daily living, instrumental activities of daily living, education, work, play, leisure, and social participation, including, but not limited to, sensory motor abilities, vision, perception, cognition, psychosocial, and communication and interaction skills; (3) Interventions and procedures to promote or enhance safety and performance in activities of daily living, education, work, play, leisure, and social participation, including, but not limited to, application of physical agent modalities, use of a range of specific therapeutic procedures to enhance performance skills, rehabilitation of driving skills to facilitate community mobility, and management of feeding, eating, and swallowing to enable eating and feeding performance; (4) Consultative services, case management, and education of patients, clients, or other individuals to promote self- management, home management, and community and work reintegration; (5) Designing, fabricating, applying, recommending, and instructing in the use of selected orthotic or prosthetic devices and other equipment which assists the individual to adapt to the individual's potential or actual impairment; (6) Administration of topical drugs that have been prescribed by a licensed health professional authorized to prescribe drugs, as defined in section 4729.01 of the Revised Code.

Oklahoma	**Statute: Oklahoma Statutes, Title 59, Section §888.3** "Occupational therapy" is a health profession for which practitioners provide assessment, treatment, and consultation through the use of purposeful activity with individuals who are limited by or at risk of physical illness or injury, psycho-social dysfunction, developmental or learning disabilities, poverty and cultural differences or the aging process, in order to maximize independence, prevent disability, and maintain health. Specific occupational therapy services include but are not limited to the use of media and methods such as instruction in daily living skills and cognitive retraining, facilitating self-maintenance, work and leisure skills, using standardized or adapted techniques, designing, fabricating, and applying selected orthotic equipment or selective adaptive equipment with instructions, using therapeutically applied creative activities, exercise, and other media to enhance and restore functional performance, to administer and interpret tests which may include sensorimotor evaluation, psycho-social assessments, standardized or nonstandardized tests, to improve developmental skills, perceptual and motor skills, and sensory integrative function, and to adapt the environment for the handicapped. These services are provided individually, in groups, via telehealth or through social systems;
Oregon	**Statute: Oregon Revised Statute §675.210** (3) "Occupational therapy" means the analysis and use of purposeful activity with individuals who are limited by physical injury or illness, developmental or learning disabilities, psycho-social dysfunctions or the aging process in order to maximize independence, prevent disability and maintain health. The practice of occupational therapy encompasses evaluation, treatment and consultation. Specific occupational therapy services includes but is not limited to: Activities of daily living (ADL); perceptual motor and sensory integrated activity; development of work and leisure skills; the design, fabrication or application of selected orthotics or prosthetic devices; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; exercises to enhance functional performance; prevocational evaluation and training; performing and interpreting manual muscle and range of motion test; and appraisal and adaptation of environments for people with mental and physical disabilities. The services are provided individually, in groups, or through social systems. **Regulation: Oregon Administrative Rule §339-01-0005** (6) "Occupational Therapy" further defines scope of practice as meaning the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life: (a) Occupational Therapists use selected methods or strategies to direct the process of interventions such as: (A) Establish, remediate or restore skill or ability that has not yet developed or is impaired; (B) Compensate, modify, or adapt activity or environment to enhance performance; (C) Maintain and enhance capabilities without which performance in everyday life activities would decline; (D) Promote health and wellness to enable or enhance performance in everyday life activities; (E) Prevent barriers to performance, including disability prevention. (b) Occupational Therapists evaluate factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation, including: (A) Client factors, including body functions (such as neuromuscular, sensory, visual, perceptual, cognitive) and body structures (such as cardiovascular, digestive, integumentary, genitourinary systems); (B) Habits, routines, roles and behavior patterns; (C) Cultural, physical, environmental, social, and spiritual contexts and activity demands that affect performance; (D) Performance skills, including motor, process, and [communication/] interaction skills. (c) Occupational Therapists use the following interventions and procedures to promote or enhance safety and performance in activities

	of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation, including: (A) Therapeutic use of occupations, exercise, and activities; (B) Training in self-care, self-management, home management and community/work reintegration; (C) Development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions and behavior skills; (D) Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process; (E) Education and training of individuals, including family members, caregivers, and others; (F) Care coordination, case management, and transition services; (G) Consultative services to groups, programs, organizations, or communications; (H) Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles; (I) Assessment, design, fabrication, application, fitting, and training in assistive technology, adaptive devise, and orthotic devices, and training in the use of prosthetic devices; (J) Assessment, recommendation, and training in techniques to enhance functional mobility, including wheelchair management; (K) Driver rehabilitation and community mobility; (L) Management of feeding, eating, and swallowing to enable eating and feeding performance; (M) Application of physical agent modalities, and use of a range of specific therapeutic procedures (such as wound care management; techniques to enhance sensory, perceptual, and cognitive processing, manual therapy techniques) to enhance performance skills as they relate to occupational therapy services.
Pennsylvania	**Statute: 63 P.L. 502, No. 140 Cl. 63** "Occupational therapy." The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person's developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific techniques which include: (1) Planning and implementing activity programs to improve sensory and motor functioning at the level of performance normal for the individual's stage of development. (2) Teaching skills, behaviors and attitudes crucial to the individual's independent, productive and satisfying social functioning. (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment. (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability.
Puerto Rico	**Statute: 20 L.P.R.A. § 1047** d) Occupational therapy. — Means the science that studies occupation by means of the therapeutic use of activities of daily living (occupations) with individuals or groups of individuals so that they may participate in their roles and situations at home, in school, at work, in the community and in other scenarios. Occupational therapy services are provided with the purpose of promoting health and well-being for those who have developed or are at risk of developing illnesses, injuries, disorders, conditions, disabilities, deficiencies, limitations in activities or social participation restrictions. Occupational therapy addresses physical, cognitive, and sensory aspects, as well as other aspects of performance in a variety of contexts to support participation in daily living activities that affect health, well-being and quality of life.
Rhode Island	**Statute: Rhode Island General Laws §5-40.1-3** (g) (1) "Occupational therapy" (OT) is the use of purposeful activity or interventions designed to achieve functional outcomes which promote health, prevent injury or disability, and develop, improve, sustain, or restore the highest possible level of independence of any

	individual who has an injury, illness, cognitive impairment, sensory impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, or other disorder or condition. (2) Occupational therapy includes evaluation by means of skilled observation of functional performance and/or assessment through the administration and interpretation of standardized or non-standardized tests and measurements. (j) (1)"Occupational therapy services" includes, but is not limited to: (i) Evaluating and providing treatment in consultation with the individual, family, or other appropriate persons; (ii) Interventions directed toward developing, improving, sustaining, or restoring daily living skills, including self-care skills and activities that involve interactions with others and the environment, work readiness or work performance, play skills or leisure capacities or educational performance skills; (iii) Developing, improving, sustaining, or restoring sensory-motor, oral-motor, perceptual, or neuromuscular functioning; or emotional, motivational, cognitive, or psychosocial components of performance; and (iv) Educating the individual, family, or other appropriate persons in carrying out appropriate interventions. (2) These services may encompass evaluating need; and designing, developing, adapting, applying, or training in the use of assistive technology devices; designing, fabricating or applying rehabilitative technology, such as selected orthotic devices; training in the functional use of orthotic or prosthetic devices; applying therapeutic activities, modalities, or exercise as an adjunct to or in preparation for functional performance; applying ergonomic principles; adapting environments and processes to enhance daily living skills; or promoting health and wellness.
South Carolina	**Statute: South Carolina Code of Laws §40-36-20** (7) "Occupational therapy" means the functional evaluation and treatment of individuals whose ability to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, poverty and cultural differences, physical injury or illness, or psychological or social disability. The treatment utilizes occupational, namely goal-oriented activities, to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual. Specific occupational therapy techniques include, but are not limited to, activities of daily living (ADL), the fabrication and application of splints, sensory-motor activities, the use of specifically designed crafts, guidance in the selection and use of adaptive equipment, exercises to enhance functional performance, prevocational evaluation and treatment and consultation concerning adaption of physical environments for the handicapped. These techniques are applied in the treatment of individual patients or clients, in groups, or through social systems.
South Dakota	**Statute: South Dakota Codified Laws §36-31-1** (4) "Occupational therapy," the evaluation, planning and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his or her daily pursuits. The practice of occupational therapy includes consultation, evaluation, and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities, or anticipated dysfunction. Occupational therapy services include such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual; such evaluation techniques as assessment of sensory integration and motor abilities, assessment of development of self-care and feeding, activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the handicapped; physical agent modalities limited to the upper extremities to enhance physical functional performance, if certified in accordance with § 36-31-6; and specific occupational therapy techniques such as activities of daily living skills, designing, fabricating, or applying selected orthotic devices or selecting adaptive equipment, sensory integration and motor activities, the use of specifically designed manual and creative activities, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities. Such techniques are applied in the treatment of individual patients or clients, in groups, or through social systems;

Tennessee	**Statute: Tennessee Code §63-13-103, Chapter definitions** (10) (A) "Occupational therapy practice" means the therapeutic use of everyday life activities (occupations) for the purpose of enabling individuals or groups to participate in roles and situations in home, school, workplace, community and other settings. Occupational therapy addresses the physical, cognitive, psychosocial and sensory aspects of performance in a variety of contexts to support engagement in occupations that affect health, well-being and quality of life. "Occupational therapy practice" includes, but is not limited to: (i) Screening, evaluation, assessment, planning, implementation or discharge planning in order to determine an occupational therapy treatment diagnosis, prognosis, plan on therapeutic intervention, or discharge plan, or to assess the ongoing effect of intervention; (ii) Selection and administration of standardized and nonstandardized tests and measurements to evaluate factors affecting activities of daily living, instrumental activities of daily living, education, work, play, leisure and social participation, including: (a) Body functions and body structures; (b) Habits, routines, roles and behavior patterns; (c) Cultural, physical, environmental, social and spiritual context and activity demands that affect performance; and (d) Performance skills, including motor, process and communication/interaction skills; (iii) Methods or strategies selected to direct the process of interventions, such as: (a) Modification or adaptation of an activity or the environment to enhance performance; (b) Establishment, remediation or restoration of a skill or ability that has not yet developed or is impaired; (c) Maintenance and enhancement of capabilities without which performance in occupations would decline; (d) Health promotion and wellness to enable or enhance performance and safety of occupations; and (e) Prevention of barriers to performance, including disability prevention; (iv) Interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, education, work, play, leisure and social participation, including: (a) Therapeutic use of occupations, exercises and activities; (b) Training in self-care, self-management, home management and community/work reintegration; (c) Development, remediation or compensation of physical, cognitive, neuromuscular and sensory functions and behavioral skills; (d) Therapeutic use of self, including an individual's personality, insights, perceptions and judgments as part of the therapeutic process; (e) Education and training of individuals, family members, caregivers and others; (f) Care coordination, case management, discharge planning and transition services; (g) Consulting services to groups, programs, organizations or communities; (h) Assessment, recommendations and training in techniques and equipment to enhance functional mobility, including wheelchair management; (i) Driver rehabilitation and community mobility; and (j) Management of feeding and eating skills to enable feeding and eating performance; (v) Management of occupational therapy services, including the planning, organizing, staffing, coordinating, directing or controlling of individuals and organizations; (vi) Providing instruction in occupational therapy to students in an accredited occupational therapy or occupational therapy assistant educational program by persons who are trained as occupational therapists or occupational therapy assistants; and (vii) Administration, interpretation and application of research to occupational therapy services;

	(B) Occupational therapy services are provided for the purpose of promoting health and wellness to those clients who have, or are at risk of developing, illness, injury, disease, disorder, impairment, disability, activity limitation or participation restriction and may include: (i) Training in the use of prosthetic devices; (ii) Assessment, design, development, fabrication, adaptation, application, fitting and training in the use of assistive technology and adaptive and selective orthotic devices; (iii) Application of physical agent modalities with proper training and certification; (iv) Assessment and application of ergonomic principles; and (v) Adaptation or modification of environments, at home, work, school or community, and use of a range of therapeutic procedures, such as wound care management, techniques to enhance sensory, perceptual and cognitive processing and manual therapy techniques, to enhance performance skills, occupational performance or the promotion of health and wellness; (vi) Practice of dry needling of the upper limb, with proper training and certification; (C) Occupational therapy practice may occur in a variety of settings, including, but not limited to: (i) Institutional inpatient settings, such as acute rehabilitation facilities, psychiatric hospitals, community and specialty hospitals, nursing facilities and prisons; (ii) Outpatient settings, such as clinics, medical offices and therapist offices; (iii) Home and community settings, such as homes, group homes, assisted living facilities, schools, early intervention centers, daycare centers, industrial and business facilities, hospices, sheltered workshops, wellness and fitness centers and community mental health facilities; (iv) Research facilities; and (v) Educational institutions; (vi) Telehealth, telemedicine, or provider-based telemedicine, as authorized by §63-1-155; (D) “Occupational therapy practice” includes specialized services provided by occupational therapists or occupational therapy assistants who are certified or trained in areas of specialization that include, but are not limited to, hand therapy, neurodevelopmental treatment, dry needling of the upper limb, sensory integration, pediatrics, geriatrics and neurorehabilitation, through programs approved by AOTA or other nationally recognized organizations;
Texas	**Statute: Texas Health and Safety Code § 454.006**, **PRACTICE OF OCCUPATIONAL THERAPY**. (a) In this section, "diagnosis" means the identification of a disease from its symptoms. (b) A person practices occupational therapy if the person: (1) evaluates or treats a person whose ability to perform the tasks of living is threatened or impaired by developmental deficits, the aging process, environmental deprivation, sensory impairment, physical injury or illness, or psychological or social dysfunction; (2) uses therapeutic goal-directed activities to: (A) evaluate, prevent, or correct physical or emotional dysfunction; or (B) maximize function in a person's life; or (3) applies therapeutic goal-directed activities in treating patients on an individual basis, in groups, or through social systems, by means of direct or monitored treatment or consultation. (c) The practice of occupational therapy does not include diagnosis or psychological services of the type typically performed by a licensed psychologist. **Regulation: Texas Administrative Code, Title 40, Part 12, § 362.1** (32) Occupational Therapy Practice--Includes: (A) Methods or strategies selected to direct the process of interventions such as: (i) Establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired.

	(ii) Compensation, modification, or adaptation of activity or environment to enhance performance. (iii) Maintenance and enhancement of capabilities without which performance in everyday life activities would decline. (iv) Health promotion and wellness to enable or enhance performance in everyday life activities. (v) Prevention of barriers to performance, including disability prevention. (B) Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation, including: (i) Client factors, including body functions (such as neuromuscular, sensory, visual, perceptual, cognitive) and body structures (such as cardiovascular, digestive, integumentary, genitourinary systems). (ii) Habits, routines, roles and behavior patterns. (iii) Cultural, physical, environmental, social, and spiritual contexts and activity demands that affect performance. (iv) Performance skills, including motor, process, and communication/interaction skills. (C) Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure, and social participation, including: (i) Therapeutic use of occupations, exercises, and activities. (ii) Training in self-care, self-management, home management and community/work reintegration. (iii) Development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions and behavioral skills. (iv) Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process. (v) Education and training of individuals, including family members, caregivers, and others. (vi) Care coordination, case management and transition services. (vii) Consultative services to groups, programs, organizations, or communities. (viii) Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles. (ix) Assessment, design, fabrication, application, fitting and training in assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices. (x) Assessment, recommendation, and training in techniques to enhance functional mobility including wheelchair management. (xi) Driver rehabilitation and community mobility. (xii) Management of feeding, eating, and swallowing to enable eating and feeding performance. (xiii) Application of physical agent modalities, and use of a range of specific therapeutic procedures (such as wound care management; techniques to enhance sensory, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills.
Utah	**Statute: Utah Code §58-42a-102** (6) (a) "Practice of occupational therapy" means the therapeutic use of everyday life activities with an individual: (i) that has or is at risk of developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction; and (ii) to develop or restore the individual's ability to engage in everyday life activities by addressing physical, cognitive, psychosocial, sensory, or other aspects of the individual's performance. (b) "Practice of occupational therapy" includes: (i) establishing, remediating, or restoring an undeveloped or impaired skill or ability of an individual; (ii) modifying or adapting an activity or environment to enhance an individual's performance; (iii) maintaining and improving an individual's capabilities to avoid declining performance in everyday life activities;

	(iv) promoting health and wellness to develop or improve an individual's performance in everyday life activities; (v) performance-barrier prevention for an individual, including disability prevention; (vi) evaluating factors that affect an individual's activities of daily living in educational, work, play, leisure, and social situations, including: (A) body functions and structures; (B) habits, routines, roles, and behavioral patterns; (C) cultural, physical, environmental, social, virtual, and spiritual contexts and activity demands that affect performance; and (D) motor, process, communication, interaction, and other performance skills; (vii) providing interventions and procedures to promote or enhance an individual's safety and performance in activities of daily living in educational, work, and social situations, including: (A) the therapeutic use of occupations and exercises; (B) training in self-care, self-management, home-management, and community and work reintegration; (C) the development, remediation, or compensation of behavioral skills and physical, cognitive, neuromuscular, and sensory functions; (D) the education and training of an individual's family members and caregivers; (E) care coordination, case management, and transition services; (F) providing consulting services to groups, programs, organizations, or communities, (G) modifying the environment and adapting processes, including the application of ergonomic principles; (H) assessing, designing, fabricating, applying, fitting, and providing training in assistive technology, adaptive devices, orthotic devices, and prosthetic devices; (I) assessing, recommending, and training an individual in techniques to enhance functional mobility, including wheelchair management; (J) driver rehabilitation and community mobility; (K) enhancing eating and feeding performance; and (L) applying physical agent modalities, managing wound care, and using manual therapy techniques to enhance an individual's performance skills, if the occupational therapist has received the necessary training as determined by division rule in collaboration with the board.
Vermont	**Statute: Vermont Statutes Title 26, Chapter 71, §3351, Definitions.** (5) "Occupational therapy practice" means 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 that interferes with their ability to function independently in daily life roles, and to promote health and wellness. Occupational therapy intervention may include: (A) remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes; (B) adaptation of task, process, or the environment, or the teaching of compensatory techniques, in order to enhance performance; (C) disability prevention methods and techniques that facilitate the development of safe application of performance skills; (D) health promotion strategies and practices that enhance performance abilities. (6) "Occupational therapy services" include: (A) evaluating, developing, improving, sustaining, or restoring skills in activities of daily living, work, or productive activities, including instrumental activities of daily living, and play and leisure activities; (B) evaluating, developing, remediating, or restoring sensorimotor, cognitive, or psychosocial components of performance; (C) designing, fabricating, applying, or training in the use of assistive technology or orthotic devices, and training in the use of prosthetic devices;

	(D) adaptation of environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles; (E) application of physical agent modalities as an adjunct to or in preparation for engagement in occupations; (F) evaluating and providing intervention in collaboration with the individual receiving treatment, family, caregiver, or others; (G) educating the individual receiving treatment, family, caregiver, or others in carrying out appropriate nonskilled interventions; and (H) consulting with groups, programs, organizations, or communities to provide population-based services.
Virginia	**Statute: Code of Virginia §54.1-2900, Definitions.** "Practice of occupational therapy" means the therapeutic use of occupations for habilitation and rehabilitation to enhance physical health, mental health, and cognitive functioning and includes the evaluation, analysis, assessment, and delivery of education and training in basic and instrumental activities of daily living; the design, fabrication, and application of orthoses (splints); the design, selection, and use of adaptive equipment and assistive technologies; therapeutic activities to enhance functional performance; vocational evaluation and training; and consultation concerning the adaptation of physical, sensory, and social environments. **Regulation: Virginia Administrative Code, 18 VA C85-80-90 and 18VAC85-80-100** **18 VAC 85-80-90. General responsibilities.** A. An occupational therapist renders services of assessment, program planning, and therapeutic treatment upon request for such service. The practice of occupational therapy includes therapeutic use of occupations for habilitation and rehabilitation to enhance physical health, mental health, and cognitive functioning. The practice of occupational therapy may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services. B. An occupational therapy assistant renders services under the supervision of an occupational therapist that do not require the clinical decision or specific knowledge, skills and judgment of a licensed occupational therapist and do not include the discretionary aspects of the initial assessment, evaluation or development of a treatment plan for a patient. **18VAC 85-80-100. Individual responsibilities.** A. An occupational therapist provides assessment by determining the need for, the appropriate areas of, and the estimated extent and time of treatment. His responsibilities include an initial screening of the patient to determine need for services and the collection, evaluation and interpretation of data necessary for treatment. B. An occupational therapist provides program planning by identifying treatment goals and the methods necessary to achieve those goals for the patient. The therapist analyzes the tasks and activities of the program, documents the progress, and coordinates the plan with other health, community or educational services, the family and the patient. The services may include but are not limited to education and training in basic and instrumental activities of daily living (ADL); the design, fabrication, and application of orthoses (splints); the design, selection, and use of adaptive equipment and assistive technologies; therapeutic activities to enhance functional performance; vocational evaluation and training; and consultation concerning the adaptation of physical, sensory, and social environments. C. An occupational therapist provides the specific activities or therapeutic methods to improve or restore optimum functioning, to compensate for dysfunction, or to minimize disability of patients impaired by physical illness or injury, emotional, congenital or developmental disorders, or by the aging process. D. An occupational therapy assistant is responsible for the safe and effective delivery of those services or tasks delegated by and under the direction of the occupational therapist. Individual responsibilities of an occupational therapy assistant may include: 1. Participation in the evaluation or assessment of a patient by gathering data, administering tests, and reporting observations and client capacities to the occupational therapist; 2. Participation in intervention planning, implementation, and review; 3. Implementation of interventions as determined and assigned by the occupational therapist;

	4. Documentation of patient responses to interventions and consultation with the occupational therapist about patient functionality; 5. Assistance in the formulation of the discharge summary and follow-up plans; and 6. Implementation of outcome measurements and provision of needed patient discharge resources.
Washington	**Statute: Washington Revised Code Chapter 18.59, Occupational Therapy** **§18.59.020. Definitions.** (4) "Occupational therapy" is the scientifically based use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation. Specific occupational therapy services include but are not limited to: Using specifically designed activities and exercises to enhance neurodevelopmental, cognitive, perceptual motor, sensory integrative, and psychomotor functioning; administering and interpreting tests such as manual muscle and sensory integration; teaching daily living skills; developing prevocational skills and play and avocational capabilities; designing, fabricating, or applying selected orthotic and prosthetic devices or selected adaptive equipment; wound care management as provided in RCW 18.59.170; and adapting environments for persons with disabilities. These services are provided individually, in groups, or through social systems. (10) "Sharp debridement" means the removal of loose or loosely adherent devitalized tissue with the use of tweezers, scissors, or scalpel, without any type of anesthesia other than topical anesthetics. "Sharp debridement" does not mean surgical debridement. (11) "Wound care management" means a part of occupational therapy treatment that facilitates healing, prevents edema, infection, and excessive scar formation, and minimizes wound complications. Treatment may include: Assessment of wound healing status; patient education; selection and application of dressings; cleansing of the wound and surrounding areas; application of topical medications, as provided under RCW 18.59.160; use of physical agent modalities; application of pressure garments and nonweight-bearing orthotic devices, excluding high-temperature custom foot orthotics made from a mold; sharp debridement of devitalized tissue; debridement of devitalized tissue with other agents; and adapting activities of daily living to promote independence during wound healing. **18.59.170. Scope of practice—Wound care management.** (1) (a) An occupational therapist licensed under this chapter may provide wound care management only: (i) In the course of occupational therapy treatment to return patients to functional performance in their everyday occupations under the referral and direction of a physician or other authorized health care provider listed in RCW 18.59.100 in accordance with their scope of practice. The referring provider must evaluate the patient prior to referral to an occupational therapist for wound care; and (ii) After filing an affidavit under subsection (2)(b) of this section. (b) An occupational therapist may not delegate wound care management, including any form of debridement. (2) (a) Debridement is not an entry-level skill and requires specialized training, which must include: Indications and contraindications for the use of debridement; appropriate selection and use of clean and sterile techniques; selection of appropriate tools, such as scissors, forceps, or scalpel; identification of viable and devitalized tissues; and conditions which require referral back to the referring provider. Training must be provided through continuing education, mentoring, cotreatment, and observation. Consultation with the referring provider is required if the wound exposes anatomical structures underlying the skin, such as tendon, muscle, or bone, or if there is an obvious worsening of the condition, or signs of infection. (b) (i) Occupational therapists may perform wound care management upon showing evidence of adequate education and training by submitting an affidavit to the board attesting to their education and training as follows: (A) For occupational therapists performing any part of wound care management, except sharp debridement with a scalpel, a minimum of fifteen hours of mentored training in a clinical setting is required to be documented in the affidavit. Mentored training includes observation, cotreatment, and supervised treatment by a licensed occupational therapist who is authorized to perform wound care management under this section or a health care provider who is

	authorized to perform wound care management in his or her scope of practice. Fifteen hours mentored training in a clinical setting must include a case mix similar to the occupational therapist's expected practice; (B) For occupational therapists performing sharp debridement with a scalpel, a minimum of two thousand hours in clinical practice and an additional minimum of fifteen hours of mentored sharp debridement training in the use of a scalpel in a clinical setting is required to be documented in the affidavit. Mentored training includes observation, cotreatment, and supervised treatment by a licensed occupational therapist who is authorized to perform sharp debridement with a scalpel under this section or a health care provider who is authorized to perform wound care management, including sharp debridement with a scalpel, in his or her scope of practice. Both the two thousand hours in clinical practice and the fifteen hours of mentored training in a clinical setting must include a case mix similar to the occupational therapist's expected practice. (ii) Certification as a certified hand therapist by the hand therapy certification commission or as a wound care specialist by the national alliance of wound care or equivalent organization approved by the board is sufficient to meet the requirements of (b)(i) of this subsection. (c) The board shall develop an affidavit form for the purposes of (b) of this subsection. **<u>Regulation:</u> Washington Administrative Code §246-847-010** (1) "Adapting environments for individuals with disabilities" includes assessing needs, identifying strategies, implementing and training in the use of strategies, and evaluating outcomes. Occupational therapy focuses on the interaction of an individual's skills and abilities, the features of the environment, and the demands and purposes of activities. (4) "Client-related tasks" are routine tasks during which an occupational therapy aide may interact with the client but does not act as a primary service provider of occupational therapy services. The following factors must be present when an occupational therapist or occupational therapy assistant delegates a selected client-related task to the aide: (a) The outcome anticipated for the delegated task is predictable; (b) The status of the client and the environment is stable and will not require that the aide make judgments, interpretations, or adaptations; (c) The client has demonstrated some previous performance ability in executing the task; and (d) The task routine and process have been clearly established. (7) "Evaluation" means the process of obtaining and interpreting data necessary for treatment which includes, but is not limited to, planning for and documenting the evaluation process and results. The evaluation data may be gathered through record review, specific observation, interview, and the administration of data collection procedures which include, but are not limited to, the use of standardized tests, performance checklists, and activities and tasks designed to evaluate specific performance abilities. (11) "Scientifically based use of purposeful activity" means the treatment of individuals using established methodology based upon the behavioral and biological sciences and includes the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. "Occupations" are activities having unique meaning and purpose in an individual's life. (12) "Teaching daily living skills" means the instruction in daily living skills by an occupational therapist or occupational therapy assistant based upon the evaluation of all the components of the individual's disability and the adaptation or treatment based on the evaluation.
West Virginia	**<u>Statute:</u> West Virginia Code §§30-28-3 and 30-28-4.** **§30-28-3. Definitions** (n) "The practice of occupational therapy" means the therapeutic use of everyday life activities or occupations to address the physical, cognitive, psychosocial, sensory, and other aspects of performance of individuals or groups of individuals, including those who have or are at

risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation or participation restriction, to promote health, wellness and participation in roles and situations in home, school, workplace, community and other settings.

§30-28-4. Scope of practice;

(a) The scope of practice of occupational therapy includes, but is not limited to:

(1) Methods or strategies selected to direct the process of interventions such as:

(A) Establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired;

(B) Compensation, modification, or adaptation of activity or environment to enhance performance;

(C) Maintenance and enhancement of capabilities without which performance in everyday life activities would decline;

(D) Health promotion and wellness to enable or enhance performance in everyday life activities; and

(E) Prevention of barriers to performance, including disability prevention.

(2) Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure and social participation, including:

(A) Client factors, including body functions and body structures;

(B) Habits, routines, roles and behavior patterns;

(C) Cultural, physical, environmental, social and spiritual contexts and activity that affect performance; and

(D) Performance skills, including motor, process and communication/interaction skills.

(3) Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, leisure and social participation, including:

(A) Therapeutic use of occupations and preparatory, adjunctive and functional activities;

(B) Training in self-care, self-management home management and community/work reintegration;

(C) Development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions, visual, vestibular and behavioral skills;

(D) Therapeutic use of self, including one's personality, insights, perceptions and judgments, as part of the therapeutic process;

(E) Education and training of individuals, including family members, care givers and others;

(F) Care coordination, case management and transition services;

(G) Consultative services to groups, programs, organizations or communities;

(H) Modification of environments (home, work, school or community) and adaptation of processes, including the application of ergonomic principles;

(I) Assessment, design, fabrication, application, fitting and training in assistive technology, adaptive devices, orthotic devices and training in the use of prosthetic devices to enhance occupational performance;

(J) Assessment, recommendation and training in techniques to enhance functional mobility, including wheelchair management;

(K) Community mobility and re-entry;

(L) Management of feeding, eating and swallowing to enable eating and feeding performance; and

(M) Application of physical agent modalities, and use of a range of specific therapeutic procedures and techniques to enhance occupational performance skills. Use of physical agent modalities by occupational therapy assistants must be consistent with their education (e.g. superficial thermal and mechanical modalities) and used under the general supervision of an occupational therapist.

The use of deep thermal or electrical modalities may only be performed by the occupational therapy assistant under the direct supervision of an occupational therapist, until the board shall promulgate rules as well as establish competency standards for the use of the modalities.

Wisconsin	**Statute: Wisconsin Statutes §448.96** (5) “Occupational therapy" means the therapeutic use of purposeful and meaningful occupations to evaluate and treat individuals of all ages who have a disease, disorder, impairment, activity limitation or participation restriction that interferes with their ability to function independently in daily life roles and environments and to promote health and wellness. **Regulation: Wisconsin Administrative Code OT 1.02 and 4.02** **OT 1.02 Definitions.** (2) “Assessment" is a component part of the evaluation process, and means the process of determining the need for, nature of, and estimated time of treatment at different intervals during the treatment, determining needed coordination with or referrals to other disciplines, and documenting these activities. (7) “Consultation" means a work-centered, problem-solving helping relationship in which knowledge, experience, abilities, and skills are shared with client, family, caregivers, and other professionals, including physicians, in the process of helping to habilitate or rehabilitate through the use of occupational therapy. (9) “Evaluation" means the process of obtaining and interpreting data necessary for understanding the individual system or situation. This includes planning for and documenting the evaluation process, results, and recommendations, including the need for intervention and potential change in the intervention plan. (11) “Habilitation" means an occupational therapy intervention designed for the education, training or support services provided to individuals to assist them in acquiring and maintaining skills not yet gained or learned, thus enabling them to learn, practice, and refine skills needed for independent living, productive employment, activity, and community participation. (23) “Rehabilitation" means the process of treatment and education to restore a person's ability to live and work as independently as possible after a disabling injury or illness. (24) Screening" means the review of occupational performance skills in natural environments or educational, or clinical settings to determine the significance of any discrepancy between current performance and expected level of performance, which may be done in consultation with a physician. (25) “Service competence" means the determination made by various methods that 2 people performing the same or equivalent procedures will obtain the same or equivalent results. **OT 4.02 Scope of practice.** (1) “Occupational therapy," as defined at s. 448.96 (5), Stats., may include the following interventions: (a) Remediation or restitution of performance abilities that are limited due to impairment in biological, physiological, psychological or neurological processes. (b) Adaptation of task, process or environment, or the teaching of compensatory techniques, in order to enhance performance. (c) Disability prevention methods and techniques which facilitate the development or safe application of performance skills. (d) Health promotion strategies and practices which enhance performance abilities. (2) Occupational therapy interventions include the following: (a) Screening, evaluating, developing, improving, sustaining, or restoring skills in activities of daily living, work or productive activities, instrumental activities of daily living, play, leisure activities, rest and sleep, education and social participation. (b) Evaluating, developing, remediating, or restoring sensorimotor, sensoriperceptual neuromusculoskeletal, emotional regulation, cognition, communication, social skills, or psychosocial components of performance. (c) Designing, fabricating or training in the use of assistive technology, upper extremity orthotic devices and lower extremity positioning orthotic devices. (d) Training in the use of prosthetic devices, excluding gait training.

	(e) Adaptation of environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles. (f) Application of physical agent modalities. Application is performed by an experienced therapist with demonstrated and documented evidence of theoretical background, technical skill and competence. (g) Evaluating and providing intervention and care in collaboration with the client, family, caregiver or other involved individuals or professionals. (h) Educating the client, family, caregiver, or others in carrying out appropriate nonskilled interventions. (i) Consulting with groups, programs, organizations, or communities to provide population-based services. (j) Therapeutic use of occupations, exercises, and activities. (k) Training in self-care, self-management, health management and maintenance, home management, community work reintegration, and school activities and work performance. (l) Therapeutic use of self, including one's personality, insights, perceptions and judgments, as part of the therapeutic process. (m) Assessment, recommendation, and training in techniques to enhance functional mobility, including management of wheelchair and other mobility devices. (n) Vision and low vision rehabilitation. (o) Driver rehabilitation and community mobility. (p) Management of feeding, eating, and swallowing to enable eating and feeding performance. (q) Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and adaptation processes. (r) Use of a range of specific therapeutic procedures, including wound care management; techniques to enhance sensory, perceptual, and cognitive processing; and pain management, lymphedema management, and manual therapy techniques, to enhance performance skills.
Wyoming	**Statute: Wyoming Statutes §33-40-102** (iii) "Occupational therapy" means: (J) The therapeutic use of occupations including everyday life activities with individuals, groups, populations or organizations to support participation, performance and function in roles and situations in home, school, workplace, community and other settings; (K) The provision of services for habilitation, rehabilitation and the promotion of health and wellness to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation or participation restriction; (M) Addressing the physical, cognitive, psychosocial, sensory-perceptual and other aspects of performance in a variety of contexts and environments to support engagement in occupations, contexts and environments that affect physical and mental health, well-being and quality of life; (N) Performing the tasks of occupational therapy through personal interaction or appropriate use of telecommunication services and other communication technologies; (O) Performing the tasks of an occupational therapist or occupational therapy assistant commensurate with his education, training and experience; (P) The practice of occupational therapy which includes: (I) The evaluation of factors affecting activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure and social participation; (II) The use of methods or approaches to direct the process of interventions; and (III) The use of interventions and procedures to promote or enhance safety and performance in activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure and social participation.

The Issue Is . . .

Role of Sonographic Imaging in Occupational Therapy Practice

Shawn C. Roll

MeSH TERMS
- occupational therapy
- outcome assessment (health care)
- patient care planning
- professional role
- rehabilitation
- ultrasonography

Occupational therapy practice is grounded in the delivery of occupation-centered, patient-driven treatments that engage clients in the process of doing to improve health. As emerging technologies, such as medical imaging, find their way into rehabilitation practice, it is imperative that occupational therapy practitioners assess whether and how these tools can be incorporated into treatment regimens that are dually responsive to the medical model of health care and to the profession's foundation in occupation. Most medical imaging modalities have a discrete place in occupation-based intervention as outcome measures or for patient education; however, sonographic imaging has the potential to blend multiple occupational therapy practice forms to document treatment outcomes, inform clinical reasoning, and facilitate improved functional performance when used as an accessory tool in direct intervention. Use of medical imaging is discussed as it relates to occupational foundations and the professional role within the context of providing efficient, effective patient-centered rehabilitative care.

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Occupational therapy practice is grounded in the provision of occupation-centered, patient-driven treatments that engage clients in the process of doing to maximize health. Concern about the profession straying from these roots has been raised for more than 3 decades (Gillen, 2013; Kielhofner, 1983; Wood, 1998). At the center of the debate are preparatory activities and other easily reimbursable interventions that are not perceived as occupation centered and that appear to mimic other professions (e.g., physical therapy).

Unfortunately, in rehabilitative care, a bottom-up focus on individual body structures and performance components is often the path of least resistance to meet efficient, cost-conscious reimbursement expectations (Fisher & Friesema, 2013). In addition, there is no easy solution to the disconnect between the field's occupation-centered foundation and the delivery of increasingly medically focused services. Consequently, as technologies such as medical imaging find their way into rehabilitation practice, it is imperative that occupational therapy practitioners assess whether and how these tools can be incorporated into treatment regimens that are dually responsive to the medical model of health care and to the foundation in occupation.

Although medical imaging as a whole may be viewed as preparatory and reductionistic, for occupational therapy practitioners to stay relevant in an environment in which other medical and rehabilitation providers increasingly use medical imaging, the question is, Is medical imaging an appropriate occupation-centered tool to be used in occupational therapy interventions? Moreover, is medical imaging a viable means for enhancing the delivery of efficient and effective care? To this end, this article discusses the use of medical imaging by rehabilitation providers and occupational therapy practitioners in the context of efficient, effective patient- and occupation-centered care. Specifically, this article highlights the utility of musculoskeletal sonographic imaging to facilitate patient engagement in occupation-centered treatments and discusses challenges and implications of integrating sonographic imaging into occupational therapy practice.

Medical Imaging in Rehabilitation

For people with neurologic, musculoskeletal, and orthopedic conditions, medical imaging for diagnosis is compulsory. MRI is used to diagnose central neurologic disorders of the brain and spinal cord, and both MRI and X ray are regularly used for diagnosing injuries of muscles, tendons, bones, and joints. In certain rehabilitation populations, follow-up MRI or X ray assessment after intervention is common to evaluate changes or improvement in tissues and structures. In addition, although during functional MRI (fMRI) and diffusion tensor imaging (DTI) the body segment being imaged must remain static, these modalities can be used to evaluate dynamic changes during and after participation in functional tasks and therapeutic activities (Cagnie et al., 2011; Lin et al., 2010; Voelbel, Genova, Chiaravalotti, & Hoptman, 2012).

These imaging modalities will continue to be important for diagnosing and building research evidence for rehabilitation interventions; however, these techniques have limited applied clinical utility for occupational therapy practitioners. MRI is expensive to obtain and operate, requires substantial training, and has numerous contraindications. X ray provides low-dose radiation to patients and is limited to evaluating bones, metal, and radioactive materials. With the exception of dynamic X ray fluoroscopy in the evaluation and treatment of swallowing disorders (Cha, Oh, & Shim, 2010), MRI, fMRI, DTI, and X ray, along with computed tomography and positron emission tomography, are primarily static medical imaging modalities. These static images have a discrete place in occupation-centered intervention for patient education and as a measurement tool.

In contrast, sonography is a dynamic medical imaging modality with broader clinical application for occupational therapy practitioners. Using a piezoelectric transducer and coupling gel, sonography sends high-frequency sound waves (i.e., vibrations) into the body. In contrast to thermal ultrasound transducers that focus the sound waves into one high-energy beam, sonography transducers send individual sound waves into the body, which do not have enough energy on their own to cause tissue heating. Once through the skin, the varied density and physiologic properties of the subcutaneous tissues alter the frequency and amplitude of the sound waves and refract and reflect portions of the sound waves back to the transducer (i.e., echoes). The altered sound waves return to the transducer and are converted into electrical impulses, and an image is created. Different tissue types (e.g., bone, muscle) are represented with various shades of gray based on the frequency, amplitude, and amount of returning echoes, and the timing and returning angle of the sound waves are used to spatially orient each structure in the image.

Sonography has numerous benefits over other medical imaging technologies. It can show real-time movement of musculoskeletal tissues in a quick, efficient, pain-free manner, with no radiation or side effects and minimal contraindications. When compared with other medical imaging equipment, sonography is affordable and portable and can produce high-definition images of exceedingly small musculoskeletal structures. Performing sonographic imaging for diagnostic purposes requires certification and, in some states, licensure (i.e., Oregon, New Jersey, New Mexico, and West Virginia). However, the use of sonography as a supplementary tool to augment routine service delivery by other, noncertified or nonlicensed professionals is not regulated. Moreover, because sonographic imaging has no direct patient bioeffects, it is not a physical agent modality (PAM; McPhee, Bracciano, & Rose, 2008); therefore, its use is not regulated by therapy licensure requirements for PAMs.

These limited regulations, combined with the ability to rapidly acquire dynamic, point-of-care images, have led to expanded use of musculoskeletal sonography beyond diagnostics. Clinical use is being reported with increasing frequency by rheumatologists (Brown et al., 2004; Cunnington, Platt, Raftery, & Kane, 2007), sports medicine practitioners (Tok, Özçakar, De Muynck, Kara, & Vanderstraeten, 2012; Yim & Corrado, 2012), physical medicine physicians (Özçakar, Tok, De Muynck, & Vanderstraeten, 2012), and orthopedic surgeons (Seagger, Bunker, & Hamer, 2011; Thomason & Cooke, 2012; Ziegler, 2010). Musculoskeletal sonography is also being incorporated into research and clinical practice by athletic trainers and physical therapy practitioners (Teyhen, 2007). Physical therapists use sonography to visualize morphological changes over time as a clinical outcome measure (Brown, 2009), to monitor tissue response to therapy as a means for clinical decision making (Callaghan, 2012), and to provide biofeedback for enhancing patient engagement and improve the precision of clinical interventions (Ariail, Sears, & Hampton, 2008; Herbert, Heiss, & Basso, 2008; Worth, Henry, & Bunn, 2007). Despite increasing use by other medical and rehabilitation providers, no evidence describes clinical use of sonographic imaging by occupational therapy practitioners.

Sonography in Occupational Therapy Practice

Sonographic imaging has the potential to blend multiple forms of intervention to document treatment outcomes and inform clinical reasoning. Additionally, as a supplementary tool in rehabilitative, preventive, and wellness interventions, sonography may be useful for facilitating patient engagement and adherence, resulting in improved occupational performance.

Outcome Measures

Clinical studies using sonography to document structural and tissue morphology changes after medication regimens, surgery, and rehabilitative interventions are rapidly expanding. In follow-up after carpal tunnel release, sonography shows a large reduction in swelling of the median nerve in the carpal tunnel (Kim, Yoon, Kim, Won, & Jeong, 2012). Similarly, sonographic imaging has been extensively used to document reduction in joint swelling and improvement in cartilage health in response to injections and medication regimens for people with arthritis (Henrotin, Hauzeur, Bruel, & Appelboom, 2012; Montecucco, Todoerti, Sakellariou, Sciré, & Caporali, 2012; Seymour et al., 2012). Although not as prolific, examples of sonographic imaging in rehabilitation exist. Sonography was used to document

increased thickness of triceps and extensor carpi radialis muscles by nearly 12% and 25%, respectively, after comprehensive functional strength training for children with cerebral palsy (Lee et al., 2013). Similarly, muscle hypertrophy has been observed with sonography after therapeutic intervention for people with spinal cord injuries (Dudley-Javoroski, McMullen, Borgwardt, Peranich, & Shields, 2010).

Although measuring objective physiological changes follows the medical model, relating these changes to patient-centered functional and occupational performance outcomes as a result of occupation-centered interventions is crucial for occupational therapy practitioners (Hocking, 2001). Point-of-care musculoskeletal sonographic imaging is positioned at the intersection of objective outcome measures and patient-reported functional performance. The association of these constructs has been explored in people with symptoms of carpal tunnel syndrome, whereby an increase in the size of the median nerve in the carpal tunnel as measured with sonographic imaging has been linked to decreased functional tolerances, even in people without a formal diagnosis (Roll, Evans, Li, Sommerich, & Case-Smith, 2013). Moreover, after intervention for people with carpal tunnel syndrome, changes in sonographic measures (e.g., reduced nerve swelling, increased muscle size) have been associated with improved occupational performance (Kim et al., 2012; Lee et al., 2013). An association between sonographic measures of morphology and functional performance has also been reported in the development of abnormal gait patterns in older women that coincided with a loss in muscle mass of adductor and quadriceps muscles (Abe et al., 2012). Given the link to functional outcomes, objective measurement of changes in tissue morphology using sonographic imaging has the potential to enrich clinical and research evidence for occupation-centered interventions.

Clinical Reasoning

In addition to capturing outcomes after an intervention, sonographic imaging could be integrated throughout the episode of care to inform clinical reasoning. Trombly (1993) suggested that a narrowly focused evaluation may assist in tailoring rehabilitation interventions, especially when the cause of an occupational limitation is not fully apparent. In this way, sonographic evaluation could assist occupational therapy practitioners in identifying the source, location, and severity of pathology that is limiting functional performance.

In a recent qualitative study, multiple instances were identified in which the use of sonographic imaging assisted in ongoing evaluation by the occupational therapists, leading to patient-specific tailored interventions (Roll, Gray, Frank, & Wolkoff, in press). One therapist indicated that imaging was beneficial for "gathering more information at the beginning of the treatment process [for patients] where the evaluation alone and the operative report don't really give a full picture of exactly what's happening" (Roll et al., in press). In one case, sonography permitted the therapist to detect nonpalpable tendon scarring in a location proximal to a surgical incision that was limiting tendon movement, a problem she likely would not have identified or addressed in her intervention had she not used imaging in her evaluation (Roll et al., in press).

This use of imaging for successful differential clinical diagnosis could drastically affect intervention effectiveness. For example, although occupational therapy practitioners often equate trigger finger with swelling of the involved flexor tendon, sonographic data have indicated that fewer than half of people with trigger finger have tendonopathy (Guerini et al., 2008). Instead, regardless of the presence of tendonopathy, nearly all people with trigger finger have a thickened pulley, limiting tendon gliding (Guerini et al., 2008; Sato, Ishii, Noguchi, & Takeda, 2012). Therefore, in patients whose functional deficits occur as a result of pulley hypertrophy, with no associated tendonopathy, conservative therapeutic interventions may not be effective. In these cases, delivery of occupational therapy intervention may be fiscally irresponsible until surgical intervention reduces impingement caused by the pulley. The utility of imaging for differentiation of tissues involved in clinical diagnoses extends to practice settings beyond orthopedics, for example, to examine hemiplegic shoulder pain (Huang, Liang, Pong, Leong, & Tseng, 2010) and secondary tendonopathies after a stroke or brain injury (Falsetti, Acciai, Carpinteri, Palilla, & Lenzi, 2010; Pong et al., 2012).

Direct Intervention

Beyond evaluation, point-of-care sonographic imaging can augment numerous biopsychosocial occupation-centered interventions. Central to imaging use in direct intervention is the opportunity for a patient to observe his or her own anatomy and pathology, a vital step in establishing a mind–body connection. As such, patient education is not limited to the use of static textbook images or models but can use real-time, dynamic images of a patient's own structures. Both pathologic and normal tissue appearance and movement can be quickly displayed by scanning a patient's affected and unaffected side. Establishing a mind–body connection through education with sonographic imaging could enhance the patient learning experience and assist in building self-determination, leading to increased engagement and overall patient adherence (Radomski, 2011).

Moreover, educating a patient using his or her own anatomy could lead to enriched patient-specific evidence discussions between the patient and practitioner, which in turn will improve self-awareness and self-calibration, pillars of successful biopsychosocial interventions (Borrell-Carrió, Suchman, & Epstein, 2004). This use of imaging is highly responsive to the call in the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) for patients to be actively engaged in decisions about their care and the treatment process, leading to empowerment for continued health and recovery after discharge from care.

This ability of sonographic imaging to engage and empower a patient by establishing a mind–body connection perfectly situates it as a visual biofeedback tool. Dynamic sonographic imaging can be used to enhance mental imagery and improve proper performance of therapeutic exercises and functional, occupation-centered tasks. Sonographic visual biofeedback has been primarily applied as a tool for rehabilitation of

back pain (Herbert et al., 2008; Van, Hides, & Richardson, 2006; Worth et al., 2007) and pelvic floor disorders (Ariail et al., 2008; Dietz, Wilson, & Clarke, 2001). In both cases, the biofeedback is valuable to help patients learn which muscles to use and enhances the quality of exercises. This biofeedback process could also be used to improve performance of occupational tasks (e.g., tendon travel during pinching of a key) and may supplement other mind–body and mental imagery techniques currently being used in upper-extremity rehabilitation (Nilsen, Gillen, DiRusso, & Gordon, 2012). A variety of client populations could benefit from increased understanding of their own tissue pathology and how these tissues may or may not be appropriately moving during functional tasks to enhance their occupational performance.

Prevention and Wellness

With the ability to quickly visualize and measure musculoskeletal structures, use of sonographic imaging for regular health screening is increasing. Evidence for preventive sonographic screening by physicians to monitor the development and progression of rheumatic and arthritic conditions is prolific, and literature discussing preventive screening that is relevant to occupational therapy practitioners is increasing. For people with decreased mobility, visually undetectable pressure ulcers can be identified in early stages of development using sonography to monitor internal soft tissue breakdown (Deprez, Brusseau, Fromageau, Cloutier, & Basset, 2011) or thinning of the skin over bony prominences (Yalcin, Akyuz, Onder, Unalan, & Degirmenci, 2013). Similarly, sonography has also been used to monitor joint integrity in people with paretic extremities (Tunç et al., 2012).

In contrast to inactivity, evidence supporting the use of sonography in the identification of negative tissue responses to occupational performance has also begun to grow. One group of researchers is using sonography to evaluate overuse syndromes and changes in musculoskeletal structures of the shoulder and wrist as a result of their use in wheelchair propulsion (Collinger, Impink, Ozawa, & Boninger, 2010; Impink, Collinger, & Boninger, 2011). A second research group is exploring methods for the use of sonography screening in early identification of carpal tunnel syndrome and upper-extremity work-related musculoskeletal disorders (Evans, Roll, Li, & Sammet, 2010; Evans & Sommerich, 2009; Roll, Evans, Li, Freimer, & Sommerich, 2011; Roll, Evans, Volz, & Sommerich, 2013). The growing evidence for health screening in both inactive and active people expands the relevance of sonographic imaging beyond clinic-based services to occupational therapy practitioners providing industrial and community-based services.

Challenges and Potential Pitfalls

Although sonography has the potential to enhance occupational therapy practice, its use comes with multiple challenges and potential pitfalls. It is imperative that occupational therapy practitioners consider their professional foundation and ensure beneficence when providing any client intervention. Therefore, to adequately discuss integration of medical imaging into clinical practice, one must identify the relation of imaging to occupation-centered activities and the occupational therapy scope of practice and determine implications related to the delivery of skilled, efficient, and effective services.

Occupational Foundations

Occupation-centered practice has been discussed as *occupation as ends* versus *occupation as means* (Gray, 1998). On the surface, medical imaging inherently supports occupation as ends; however, multiple opportunities are available to use imaging to augment occupational-centered treatment, that is, occupation as means (e.g., biofeedback). Sonography can be used to provide a deeper understanding of and leverage the link between body structures and occupational performance to enhance intervention. Additionally, although occupational therapy practitioners consider occupation to be essential in improving body structures and functional restoration, sonographic images can contradict this positive preconceived notion. Sonography can show the negative effects on body structures caused by the performance of repetitive, high-risk occupational tasks.

Occupational therapy practitioners use a diverse clinical toolbox and varied forms of intervention (e.g., preparatory, purposeful, and occupational) to address physical, psychological, and contextual factors and maximize occupational performance for each unique patient (American Occupational Therapy Association, 2014; Clark et al., 1991). They should avoid the use of sonography as the sole preparatory, evaluation, or outcome measurement tool because using this type of narrowly focused assessment risks neglecting important occupational performance issues (Hocking, 2001). In addition, measured improvement in tissue pathophysiology may not necessarily always relate to improved functional outcomes (Trombly, 1993). However, as a multidimensional assessment and biopsychosocial intervention tool, sonography may be a useful addition to occupational therapy's clinical toolbox. Clinical use to establish mind–body connections, to engage patients through education and dynamic biofeedback during functional activity, and to monitor for negative effects of activity performance should be priority considerations for integrating sonographic imaging into occupational therapy practice.

Professional Scope and Interprofessional Jurisdiction

Although a solid occupational theoretical foundation underlies the profession of occupational therapy, the integration of medical imaging into practice extends a historical trend of being influenced by and adopting the approaches of other professions (Gillen, 2013). However, this incorporation of other approaches is not unique to occupational therapy. Professions exist in an intermingled ecologic system in which the systemic environment constantly promotes creation, destruction, reshaping, and swapping of roles and tasks among the professions (Abbott, 1988). Technology and culture are frequent drivers of this jurisdictional creation, destruction, and redefinition (Abbott, 1988).

Together, advances in imaging technology and a rapidly changing health care environment requiring efficient, point-of-care services have prompted numerous professions to adopt imaging (i.e., sonography) into their clinical practice. Although medical imaging has long been exclusive to radiologic professions, the credentialing process for musculoskeletal sonography was recently opened to nontraditional providers (i.e., health professionals without extensive sonographic training or certification). This change demonstrates a willingness of radiologic professionals to relinquish a portion of their jurisdiction over this technology. Moreover, the use of sonographic imaging by occupational therapy practitioners for differential clinical diagnosis would not likely be viewed as an encroachment on the primary diagnostic role of the physician. Instead, complementary use of sonographic imaging by all rehabilitation team members will inform treatment planning and enhance outcomes and lead to profession-specific interventions (e.g., occupation-centered biofeedback), all of which enrich the system of professions as a whole.

Despite generating interventions unique to occupational therapy, the rapid advancement and adoption of emerging point-of-care musculoskeletal sonography by numerous providers create various blurred jurisdictional lines. Vigilance is necessary to ensure that public, legal, and workplace jurisdiction claims do not limit the ability of occupational therapy practitioners to advance patient care through integration of imaging into clinical practice (Abbott, 1988). These claims are typically manifested in scope-of-practice and licensure legislation and continuously shifting reimbursement practices.

This article does not suggest that using medical imaging to diagnose patients should be included in occupational therapy's scope of practice. However, given the potential for imaging to enhance occupation-centered treatments, it is important that access to this technology not be limited by jurisdictional claims of other professions, legal or otherwise. Similarly, as a supplementary tool for augmenting patient-centered care, it may not be appropriate for practitioners to expect individual reimbursement for the use of sonographic imaging. Instead, reimbursement requests should be based on the primary occupation-centered service being provided. When combined with increased clinical documentation reflecting the role of sonographic imaging within the occupational treatment context, research demonstrating the benefit of sonographic imaging for biofeedback and other occupation-centered interventions will strengthen any future claims for direct reimbursement or inclusion of imaging within the scope of occupational therapy practice.

Skilled Service Delivery

With any new intervention tool or technique, adequate training and competency are crucial to ensure that the delivery of efficient, effective patient care is enhanced and not hindered. Increased point-of-care clinical use has prompted an expansion of sonography training in numerous health care professional curricula. Expanded training has been most prolific in physician education, including the recent establishment of the Society of Ultrasound in Medical Education, which now hosts an annual world congress to advance sonography training in general medical education. Similarly, the Commission on Accreditation in Physical Therapy Education (2014) noted an increase in medical imaging content in physical therapy curricula after the shift to doctoral training for entry-level education.

Despite increased training within these professional curricula, establishing comprehensive proficiency in sonographic imaging could require up to 100 hr of training (Brown et al., 2004). With current extensive curriculum requirements, this quantity of applied training in medical imaging is not appropriate within master's-level occupational therapy education. However, as a requirement for doctoral-level training is considered, providing foundational knowledge of imaging techniques and establishing basic skill in reading medical images will allow practitioners to remain relevant in the technologically progressing health care system. Additionally, this basic knowledge would benefit those students who wish to develop applied competency once they are in clinical practice.

Postprofessional training in sonographic imaging is increasingly available through hands-on training workshops developed specifically for nontraditional users. Although training workshops can establish technical proficiency, substantial practice beyond didactic training is essential in establishing the clinical competency necessary to ensure efficient, effective use of sonographic imaging. Clinical competency involves comprehensive understanding of mechanical operation of the equipment; continuous evaluation of image quality; and detailed analysis of images, along with the skill to differentiate normal from pathologic characteristics.

Occupational therapy practitioners who complete training and develop clinical competency can obtain a certification in musculoskeletal sonography; however, with an intended use to supplement routine clinical practices, the credentialing process may be excessive for most practitioners. Moreover, because components of clinical competency for occupational therapy practitioners have not been established, additional research is needed to more clearly determine clinical applications and competencies that may or may not be adequately addressed by this credentialing process.

Conclusion

As the profession and individual occupational therapy practitioners contemplate clinical implementation of medical imaging, we must move forward cautiously with a focus on the delivery of efficient, effective patient-centered care. Although use of most medical imaging modalities by occupational therapy practitioners is limited, sonographic imaging has numerous potential applications for enhancing rehabilitative care as part of an occupation-centered intervention plan. First, evidence places point-of-care sonographic imaging of musculoskeletal structures at the intersection of subjective reports, objective findings, and functional performance. This convergence has important implications for improving intervention efficacy through enhanced clinical reasoning and

for advancing evidence that substantiates clinical interventions.

Second, sonography has exceptional potential to augment the biospsychosocial principles central to occupational therapy interventions. A growing body of evidence supports the use of integrative, mind–body interventions to reduce clients' length of stay in a clinical setting and speed recovery. Therefore, occupational therapy practitioners can use sonographic imaging for patient education and dynamic visual biofeedback during functional activity performance to actively engage patients and establish a mind–body connection.

Further examination of implementation strategies and development of occupation-centered imaging interventions, training models, and definitions of clinical competency are necessary to ensure that occupational therapy practitioners are adequately informed and prepared to use this technology in a manner consistent with the profession's occupational foundation while providing the efficient, effective care required by the medical system. Given careful consideration to the process, medical imaging has great potential for enhancing occupation-centered occupational therapy care. ▲

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Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services

This document is a set of guidelines describing the supervision, roles, and responsibilities of occupational therapy practitioners. Intended for both internal and external audiences, it also provides an outline of the roles and responsibilities of occupational therapists, occupational therapy assistants, and occupational therapy aides during the delivery of occupational therapy services.

General Supervision

These guidelines provide a definition of supervision and outline parameters regarding effective supervision as it relates to the delivery of occupational therapy services. The guidelines themselves cannot be interpreted to constitute a standard of supervision in any particular locality. Occupational therapists, occupational therapy assistants, and occupational therapy aides are expected to meet applicable state or jurisdictional and federal regulations, adhere to relevant workplace and payer policies and to the *Occupational Therapy Code of Ethics (2015)* (American Occupational Therapy Association [AOTA], 2015), and participate in ongoing professional development activities to maintain continuing competence.

Within the scope of occupational therapy practice, supervision is a process aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and professional development. In addition, in these guidelines, *supervision* is viewed as a cooperative process in which two or more people participate in a joint effort to establish, maintain, and/or elevate competence and performance. Supervision is based on mutual understanding between the supervisor and the supervisee about each other's education, experience, credentials, and competence. The supervisory relationship and supervisory process provide education and support, foster growth and development, promote effective utilization of resources, and encourage creativity and innovation.

Supervision of Occupational Therapists and Occupational Therapy Assistants

Occupational Therapists

Based on their education and training, occupational therapists, after initial certification and relevant state licensure or other governmental requirements, are autonomous practitioners who are able to deliver occupational therapy services independently. Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of occupational therapy services and the service delivery process. Occupational therapists are encouraged to seek peer supervision,

interprofessional collaboration, and mentoring to promote their ongoing professional development and to ensure they are using best practice approaches in the delivery of occupational therapy services.

Occupational Therapy Assistants

Based on their education and training, occupational therapy assistants, after completing initial certification and meeting state or jurisdictional regulatory requirements, receive supervision from an occupational therapist when delivering occupational therapy services. Occupational therapy assistants deliver occupational therapy services within a supervisory relationship and in partnership with occupational therapists.

General Principles

1. Occupational therapists and occupational therapy assistants are equally responsible for developing a collaborative plan for supervision. The occupational therapist is ultimately responsible for the implementation of appropriate supervision, but the occupational therapy assistant also has a responsibility to seek and obtain appropriate supervision.
2. To ensure safe and effective occupational therapy services, it is the responsibility of occupational therapy practitioners to recognize when they require peer supervision or mentoring that supports current and advancing levels of competence and professional development.
3. The specific frequency, methods, and content of supervision may vary depending on the client (person, group, or population) and on the
   a. Complexity of client needs,
   b. Number and diverse needs of the client,
   c. Knowledge and skill levels of the occupational therapist and the occupational therapy assistant,
   d. Type of practice setting,
   e. Service delivery approach,
   f. Requirements of the practice setting,
   g. Payer requirements, and
   h. Other regulatory requirements.
4. More frequent supervision of the occupational therapy assistant may be necessary when
   a. The needs of the client and the occupational therapy process are complex, diverse, and changing or
   b. The occupational therapist and occupational therapy assistant collaborate and determine that additional supervision is necessary to ensure safe and effective delivery of occupational therapy services.
5. A variety of types and methods of supervision apply to occupational therapy practice settings. Methods can include, but are not limited to, direct face-to-face contact and indirect contact. Examples of methods or types of supervision that involve direct face-to-face contact include observation, modeling, demonstration with a client, discussion, teaching, and instruction. Examples of methods or types of supervision that involve indirect contact include phone and virtual interactions, telehealth, written correspondence, and other forms of secure electronic exchanges.
6. Occupational therapists and occupational therapy assistants must abide by facility, state or jurisdictional, and payer requirements regarding the documentation of a supervision plan and supervision contacts. Documentation may include the following information:
   a. Frequency of supervisory contact
   b. Methods or types of supervision
   c. Content areas addressed
   d. Evidence to support areas of practice and levels of competence applicable to the setting
   e. Names and credentials of the persons participating in the supervisory process.

Roles and Responsibilities of Occupational Therapists and Occupational Therapy Assistants

Overview of the Occupational Therapy Process

The focus of occupational therapy is to assist the client in "achieving health, well-being, and participation in life through engagement in occupation" (AOTA, 2020). Occupational therapy addresses the needs and goals of the client related

to engagement in areas of occupation, and the profession's domain consists of occupations, contexts, performance patterns, performance skills, and client factors that may influence participation in various areas of occupation.

The occupational therapist must be directly involved in the delivery of services during the initial evaluation and regularly throughout the course of intervention planning, implementation, and review and outcome evaluation.

1. The occupational therapy assistant delivers safe and effective occupational therapy services under the supervision of and in partnership with the occupational therapist.
2. It is the responsibility of the occupational therapist to determine when to delegate responsibilities to an occupational therapy assistant. It is the responsibility of the occupational therapy assistant who performs the delegated responsibilities to demonstrate service competence and to not accept delegated responsibilities that go beyond the legal and professional scope or beyond the demonstrated skill and competence of the occupational therapy assistant.
3. The occupational therapist and the occupational therapy assistant demonstrate and document service competence for clinical and professional reasoning and judgment during the service delivery process and for the performance of specific assessments, techniques, and interventions used.
4. When delegating aspects of occupational therapy services, the occupational therapist considers the following factors:
    a. Complexity of the client's condition and needs
    b. Knowledge, skill, and competence of the occupational therapy assistant
    c. Nature and complexity of the intervention
    d. Needs and requirements of the practice setting
    e. Appropriate scope of practice of the occupational therapy assistant within the boundaries of jurisdictional regulations, payment source requirements, and other requirements.

Roles and Responsibilities

Regardless of the setting in which occupational therapy services are delivered, occupational therapists and occupational therapy assistants assume the following general responsibilities during the evaluation process, the intervention process, and the process of targeting and evaluating outcomes.

Evaluation

1. The occupational therapist directs the evaluation process.
2. The occupational therapist is responsible for directing all aspects of the initial contact during the occupational therapy evaluation, including
    a. Determining the need for service,
    b. Defining the problems within the domain of occupational therapy to be addressed,
    c. Determining the client's goals and priorities,
    d. Establishing intervention priorities,
    e. Determining specific further assessment needs, and
    f. Determining specific assessment tasks that can be delegated to the occupational therapy assistant.
3. The occupational therapist initiates and directs the evaluation, interprets the data, and develops the intervention plan.
4. The occupational therapy assistant contributes to the evaluation process by implementing delegated assessments and by providing verbal and written reports of assessments, analysis of performance, and client capacities to the occupational therapist.
5. The occupational therapist interprets the information provided by the occupational therapy assistant and integrates that information into the evaluation and decision-making process.

Intervention Planning

1. The occupational therapist has overall responsibility for the development of the occupational therapy intervention plan.
2. The occupational therapist and the occupational therapy assistant collaborate with the client to develop the plan.
3. The occupational therapy assistant is responsible for understanding evaluation results and providing input

into the intervention plan on the basis of client needs and priorities.

Intervention Implementation

1. The occupational therapist has overall responsibility for intervention implementation.
2. When delegating aspects of the occupational therapy intervention to the occupational therapy assistant, the occupational therapist is responsible for providing appropriate supervision.
3. The occupational therapy assistant is responsible for understanding and supporting the client's occupational therapy goals.
4. The occupational therapy assistant, in collaboration with the occupational therapist, selects, implements, and makes modifications to occupational therapy interventions consistent with demonstrated competence levels, client goals, and the requirements of the practice setting, including payment source requirements.

Intervention Review

1. The occupational therapist is responsible for determination of the need to continue, modify, or discontinue occupational therapy services.
2. The occupational therapy assistant contributes to this process by exchanging information with and providing documentation to the occupational therapist about the client's responses to and communications during intervention.

Outcomes

1. The occupational therapist is responsible for the selection, measurement, and interpretation of outcomes related to the client's ability to engage in occupations.
2. The occupational therapy assistant is responsible for being knowledgeable about the client's targeted occupational therapy outcomes and for providing information and documentation related to outcome achievement.
3. The occupational therapy assistant may implement outcome measurements and provide needed resources for transition or discharge.

Service Delivery Outside of Occupational Therapy Practice Settings

The education and expertise of occupational therapists and occupational therapy assistants prepare them for employment in arenas other than those typically related to the delivery of occupational therapy. In these other arenas, supervision of the occupational therapy assistant may be provided by non–occupational therapy professionals, or supervisory relationships may not be applicable when the occupational therapy assistant is a sole proprietor.

1. The guidelines of the setting, regulatory agencies, and funding sources may direct the supervision requirements.
2. The occupational therapist and occupational therapy assistant should obtain and use credentials or job titles commensurate with their roles in these other employment arenas.
3. The following sources can be used to determine whether the services provided are related to the delivery of occupational therapy:
    a. State or jurisdictional practice acts
    b. Regulatory agency standards and rules
    c. Payment and reimbursement sources
    d. *Occupational Therapy Practice Framework: Domain and Process* (4th ed.; AOTA, 2020) and other AOTA official documents
    e. Written or verbal concurrence among the occupational therapist, the occupational therapy assistant, the client, and the agency or payer about the services provided.

Supervision of Occupational Therapy Aides

An *aide,* as the term is used in occupational therapy practice, is an individual who provides supportive services to the occupational therapist and the occupational therapy assistant. Aides do not provide skilled occupational therapy services. An aide is trained by an occupational therapist or an occupational therapy assistant to perform specifically delegated tasks. The occupational

therapist is responsible for the overall use and actions of the aide. An aide first must demonstrate competence before performing assigned, delegated client-related and non–client-related tasks.

1. The occupational therapist oversees the development, documentation, and implementation of a plan to supervise and routinely assess the ability of the occupational therapy aide to carry out client-related and non–client-related tasks. The occupational therapy assistant may contribute to the development, documentation, and implementation of this plan.
2. The occupational therapy assistant can serve as the direct supervisor of the aide.
3. *Non–client-related tasks* include clerical activities and preparation of the work area or equipment.
4. *Client-related tasks* are routine tasks during which the aide may interact with the client. The following factors must be present when an occupational therapist or occupational therapy assistant delegates a selected client-related task to the aide:
    a. The outcome anticipated for the delegated task is predictable.
    b. The client's condition and the environment are stable and will not require that judgment, interpretations, or adaptations be made by the aide.
    c. The client has demonstrated previous performance ability in executing the task.
    d. The task routine and process have been clearly established.
5. When delegating client-related tasks, the supervisor must ensure that the aide
    a. Is trained and able to demonstrate competence in carrying out the selected task and using related equipment, if appropriate;
    b. Has been instructed on how specifically to carry out the delegated task with the specific client;
    c. Knows the precautions, signs, and symptoms for the particular client that would indicate the need to seek assistance from the occupational therapist or occupational therapy assistant; and
    d. Is not used to perform billable functions that are prohibited by the payment source of the client being served.
6. The supervision of the aide needs to be documented (e.g., orientation checklist, performance review, skills checklist, in-service participation). Documentation includes information about the frequency and methods of supervision used, the content of supervision, and the names and credentials of all persons participating in the supervisory process.

Summary

These guidelines are designed to define and delineate the professional roles of occupational therapy practitioners. The guidelines also address supervision when occupational therapy practitioners provide services in arenas outside typical occupational therapy practice settings. It is expected that occupational therapy services are delivered in accordance with applicable state or jurisdictional and federal regulations, relevant workplace policies, the *Occupational Therapy Code of Ethics (2015)* (AOTA, 2015), and continuing competence and professional development guidelines. For information regarding the supervision of occupational therapy students, refer to *Fieldwork Level 2 and Occupational Therapy Students* (AOTA, 2018).

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Additional Reading

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OTA Supervision

State	Statute or Regulation[1]
Alabama	**Statute: Code of Alabama §34-39-3, Definitions** (6) OCCUPATIONAL THERAPY ASSISTANT. A person licensed to assist in the practices of occupational therapy under the supervision of, or with the consultation of, a licensed occupational therapist whose license is in good standing. **Regulation: Alabama Administrative Code 625-X-8-.01 Supervision Of Licensed Occupational Therapy Assistants.** (1) "Occupational therapy assistant" means a person licensed to assist in the practices of occupational therapy under the supervision of, or with the consultation of, a licensed occupational therapist whose license is in good standing. (2) "Supervision" means a collaborative process for the responsible periodic review and inspection of all aspects of occupational therapy services. Responsibility of supervision is shared between the supervising occupational therapist(s) and the occupational therapy assistant(s) and/or all unlicensed personnel involved with the provision of occupational therapy services, including aides and students. (3) An occupational therapist may assign an increased level of supervision if necessary for the safety of a patient or client. The levels of supervision are: a. Direct Supervision: the supervising occupational therapist is in the immediate area of the occupational therapy assistant while performing supportive services. b. Close Supervision: the supervising occupational therapist provides initial direction to the occupational therapy assistant and daily contact while on the premises at least 50% of the occupational therapy assistant's direct patient care hours per month. c. General Supervision: the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 30-calendar days, with the supervising occupational therapist available by telephone, electronic, or written communication. (4) Supervision Ratios: An occupational therapist may supervise up to three (3) full-time occupational therapy assistants, but never more than two (2) occupational therapy assistants who require "direct" level of supervision. The total number of supervised occupational therapy assistants, occupational therapy personnel on a limited permit, and non-licensed occupational therapy personnel (including any occupational therapy students, occupational therapy assistant students, licensee applicants required to perform a preceptorship, and/or aides) may not exceed five (5) without prior Board approval. The Board may permit the supervision of a greater number by an occupational therapist if, in the Board's opinion, there would be adequate supervision to protect public health and safety. (5) Only a licensed occupational therapist shall: a. Prepare a written initial treatment plan prior to implementation by the occupational therapy assistant, initiate or re-evaluate a client or patient's treatment plan, or authorize in writing a change of a treatment plan b. Delegate duties to a licensed occupational therapy assistant, designate an assistant's duties, and assign a level of supervision; and c. Authorize a patient discharge.

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	(6) A licensed occupational therapy assistant shall not: a. Evaluate or develop a treatment plan independently; b. Initiate a treatment plan before a client or patient is evaluated and a written treatment plan is prepared by an occupational therapist; c. Continue a treatment procedure appearing harmful to a patient or client until the procedure is reevaluated by an occupational therapist; or d. Continue or discontinue occupational therapy services unless the treatment plan is approved or re-approved by a supervising occupational therapist. (7) A supervising occupational therapist shall supervise a licensed occupational therapy assistant as follows: a. Supervision should be "Direct" at the discretion of the supervising occupational therapist. b. Supervision should be "Close" if the occupational therapy assistant has less than 12 months of experience. c. Supervision should be at least "General" if an occupational therapy assistant has more than 12 months of experience. d. For occupational therapy assistants employed by state agencies and those employed by public schools and colleges of this state who provide screening and rehabilitation services for the educationally related needs of the student, the "Direct" and "close" supervision mandate based on work experience does not apply. In these instances, supervision should be at least "General". e. The following levels of supervision are minimal. An occupational therapist must assign an increased level of supervision if the occupational therapy assistant is new to a practice setting or particular skill. An occupational therapist must assign an increased level of supervision if necessary for the safety of a patient or client. f. All occupational therapist(s) who delegate to occupational therapy assistants must participate in the supervision of that occupational therapy assistant. g. Occupational therapy assistants working part-time should have no less than one hour of direct supervision per calendar month, and meet all other supervision requirements within this section. h. Occupational therapy assistants who work with more than one employer must notify the board of the supervisor(s) for each employer. i. The occupational therapist shall ensure that the occupational therapy assistant is assigned only those duties and responsibilities for which the assistant has been specifically educated and which the occupational therapy assistant is qualified to perform.
Alaska	**Statute: Alaska Statutes 08.84.190, Definitions** (4) "occupational therapy assistant" means a person who assists in the practice of occupational therapy under the supervision of an occupational therapist; **Regulation: Title 12, Chapter 54, Article 7, Occupational Therapy Standards of Practice.** **§12 AAC 54.800. OCCUPATIONAL THERAPY STANDARDS.** (a) In order to maintain a high standard of integrity in the profession and to safeguard the health and welfare of the public, occupational therapists and occupational therapy assistants shall adhere to *the State Physical Therapy and Occupational Therapy Board Principles of Practice*, dated March 2015. *The State Physical Therapy and Occupational Therapy Board Principles of Practice* is adopted by reference. (b) An occupational therapist may not supervise more than three aides, assistants, students, foreign-educated candidates, or permittees at the same time, in any combination.

	§12 AAC 54.810, SUPERVISION OF OCCUPATIONAL THERAPY ASSISTANTS. (a) An occupational therapy assistant shall work under the supervision of a licensed occupational therapist. To meet this supervision requirement, (1) at least once every month, while the occupational therapy assistant being supervised implements a treatment plan for a patient, the occupational therapist supervising the licensed occupational therapy assistant shall be physically present, or shall be present by video or teleconference when in-person supervision is not reasonable or practicable; and (2) the occupational therapist supervising the occupational therapy assistant shall be available for consultation with the occupational therapy assistant being supervised, through telephone consultations, written reports, or in person conferences. (b) If the licensed occupational therapist agrees to supervise an occupational therapy assistant, the occupational therapist shall (1) determine the frequency and manner of consultations, taking into consideration the treatment settings being used, patient rehabilitation status, and the competency of the occupational therapy assistant being supervised; (2) fully document the supervision provided, including a record of all consultations provided, and maintain those records at the occupational therapy assistant's place of employment; and (3) countersign the patient treatment record each time the occupational therapist supervising the occupational therapy assistant is physically present and directly supervises or supervises by video or teleconference the treatment of a patient by the occupational therapy assistant being supervised. §**12 AAC 54.890, Definitions related to occupational therapy** (1) "continual on-site supervision" means the supervising occupational therapist or occupational therapy assistant (A) is present in the department or facility where services are being provided; (B) is immediately available to the non-licensed personnel being supervised; and (C) maintains continual oversight of patient-related duties performed by the non-licensed personnel; (6) "supervision" means (A) the licensed occupational therapist will be present whenever a patient is evaluated, a treatment program is established, or a treatment program is changed; and (B) the licensed occupational therapist is present to personally review the diagnosis of the condition to be treated, to authorize the procedure, and before dismissal of the patient, to evaluate the performance of the treatment given.
Arizona	**<u>Statute:</u> Arizona Revised Statutes §32-3401 Definitions.** 7. "Occupational therapy assistant" means a person who is licensed pursuant to this chapter, who is a graduate of an accredited occupational therapy assistant education program, who assists in the practice of occupational therapy and who performs delegated procedures commensurate with the person's education and training. 9. "Supervision" means the giving of instructions by the supervising occupational therapist or the occupational therapy assistant that are adequate to ensure the safety of clients during the provision of occupational therapy services and that take into consideration at least the following factors: (a) Skill level. (b) Competency. (c) Experience. (d) Work setting demands. (e) Client population.

	<u>Regulation:</u> Arizona Administrative Code R4-43-101, Definitions. 11. "Supervision" means a collaborative process for the responsible periodic review and inspection of all aspects of occupational therapy services. The following levels of supervision are minimal. An occupational therapist may assign an increased level of supervision if necessary for the safety of a patient or client. The levels of supervision are: a. "Close supervision" means the supervising occupational therapist provides initial direction to the occupational therapy assistant and daily contact while on the premises. b. "Continuous supervision" means the supervising occupational therapist is in the immediate area of the occupational therapy aide performing supportive services. c. "General supervision" means the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 30-calendar days on a per patient or client basis while on the premises, with the supervising occupational therapist available by telephone or by written communication. d. "Minimal supervision" means the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 30-calendar days while on the premises. e. "Routine supervision" means the supervising occupational therapist has face-to-face contact with the occupational therapy assistant at least once every 15-calendar days on a per patient or client basis while on the premises, with the supervising occupational therapist available by telephone or by written communication. **<u>Regulation:</u> Arizona Administrative Code R4-43-401, Supervision of Occupational Therapy Assistants** A. Only a licensed occupational therapist shall: 1. Prepare an initial treatment plan, initiate or re-evaluate a client or patient's treatment plan, or authorize in writing a change of a treatment plan; 2. Delegate duties to a licensed occupational therapy assistant, designate an assistant's duties, and assign a level of supervision; and 3. Authorize a patient discharge. B. A licensed occupational therapy assistant shall not: 1. Evaluate or develop a treatment plan independently; 2. Initiate a treatment plan before a client or patient is evaluated and a treatment plan is prepared by an occupational therapist; 3. Continue a treatment procedure appearing harmful to a patient or client until the procedure is reevaluated by an occupational therapist; or 4. Continue or discontinue occupational therapy services unless the treatment plan is approved or re-approved by a supervising occupational therapist. C. A supervising occupational therapist shall supervise a licensed occupational therapy assistant as follows: 1. Not less than routine supervision if the occupational therapy assistant has less than 12 months work experience in a particular practice setting or with a particular skill. 2. Not less than general supervision if the occupational therapy assistant has more than 12 months but less than 24 months of experience in a particular practice setting or with a particular skill. 3. Not less than minimal supervision if an occupational therapy assistant has more than 24 months of experience in a particular practice setting or with a particular skill. 4. Increased level of supervision, if necessary, for the safety of a patient or client.

Arkansas	**<u>Statutes:</u> Code of Arkansas §17-88-102 Definitions.** (7) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the frequent and regular supervision by or with consultation with an occupational therapist, whose license is in good standing. The definition of "frequent" and "regular" will be established by the Arkansas State Occupational Therapy Examining Committee; **<u>Regulation:</u> Arkansas Administrative Rules Regulation No. 6, 6.2 FREQUENT AND REGULAR SUPERVISION DEFINED** As specified in the Occupational Therapy Practice Act 17-88-102, (3) an "occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the frequent and regular supervision by or in consultation with an occupational therapist whose license is in good standing. "Frequent" and "regular" are defined by the Arkansas State Occupational Therapy Examining Committee as consisting of the following elements: (A) The supervising occupational therapist shall have a legal and ethical responsibility to provide supervision, and the supervisee shall have a legal and ethical responsibility to obtain supervision regarding the patients seen by the occupational therapy assistant. (B) Supervision by the occupational therapist of the supervisee's occupational therapy services shall always be required, even when the supervisee is experienced and highly skilled in a particular area. (C) Frequent/Regular Supervision of an occupational therapy assistant by the occupational therapist is as follows: 1) The supervising occupational therapist shall meet with the occupational therapy assistant for onsite, face to face supervision a minimum of one (1) hour per forty (40) occupational therapy work hours performed by the occupational therapy assistant, to review each patient's progress and objectives. 2) The supervising occupational therapist shall meet with each patient and the occupational therapy assistant providing services on a monthly basis, to review patient progress and objectives. 3) Supervision Log. It is the responsibility of the occupational therapy assistant to maintain on file signed documentation reflecting supervision activities. This supervision documentation shall contain the following: date of supervision, time (start to finish), means of communication, information discussed, number of patients, and outcomes of the interaction. Both the supervising occupational therapist and the occupational therapy assistant must sign each entry. 4) Each occupational therapy assistant will maintain for a period of three (3) years proof of a supervision log, should it be requested by the Board for audit purposes. (D) The occupational therapists shall assign, and the occupational therapy assistant shall accept, only those duties and responsibilities for which the occupational therapy assistant has been specifically trained and is qualified to perform, pursuant to the judgment of the occupational therapist. (1) Assessment/reassessment. Patient evaluation is the responsibility of the occupational therapists. The occupational therapy assistant may contribute to the evaluation process by gathering data, and reporting observations. The occupational therapy assistant may not evaluate independently or initiate treatment prior to the occupational therapist's evaluation. (2) Treatment planning/Intervention. The occupational therapy assistant may contribute to treatment planning as directed by the occupational therapist. The occupational therapist shall advise the patient/client as to which level of practitioner will carry out the treatment plan.

	(3) Discontinuation of intervention. The occupational therapy assistant may contribute to the discharge process as directed by the occupational therapist The occupational therapist shall be responsible for the final evaluation session and discharge documentation. (E) Before an occupational therapy assistant can assist in the practice of occupational therapy, he or she must file with the Board a signed, current statement of supervision of the licensed occupational therapist(s) who will supervise the occupational therapy assistant. Change in supervision shall require a new status report to be filed with the Board, prior to starting work and when supervision ends. (F) In extenuating circumstances, when the occupational therapy assistant is without supervision, the occupational therapy assistant may carry out established programs for up to thirty (30) calendar days while appropriate occupational therapy supervision is sought. It shall be the responsibility of the occupational therapy assistant to notify the Board of these circumstances. (G) Failure to comply with the above will be considered unprofessional conduct and may result in punishment by the Board.
California	**Statute: California Business & Professions Code Division 2, Chapter 5.6** **§2570.2** (i) "Occupational therapy assistant" means an individual who is licensed pursuant to the provisions of this chapter, who is in good standing as determined by the board, and based thereon, who is qualified to assist in the practice of occupational therapy under this chapter, and who works under the appropriate supervision of a licensed occupational therapist. (j) "Occupational therapy services" means the services of an occupational therapist or the services of an occupational therapy assistant under the appropriate supervision of an occupational therapist. **§2570.3** (a) No person shall practice occupational therapy or hold himself or herself out as an occupational therapist or as being able to practice occupational therapy, or to render occupational therapy services in this state unless he or she is licensed as an occupational therapist under the provisions of this chapter. No person shall hold himself or herself out as an occupational therapy assistant or work as an occupational therapy assistant under the supervision of an occupational therapist unless he or she is licensed as an occupational therapy assistant under the provisions of this chapter. (j) "Supervision of an occupational therapy assistant" means that the responsible occupational therapist shall at all times be responsible for all occupational therapy services provided to the client. The occupational therapist who is responsible for appropriate supervision shall formulate and document in each client's record, with his or her signature, the goals and plan for that client, and shall make sure that the occupational therapy assistant assigned to that client functions under appropriate supervision. As part of the responsible occupational therapist's appropriate supervision, he or she shall conduct at least weekly review and inspection of all aspects of occupational therapy services by the occupational therapy assistant. (1) The supervising occupational therapist has the continuing responsibility to follow the progress of each client, provide direct care to the client, and to assure that the occupational therapy assistant does not function autonomously. (2) An occupational therapist shall not supervise more occupational therapy assistants, at any one time, than can be appropriately supervised in the opinion of the board. Three occupational therapy assistants shall be the maximum number of occupational therapy assistants supervised by an occupational therapist at any one time, but the board may permit the supervision of a greater number by an occupational therapist if, in the opinion of the board, there would be adequate supervision and the public's health and safety would be served. In no case shall the total number of occupational therapy assistants exceed twice the number of occupational therapists regularly employed by a facility at any one time.

§2570.13
(a) Consistent with this section, subdivisions (a), (b), and (c) of Section 2570.2, and accepted professional standards, the board shall adopt rules necessary to assure appropriate supervision of occupational therapy assistants and aides.
(b) An occupational therapy assistant may practice only under the supervision of an occupational therapist who is authorized to practice occupational therapy in this state.
(c) An aide providing delegated, client-related supportive services shall require continuous and direct supervision by an occupational therapist or occupational therapy assistant.

Regulations: California Code of Regulations Title 16, Division 39, Article 9
§4181. Supervision Parameters
(a) Appropriate supervision of an occupational therapy assistant includes, at a minimum:
(1) The weekly review of the occupational therapy plan and implementation and periodic onsite review by the supervising occupational therapist. The weekly review shall encompass all aspects of occupational therapy services and be completed by telecommunication or onsite.
(2) Documentation of the supervision, which shall include either documentation of direct client care by the supervising occupational therapist, documentation of review of the client's medical and/or treatment record and the occupational therapy services provided by the occupational therapy assistant, or co-signature of the occupational therapy assistant's documentation.
(3) The supervising occupational therapist shall be readily available in person or by telecommunication to the occupational therapy assistant at all times while the occupational therapy assistant is providing occupational therapy services.
(4) The supervising occupational therapist shall provide periodic on-site supervision and observation of client care rendered by the occupational therapy assistant.
(b) The supervising occupational therapist shall at all times be responsible for all occupational therapy services provided by an occupational therapy assistant, a limited permit holder, a student or an aide. The supervising occupational therapist has continuing responsibility to follow the progress of each client, provide direct care to the client, and assure that the occupational therapy assistant, limited permit holder, student or aide do not function autonomously.
(c) The level of supervision for all personnel is determined by the supervising occupational therapist whose responsibility it is to ensure that the amount, degree, and pattern of supervision are consistent with the knowledge, skill and ability of the person being supervised.
(d) Occupational therapy assistants may supervise:
(1) Level I occupational therapy students;
(2) Level I and Level II occupational therapy assistant students; and
(3) Aides providing non-client related tasks.
(e) The supervising occupational therapist shall determine that the occupational therapy practitioner possesses a current license or permit to practice occupational therapy prior to allowing the person to provide occupational therapy services.

§4182. Treatments Performed by Occupational Therapy Assistants.
(a) The supervising occupational therapist shall determine the occupational therapy treatments the occupational therapy assistant may perform. In making this determination, the supervising occupational therapist shall consider the following:
(1) the clinical complexity of the patient/client;
(2) skill level of the occupational therapy assistant in the treatment technique; and

	(3) whether continual reassessment of the patient/client status is needed during treatment. This rule shall not preclude the occupational therapy assistant from responding to acute changes in the client's condition that warrant immediate action. The occupational therapy assistant shall inform the supervising occupational therapist immediately of the acute changes in the patient's/client's condition and the action taken. (b) The supervising occupational therapist shall assume responsibility for the following activities regardless of the setting in which the services are provided: (1) Interpretation of referrals or prescriptions for occupational therapy services. (2) Interpretation and analysis for evaluation purposes. (A) The occupational therapy assistant may contribute to the evaluation process by gathering data, administering standardized tests and reporting observations. The occupational therapy assistant may not evaluate independently or initiate treatment before the supervising occupational therapist performs an assessment/evaluation. (3) Development, interpretation, implementation, and modifications of the treatment plan and the discharge plan. (A) The supervising occupational therapist shall be responsible for delegating the appropriate interventions to the occupational therapy assistant. (B) The occupational therapy assistant may contribute to the preparation, implementation and documentation of the treatment and discharge summary. **§4187. Occupational Therapy Assistants Serving in Administrative Positions.** An occupational therapy assistant in an administrative role, or supervisory role related to the provision of occupational therapy services may provide administrative responsibilities in a setting where permitted by law.
Colorado	**Statute: Colorado Revised Statutes Title 12, Article 270** **§12-270-104 Definitions.** (7) “Occupational therapy assistant” means a person licensed under this article 270 to practice occupational therapy under the supervision of an in partnership with an occupational therapist. (8) "Supervision" means the giving of aid, directions, and instructions that are adequate to ensure the safety and welfare of clients during the provision of occupational therapy by the occupational therapist designated as the supervisor. Responsible direction and supervision by the occupational therapist shall include consideration of factors such as level of skill, the establishment of service competency, experience, work setting demands, the complexity and stability of the client population, and other factors. Supervision is a collaborative process for responsible, periodic review and inspection of all aspects of occupational therapy services, and the occupational therapist is legally accountable for occupational therapy services provided by the occupational therapy assistant and the aide. **§12-270-109 Supervision of occupational therapy assistants and aides.** (1) An occupational therapy assistant may practice only under the supervision of an occupational therapist who is licensed to practice occupational therapy in this state. The occupational therapist is responsible for occupational therapy evaluation, appropriate reassessment, treatment planning, interventions, and discharge from occupational therapy services based on standard professional guidelines. Supervision of an occupational therapy assistant by an occupational therapist is a shared responsibility. The supervising occupational therapist and the supervised occupational therapy assistant have legal and ethical responsibility for ongoing management of supervision, including providing, requesting, giving, or obtaining supervision. The supervising occupational therapist shall determine the frequency, level, and nature of supervision with input from the occupational therapy assistant and shall base the supervision determination

	on a variety of factors, including the clients' required level of care, the treatment plan, and the experience and pertinent skills of the occupational therapy assistant. (2) The supervising occupational therapist shall supervise the occupational therapy assistant in a manner that ensures that the occupational therapy assistant: (a) Does not initiate or alter a treatment program without prior evaluation by and approval of the supervising occupational therapist; (b) Obtains prior approval of the supervising occupational therapist before making adjustments to a specific treatment procedure; and (c) Does not interpret data beyond the scope of the occupational therapy assistant's education and training. **<u>Regulations:</u> Colorado Code of Regulations 3 CCR 715-1.8, Supervision of Licensed Occupational Therapy Assistants and Aides** A. The occupational therapist is legally responsible for the performance of the licensed occupational therapy assistant(s) and aide(s) operating under the occupational therapist's direction and supervision as authorized by § 12-270-104(12), C.R.S. That responsibility in turn requires the occupational therapist to provide supervision adequate to ensure the safety and welfare of clients. B. Adequate supervision of licensed occupational therapy assistants and aides requires, at a minimum, that a supervising occupational therapist perform the following: 1. Provide client evaluation and appropriate reassessment; 2. Interpret available information concerning the individual under care; 3. Develop a plan of care, including long and short term goals; 4. Identify and document precautions, special problems, contraindications, anticipated progress, and/or plans for reevaluation; 5. Select and delegate appropriate tasks in the plan of care; 6. Designate or establish channels of written and oral communication; 7. Assess competence of personnel to perform assigned tasks; 8. Direct and supervise personnel in delegated tasks; and 9. When necessary, re-evaluate, adjust plan of care, perform final evaluation, and/or establish follow-up plan. C. An occupational therapist must exercise professional judgment when determining the number of personnel the occupational therapist can safely and effectively supervise to ensure that quality client care is provided at all times. D. An occupational therapist must provide adequate staff-to-client ratio at all times to ensure the provision of safe, quality care. E. Supervision of licensed occupational therapy assistants shall be accomplished to ensure that: 1. Licensed occupational therapy assistants do not initiate or alter a treatment program without prior evaluation by and approval of the supervising occupational therapist. 2. Licensed occupational therapy assistants obtain prior approval of the supervising occupational therapist before making adjustments to a specific treatment procedure. 3. Licensed occupational therapy assistants do not interpret data beyond the scope of their occupational therapy assistant education and training. 4. Licensed occupational therapy assistants respond to inquiries regarding client status to appropriate parties within the protocol established by the supervising occupational therapist. 5. Licensed occupational therapy assistants refer inquiries regarding client prognosis to a supervising occupational therapist.

Connecticut	**Statute: General Statutes of Connecticut Chapter 376a, Sec. 20-74a** (3) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy, under the supervision of or with the consultation of a licensed occupational therapist, and whose license is in good standing.

Delaware	**Statute: Delaware Code Title 24, Chapter 20, § 2002**
	(8) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist.
	(15) "Supervision" means the interactive process between a licensed occupational therapist and an occupational therapy assistant, and requires more than a paper review or cosignature. "Supervision" means that the supervising occupational therapist is responsible for insuring the extent, kind, and quality of the services that the occupational therapy assistant renders.
	
	Regulation: Delaware Administrative Code Title 24, Section 2000, 1.0 Supervision/consultation Requirements for Occupational Therapy Assistants
	1.1 Definitions. The following words and terms, when used in this regulation shall have the following meaning unless the context clearly indicates otherwise:
	
	"Occupational therapy assistant" shall mean a person licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist.
	
	"Under the supervision of an occupational therapist" means the interactive process between the licensed occupational therapist and the occupational therapy assistant. It shall be more than a paper review or co-signature. The supervising occupational therapist is responsible for insuring the extent, kind, and quality of the services rendered by the occupational therapy assistant.
	
	• The phrase, "under the supervision of an occupational therapist," as used in the definition of occupational therapist assistant includes, but is not limited to the following requirements:
	  • Communicating to the occupational therapy assistant the results of patient/client evaluation and discussing the goals and program plan for the patient/client;
	  • In accordance with supervision level and applicable health care, educational, professional and institutional regulations, reevaluating the patient/client, reviewing the documentation, modifying the program plan if necessary and co-signing the plan.
	  • Case management;
	  • Determining program termination;
	  • Providing information, instruction and assistance as needed;
	  • Observing the occupational therapy assistant periodically; and
	  • Preparing on a regular basis, but at least annually, a written appraisal of the occupational therapy assistant's performance and discussion of that appraisal with the assistant.
	
	1.2 Supervision for Occupational Therapy Assistants
	1.2.1 Supervising occupational therapists must have at least 1 year clinical experience after they have received permanent licensure. The supervisor may assign to a competent occupational therapy assistant the administration of standardized tests, the performance of activities of daily living evaluations and other elements of patient/client evaluation and reevaluation that do not

	require the professional judgment and skill of an occupational therapist. The occupational therapy assistant may not evaluate or develop a treatment plan independently. 1.2.2 The amount of supervision should be determined by the occupational therapist before the individuals enter into a supervisor/supervisee relationship. The chosen amount of supervision should be reevaluated regularly for effectiveness. Special consideration should be given to experience and any changes in practice area concentrations. 1.2.3 The supervising occupational therapist, in collaboration with the occupational therapy assistant, shall maintain a written supervisory plan specifying the amount of supervision and shall document the supervision of each occupational therapy assistant. The amount of supervision should be determined by the occupational therapist before the individuals enter into a supervisor/supervisee relationship. The chosen amount of supervision should be reevaluated regularly for effectiveness. This plan shall be reviewed at least every 6 months or more frequently as demands of service changes. 1.2.4 A supervisor who is temporarily unable to provide supervision shall arrange for substitute supervision by an occupational therapist licensed by the Board with at least 1 year of clinical experience, as defined above, to provide supervision as specified by Section 1.0 of this regulation.
District of Columbia	**Statute: DC Code §3–1201.02** (9)(B) An individual licensed as an occupational therapy assistant pursuant to this chapter may assist in the practice of occupational therapy under the general supervision of a licensed occupational therapist. **Regulation: DC Municipal Regulations, §17–63 (Occupational Therapists)** **§6312 RESPONSIBILITIES** 6312.5 An occupational therapist supervising an occupational therapy assistant shall be responsible for all of the occupational therapy assistant's actions performed within the scope of practice during the time of supervision and shall be subject to disciplinary action for any violation of the Act or this chapter by the occupational therapy assistant under his or her supervision. 6312.6 A supervising occupational therapist shall provide the following: (a) Direct supervision of an occupational therapy assistant prior to initiating treatment programs and before planned discharges for patients; (b) An initial and, at a minimum, bimonthly direction to the occupational therapy assistant; and (c) Documentation for verification of supervision and direction. 6312.7 A supervising occupational therapist shall only delegate duties and responsibilities for the care of patients to the occupational therapy assistant with consideration given to the following: (a) The level of skill shown by the occupational therapy assistant; (b) The ability to use identified intervention in a safe and effective manner; (c) Experience of the occupational therapy assistant and work setting demands; and (d) The complexity and stability of the patient population to be treated. **§6399 DEFINITIONS.** 6399.1 As used in this chapter, the following terms and phrases shall have the meanings ascribed:

	Direct supervision - Supervision in which the supervisor is personally present and immediately available within the treatment area to give aid, direction, and instruction when occupational therapy procedures or activities are performed. General supervision - Supervision in which the supervisor is available on the premises or by communication device at the time the supervisee is practicing, and can be on-site in the event of a clinical emergency within two (2) hours. Occupational therapy assistant - A person licensed to practice as an occupational therapy assistant under the Act. Supervised practice - unlicensed practice by a student, graduate, or person seeking reactivation, reinstatement, or re-licensure, as authorized by the Board and subject to the general supervision of an occupational therapist. **<u>Regulation:</u> DC Municipal Regulations, §17–73 (Occupational Therapy Assistants)** **§7314 SUPERVISION OF OCCUPATIONAL THERAPY ASSISTANTS** An occupational therapy assistant may only practice under the supervision, as specified in this section, of an occupational therapist with an active, unrestricted license in good standing in the District of Columbia. The supervising occupational therapist must be available on an as-needed basis and must be able to be on-site within two (2) hours if a need arises. 7314.2 The supervising occupational therapist shall provide the following: (a) Direct supervision of an occupational therapy assistant prior to initiating treatment programs and before planned discharges for patients; (b) An initial and, at a minimum, bimonthly direction to the occupational therapy assistant; and (c) Documentation to verify details of supervision and direction. 7314.3 The supervising occupational therapist shall only delegate duties and responsibilities for the care of patients to the occupational therapy assistant with consideration given to the following: (a) The level of skill shown by the occupational therapy assistant; (b) The occupational therapy assistant's ability to use identified intervention in a safe and effective manner; (c) Experience of the occupational therapy assistant and work setting demands; and (d) The complexity and stability of the patient population to be treated. 7314.4 An occupational therapy assistant may assist in the collection and some of the documentation of patient information pertaining to the evaluation and treatment of a patient provided that the supervising occupational therapist bases such assignment or delegation of duties on the demonstrated competency of the occupational therapy assistant. This demonstrated competency shall be documented and maintained on file by the supervising occupational therapist. 7314.5 An occupational therapy assistant shall not supervise another occupational therapy assistant. 7314.6 An occupational therapy assistant shall immediately inform the supervising occupational therapist and discontinue treatment if a procedure appears to be harmful to the patient.

	§7399 DEFINITIONS 7399.1 As used in this chapter, the following terms and phrases shall have the meanings ascribed: Direct supervision - supervision in which the supervisor is personally present and immediately available within the treatment area to give aid, direction, and instruction when occupational therapy procedures or activities are performed. General supervision - supervision in which the supervisor is available on the premises or by communication device at the time the supervisee is practicing, and can be on-site within two (2) hours in the event of a clinical emergency.
Florida	**Statute: Florida Statutes Title XXXII, §468.203 Definitions.** As used in this act, the term: (6) “Occupational therapy assistant” means a person licensed to assist in the practice of occupational therapy, who works under the supervision of an occupational therapist, and whose license is in good standing. (8) “Supervision” means responsible supervision and control, with the licensed occupational therapist providing both initial direction in developing a plan of treatment and periodic inspection of the actual implementation of the plan. Such plan of treatment shall not be altered by the supervised individual without prior consultation with, and the approval of, the supervising occupational therapist. The supervising occupational therapist need not always be physically present or on the premises when the assistant is performing services; however, except in cases of emergency, supervision shall require the availability of the supervising occupational therapist for consultation with and direction of the supervised individual.
Georgia	**Statute: Official Code of Georgia §43–28–3 Definitions** (8) "Occupational therapy assistant" means a person licensed to assist the occupational therapist in the practice of occupational therapy under the supervision of or with the consultation of the licensed occupational therapist and whose license is in good standing. **Regulation: Rules and Regulations of the State of Georgia Department 671, Chapter 671–2, DEFINITIONS** Rule 671-2-.02 Supervision Defined Supervision as used in the law shall mean personal involvement of the licensed occupational therapist in the supervisee's professional experience which includes evaluation of his or her performance. Further, supervision shall mean personal supervision with weekly verbal contact and consultation, monthly review of patient care documentation, and specific delineation of tasks and responsibilities by the licensed occupational therapist and shall include the responsibility for personally reviewing and interpreting the results of any habilitative or rehabilitative procedures conducted by the supervisee. It is the responsibility of the licensed occupational therapist to ensure that the supervisee does not perform duties for which he or she is not trained. C.O.T.A.s and limited permit holders must be supervised. Rule 671-2-.03 Direct Supervision Defined Direct Supervision as used in the Law shall mean daily on-site, close contact whereby the supervisor is able to respond quickly to the needs of the client or supervisee. It requires specific delineation of task and responsibilities by a licensed Occupational Therapist and shall include the responsibility for personally reviewing and interpreting the result of any habilitative or rehabilitative procedures conducted by the supervisee. It is the responsibility of the licensed occupational therapist to ensure that the supervisee does not perform duties for which he/she is not trained.

Guam	**Statute: Guam Code Annotated Title 10, Chapter 12, Part 2, Article 14, Occupational Therapy.** **§121401. Definitions.** (d) Occupational therapy assistant means a person licensed to assist in the practice of occupational therapy who works under the indirect supervision of an occupational therapist, or as otherwise determined by the supervising occupational therapist. **§121410. Scope of practice; Occupational Therapy Assistant.** The occupational therapy assistant works under the supervision of the occupational therapist. The amount, degree and pattern of supervision a practitioner requires varies depending on the employment setting, method of service provision, the practitioner's competence and the demands of service. The occupational therapist is responsible for the evaluation of the client or patient. The treatment plan may be developed by the occupational therapist in collaboration with the occupational therapy assistant. Once the evaluation and treatment plans are established, the occupational therapy assistant may implement and modify various therapeutic interventions, as permitted by the Board under the supervision of the occupational therapist.
Hawaii	**Statute: Hawaii Revised Statutes Chapter 457G** **§457G-1 Definitions** "Occupational therapy assistant" means a person who engages in the practice of occupational therapy under the supervision of and in partnership with an occupational therapist. **§457G-2.7 Supervision of occupational therapy assistants; partnership with occupational therapists** (a) An occupational therapy assistant may practice occupational therapy only under the supervision of, and in partnership with, an occupational therapist who is licensed to practice occupational therapy in the State. The occupational therapist shall be responsible for occupational therapy evaluation, appropriate reassessment, treatment planning, interventions, and discharge from occupational therapy based on standard professional guidelines. The supervising occupational therapist and the supervised occupational therapy assistant shall have legal and ethical responsibility for ongoing management of supervision, including providing, requesting, giving, or obtaining supervision. (b) The supervising occupational therapist shall: (1) Determine the frequency, level, and nature of supervision with input from the occupational therapy assistant; and (2) Base the supervision determination on a variety of factors, including the clients' required level of care, treatment plan, and experience and pertinent skills of the occupational therapy assistant. (c) The supervising occupational therapist shall supervise the occupational therapy assistant to ensure that the occupational therapy assistant: (1) Does not initiate or alter a treatment program without prior evaluation by and approval of the supervising occupational therapist; (2) Obtains prior approval of the supervising occupational therapist before making adjustments to a specific treatment procedure; and (3) Does not interpret data beyond the scope of the occupational therapy assistant's education and training.
Idaho	**Statute: Idaho Statutes Title 54, Chapter 37** **§54-3702 DEFINITIONS.** As used in this chapter: (12) "Occupational therapy assistant" means a person licensed under this chapter to practice occupational therapy and who works under the supervision of an occupational therapist.

	§54-3715 SUPERVISION Within the scope of occupational therapy practice, supervision is aimed at ensuring the safe and effective delivery of occupational therapy services and the fostering of professional competence and development. Practices and procedures governing the supervision of occupational therapy assistants, a limited permit holder and an aide in the delivery of occupational therapy services shall be established in rule and be adopted by the board. **<u>Regulation:</u> Idaho Administrative Code 24.06.01** **010. DEFINITIONS.** 02. Direct Line-of-Site Supervision. Direct line-of-sight supervision requires the supervisor's physical presence when services are being provided to clients by the individual under supervision. 03. Direct Supervision. Direct supervision requires daily, in-person contact by the supervisor at the site where services are provided to clients by the individual under supervision. 05. General Supervision. General Supervision requires in-person or synchronous interaction at least once per month by an occupational therapist and contact by other means as needed. Other means of contact include, but are not limited to, electronic communications such as email. 06. Routine Supervision. Routine Supervision requires in-person or synchronous interaction at least once every two (2) weeks by an occupational therapist and contact by other means as needed. Other means of contact include, but are not limited to, electronic communications such as email. **011. SUPERVISION.** An occupational therapist shall supervise and be responsible for the patient care given by occupational therapy assistants, limited permit holders, aides, and students. An occupational therapist's or occupational therapy assistant's failure to provide appropriate supervision in accordance with these rules is grounds for discipline. 01. Occupational Therapy Assistants. Occupational therapy assistants must be supervised by an occupational therapist. General Supervision must be provided at a minimum. 05. Supervision Requirements. Supervision is the direction and review of service delivery, treatment plans, and treatment outcomes. Unless otherwise specified in this rule, General Supervision is the minimum level of supervision that must be provided. Methods of supervision may include, but are not limited to, Direct Line-of-Sight Supervision, Direct Supervision, Routine Supervision, or General Supervision, as needed to ensure the safe and effective delivery of occupational therapy. a. An occupational therapist and an occupational therapy assistant must ensure the delivery of services by the individual being supervised is appropriate for client care and safety and must evaluate: i. The complexity of client needs; ii. The number and diversity of clients; iii. The skills of the occupational therapist and the occupational therapist assistant, aide, or limited permit holder; iv. The type of practice setting; v. The requirements of the practice setting; and vi. Other regulatory requirements applicable to the practice setting or delivery of services. b. Supervision must be documented in a manner appropriate to the individuals and the setting. The documentation must be kept as required by Section 013 of these rules.

	c. Supervision must include consultation at appropriate intervals regarding evaluation, intervention, progress, reevaluation and discharge planning for each patient. Consultation must be documented and signed by the supervisor and supervisee.
Illinois	**Statute: 225 ILCS 75/2 Definitions** In this Act: (5) "Occupational therapy assistant" means a person initially registered and licensed who assists in the practice of occupational therapy under this Act. The occupational therapy assistant shall work under appropriate supervision of an in partnership with a licensed occupational therapist. **Regulation: Illinois Administrative Code Title 68, Chapter VII, Subchapter b, Part 1315** **Section 1315.163 Supervision of an Occupational Therapy Assistant** a) A certified occupational therapy assistant shall practice only under the supervision of a registered occupational therapist. Supervision is a process in which 2 or more persons participate in a joint effort to establish, maintain and elevate a level of performance and shall include the following criteria: 1) To maintain high standards of practice based on professional principles, supervision shall connote the physical presence of the supervisors and the assistant at regularly scheduled supervision sessions. 2) Supervision shall be provided in varying patterns as determined by the demands of the areas of patient/client service and the competency of the individual assistant. Such supervision shall be structured according to the assistant's qualifications, position, level of preparation, depth of experience and the environment within which he/she functions. 3) The supervisors shall be responsible for the standard of work performed by the assistant and shall have knowledge of the patients/clients and the problems being discussed. Co-signature does not reflect supervision. 4) A minimum guideline of formal supervision is as follows: A) The occupational therapy assistant who has less than one year of work experience or who is entering new practice environments or developing new skills shall receive a minimum of 5% on-site face-to-face supervision from a registered occupational therapist per month. On-site supervision consists of direct, face-to-face collaboration in which the supervisor must be on the premises. The remaining work hours shall be supervised by a combination of telephone, electronic communication, telecommunication, technology or face-to-face consultation. B) The occupational therapy assistant with more than one year of experience in his/her current practice shall have a minimum of 5% direct supervision from a registered occupational therapist per month. The 5% direct supervision shall consist of 2% direct, face-to-face collaboration. The remaining 3% of supervision shall be a combination of telephone, electronic communication, telecommunication technology or face-to-face consultation. The remaining work hours will be supervised in accordance with subsection (a)(2). b) Record Keeping. It is the responsibility of the occupational therapy assistant to maintain on file at the job site signed documentation reflecting supervision activities. This supervision documentation shall contain the following: date of supervision, means of communication, information discussed and the outcomes of the interaction. Both the supervising occupational therapist and the occupational therapy assistant must sign each entry.
Indiana	**Statute: Indiana Code 25-23.5** **Chapter 0.5 Applicability** Sec. 3. An occupational therapy assistant shall: (1) be licensed under this article; and (2) practice under the supervision of an occupational therapist who is licensed under this article.

	Chapter 1. Definitions Sec. 6. "Occupational therapy assistant" means a person who provides occupational therapy services under the supervision of an occupational therapist. **<u>Regulation:</u> Indiana Administrative Code Title 844, Article 10, Rule 5. Standards of Competent Practice of Occupational Therapy** **Sec. 5. Supervision of occupational therapy assistant** Under the supervision of an occupational therapist, an occupational therapy assistant may contribute to the screening and evaluation process. The occupational therapy assistant may also contribute to the following: (1) The development and implementation of the intervention plan. (2) The monitoring and documentation of progress. (3) The discontinuation or discharge from care or transitioning to another level of care. The occupational therapy assistant may not independently develop the intervention plan or initiate treatment.
Iowa	**<u>Statute:</u> Iowa Code Title IV, Section 148B2 Definitions.** As used in this chapter: 4. “Occupational therapy assistant” means a person licensed under this chapter to assist in the practice of occupational therapy. **<u>Regulation:</u> Iowa Administrative Code Division 645, Chapter 206 Licensure of Occupational Therapists and Occupational Therapy Assistants** **645–206.1 Definitions** “Occupational therapy assistant” means a person licensed under this chapter to assist in the practice of occupational therapy. “On site” means: 1. To be continuously onsite and present in the department or facility where the assistive personnel are performing services; 2. To be immediately available to assist the person being supervised in the services being performed; and 3. To provide continued direction of appropriate aspects of each treatment session in which a component of treatment is delegated to assistive personnel. **<u>Regulation:</u> Iowa Administrative Code Division 645, Chapter 208 Practice of occupational Therapists and Occupational Therapy Assistants** **645–208.5 Supervision requirements.** **208.5(2)** Occupational therapist supervisor responsibilities. The supervisor shall: a. Provide supervision to a licensed OTA, OT limited permit holder and OTA limited permit holder any time occupational therapy services are rendered. Supervision may be provided on site or through the use of telecommunication or other technology. b. Ensure that every licensed OTA, OT limited permit holder and OTA limited permit holder being supervised is aware of who the supervisor is and how the supervisor can be contacted any time occupational therapy services are rendered. c. Assume responsibility for all delegated tasks and shall not delegate a service that exceeds the expertise of the OTA or OTA limited permit holder. d. Provide evaluation and development of a treatment plan for use by the OTA.

	e. Ensure that the OTA, OT limited permit holder and OTA limited permit holder under the OT's supervision have current licenses to practice. f. Ensure that the signature of an OTA on an occupational therapy treatment record indicates that the occupational therapy services were provided in accordance with the rules and regulations for practicing as an OTA. **208.5(3)** The following are functions that only an occupational therapist may provide and that shall not be delegated to an OTA: a. Interpretation of referrals; b. Initial occupational therapy evaluation and reevaluations; c. Identification, determination or modification of patient problems, goals, and care plans; d. Final discharge evaluation and establishment of the discharge plan; e. Assurance of the qualifications of all assistive personnel to perform assigned tasks through written documentation of their education or training that is maintained and available at all times; f. Delegation of and instruction in the services to be rendered by the OTA, including but not limited to specific tasks or procedures, precautions, special problems, and contraindicated procedures; and g. Timely review of documentation, reexamination of the patient and revision of the plan when indicated. **208.5(5)** Minimum frequency of OT interaction. At a minimum, an OT must directly participate in treatment, either in person or through a telehealth visit, every twelfth visit for all patients and must document each visit. The occupational therapist shall participate at a higher frequency when the standard of care dictates. **208.5(6)** Occupational therapy assistant responsibilities. a. The occupational therapy assistant shall: (1) Provide only those services for which the OTA has the necessary skills and shall consult the supervising occupational therapist if the procedures are believed not to be in the best interest of the patient; (2) Gather data relating to the patient's disability during screening, but shall not interpret the patient information as it pertains to the plan of care; (3) Communicate any change, or lack of change, that occurs in the patient's condition and that may need the assessment of the OT; (4) Provide occupational therapy services only under the supervision of the occupational therapist; (5) Provide treatment only after evaluation and development of a treatment plan by the occupational therapist; (6) Refer inquiries that require interpretation of patient information to the occupational therapist; (7) Be supervised by an occupational therapist, either on site or through the use of telecommunication or other technology, at all times when occupational therapy services are being rendered; (8) Receive supervision from any number of at least one occupational therapist; and (9) Record on every patient chart the name of the OTA's supervisor for each treatment session. b. The signature of an OTA on the occupational therapy treatment record indicates that occupational therapy services were provided in accordance with the rules and regulations for practicing as an OTA.
Kansas	**<u>Statute:</u> Kansas Statutes Annotated §65-5402. Definitions.** (e) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist.

Regulation: Kansas Administrative Regulations Agency 100, Article 54 Occupational Therapy
§100-54-9. Occupational therapy assistants; information to board.
Before an occupational therapist allows an occupational therapy assistant to work under the occupational therapist's direction, the occupational therapist shall inform the board of the following:

(a) The name of each occupational therapy assistant who intends to work under the direction of that occupational therapist;
(b) the occupational therapy assistant's place of employment; and
(c) the address of the employer.

§100-54-10 Delegation and supervision.
(a) Occupational therapy procedures delegated by an occupational therapist or occupational therapy assistant to an occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional shall be performed under the direct, on-site supervision of a licensed occupational therapist or occupational therapy assistant.
(b) (1) "Occupational therapy technician" as used in this regulation, shall mean "occupational therapy tech" pursuant to K.S.A. 65-5419 and amendments thereto.
(2) An occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional shall mean an individual who provides support services to the occupational therapist and occupational therapy assistant.
(c) A task delegated to an occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional by an occupational therapist or occupational therapy assistant shall not exceed the level of training, knowledge, skill, and competence of the individual being supervised. The occupational therapist or occupational therapy assistant shall be responsible for the acts or actions performed by the occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional functioning in a practice setting.
(d) Each occupational therapist and each occupational therapy assistant shall delegate only specific tasks to an occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional that meet all of the following conditions:
(1) The tasks are routine in nature.
(2) The treatment outcome is predictable.
(3) The task does not require judgment, interpretation, or adaptation by the occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional.
(e) The tasks that an occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional may perform shall include the following specifically selected routine tasks:
(1) Clerical, secretarial, or administrative duties;
(2) transportation of patients, clients, or students;
(3) preparation or setup of the treatment equipment and work area;
(4) attending to a patient's, client's, or student's needs during treatment; and
(5) maintenance or restorative services to patients, clients, or students.
(f) Any occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional may assist in the delivery of occupational therapy services. However, no occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional shall provide independent treatment or use any title or description implying that the occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional is a provider of occupational therapy services.
(g) An occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional shall not perform any of the following:

(1) Interpret referrals or prescriptions for occupational therapy services;
(2) evaluate treatment procedures;
(3) develop, plan, adjust, or modify treatment procedures;
(4) act on behalf of the occupational therapist or occupational therapy assistant relating to direct patient care that requires judgment or decision making; and
(5) act independently or without the supervision of an occupational therapist or occupational therapy assistant.

§100-54-12. Supervision of occupational therapy assistants.

(a) For the purposes of this regulation, each of the following terms shall have the meaning specified in this subsection:
(1) "Full-time" means employed for 30 or more hours per week.
(2) "Supervision" means oversight of an occupational therapy assistant by a licensed occupational therapist that includes initial direction and periodic review of service delivery and the provision of relevant instruction and training.

(b) Supervision shall be considered adequate if the occupational therapist and occupational therapy assistant have on-site contact at least monthly and interim contact occurring as needed by other means, including telephone, electronic mail, text messaging, and written communication.

(c) Each occupational therapist who supervises an occupational therapy assistant shall meet the following requirements:
(1) Be licensed in Kansas;
(2) be actively engaged in the practice of occupational therapy in Kansas;
(3) be responsible for the services and tasks performed by the occupational therapy assistant under the supervision of the occupational therapist;
(4) be responsible for any tasks that the supervised occupational therapy assistant delegates to an occupational therapy aide, occupational therapy technician, or occupational therapy paraprofessional;
(5) delegate only those services for which the occupational therapist has reasonable knowledge that the occupational therapy assistant has the knowledge, experience, training, and skill to perform;
(6) document in the patient's chart any direction or review of occupational therapy services provided under supervision by the occupational therapy assistant; and
(7) report to the board any knowledge that the occupational therapy assistant has committed any act specified in K.S.A. 65-5410, and amendments thereto. The occupational therapist shall report this information to the board within 10 days of receiving notice of the information.

(d) An occupational therapist shall not supervise more than the combined equivalent of four fulltime occupational therapy assistants. This combination shall not exceed a total of eight occupational therapy assistants.

(e) Each occupational therapist's decision to delegate components of occupational therapy services under this regulation to an occupational therapy assistant shall be based on that occupational therapist's education, expertise, and professional judgment.

(f) An occupational therapy assistant shall not initiate therapy for any patient or client before the supervising occupational therapist's evaluation of the patient or client.

(g) An occupational therapy assistant shall not perform any of the following services for a patient or client:
(1) Performing and documenting an initial evaluation;
(2) developing or modifying the treatment plan; or
(3) developing a plan of discharge from treatment.

(h) Any occupational therapy assistant, under supervision, may perform the following services for a patient or client:
(1) Collecting initial patient data through screening and interviewing;

	(2) assessing initial activities of daily living by administering standardized assessments; (3) performing a chart review; (4) implementing and coordinating occupational therapy interventions; (5) providing direct services that follow a documented routine and accepted protocol; (6) grading and adapting activities, media, or the environment according to the needs of the patient or client; (7) contributing to the reassessment process; and (8) contributing to the discontinuation of intervention, as directed by the occupational therapist, by implementing a discharge plan and providing necessary client discharge resources. (i) Failure by any occupational therapist or occupational therapy assistant to meet the applicable requirements of this regulation shall constitute evidence of unprofessional conduct.
Kentucky	**Statute: Kentucky Revised Statutes 319A.010, Definitions for chapter.** As used in this chapter: (4) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under this chapter, who works under the supervision of an occupational therapist; **Regulation: Kentucky Administrative Regulations 201 KAR 28:010, Section 1. Definitions.** (11) "General supervision" means an interactive process for collaboration on the practice of occupational therapy which includes the review and oversight of all aspects of the services being provided by the individual under supervision. **Regulation: Kentucky Administrative Regulations 201 KAR 28:130, Supervision of occupational therapy assistant, occupational therapy aides, occupational therapy students, and temporary permit holders** Section 1. Definitions. (1) "Countersign" means the OT/L signs the client's documentation after actively reviewing the history of the intervention provided to the client and confirming that, in light of the entire intervention plan, the OTA/L's entry is proper. (2) "Face-to-face supervision" means being physically present in the room and being able to directly communicate with an individual while observing and guiding the activities of that individual, including: (a) A review of the occupational therapy services being provided to a client that might affect the therapeutic outcomes and the revision of the plan of care for each client; and (b) An interactive process between the supervisor and the individual under supervision involving direct observation, co-treatment, dialogue, teaching, and instruction in a face-to face setting. (3) "Supervisor" means the OT/L who is providing supervision. Section 2. General Policy Statement for Supervision. (1) The OT/L shall have the ultimate responsibility for occupational therapy outcomes. Supervision shall be a shared responsibility. (2) The supervising OT/L shall have a legal and ethical responsibility to provide supervision and the supervisee shall have a legal and ethical responsibility to obtain supervision. (3) Supervision by the OT/L of the supervisee's provision of occupational therapy services shall always be required, even when the supervisee is experienced and skilled in a particular practice area.

	Section 3. Supervision of Licensed Occupational Therapy Assistants. (1) An OTA/L shall assist in the practice of occupational therapy only under the supervision of an OT/L. (2) The supervisor shall provide no less than four (4) hours per month of general supervision for each occupational therapy assistant which shall include no less than two (2) hours per month of face-to-face supervision. (3) The amount of supervision time shall be prorated for a part-time OTA/L. (4) The supervisor or the OTA/L may institute additional supervision based on the competence and experience of the OTA/L. (5) The supervisor shall assign and the OTA/L shall accept only those duties and responsibilities for which the OTA/L has been specifically trained and which the OTA/L is qualified to perform. (6) Specific responsibilities for supervising OT/Ls and OTA/Ls. (a) Assessment and reassessment. 1. Client evaluation is the responsibility of the OT/L. 2. The OTA/L may contribute to the evaluation process by gathering data, administering structured tests, and reporting observations. 3. The OTA/L may not evaluate independently or initiate therapy prior to the OT/L's evaluation. (b) Intervention planning. 1. The OT/L shall take primary responsibility for the intervention planning. 2. The OTA/L may contribute to the intervention planning as directed by the OT/L. (c) Intervention. 1. The OT/L shall be responsible for the outcome and delivery of the occupational therapy intervention. 2. The OT/L shall be responsible for assigning appropriate therapeutic interventions to the OTA/L. (d) Discontinuation of intervention. 1. The OT/L shall be responsible for the discontinuation of occupational therapy services. 2. The OTA/L may contribute to the discontinuation of intervention as directed by the OT/L. (7) Documentation requirements. (a) Notations recorded by an OTA/L to an initial evaluation, plan of care, or discharge summary, that are documented in a client's permanent record, shall be countersigned by the supervisor within fourteen (14) calendar days of the notation. (b) The supervising OT/L and individuals under supervision shall each maintain a log which shall document: 1. The frequency of the supervision provided; 2. The observation, dialogue and discussion, and instructional techniques employed; 3. The type of supervision provided, either general or face-to-face; 4. The dates on which the supervision occurred; and 5. The number of hours worked by the OTA/L each month. (c) It shall be the responsibility of the supervising OT/L to maintain a list of any OTA/L that he or she has supervised with the OTA/L's name and license number. (d) It shall be the responsibility of the OTA/L under supervision to maintain a list of his or her supervising OT/L with that individual's name and license number. (8) A supervising OT/L shall not have more than the equivalent of three (3) full time OTA/Ls under supervision at any one (1) time. (9) (a) In extenuating circumstances, when the OTA/L is without supervision, the OTA/L may continue carrying out established programs for up to thirty (30) calendar days under agency supervision while appropriate occupational therapy supervision is sought.

	(b) It shall be the responsibility of the OTA/L to notify the board of these circumstances and to submit, in writing, a plan for resolution of the situation. (10) A supervisor shall be responsible for ensuring the safe and effective delivery of OT services and for fostering the professional competence and development of the OTA/Ls under his or her supervision.
Louisiana	**Statute: Louisiana Revised Statutes Title 37, Chapter 39, §3003 Definitions.** (5) "Occupational therapy assistant" means a person who is certified as a certified occupational therapy assistant (COTA) by the American Occupational Therapy Association, Inc. (AOTA), and is licensed to assist in the practice of occupational therapy under the supervision of, and in activity programs with the consultation of, an occupational therapist licensed under this Act. **Regulation: Louisiana Administrative Code Title 46, Part XLV, Subpart 2, Chapter 19, Subchapter A, §1901. Definitions** Occupational Therapy Assistant—a person who is licensed to assist in the practice of occupational therapy under the supervision of, and in activity programs with the consultation of, an occupational therapist licensed under this Chapter. **Regulation: Louisiana Administrative Code Title 46, Part XLV, Subpart 3, Chapter 49, Subchapter A** **§4903. Definitions.** Close Client Care Supervision—face to face observation of an occupational therapy assistant administering occupational therapy to a client, accompanied or followed in a timely fashion by verbal discussion of client goals, the individual program plan and other matters which may affect the client's plan of care. Occupational Therapy Assistant—a person who is licensed to assist in the practice of occupational therapy under the supervision of, and in activity programs with the consultation of, an occupational therapist licensed under this Chapter. Periodically—occurring at regular intervals of time not less than every two weeks or the sixth visit, whichever comes first. Supervising Occupational Therapist—an occupational therapist responsible to the client for occupational therapy who observes, directs, consults with and retains responsibility for the service competence and performance of an occupational therapy assistant in the administration of occupational therapy to such client. **§4919. Quality Assurance and Service Competency** C. Any occupational therapist supervising an occupational therapy assistant must have performed and documented a service competency on the occupational therapy assistant. The occupational therapist must have previously evaluated and/or treated any client being seen by an occupational therapy assistant he or she is supervising. In addition: 1. initial service competency. Following acceptance of responsibility to supervise an occupational therapy assistant, but prior to utilization of such assistant in the implementation of any client program plan or other administration of occupational therapy to a client, the supervising occupational therapist shall initially evaluate and document the occupational therapy assistant's service competency to administer all occupational therapy services which are to be performed under his or her supervision and direction. The service competency is designed to document the occupational therapy assistant's skill set; 2. annual service competency. Following such an initial evaluation the supervising occupational therapist shall thereafter annually conduct and document a service competency to determine the occupational therapy assistant's skill set;

	3. documentation of service competency. Documentation of initial and annual competency shall include the date the evaluation was performed, a description of the tasks evaluated, and the name, signature and Louisiana license number of the supervising occupational therapist conducting the service competency evaluation; 4. in practice settings where an occupational therapy assistant is supervised by more than one occupational therapist, service competencies (initial and/or annual) performed by one supervising occupational therapist will satisfy the requirements of this Section for all occupational therapists supervising the occupational therapy assistant in the performance of the same services, provided that their name, signature and Louisiana license number appears on the evaluation; 5. a supervising occupational therapist shall insure such documentation is maintained by the occupational therapy assistant and at each clinic, facility or home health agency where the occupational therapy assistant practices under his or her supervision. D. A supervising occupational therapist is responsible for and must be capable of demonstrating compliance with the requirements of this Chapter and AOTA supervision guidelines respecting supervision of occupational therapy assistants. **§4925. Supervision of Occupational Therapy Assistants** A. The rules of this Section, together with those specified in §4915 and §4919, govern supervision of an occupational therapy assistant by a supervising occupational therapist in any clinical setting. B. An occupational therapy assistant may assist in implementation of a client program plan in consultation with and under the supervision of an occupational therapist. Such supervision shall not be construed in every case to require the continuous physical presence of the supervising occupational therapist provided, however, that the supervising occupational therapist and the occupational therapy assistant must have the capability to be in contact with each other by telephone or other telecommunication which allows for simultaneous interactive discussion between the supervising occupational therapist and occupational therapy assistant. Supervision shall exist when the occupational therapist responsible for the client gives informed concurrence of the actions of the occupational therapy assistant and adheres to all requirements set forth in this Chapter. C. Prior to Implementation of Program Plan. Prior to the administration of occupational therapy by an occupational therapy assistant, the supervising occupational therapist shall, in accordance with AOTA standards of practice as may from time to time be amended: 1. perform an evaluation; 2. identify and establish occupational therapy needs, goals and an individual program plan; 3. ensure that the documents created pursuant to §4925.C.1 and §4925.C.2 are made part of the client's record and accessible to the occupational therapy assistant prior to his or her the first treatment session with the client; and 4. be available for a client care conference. D. Throughout the Duration of Program Plan. Following implementation and throughout the duration of the program plan: 1. a supervising occupational therapist shall periodically and systematically re-evaluate the appropriateness of all services delivered. Such information shall be documented in the client's record, which shall be made available to the occupational therapy assistant. The supervising occupational therapist preparing such revisions shall communicate any critical aspect or significant change in the program plan to the occupational therapy assistant by means of a client care conference prior to the occupational therapy assistant's next treatment session with the client; 2. at all times during which an occupational therapy assistant assists in program plan implementation, the supervising occupational therapist shall be immediately accessible for a client care conference; and 3. an occupational therapy assistant shall not administer occupational therapy to any client whose physical, cognitive, functional or mental status differs substantially from that identified by the supervising occupational therapist's individual program plan in the absence of re-evaluation by, or an immediate prior client care conference with, the supervising occupational therapist.

	E. In addition to the terms and conditions specified in §4919 and §4925.A-D, the following additional requirements are applicable to an occupational therapy assistant's administration of occupational therapy under the supervision of an occupational therapist. 1. In any clinical setting, other than specified by §4925.E.3: a. an occupational therapy assistant with less than one year of practice experience: i. shall receive close client care supervision in each clinical setting for not less than one of every four, or 25+ percent, of those clients to whom he or she has administered occupational therapy during an average weekly case load; ii. in addition, a client care conference shall be held with respect to each client to whom the occupational therapy assistant administers occupational therapy; b. an occupational therapy assistant with more than one but less than two years of practice experience: i. shall receive close client care supervision in each clinical setting for not less than one of every 10, or 10 percent, of those clients seen during an average weekly case load; ii. in addition, a client care conference shall be held with respect to each client to whom the occupational therapy assistant administers occupational therapy; c. an occupational therapy assistant with more than two years of practice experience: i. shall receive a client care conference with respect to each client to whom the occupational therapy assistant administers occupational therapy. 2. School System, Long-Term Psychiatric and Nursing Home Facility Settings. In addition to the requirements prescribed in §4925.E.1, clients in school system, long-term psychiatric or nursing home facility settings shall be re-evaluated or treated by the supervising occupational therapist not less frequently than the earlier of once a month or every sixth treatment session. 3. Home Health Setting. The terms and conditions prescribed by §4925.E.1 shall not be applicable to a home health setting. An occupational therapy assistant may assist in implementation of a client program plan in a home health setting under the supervision of an occupational therapist provided all the following terms, conditions and restrictions of this Chapter, except §4925.E.1, are strictly observed: a. an occupational therapy assistant shall have had not less than two years practice experience in providing occupational therapy prior to administering occupational therapy in a home health environment; b. each client in a home health setting to whom an occupational therapy assistant administers occupational therapy shall be re-evaluated or treated by the supervising occupational therapist not less frequently than the earlier of once every two weeks or every sixth treatment session; and c. a face-to-face client care conference shall occur not less frequently than once every two weeks to discuss all clients to whom the occupational therapy assistant has administered occupational therapy in a home health setting. Such conference shall be documented by the supervising occupational therapist in a supervisory log and maintained by or at the home health entity. 4. Early Intervention Setting. The terms and conditions prescribed by §4925.E.1 shall not be applicable to an early intervention setting. An occupational therapy assistant may assist in implementation of a client program plan in an early intervention setting under the supervision of an occupational therapist provided all the following terms, conditions and restrictions of this Chapter, except §4925.E.1, are strictly observed: a. an occupational therapy assistant shall have had not less than two years practice experience in providing occupational therapy prior to administering occupational therapy in an early intervention setting;

	b. each client in an early intervention setting to whom an occupational therapy assistant administers occupational therapy shall be re-evaluated or treated by the supervising occupational therapist not less frequently than the earlier of once a month or every sixth treatment session; and c. a client care conference shall occur not less frequently than the earlier of once every month or every sixth treatment session to discuss all clients to whom the occupational therapy assistant has administered occupational therapy in an early intervention setting. Such conference shall be documented and maintained by the supervising occupational therapist in a supervisory log. F. Mutual Obligations and Responsibilities. A supervising occupational therapist and occupational therapy assistant shall bear equal reciprocal obligations to insure strict compliance with the obligations, responsibilities and provisions set forth in this Chapter. G. The administration of occupational therapy other than in accordance with the provisions of this Section and §4919 shall be deemed a violation of these rules, subjecting the occupational therapist and/or an occupational therapy assistant to suspension or revocation of licensure pursuant to §4921.B.18.
Maine	**<u>Statute:</u> Maine Revised Statutes Title 32, Chapter 32, §2272 Definitions** 12–B. "Occupational therapy assistant" means an individual who has passed the certification exam of the NBCOT for an occupational therapy assistant or who was certified as an occupational therapy assistant prior to June 1977 and who is licensed to practice occupational therapy under this chapter in the State under the supervision of a licensed occupational therapist. 14. "Supervision of OTA" means initial directions and periodic inspection of the service delivery and provision of relevant in-service training. The supervising licensed occupational therapist shall determine the frequency and nature of the supervision to be provided based on the clients' required level of care and the OTA's caseload, experience and competency. **<u>Regulations:</u> Maine Rules 02-477, Chapter 5 ROLE OF THE OCCUPATIONAL THERAPY ASSISTANT; SUPERVISION OF OCCUPATIONAL THERAPY ASSISTANTS AND TEMPORARY LICENSEES** 1. Role of the Occupational Therapy Assistant The occupational therapy assistant: 1. May assist in the practice of occupational therapy only with the supervision of an occupational therapist; 2. Shall apply critical thinking and clinical reasoning, including reflection and reassessment, in addressing clients' needs; 3. May initiate a treatment intervention program only when the client has been evaluated and intervention treatment has been planned by the occupational therapist, and may discharge the client from a treatment intervention program only in collaboration with or after consultation with the occupational therapist; 4. May not perform an evaluation independently, but may contribute to the evaluation process in collaboration or consultation with the occupational therapist; 5. May participate in the screening process by collecting data, such as records, by general observation and/or by conducting a general interview, and may communicate in writing or orally the information gathered to the occupational therapist; 6. May track the need for reassessment, report changes in status that might warrant reassessment or referral, and administer the reassessment under the supervision of the occupational therapist; and 7. Shall immediately discontinue any specific treatment procedure which appears harmful to the client and so notify the supervising occupational therapist. NOTE: The permissible activities of occupational therapists are set forth in 32 MRSA §2272(12) (statutory definition of occupational therapy).

	2. Supervision of Occupational Therapy Assistants and Temporary Licensees 1. Principles of Supervision The occupational therapist has the ultimate responsibility for occupational therapy treatment outcomes. Supervision is a shared responsibility. The supervising occupational therapist has a legal and ethical responsibility to provide supervision, and the supervisee has a legal and ethical responsibility to obtain supervision. Supervision is required even when the supervisee is experienced and/or highly skilled in a particular area. A supervisor is legally and ethically responsible for the professional activities of an occupational therapy assistant or temporary licensee under his or her supervision. 2. Knowledge of Client The supervising occupational therapist must have knowledge of the client, or the occupational therapy services received by the client, and the problems being discussed. 3. Supervision of Occupational Therapy Assistants Supervision consists of "initial directions and periodic inspection of the service delivery and provision of relevant in-service training. The supervising licensed occupational therapist shall determine the frequency and nature of the supervision to be provided based on the clients' required level of care and the COTA's caseload, experience and competency."32 MRSA §2272(14) 5. Supervision Requirement; Supervision Forms A. Each occupational therapy assistant and temporary licensee must have a supervisor of record for each facility or work setting at or in which the occupational therapy assistant or temporary licensee is employed. The supervising occupational therapist must agree in writing, on a form provided by the board, to provide supervision to the named supervisee pursuant to the laws and rules governing the practice of occupational therapy. Any change of supervisor must be documented by a replacement or supplemental supervision form, as the case may be. B. All supervision forms must be must sent to the board no later than 10 days after execution by the supervisor and supervisee. The supervisor and supervisee are equally responsible for sending the forms to the board and ensuring that accurate, up-to-date supervision forms are on file with the board at all times.
Maryland	**<u>Statute:</u> Annotated Code of Maryland Health Occupations Article, Title 10** **§10-101 Definitions.** (e) "Direct supervision" means supervision provided on a face-to-face basis by a supervising therapist when delegated client-related tasks are performed. (h) "Licensed occupational therapy assistant" means, unless the context requires otherwise, an occupational therapy assistant who is licensed by the Board to practice limited occupational therapy. (i) (1) "Limited occupational therapy" means participation, while under the periodic supervision of a licensed occupational therapist, in: (i) An initial screening and evaluation that applies the principles and procedures of occupational therapy; and (ii) A treatment program that applies the principles and procedures of occupational therapy. (2) "Limited occupational therapy" does not include: (i) Initiation and interpretation of evaluation data; and (ii) Initiation of a treatment program before the client has been evaluated and a licensed occupational therapist has rendered a treatment plan. (q) "On-site supervision" means supervision in which a supervisor is immediately available on a face-to-face basis when client procedures are performed or as otherwise necessary.

	(r) (1) “Periodic supervision” means supervision by a licensed occupational therapist on a face-to-face basis, occurring the earlier of at least: (i) Once every 10 therapy visits; or (ii) Once every 30 calendar days. (2) “Periodic supervision” includes: (i) Chart review; and (ii) Meetings to discuss client treatment plans, client response, or observation of treatment. (s) “Supervision” means aid, direction, and instruction provided by an occupational therapist to adequately ensure the safety and welfare of clients during the course of occupational therapy. **§10-310. Scope of occupational therapy assistant license** (a) Subject to subsection (b) of this section, an occupational therapy assistant license authorizes the licensee to practice limited occupational therapy while the license is effective. (b) A licensed occupational therapy assistant may practice limited occupational therapy only under the supervision of an occupational therapist who is authorized to practice occupational therapy in this State. **Regulation: Code of Maryland Regulations 10.46.01** **.01 Definitions.** (8) "Direct supervision" means supervision provided on a face-to-face basis by a supervisor who is a licensed occupational therapist or occupational therapy assistant, during the performance of delegated client-related tasks. (18) "Occupational therapy assistant" means, unless the context requires otherwise, an occupational therapy assistant who is licensed by the Board to practice limited occupational therapy. (19) "On-site supervision" means supervision provided by a supervisor who is: (a) A licensed occupational therapist or occupational therapy assistant; and (b) Immediately available on the premises to provide direct supervision, if needed, when client-related procedures are performed or as otherwise necessary. (20) Periodic Supervision. (a) "Periodic supervision" means supervision provided by a supervisor who is a licensed occupational therapist on a face-to-face basis, for each client who is being treated by the licensed occupational therapy assistant supervisee, occurring the earlier of at least: (i) Once every 10 therapy visits; or (ii) Once every 30 calendar days. (b) "Periodic supervision" includes: (i) Chart review; and (ii) Meetings to discuss client treatment plans, client response to treatment, or observation of treatment, as indicated to ensure the competent and safe provision of occupational therapy services. (26) “Supervision” means the provision of clinical aid, direction, and instruction, by either a licensed occupational therapist or an occupational therapy assistant, to ensure the competent delivery of occupational therapy services. (27) “Supervisor” means an occupational therapist or occupational therapy assistant, excluding temporary licensees, who is licensed by the Board and has the responsibility of clinically supervising the provision of occupational therapy treatment services.

	.04 Supervision requirements A. Occupational Therapist. (1) A licensed occupational therapist may supervise the clinical practice of the following: (a) Occupational therapist; (b) Occupational therapy assistant; (c) Temporary occupational therapist; (d) Temporary occupational therapy assistant; (e) Aide; and (f) Occupational therapy student or occupational therapy assistant student. (2) Unless otherwise stated, a supervisor need not be physically present on the premises at all times, but may be available by telephone or by other electronic communication means. B. Occupational Therapy Assistant. (1) Subject to the requirements of this section, an occupational therapy assistant may practice limited occupational therapy under the supervision of an occupational therapist provided it is at least periodic supervision. (2) The supervising occupational therapist working with the occupational therapy assistant shall determine the appropriate amount and type of supervision necessary, taking into consideration: (a) Skills, experience, and education of the occupational therapy assistant and the occupational therapist; (b) Change in a client's status; (c) Complexity of the treatment program; and (d) Type and requirements of practice setting. (3) In addition to the other requirements specified by this section, supervision requires that, before the initiation of the treatment program and before a planned discharge, the supervising occupational therapist shall provide direction to the occupational therapy assistant by verbal, written, or electronic communication. (4) An occupational therapy assistant, under the direction of the occupational therapist, is permitted to be the primary clinical supervisor for the following: (a) Aide; (b) Temporary occupational therapy assistant; (c) Level I fieldwork occupational therapy student; and (d) Level I and Level II fieldwork occupational therapy assistant student. (5) The occupational therapy assistant may be utilized to facilitate occupational therapy student and occupational therapy assistant student learning experiences in both Level I and Level II fieldwork under the direction of the occupational therapist. (6) The supervising occupational therapist and the occupational therapy assistant are jointly responsible for maintaining formal documentation of periodic supervision as set forth in Regulation .05 of this chapter.
Massachusetts	**Statute: Massachusetts General Laws, Part I, Title XVI, Chapter 112, Section 23A** Occupational therapy shall also include delegating of selective forms of treatment to occupational therapy assistants and occupational therapy aides; provided, however, that the occupational therapist so delegating shall assume the responsibility for the care of the patient and the supervision of the occupational therapy assistant or the occupational therapy aide. "Occupational therapy assistant", a person duly licensed in accordance with section twenty-three B and who assists in the practice of occupational therapy who works under the supervision of a duly licensed occupational therapist.

	<u>Regulation:</u> Code of Massachusetts Regulations 259 CMR 3.00 **3.01: Definitions.** Assessment. An assessment is a standardized or non-standardized tool or instrument used in the evaluation process. Client. A client is the entity receiving occupational therapy services. Clients may include: (a) individuals and other persons relevant to an individual's life, including family, caregivers, teachers, employers, and others who also may help or be served indirectly; (b) organizations such as businesses, industries or agencies; and (c) populations within a community. Evaluation. The process of obtaining and interpreting data necessary for an intervention, including planning for and documenting the evaluation process and results. Intervention Plan. An outline of selected approaches and types of interventions, based on the results of the evaluation process and developed to reach the client's identified targeted outcomes. Occupational Therapy Service Delivery Process. The process of evaluation, intervention planning, intervention implementation, intervention review, and outcome evaluation for a client. Screening. An initial brief assessment to determine the need for occupational therapy evaluation and intervention, consisting of record review, observation, and consultation. Service Competency. Demonstration of specific knowledge and skills to permit safe and competent delivery of occupational therapy services. **3.02: Occupational Therapy Service Delivery Process.** (1) Responsibility of the Occupational Therapist. (a) Responsible for all aspects of occupational therapy service delivery, including Screening, Evaluation and reevaluation and is accountable for the safety and effectiveness of the Occupational Therapy Service Delivery Process. (b) Must be directly involved in the delivery of services during the Screening, initial Evaluation, reevaluation, and regularly throughout the course of intervention, including discharge/outcome Evaluation. (c) Responsible for determining when to delegate to other occupational therapy personnel. When delegating aspects of occupational therapy services, the occupational therapist considers the following factors 1. The complexity of the Client's condition. 2. The knowledge, skill and competence of the occupational therapy practitioner and/or the Occupational Therapy Aide. 3. The nature and complexity of the intervention. 4. The needs and requirements of the practice setting. (d) Assumes primary responsibility for obtaining informed consent from the Client for occupational therapy services to be provided.

	(e) Provides appropriate and required supervision (see 259 CMR 3.05) to other occupational therapy personnel, including occupational therapy assistant, occupational therapy student or occupational therapy assistant student and Occupational Therapy Aide. (f) Assumes responsibility for communicating results of Evaluation, goals, and Intervention Plan to the Client with recommendations about occupational therapy services to be provided. (g) Initiates and directs the Screening process, analyzes and interprets the data in accordance with applicable laws, other regulatory requirements and AOTA documents. (h) Initiates and directs the Evaluation process, analyzes and interprets the data in accordance with applicable laws, other regulatory requirements, and AOTA documents. 1. Uses current Assessments and Assessment procedures and follows defined protocols of standardized Assessments. 2. Uses best evidence to inform intervention. 3. Directs all aspects of the initial contact during the occupational therapy Evaluation, including: a. Determining the need for service (Screening). b. Determining the Client's goals and priorities based on collaborative discussion with the Client. c. Establishing intervention priorities. d. Determining specific needs for further Assessment. e. Determining specific Assessment tasks that can be delegated to the occupational therapy assistant. 4. Interpret Evaluation data, including information provided by the occupational therapy assistant, occupational therapy student, or occupational therapy assistant student. (i) Assumes primary responsibility for the development of the occupational therapy Intervention Plan based on the initial Evaluation, including long and short term goals, expected frequency, and duration. Identifies and documents precautions, contraindications, anticipated progress, and plans for reevaluation on a regular basis or as required by payors and other regulatory bodies. (j) Assumes primary responsibility for the intervention process. 1. Assumes responsibility for providing appropriate supervision to the occupational therapy assistant when delegating aspects of the occupational therapy intervention. 2. Determines the need for continuing, modifying or discontinuing occupational therapy services in consultation with the Client. 3. Designates or establishes channels of written and/or oral communication with all other care providers, regarding Client's status. 4. Recommends additional consultations or refers Clients to appropriate resources when the needs of the Client can best be served by the expertise of other professionals or services. (k) Assumes primary responsibility for selecting, measuring and interpreting discharge data/outcomes. 1. Prepares and implements a transition or discontinuation plan based on the Client's needs, goals, performance, and appropriate follow-up resources. 2. Directs responsibility for the contents of the discharge Evaluation/summary. 3. Makes necessary referrals to other professionals or facilities. (2) Responsibility of Occupational Therapy Assistants. (a) Occupational therapy assistants may contribute to the Screening process by collecting data with Service Competency and shall communicate the information gathered to the supervising occupational therapist.

(b) Occupational therapy assistants may contribute to the Evaluation process by collecting data and administering specific Assessments, with Service Competency, and shall communicate the information gathered to the supervising occupational therapist.
(c) Occupational therapy assistants may not interpret data beyond the scope of their occupational therapy assistant education or current Service Competency.
(d) Occupational therapy assistants may not initiate or alter an Intervention Plan without prior Evaluation by and approval of the supervising occupational therapist.
(e) Occupational therapy assistants may, with prior documented approval of the supervising occupational therapist, adjust a specific intervention procedure in accordance with changes in Client status.
(f) Occupational therapy assistants may respond to inquiries regarding Client status to appropriate parties within the protocol established by the supervising occupational therapist.
(g) Occupational therapy assistants shall refer inquiries regarding Client prognosis to a supervising occupational therapist.

3.03: Documentation.
Timely and accurate documentation is necessary whenever occupational therapy services are provided, regardless of payer source. The Client's record must be signed with the provider's name, professional designation, and license number.

(1) The occupational therapist's primary role in documentation is to ensure that documentation is completed timely, following formats and standards established by the practice setting, agencies, external accreditation programs, state and federal law, and other regulators and payers. The occupational therapist's primary role is to document the following, with input from the occupational therapy assistant, as applicable:
(a) Screenings;
(b) Evaluations;
(c) Initial goals and any modifications in goals, as needed;
(d) Initial Intervention Plans and any modifications;
(e) Patient progress notes;
(f) Formal reviews of the initial Intervention Plan (or reevaluations); and
(g) Discharge Evaluations or summaries.
(2) The occupational therapy assistant's primary role is to document the following:
(a) Objective data from Assessments with established Service Competency; and
(b) Patient progress notes as directed by the Occupational Therapist.

3.04: Co-Signing of Documentation
(1) The supervising occupational therapist must co-sign the documentation of occupational therapy students and those holding temporary licenses as occupational therapists.
(2) The supervising occupational therapist or occupational therapy assistant must co-sign the documentation of occupational therapy assistant students and those holding temporary licenses as occupational therapy assistants.
(3) Occupational therapy assistants are not required to have their documentation co-signed.
(4) The supervising occupational therapist or occupational therapy assistant must co-sign the documentation of Occupational Therapy Aides.

	3.05: Supervision of Personnel Various types and methods of supervision should be used. These may include direct, face-to-face contact and indirect contact. Examples of supervision involving direct, face-to-face contact include: observation, modeling, co-intervention, discussions, teaching, and instruction. Examples of supervision involving indirect contact include: telephone conversations, written correspondence, and electronic exchanges. (1) Primary responsibility for occupational therapy services rendered by supportive personnel rests with the supervising occupational therapist. (2) Occupational therapists and occupational therapy assistants must exercise their professional judgment when determining the number of personnel they can safely and effectively supervise to ensure that safe and appropriate care is provided at all times. (a) Specific frequency, methods, and content of supervision should be determined based on the following factors: 1. Complexity of Clients' needs; 2. Number of Clients; 3. Diversity of Client conditions; 4. Service Competency of the occupational therapist and the occupational therapy assistant; 5. Type of practice setting and the administrative requirements of that setting; and 6. Other regulatory requirements. (b) Supervision may necessarily be more frequent than the minimum required by the practice setting or regulatory agencies depending upon: 1. The complexity or unpredictability of the Client's needs or the Occupational Therapy Service Delivery Process. 2. The number of Clients and the diversity of their conditions within a particular practice setting. 3. The professional judgment of the occupational therapist or occupational therapy assistant, that additional supervision is necessary to ensure the safe and effective delivery of occupational therapy services.
Michigan	**<u>Statute:</u> Michigan Compiled Laws, Chapter 333, Section 333.18301, Definitions.** (1) As used in this part: (a) "Occupational therapy assistant" means an individual licensed under this article to engage in practice as an occupational therapy assistant. (d) "Practice as an occupational therapy assistant" means the practice of occupational therapy under the supervision of an occupational therapist licensed under this article. **<u>Regulation:</u> Michigan Administrative Code R338.1211, Definitions.** As used in these rules: (f) “Direct supervision” means that the occupational therapist is physically present or present via telemedicine with the individual being supervised or immediately available for direction and onsite supervision when the limited assessment, task, intervention, or interaction with the client is performed. (g) “General supervision” means that the occupational therapist is not required to be physically present on site or present during a telemedicine visit but is continuously available when the limited assessment, task, intervention, or interaction with the client is performed. Continuously available includes availability by telecommunication or another electronic device.

	<u>Regulation:</u> Michigan Administrative Code R338.1229, Delegation of limited assessments, tasks or interventions to an occupational therapy assistant; supervision of an occupational therapy assistant; requirements. Rule 29. (1) An occupational therapist who delegates the performance of limited assessments, tasks or interventions to an occupational therapy assistant as allowed under section 16215 of the code, MCL 333.16215, shall supervise the occupational therapy assistant consistent with section 16109(2) of the code, MCL 333.16109, and satisfy the requirements of this rule. As used in this rule, "limited assessment" means those parts of an evaluation that an occupational therapy assistant is qualified by education and training to perform while under the supervision of an occupational therapist. (2) Before an occupational therapist delegates limited assessments, tasks, or interventions to an occupational therapy assistant, the occupational therapist shall evaluate the qualifications of the occupational therapy assistant, including verification of the occupational therapy assistant's training, education, and licensure. (3) An occupational therapist who delegates limited assessments, tasks, or interventions to an occupational therapy assistant shall determine and provide the appropriate level of supervision required for the occupational therapy assistant's performance of the delegated limited assessment, task, or intervention. The appropriate level of supervision must be determined based on the occupational therapy assistant's education, training, and experience. The level of supervision must be either general supervision or direct supervision. (4) An occupational therapist who delegates limited assessments, tasks, or interventions under this rule shall also comply with all of the following: (a) Initiate and direct the evaluation of the patient or client before delegating limited assessments. (b) Complete the evaluation of the patient or client before delegating tasks or interventions to be performed by an occupational therapy assistant. (c) Supervise an occupational therapy assistant to whom limited assessments, tasks, or interventions are delegated. (d) Provide predetermined procedures and protocols for limited assessments, tasks, or interventions that are delegated. (e) Monitor an occupational therapy assistant's practice of assigned limited assessments, tasks, or interventions. (f) Maintain a record of the names of the occupational therapy assistants to whom limited assessments, tasks, or interventions have been delegated pursuant to section 16215 of the code, MCL 333.16215. (g) Meet using live, synchronous contact at least once per month with the occupational therapy assistant to whom limited assessments, tasks, or interventions have been delegated to accomplish all of the following: (i) Evaluate the occupational therapy assistant's performance. (ii) Review the patient or client records. (iii) Educate the occupational therapy assistant on the limited assessments, tasks, or interventions that have been delegated to facilitate professional growth and development. (h) The occupational therapist shall maintain documentation of the meeting, which must be signed by both the occupational therapist and occupational therapist assistant. Compliance with this subdivision must not be used as a substitute for the ongoing supervision required under this subrule and subrule (3) of this rule. (5) An occupational therapist shall not delegate the performance of either of the following to an occupational therapy assistant: (a) The sole development of a treatment plan. (b) The sole evaluation and interpretation of evaluation results. (6) An occupational therapist shall not supervise more than 4 occupational therapy assistants who are providing services to patients at the same time.

Minnesota	**Statute: Minnesota Statutes, Chapter 148, Occupational Therapists and Occupational Therapy Assistants.** **§148.6402. DEFINITIONS** "Direct supervision" of an occupational therapy assistant using physical agent modalities means that the occupational therapist has evaluated the patient and determined a need for use of a particular physical agent modality in the occupational therapy treatment plan, has determined the appropriate physical agent modality application procedure, and is available for in-person intervention while treatment is provided. "Occupational therapy assistant" means an individual who meets the qualifications for an occupational therapy assistant in sections 148.6401 to 148.6449 and is licensed by the board. "Service competency" of an occupational therapy assistant in performing evaluation tasks means the ability of an occupational therapy assistant to obtain the same information as the supervising occupational therapist when evaluating a client's function. Service competency of an occupational therapy assistant in performing treatment procedures means the ability of an occupational therapy assistant to perform treatment procedures in a manner such that the outcome, documentation, and follow-up are equivalent to that which would have been achieved had the supervising occupational therapist performed the treatment procedure. Service competency of an occupational therapist means the ability of an occupational therapist to consistently perform an assessment task or intervention procedure with the level of skill recognized as satisfactory within the appropriate acceptable prevailing practice of occupational therapy. **§148.6432. SUPERVISION OF OCCUPATIONAL THERAPY ASSISTANTS** 1.Applicability. If the professional standards identified in section 148.6430 permit an occupational therapist to delegate an evaluation, reevaluation, or treatment procedure, the occupational therapist must provide supervision consistent with this section. 2.Evaluations. The occupational therapist shall determine the frequency of evaluations and reevaluations for each client. The occupational therapy assistant shall inform the occupational therapist of the need for more frequent reevaluation if indicated by the client's condition or response to treatment. Before delegating a portion of a client's evaluation pursuant to section 148.6430, the occupational therapist shall ensure the service competency of the occupational therapy assistant in performing the evaluation procedure and shall provide supervision consistent with the condition of the patient or client and the complexity of the evaluation procedure. 3. Intervention. (a) The occupational therapist must determine the frequency and manner of supervision of an occupational therapy assistant performing intervention procedures delegated pursuant to section 148.6430 based on the condition of the patient or client, the complexity of the intervention procedure, and the service competency of the occupational therapy assistant. (b) Face-to-face collaboration between the occupational therapist and the occupational therapy assistant must occur every ten intervention days or every 30 days, whichever comes first, during which time the occupational therapist is responsible for: (1) planning and documenting an initial intervention plan and discharge from interventions; (2) reviewing intervention goals, therapy programs, and client progress; (3) supervising changes in the intervention plan;

	(4) conducting or observing intervention procedures for selected clients and documenting appropriateness of intervention procedures. Clients must be selected based on the occupational therapy services provided to the client and the role of the occupational therapist and the occupational therapy assistant in those services; and (5) ensuring the service competency of the occupational therapy assistant in performing delegated intervention procedures. (c) Face-to-face collaboration must occur more frequently if necessary to meet the requirements of paragraph (a) or (b). (d) The occupational therapist must document compliance with this subdivision in the client's file or chart. 4. Exception. The supervision requirements of this section do not apply to an occupational therapy assistant who: (1) works in an activities program; and (2) does not perform occupational therapy services. The occupational therapy assistant must meet all other applicable requirements of sections 148.6401 to 148.6449.
Mississippi	**Statute: Mississippi Code Annotated Title 73, Chapter 24, Section 3, Definitions.** The following words and phrases shall have the following meanings, unless the context requires otherwise: (g) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the supervision of or with the consultation of the licensed occupational therapist, and whose license is in good standing. **Regulation: Mississippi Administrative Code Title 15, Part 19, Subpart 60, Chapter 8** **Subchapter 1 General** Rule 8.1.3 Definitions: The following terms shall have the meaning set forth below, unless the context otherwise requires: 11. Occupational Therapy Assistant means a person licensed to assist in the practice of occupational therapy under the supervision of or with the consultation of a licensed occupational therapist and whose license is in good standing. 14. Direct supervision means the daily, direct, on-site contact at all times of a licensed occupational therapist or occupational therapy assistant when an occupational therapy aide assists in the delivery of patient care. **Subchapter 10 Occupational Therapy Assistant** Rule 8.10.1 Definition: An occupational therapy assistant (OTA), shall be defined as an individual who meets the qualifications and requirements as set forth in Subchapter 4 of these regulations, and has been issued a license by the Department. The roles and responsibilities of an OTA are: 1. To practice only under the supervision of, or in consultation with, an occupational therapist licensed to practice in Mississippi. 2. To assist with but not perform total patient evaluations. 3. To perform treatment procedures as delegated by the occupational therapist. 4. To supervise other supportive personnel as charged by the occupational therapist. 5. To notify the occupational therapist of changes in the patient's status, including all untoward patient responses. 6. To discontinue immediately any treatment procedures which in their judgment appear to be harmful to the patient. 7. To refuse to carry out treatment procedures that they believe to be not in the best interest of the patient. Rule 8.10.2 Supervision or Consultation: 1. An occupational therapy assistant issued a limited permit (see Rule 8.4.5). 2. An occupational therapy assistant issued a regular license.

	a. Supervision or consultation which means face-to-face meetings of supervisor and supervisee (OT and OTA) to review and evaluate treatment and progress at the work site, and regular interim communication between the supervisor and supervisee. A face-to-face meeting is held at least once every seventh treatment day or 21 calendar days, whichever comes first. b. The supervising occupational therapist must be accessible by telecommunications to the occupational therapy assistant on a daily basis while the occupational therapy assistant is treating patients. c. Regardless of the practice setting, the following requirements must be observed when the occupational therapist is supervising or consulting with the occupational therapy assistant: i. The initial visit for evaluation of the patient and establishment of a plan of care must be made by the supervising or consulting occupational therapist. ii. A joint supervisory visit must be made by the supervising occupational therapist and the occupational therapy assistant with the patient present at the patient's residence or treatment setting once every 7 treatment days or every 21 days, whichever comes first. iii. A supervisory visit should include: 1. A review of activities with appropriate revision or termination of the plan of care; 2. An assessment of utilization of outside resources (whenever applicable); 3. Documentary evidence of such visit; 4. Discharge planning as indicated. iv. An occupational therapist may not supervise/consult with more than two (2) occupational therapy assistants except in school settings, or setting where maintenance or tertiary type services are provided, such as the regional treatment centers under the direction of the Department of Mental Health.
Missouri	**<u>Statute:</u> Missouri Revised Statutes Title XXII, Chapter 324** **324.050 Occupational therapy practice act – definitions.** 2. For the purposes of sections 324.050 to 324.089, the following terms mean: (8) "Occupational therapy assistant", a person who is licensed as an occupational therapy assistant by the division, in collaboration with the board. The function of an occupational therapy assistant is to assist an occupational therapist in the delivery of occupational therapy services in compliance with federal regulations and rules promulgated by the division, in collaboration with the Missouri board of occupational therapy. **324.056 License to practice required, when — supervision of occupational therapy assistants.** 2. A licensed occupational therapy assistant shall be directly supervised by a licensed occupational therapist. The licensed occupational therapist shall have the responsibility of supervising the occupational therapy treatment program. No licensed occupational therapist shall have under his or her direct supervision more than four occupational therapy assistants. **<u>Regulation:</u> 20 CSR 2205-4.010 Supervision of Occupational Therapy Assistants and Occupational Therapy Assistant Limited Permit Holders** (1) An occupational therapy assistant and/or occupational therapy assistant limited permit holder shall assist an occupational therapist in the delivery of occupational therapy services in compliance with all state and federal statutes, regulations, and rules. (2) The occupational therapy assistant or occupational therapy assistant limited permit holder may only perform services under the direct supervision of an occupational therapist.

	(A) The manner of supervision shall depend on the treatment setting, patient/client caseload, and the competency of the occupational therapy assistant and/or occupational therapy assistant limited permit holder as determined by the supervising occupational therapist. At a minimum, supervision shall include consultation of the occupational therapy assistant and/or occupational therapy assistant limited permit holder with the supervising occupational therapist prior to the initiation of any patient's/client's treatment plan and modification of treatment plan. (B) More frequent face-to-face supervision may be necessary as determined by the occupational therapist or occupational therapy assistant and/or occupational therapy assistant limited permit holder dependent on the level of expertise displayed by the occupational therapy assistant and/or occupational therapy assistant limited permit holder, the practice setting, and/or the complexity of the patient/client caseload. (C) Supervision shall be an interactive process between the occupational therapist and occupational therapy assistant and/or occupational therapy assistant limited permit holder. It shall be more than peer review or co-signature. The interactive process shall include but is not limited to the patient/client assessment, reassessment, treatment plan, intervention, discontinuation of intervention, and/or treatment plan. (D) The supervising occupational therapist or the supervisor's designee must be available for immediate consultation with the occupational therapy assistant and/or occupational therapy assistant limited permit holder. The supervisor need not be physically present or on the premises at all times. (3) The supervising occupational therapist has the overall responsibility for providing the necessary supervision to protect the health and welfare of the patient/client receiving treatment from an occupational therapy assistant and/or occupational therapy assistant limited permit holder. The supervising occupational therapist shall— (A) Be licensed by the board as an occupational therapist; (B) Not be licensed as a limited permit holder; (C) Not be under restriction or discipline from any licensing board or jurisdiction; (D) Not have more than four (4) full-time equivalent (FTE) occupational therapy assistants under his/her supervision at one time; (E) Be responsible for all referrals of the patient/client; (F) Be responsible for completing the patient's evaluation/assessment. The occupational therapy assistant and/or occupational therapy assistant limited permit holder may contribute to the screening and/or evaluation process by gathering data, administering standardized tests and reporting observations. The occupational therapy assistant and/or occupational therapy assistant limited permit holder may not evaluate independently or initiate treatment before the supervising occupational therapist's evaluation/assessment; (G) Be responsible for developing and modifying the patient's treatment plan. The treatment plan must include goals, interventions, frequency, and duration of treatment. The occupational therapy assistant and/or occupational therapy assistant limited permit holder may contribute to the preparation, implementation and documentation of the treatment plan. The supervising occupational therapist shall be responsible for the outcome of the treatment plan and assigning of appropriate intervention plans to the occupational therapy assistant and/or occupational therapy assistant limited permit holder within the competency level of the occupational therapy assistant and/or occupational therapy assistant limited permit holder; (H) Be responsible for developing the patient's discharge plan. The occupational therapy assistant and/or occupational therapy assistant limited permit holder may contribute to the preparation, implementation and documentation of the discharge plan. The supervising occupational therapist shall be responsible for the outcome of the discharge plan and assigning of appropriate tasks to the occupational therapy assistant and/or occupational therapy assistant limited permit holder within the competency level of the occupational therapy assistant and/or occupational therapy assistant limited permit holder; and (I) Ensure that all patient/client documentation becomes a part of the permanent record.

	(4) The supervising occupational therapist has the overall responsibility for providing the necessary supervision to protect the health and welfare of the patient/client receiving treatment from an occupational therapy assistant and/or occupational therapy assistant limited permit holder. However, this does not absolve the occupational therapy assistant and/or occupational therapy assistant limited permit holder from his/her professional responsibilities. The occupational therapy assistant and/or occupational therapy assistant limited permit holder shall exercise sound judgement and provide adequate care in the performance of duties. The occupational therapy assistant and/or occupational therapy assistant limited permit holder shall— (A) Not initiate any patient/client treatment program or modification of said program until the supervising occupational therapist has evaluated, established a treatment plan and consulted with the occupational therapy assistant and/or occupational therapy assistant limited permit holder; (B) Not perform an evaluation/assessment, but may contribute to the screening and/or evaluation process by gathering data, administering standardized tests and reporting observations; (C) Not analyze or interpret evaluation data; (D) Track the need for reassessment and report changes in status that might warrant reassessment or referral; (E) Immediately suspend any treatment intervention that appears harmful to the patient/client and immediately notify the supervising occupational therapist; and (F) Ensure that all patient/client documentation prepared by the occupational therapy assistant and/or occupational therapy assistant limited permit holder becomes a part of the permanent record. (5) The supervisor shall ensure that the occupational therapy assistant and/or occupational therapy assistant limited permit holder provides occupational therapy as defined in section 324.050, RSMo appropriate to and consistent with his/her education, training, and experience.
Montana	**<u>Statute:</u> Montana Code Annotated §37-24-103 Definitions** As used in this chapter, unless the context requires otherwise, the following definitions apply: (2) "Certified occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under this chapter, who works under the general supervision of an occupational therapist in accordance with the provisions of the national board for certification in occupational therapy, inc., and adopted by the board. (7) "Occupational therapy assistant" means a person who is licensed to assist in the practice of occupational therapy under this chapter and who works under the general supervision of an occupational therapist. **<u>Regulation:</u> Administrative Regulations of Montana 24.165** **Subchapter 3 Definitions** 24.165.302 DEFINITIONS For the purpose of this chapter the following definitions apply: (4) “Direct supervision” means the supervisor is physically present in the direct treatment area of the client-related activity being performed by the supervisee and requires face-to-face communication, direction, observation, and daily evaluation. (6) “General supervision” means the supervisor provides face-to-face communication, direction, observation, and evaluation of a supervisee’s delivery of client services at least monthly at the site of client-related activity, with interim supervision occurring by other methods, such as telephonic, electronic, or written communication. **Subchapter 5 Licensing and Scope of Practice** 24.165.501 SUPERVISION

	(1) Supervisors shall determine the required level of supervision based on the supervisee's clinical experience, responsibilities, and competence. (2) Occupational therapists do not require supervision except for direct supervision of proctored treatments. (3) Except per 37-24-105(2) and 37-24-106(2), MCA, certified occupational therapy assistants must work under the general supervision of an occupational therapist.
Nebraska	**Statute: Nebraska Revised Statutes, Chapter 38** **38-2512 Occupational therapy assistant, defined.** Occupational therapy assistant means a person holding a current license to assist in the practice of occupational therapy. **38-2527 Occupational therapy assistant; supervision required.** An occupational therapy assistant may deliver occupational therapy services enumerated in section 38-2526 in collaboration with and under the supervision of an occupational therapist. **Regulation: Nebraska Administrative Code 172 NAC 114** 002. DEFINITIONS. Definitions are set out in the Occupational Therapy Practice Act, the Uniform Credentialing Act, 172 Nebraska Administrative Code (NAC) 10, and this chapter. 002.06 CERTIFIED OCCUPATIONAL THERAPY ASSISTANT. A person who is certified pursuant to guidelines established by the National Board for Certification in Occupational Therapy (NBCOT). 002.07 CONSULTATION OR IN ASSOCIATION WITH. Providing professional advice. 002.14 OCCUPATIONAL THERAPIST REGISTERED. A person who is registered under guidelines established by the National Board for Certification in Occupational Therapy (NBCOT). 002.15 ONSITE. The location where the occupational therapy assistant is providing occupational therapy services. 002.16 ONSITE SUPERVISION. The occupational therapist or occupational therapy assistant must be physically present at the practice site to direct all actions when occupational therapy services are being provided. 002.17 SUPERVISION. The process by which the quantity and quality of work of an occupational therapy assistant is monitored. Supervision means the directing of the authorized activities of an occupational therapy assistant by a licensed occupational therapist and will not be construed to require the physical presence of the supervisor when carrying out assigned duties. 002.18 TREATMENT PLAN. A written statement setting forth the goals, method of treatment, and time frame for goal achievement. 005. REQUIREMENTS FOR CONSULTING WITH OR SUPERVISING AN OCCUPATIONAL THERAPY ASSISTANT. An occupational therapy assistant may assist in the practice of occupational therapy under the supervision of or in consultation with an occupational therapist. 005.01 STANDARDS. An occupational therapist that is supervising or consulting with an occupational therapy assistant must meet the following standards: (A) Evaluate each patient prior to treatment by the occupational therapy assistant; (B) Develop a treatment plan outlining which elements have been delegated to the occupational therapy assistant; (C) Monitor the patient's progress; (D) Approve any change in the occupational therapy treatment plan;

	(E) Ensure that the occupational therapy assistant is assigned only to duties and responsibilities for which he or she has been specifically trained and is qualified to perform; (F) Review all documentation written by the occupational therapy assistant; (G) Interpret the results of tests which are administered by the occupational therapy assistant; and (H) Evaluate the treatment plan and determine termination of treatment. 005.02 REQUIREMENTS. An occupational therapist supervising an occupational therapy assistant must meet the following requirements: (A) A minimum of 4 hours per month of on-site supervision if an occupational therapy assistant has more than 1 year satisfactory work experience as an occupational therapy assistant; or (B) A minimum of 8 hours per month of on-site supervision if an occupational therapy assistant has less than 1 year satisfactory work experience as an occupational therapy assistant.
Nevada	**<u>Statute:</u> Nevada Revised Statutes 640A.070** "Occupational therapy assistant" means a person who is licensed pursuant to this chapter to practice occupational therapy under the general supervision of an occupational therapist. **<u>Regulation:</u> Nevada Administrative Code Chapter 640A** 1. An occupational therapist who is the treating occupational therapist of record for a patient remains the treating occupational therapist of record for the patient until the responsibility for the program of treatment for the patient is reassigned to another occupational therapist. After such a reassignment, the occupational therapist to whom the responsibility for the program of treatment for the patient is reassigned shall be the treating occupational therapist of record for the patient. 2. A reassignment of the responsibility for the program of treatment for a patient from the treating occupational therapist of record to another occupational therapist must be noted in the record of the patient. 3. Temporary or intermittent services provided to a patient by an occupational therapist who is not the treating occupational therapist of record for the patient and which are consistent with the program of intervention of the patient do not constitute a reassignment of the responsibility for the treatment of the patient for the purposes of this section. **NAC 640A.010 Definitions.** 640A.012 "Certified occupational therapy assistant" means a person who is certified as an occupational therapy assistant by the National Board for Certification in Occupational Therapy, Inc., or its successor organization. 640A.0143 "Primary supervisor" means a licensed occupational therapist who is responsible for the general supervision of an occupational therapy assistant or provisional licensee during his or her term of employment. 640A.0165 "Supervision" means a collaborative process for the responsible, periodic review and inspection of all aspects of any occupational therapy services provided. 640A.018 "Treating occupational therapist" means a licensed occupational therapist who is responsible for the program of treatment of a patient.

	NAC 640A.250 Occupational therapy assistant or provisional licensee: Practice under general supervision of occupational therapist. 1. An occupational therapy assistant or a provisional licensee shall not practice occupational therapy without the general supervision of an occupational therapist. Immediate physical presence or constant presence on the premises where the occupational therapy assistant or provisional licensee is practicing is not required of the occupational therapist. To provide satisfactory general supervision, the treating occupational therapist shall: (a) Provide an initial program of intervention, and any subsequent changes to the initial program, for patients assigned to the occupational therapy assistant or provisional licensee. (b) Not less than 1 hour for each 40 hours of work performed by the occupational therapy assistant or provisional licensee and, in any event, not less than 1 hour each month, engage in: (1) Clinical observation of the occupational therapy assistant or provisional licensee; or (2) Direct communication with the occupational therapy assistant or provisional licensee. The mode and frequency of that communication is dependent upon the setting for the practice of the occupational therapy assistant or provisional licensee. Direct communication may consist of, without limitation: (I) Direct or joint treatment of a patient; (II) Personal supervision of the occupational therapy assistant or provisional licensee while providing services; (III) Conversation, in person or by telephone; (IV) Exchange of written comments; (V) Review of patient records; or (VI) Conferences, or other face-to-face meetings; or (VII) Communications conducted using audio-video communications technology. (c) Establish the patient workload of the occupational therapy assistant or provisional licensee based on the competency of the occupational therapy assistant or provisional licensee as determined by the occupational therapist. (d) Review written documentation prepared by the occupational therapy assistant or provisional licensee during the course of treatment of a patient. The completion of this review by the occupational therapist may be evidenced by: (1) Preparation of a separate progress note; or (2) The occupational therapist signing and dating the document prepared by the occupational therapy assistant or provisional licensee. 2. The treating occupational therapist and the occupational therapy assistant or provisional licensee shall jointly: (a) Document, in a manner other than the mere signing of service records prepared by another person, the supervision required pursuant to this section. Such documentation may include, without limitation, the preparation of: (1) Daily or weekly treatment or intervention schedules; (2) Logs of supervision, which include, without limitation, the time and date of supervision, the type of supervision provided and the subject matter covered during the supervision; and (3) Patient records. (b) Ensure that the record regarding a patient treated by the occupational therapy assistant or provisional licensee is signed, dated and reviewed at least monthly by the occupational therapy assistant or provisional licensee and the occupational therapist. In reviewing the record, the occupational therapist and the occupational therapy assistant or provisional licensee shall verify, without limitation: (1) The accuracy of the record; and (2) That there is continuity in the services received by the patient pursuant to the program of intervention.

	3. An occupational therapy assistant or provisional licensee may assist an occupational therapist in: (a) Preparing and disseminating any written or oral reports, including, without limitation, the final evaluation and discharge summary of a patient; (b) Unless the treatment is terminated by a patient or his or her provider of health care, determining when to terminate treatment; and (c) Delegating duties to an occupational therapy aide or technician. 4. An occupational therapy assistant or provisional licensee shall document all treatment provided to a patient by the occupational therapy assistant or provisional licensee. 5. An occupational therapist shall not delegate responsibilities to an occupational therapy assistant or provisional licensee which are beyond the scope of the training of the occupational therapy assistant or provisional licensee. 6. The provisions of this section do not prohibit an occupational therapy assistant or provisional licensee from responding to acute changes in a patient's condition that warrant immediate assistance or treatment. 7. As used in this section, "sign" means to inscribe by handwriting or electronic means one's name, initials or license number. **NAC 640A.255 Occupational therapy assistant or provisional licensee: Review and approval of supervisory logs by primary supervisor; general supervision by treating occupational therapist.** 1. A primary supervisor of an occupational therapy assistant or a provisional licensee shall review documentation maintained by both the treating occupational therapist and the occupational therapy assistant or provisional licensee pursuant to NAC 640A.250 to ensure that such documentation satisfies the requirements of that section. 2. A treating occupational therapist shall provide general supervision, as described in NAC 640A.250, to an occupational therapy assistant or provisional licensee to whom he or she delegated duties for the provision of care to a patient. 3. A treating occupational therapist is responsible for all occupational therapy services provided by an occupational therapy assistant or provisional licensee to whom he or she delegates duties for the provision of care to a patient. **NAC 640A.260 Occupational therapy assistant or provisional licensee: Verification to Board of employment and supervision; notice of termination; number of primary supervisors required per employer of record.** 1. An occupational therapy assistant or provisional licensee shall submit verification of his or her employment and supervision by a primary supervisor to the Board within 30 days after a change in the employment or primary supervisor. The verification must be submitted in a format approved by the Board. 2. An occupational therapist who is a primary supervisor shall notify the Board within 30 days after the termination of his or her supervision of an occupational therapy assistant or provisional licensee. 3. An occupational therapy assistant or provisional licensee must have at least one primary supervisor and may have one alternate primary supervisor for each employer of record. **NAC 640A.265 Occupational therapy assistant or provisional licensee: Delegation of duties by treating occupational therapist; limitations.** 1. A treating occupational therapist shall provide direction to and supervise any program of intervention which is delegated to an occupational therapy assistant or provisional licensee and shall ensure that the occupational therapy assistant or provisional licensee does not function autonomously. 2. Only an occupational therapist may: (a) Interpret the record of a patient who is referred to the occupational therapist by a provider of health care;

	(b) Interpret the evaluation of a patient and identify any problem of the patient; (c) Develop a plan of care for a patient based upon the initial evaluation of the patient, which includes the goal of the treatment of the patient; (d) Determine the appropriate portion of the program of intervention and evaluation to be delegated to an occupational therapy assistant; (e) Delegate the treatment to be administered by the occupational therapy assistant; (f) Instruct the occupational therapy assistant regarding: (1) The specific program of intervention of a patient; (2) Any precaution to be taken to protect a patient; (3) Any special problem of a patient; (4) Any procedure which should not be administered to a patient; and (5) Any other information required to treat a patient; (g) Review the program of intervention of a patient in a timely manner; (h) Record the goal of treatment of a patient; and (i) Revise the plan of care when indicated. 3. A treating occupational therapist may delegate to an occupational therapist who holds a provisional license any of the activities identified in subsection 2. 4. An occupational therapy assistant shall not: (a) Write formal evaluations of the progress of a patient to another health care professional. For the purposes of this paragraph, daily chart notes in the records of a patient does not constitute a formal evaluation of the progress of the patient. (b) Participate in any meeting with a patient or a health care professional, including, without limitation, a meeting in an educational setting, at which: (1) The occupational therapy assistant is the sole licensee; and (2) The program of intervention of a patient may be modified. (c) Make clinical decisions regarding the provision of occupational therapy services to a patient that conflict with or overrule the decisions of an occupational therapist. 5. An occupational therapy assistant or provisional licensee shall notify the treating occupational therapist of record for a patient and document in the records of the patient any change in the: (a) General condition of the patient; and (b) Condition of a patient that is not within the planned progress or treatment goals of the patient. 6. A treating occupational therapist of record for a patient shall continuously follow the progress of the patient. 7. Except as otherwise provided in NAC 640A.267, a licensee shall not knowingly delegate to a person who is less qualified than the licensee any program of intervention which requires the skill, common knowledge and judgment of the licensee. 8. As used in this section, "health care professional" has the meaning ascribed to it in NRS 629.076, as amended by section 15 of Senate Bill No. 137, chapter 289, Statutes of Nevada 2021, at page 1595.
New Hampshire	**Statute: New Hampshire Statutes Title XXX, Chapter 326-C, Section 326-C.1, Definitions.** In this chapter and RSA 328-F, unless the context otherwise requires: IV. "Occupational therapy assistant" means a person currently licensed to assist in the practice of occupational therapy, under the supervision of an occupational therapist, in the state of New Hampshire.

	<u>Regulations:</u> New Hampshire Administrative Rules, Occ 100 ORGANIZATIONAL RULES, Rules, Section 102.04, Definitions "Occupational therapy assistant (OTA)" means "occupational therapy assistant" as defined in RSA 326-C:1, IV, namely, "a person currently licensed to assist in the practice of occupational therapy, under the supervision of an occupational therapist, in the state of New Hampshire." **<u>Regulations:</u> New Hampshire Administrative Rules, Occ 300 REQUIREMENTS FOR LICENSURE, Part Occ 301 Definitions.** **Occ 301.04** "Direct supervision" means supervision through direct and continuous observation of the activities of the person being supervised. **Occ 301.05** "Indirect supervision" means supervision through the supervisor's review of the treatment progress notes made by the person supervised, telephone conversations between the supervisor and the person supervised, electronic correspondence between the supervisor and the person supervised or any other form of supervision which is not direct supervision. **<u>Regulations:</u> New Hampshire Administrative Rules, Occ 400 CONTINUED STATUS, Part 407 ONGOING REQUIREMENTS** **Occ 407.06** Supervision of Occupational Therapy Assistants. (a) Occupational therapy assistants shall be supervised in their work in occupational therapy by occupational therapists: (1) Who meet the description in Occ 408.07; (2) In accordance with the requirements of (b), (c) and (d) below; and (3) For periods longer than those set forth in (b), (c) and (d) below whenever such longer periods are required for accurate implementation of treatment plans. (b) Occupational therapy assistants with less than one year of paid experience in occupational therapy shall be directly supervised at least 5% of their work time and indirectly supervised an additional 10% of their work time. (c) Occupational therapy assistants with one to 5 years of paid experience in occupational therapy shall be directly supervised during at least 5% of their work time and indirectly supervised an additional 5% of their work time. (d) Occupational therapy assistants with greater than 5 years of paid experience in occupational therapy shall receive both direct and indirect supervision during 5% of their work time. **Occ 407.07 Qualifications to be a Supervisor.** To qualify to supervise occupational therapy assistants individuals shall be: (a) Currently licensed in New Hampshire as occupational therapists; (b) Not under disciplinary investigation by the board or under pending disciplinary charges in the facilities where supervision is to take place; and (c) Not related in any of the following ways to the occupational therapy assistants being supervised: (1) Spouse; (2) Parent, step-parent, parent-in-law or step-parent in-law; (3) Natural, foster or adopted child or stepchild; (4) Sibling, brother-in-law or sister-in-law; (5) First or second cousin; (6) Grandparent; or (7) Aunt or uncle.

	Occ 407.08 Limitation on Number of Occupational Therapy Assistants Under Supervision. An occupational therapist shall not supervise at any one time more occupational therapy assistants than those whose combined work hours total the work hours of 2 full-time occupational therapy assistants. **Occ 407.09** Occupational Therapy Assistants' Obligation to Present Supervision Rules to Supervisors and to Report Supervision to the Board. (a) Before beginning work in occupational therapy, an occupational therapy assistant shall: (1) Give to the person intending to provide supervision to the assistant a copy of Occ 408.06-Occ 408.10 and the supervision form; (2) Discuss the supervision requirements with the person intending to provide supervision; and (3) Submit to the board the completed supervision form. (b) An occupational therapy assistant shall submit a revised or additional supervision form to the board: (1) Within 30 days of the date of change each time there is a change in the person providing supervision to the assistant; and (2) Whenever the occupational therapy assistant takes on a second employer. **Occ 407.10** Supervision Form. (a) The supervision form shall be the form as specified in Ahp 601.06.
New Jersey	**Statute: New Jersey Legislative Statutes §45:9-37.53. Definitions.** "Occupational therapy assistant" means a person licensed pursuant to the provisions of this act to assist in the practice of occupational therapy under the supervision of or in collaboration with an occupational therapist on a regularly scheduled basis for the purpose of the planning, review, or evaluation of occupational therapy services. "Supervision" means the responsible and direct involvement of a licensed occupational therapist with an occupational therapy assistant for the development of an occupational therapy treatment plan and the periodic review of the implementation of that plan. The form and extent of the supervision shall be determined by the council. **Regulation: New Jersey Administrative Code, 13:44K-1.2, DEFINITIONS** The following words and terms, as used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise: "Occupational therapy assistant" means a person licensed pursuant to the provisions of the Act and this chapter to assist in the practice of occupational therapy under the supervision of an occupational therapist on a regularly scheduled basis for the purpose of planning, review or evaluation of occupational therapy services. "Supervision" means the responsible and direct involvement of a licensed occupational therapist with an occupational therapy assistant, a temporary licensed occupational therapist, a temporary licensed occupational therapy assistant or an occupational therapy student fulfilling the required fieldwork component of his or her educational training, for the development of an occupational therapy treatment plan and the periodic review of the implementation of that plan. Such supervision shall be close, routine or general, consistent with the following: 1. "Close supervision" means daily, face-to-face contact with and frequent observation of the performance of the individual at the location where he or she is rendering services;

	2. "Routine supervision" means face-to-face contact with and observation of the performance of the individual at least once a week at the location where he or she is rendering services; and 3. "General supervision" means face-to-face contact with and observation of the performance of the individual at least once every two weeks at the location where he or she is rendering services. **<u>Regulation:</u> New Jersey Administrative Code, Tile 13, Chapter 44K, Subchapter 6, Supervision** **6.1 SUPERVISION REQUIREMENT** a) A licensed occupational therapy assistant or temporary licensed occupational therapist shall provide occupational therapy services only under the supervision of a licensed occupational therapist pursuant to the provisions of this subchapter. b) A temporary licensed occupational therapy assistant shall work only under the supervision of a licensed occupational therapist, or a licensed occupational therapy assistant who has been delegated supervisory responsibilities pursuant to N.J.A.C. 13:44K-6.6, pursuant to the provisions of this subchapter. c) The supervising occupational therapist shall retain responsibility for the occupational therapy care of the client being treated by the licensed occupational therapy assistant, a temporary licensed occupational therapist, or a temporary licensed occupational therapy assistant. d) In the event of a change of the supervising occupational therapist, the subsequent supervisor shall assume responsibility for the ongoing supervision of any occupational therapy assistant(s), temporary licensed occupational therapist(s), or temporary licensed occupational therapy assistant(s) providing care to a client and shall become the designated supervisor. **6.2 DESIGNATED SUPERVISOR: GENERAL QUALIFICATIONS AND RESPONSIBILITIES** a) Prior to supervising any person engaged in the practice of occupational therapy services, a licensed occupational therapist shall have at least 1,200 hours of work experience obtained in no less than one year and within three consecutive years of practice. b) A licensed occupational therapist shall not supervise more than five licensees, including occupational therapy assistants, temporary licensed occupational therapists or temporary licensed occupational therapy assistants. c) A licensed occupational therapist may supervise five occupational therapy students who are fulfilling the required fieldwork component of their educational training. d) Notwithstanding the provisions of (b) and (c) above, a licensed occupational therapist shall not supervise more than seven persons at one time. e) A designated supervisor shall maintain a written plan of supervision that shall include evidence of the ongoing supervision of each occupational therapy assistant and temporary licensee for whom the supervisor is responsible. **6.3 RESPONSIBILITIES OF A DESIGNATED SUPERVISOR: OCCUPATIONAL THERAPY ASSISTANT** a) A designated supervisor shall be responsible for the close, routine, or general supervision of an occupational therapy assistant. b) A designated supervisor shall determine the level of supervision required of each occupational therapy assistant consistent with the condition of the client, the education, skill, and training of the occupational therapy assistant, and the nature of the tasks and activities to be performed by the occupational therapy assistant; provided, however, that a designated supervisor shall provide close supervision for any occupational therapy assistant who has been engaged in the practice of occupational therapy services for less than one year on a full-time basis. 1) For purposes of this subsection, “full-time basis” means 1,200 hours of practice. No more than 30 hours of practice shall be obtained in any one week.

	c) When providing routine or general supervision of an occupational therapy assistant, a designated supervisor may also provide interim supervision of the occupational therapy assistant through telephonic or written communications, including reports and/or conferences, between the supervisor and the occupational therapy assistant. d) A designated supervisor who is unavailable to provide occupational therapy assistants with either routine or general supervision as required in (a), (b), or (c) above, for two or more contact periods, shall arrange for substitute supervision by a licensed occupational therapist, who shall follow the established plan of supervision. e) A designated supervisor who is unable to provide occupational therapy assistants with close supervision as required in (b) above, for more than one day, shall arrange for substitute supervision by a licensed occupational therapist, who shall follow the established plan of supervision. **6.4 RESPONSIBILITIES OF A DESIGNATED SUPERVISOR: TEMPORARY LICENSE HOLDER** a) A designated supervisor shall be responsible for the close supervision of a temporary license holder. b) A designated supervisor who is unavailable to provide a temporary license holder with supervision as required by (a) above, for more than one day, shall arrange for substitute supervision by a licensed occupational therapist, who shall follow the established plan of supervision. **6.5 RESPONSIBILITIES OF AN OCCUPATIONAL THERAPY ASSISTANT AND TEMPORARY LICENSE HOLDER** a) An occupational therapy assistant, a temporary licensed occupational therapist, or a temporary licensed occupational therapy assistant shall not render nor continue to render client care unless he or she has obtained ongoing direction from his or her designated supervisor. b) An occupational therapy assistant, a temporary licensed occupational therapist, and a temporary licensed occupational therapist assistant shall each be responsible for clients within the limits of his or her respective scope of practice pursuant to N.J.A.C. 13:44K-5.1 or 5.2, as applicable. c) An occupational therapy assistant, a temporary licensed occupational therapist, and a temporary licensed occupational therapist assistant shall maintain a record of supervision, which shall include the name and license number of his or her designated supervisor, the date when the occupational therapy assistant or temporary licensee received supervision, and the type of supervision that was provided. **6.6 DELEGATION OF SUPERVISION RESPONSIBILITIES** a) A designated supervisor providing close supervision of an occupational therapy assistant, a temporary licensed occupational therapy assistant or an occupational therapy student, may delegate his or her supervisory responsibility for the daily, face-to-face contact with and frequent observation of the performance of the occupational therapy assistant, the temporary licensed occupational therapy assistant or the occupational therapy student, to an occupational therapy assistant who, in the professional judgment of the supervising occupational therapist, has been adequately prepared by verified training and education in the provision of occupational therapy services consistent with the requirements set forth at N.J.A.C. 13:44K-2.1. b) Notwithstanding the provisions of (a) above, no designated supervisor shall delegate his or her responsibilities for close supervision of an occupational therapy assistant to an occupational therapy assistant who has less than 3,600 hours of work experience obtained within a five year period in the particular practice area in which services are being provided. c) A licensed occupational therapy assistant who has been delegated supervision responsibilities pursuant to (a) and (b) above, shall not supervise more than three persons at one time. d) Notwithstanding the provisions of (a), (b) and (c) above, a licensed occupational therapist shall not supervise more than seven persons at one time, pursuant to the provisions of N.J.A.C. 13:44K-6.2.

	e) When supervision of an occupational therapy assistant, a temporary licensed occupational therapy assistant or an occupational therapy student is delegated pursuant to the provisions of (a), (b), (c) and (d) above, the supervising occupational therapist shall retain responsibility for all occupational therapy care of the client.
New Mexico	**Statute: New Mexico Revised Statutes, Chapter 61, Article 12A** **61-12A-3. Definitions.** H. "occupational therapy assistant" means a person having no less than an associate degree in occupational therapy and holding an active license to practice occupational therapy in New Mexico who assists an occupational therapist under the supervision of the occupational therapist. **61-12A-5. Supervision; required; defined.** A. Occupational therapy shall not be performed by an occupational therapy assistant, occupational therapy aide, or technician or by any person practicing on a provisional permit unless such therapy is supervised by an occupational therapist. The Board shall adopt rules defining supervision, which definitions may include various categories such as "close supervision", "routine supervision", and "general supervision". **Regulation: New Mexico Administrative Code Title 16, Chapter 15, Part 3 Supervision** **16.15.3.7 Definitions** In this section, the following terms have the meanings indicated: A. "Aide" means a person who is not licensed by the board and who provides supportive services to occupational therapists and occupational therapy assistants. An aide shall function under the guidance and responsibility of the occupational therapist and may be supervised by the occupational therapist or an occupational therapy assistant for specifically selected routine tasks for which the aide has been trained and has demonstrated competency. B. "Board" means the board of examiners for occupational therapy. C. "Competence" refers to an individual's capacity to perform job responsibilities. D. "Competency" refers to an individual's actual performance in a specific situation. E. "Limited permit holder" means an individual who has completed the academic and fieldwork requirements of this Act for occupational therapists or occupational therapy assistants, has not yet taken or received the results of the entry level certification examination, and has applied for and been granted limited permit status. F. "Occupational therapist" means a person who holds an active license to practice occupational therapy in New Mexico. G. "Occupational therapy assistant" means a person having no less than an associate degree in occupational therapy and holding an active license to practice occupational therapy in New Mexico who assists an occupational therapist under the supervision of the occupational therapist. H. "Supervision" means a cooperative process in which two or more people participate in a joint effort to establish, maintain, and elevate a level of competence and performance. Within the scope of occupational therapy practice, supervision is aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and development. I. "Supportive services" means tasks that include providing patient transport, routine maintenance of equipment or work areas, setup, preparation, and cleanup of equipment of work areas, and supporting licensed practitioners during treatment or intervention while under the direct supervision of the licensed practitioner.

16.15.3.8 Supervision

A. Occupational therapy assistants: supervision involves guidance and oversight related to the delivery of occupational therapy services and the facilitation of professional growth and competence. It is the responsibility of the occupational therapist and the occupational therapy assistant to seek the appropriate quality and frequency of supervision to ensure safe and effective occupational therapy service delivery.

(1) The specific frequency, methods, and content of supervision may vary by practice setting and is dependent upon the:

(a) complexity of client needs;
(b) number and diversity of clients;
(c) skills of the occupational therapist and the occupational therapy assistant;
(d) type of practice setting;
(e) requirements of the practice setting; and
(f) other regulatory requirements.

(2) More frequent supervision may be necessary when:

(a) the needs of the client and the occupational therapy process are complex and changing;
(b) the practice setting provides occupational therapy services to a large number of clients with diverse needs; or
(c) the occupational therapist and occupational therapy assistant determine that additional supervision is necessary to ensure safe and effective delivery of occupational therapy services.

(3) A variety of types and methods of supervision may be used. Methods may include direct face-to-face contact and indirect contact. Examples of methods or types of supervision that involve direct face-to-face contact include but are not limited to observation, modeling, co-treatment, discussions, teaching, instruction, and video teleconferencing. Examples of methods or types of supervision that involve indirect contact include but are not limited to phone conversations, written correspondence, electronic exchanges, and other methods using secure telecommunication technology. All methods should be compliant with confidentiality requirements of government agencies, facilities, employers, or other appropriate bodies.

(4) Occupational therapists and occupational therapy assistants must document a supervision plan and supervision contacts. Documentation shall include the:

(a) frequency of supervisory contact;
(b) method(s) or type(s) of supervision;
(c) content areas addressed;
(d) names and credentials of the persons participating in the supervisory process.

(5) An occupational therapist is limited to supervising three or fewer occupational therapy assistants during their first year of licensure as an occupational therapist.

(6) After the first year of licensure, an occupational therapist must make the decision on the number of appropriate occupational therapy assistants to be supervised depending on the experience of the occupational therapy assistant, complexity of the patient or client needs and the setting of care.

16.15.3.9 Task Delegation

Regardless of the setting in which occupational therapy services are delivered, the occupational therapist and the occupational therapy assistant assume the following generic responsibilities during evaluation, intervention, and outcomes evaluation.

A. Evaluation.

(1) The occupational therapist directs the evaluation process.

	(2) The occupational therapist is responsible for directing all aspects of the initial contact during the occupational therapy evaluation, including: (a) determining the need for service; (b) defining the problems within the domain of occupational therapy that need to be addressed; (c) determining the client's goals and priorities; (d) establishing intervention priorities; (e) determining specific further assessment needs; and (f) determining specific assessment tasks that can be delegated to the occupational therapy assistant; (3) The occupational therapist initiates and directs the evaluation, interprets the data, and develops the intervention plan. (4) The occupational therapy assistant contributes to the evaluation process by implementing delegated assessments and by providing verbal and written reports of observations and client capacities to the occupational therapist. (5) The occupational therapist interprets the information provided by the occupational therapy assistant and integrates that information into the evaluation and decision making process. B. Intervention planning. (1) The occupational therapist has overall responsibility for the development of the occupational therapy intervention plan. (2) The occupational therapist and the occupational therapy assistant collaborate with the client to develop the plan. (3) The occupational therapy assistant is responsible for being knowledgeable about evaluation results and for providing input into the intervention plan, based on client needs and priorities. C. Intervention Implementation. (1) The occupational therapist has overall responsibility for implementing the intervention. (2) Then delegating aspects of the occupational therapy intervention to the occupational therapy assistant, the occupational therapist is responsible for providing appropriate supervision. (3) The occupational therapy assistant is responsible for being knowledgeable about the client's occupational therapy goals. (4) The occupational therapy assistant selects, implements, and makes modifications to therapeutic activities and interventions that are consistent with demonstrated competency levels, client goals, and the requirements of the practice setting. D. Intervention Review. (1) The occupational therapist is responsible for determining the need for continuing, modifying, or discontinuing occupational therapy services. (2) The occupational therapy assistant contributes to this process by exchanging information with and providing documentation to the occupational therapist about the client's responses to and communications during intervention. E. Outcome Evaluation. (1) The occupational therapist is responsible for selecting, measuring, and interpreting outcomes that are related to the client's ability to engage in occupations. (2) The occupational therapy assistant is responsible for being knowledgeable about the client's targeted occupational therapy outcomes and for providing information and documentation related to outcome achievement. (3) The occupational therapy assistant may implement outcome measurements and provide needed client discharge resources.

New York	**<u>Statute:</u> Laws of New York, Education Law, Article 156** **§7902-a Practice of occupational therapy assistant and use of the title "occupational therapy assistant."** Only a person licensed or otherwise authorized under this title shall participate in the practice of occupational therapy as an occupational therapy assistant or use the title "occupational therapy assistant." Practice as an occupational therapy assistant shall include the providing of occupational therapy and client related services under the direction and supervision of an occupational therapist or licensed physician in accordance with the commissioner's regulations. **§7906 Exempt persons.** This article shall not be construed to affect or prevent the following, provided that no title, sign, card or device shall be used in such manner as to tend to convey the impression that the person rendering such service is a licensed occupational therapist: 7. The following people from working under the direct supervision of a licensed occupational therapist: An individual employed by the state or municipal government at the effective date of this article who performs supportive services in occupational therapy solely for the time such person continues in that employment. **<u>Regulations:</u> New York Codes, Rules, and Regulations §76.8 Supervision of an occupational therapy assistant.** a. A written supervision plan, acceptable to the occupational therapist or licensed physician providing direction and supervision, shall be required for each occupational therapy assistant providing services pursuant to section 7902-a of the Education Law. The written supervision plan shall specify the names, professions and other credentials of the persons participating in the supervisory process, the frequency of formal supervisory contacts, the methods (e.g., in-person, by telephone) and types (e.g., review of charts, discussion with occupational therapy assistant) of supervision, the content areas to be addressed, how written treatment notes and reports will be reviewed, including, but not limited to, whether such notes and reports will be initialed or co-signed by the supervisor, and how professional development will be fostered. b. Documentation of supervision shall include the date and content of each formal supervisory contact as identified in the written supervision plan and evidence of the review of all treatment notes, reports and assessments. c. Consistent with the requirements of this section, the determination of the level and type of supervision shall be based on the ability level and experience of the occupational therapy assistant providing the delegated occupational therapy services, the complexity of client needs, the setting in which the occupational therapy assistant is providing the services, and consultation with the occupational therapy assistant. d. The supervision plan shall require that the occupational therapist or licensed physician be notified whenever there is a clinically significant change in the condition or performance of the client, so that an appropriate supervisory action can take place. e. Direction and supervision means that the occupational therapist or licensed physician: 1. initiates, directs and participates in the initial evaluation, interprets the evaluation data, and develops the occupational therapy services plan with input from the occupational therapy assistant; 2. participates, on a regular basis, in the delivery of occupational therapy services; 3. is responsible for determining the need for continuing, modifying, or discontinuing occupational therapy services, after considering any reports by the occupational therapy assistant of any changes in the condition of the client that would require a change in the treatment plan; 4. takes into consideration information provided about the client's responses to and communications during occupational therapy services; and 5. is available for consultation with the occupational therapy assistant in a timely manner, taking into consideration the practice setting, the condition of the client and the occupational therapy services being provided.

	f. In no event shall the occupational therapist or licensed physician supervise more than five occupational therapy assistants, or its full time equivalent, provided that the total number of occupational therapy assistants being supervised by a single occupational therapist or licensed physician shall not exceed 10.
North Carolina	**Statute: North Carolina General Statutes §90-270.67 DEFINITIONS** 3. Occupational therapy assistant. - An individual licensed in good standing to assist in the practice of occupational therapy under this Article, who performs activities commensurate with his or her education and training under the supervision of a licensed occupational therapist. **Regulations: North Carolina Administrative Code Title 21, Chapter 38, Section .0100 Organization and General Provisions** **.0103 DEFINITIONS** (14) "Occupational therapy practitioner" means an individual licensed by the Board as an occupational therapist or an occupational therapy assistant. (21) "Supervision" is the process by which two or more people participate in joint effort to establish, maintain, and elevate a level of performance to ensure the safety and welfare of clients during occupational therapy. Supervision is structured according to the supervisee's qualifications, position, level of preparation, depth of experience and the environment within which the supervisee functions. Levels of supervision are: (a) "General supervision," which is required for all occupational therapy assistants by an occupational therapist. It includes a variety of types and methods of supervision and may include observation, modeling, co-treatment, discussions, teaching, instruction, phone conversations, videoconferencing, written correspondence, electronic exchanges, and other telecommunication technology. Methods of observation include face-to-face, synchronous or asynchronous videoconferencing. The specific frequency, methods, and content of supervision may vary by practice setting and are dependent on the complexity of client needs, number and diversity of clients, demonstrated service competency of the occupational therapist and the occupational therapy assistant, type of practice setting, requirements of the practice setting, and federal and state regulatory requirements. General supervision shall be required at least monthly; and (b) "Direct supervision," which is required for all unlicensed personnel and volunteers. It means the Occupational Therapy supervisor must be within audible and visual range of the client and unlicensed personnel and available for immediate physical intervention. Videoconferencing is not allowed for direct supervision. **Regulations: North Carolina Administrative Code Title 21, Chapter 38, Section .0900 Supervision, Supervisory Roles, and Clinical Responsibilities of Occupational Therapist and Occupational Therapy Assistants** **.0901 NOTIFICATION OF SUPERVISION CHANGE** Occupational therapy assistants and supervising occupational therapists must notify the Board office in writing of any change in ceasing or assuming supervision. The occupational therapist is responsible for supervision of the occupational therapy assistant until official notice that supervision has ceased is received at the Board office. Failure to notify the Board may subject both the occupational therapist and occupational therapy assistant to disciplinary action. Notices must be signed. Telephone or email notices shall not be accepted. **.0902 SUPERVISION IS AN INTERACTIVE PROCESS.** The occupational therapist and the occupational therapy assistant are each responsible for supervision to ensure safe and effective service delivery of occupational therapy services and to foster professional competence and development. The supervising occupational

	therapist shall provide supervision. The occupational therapy assistant shall obtain supervision. Evidence of supervision must be recorded on a supervisory log or in the documentation. **.0903 TYPES OF SUPERVISION** (a) Occupational therapy assistants at all levels shall require general supervision by an occupational therapist pursuant to Rule .0103(21)(a) of this Chapter. **.0904 DOCUMENTATION OF SUPERVISION** (a) Documentation of supervision is the responsibility of both the occupational therapist and occupational therapy assistant. Documentation must include the frequency of supervisory contact, method(s) or type(s) of supervision, content areas addressed, and names and credentials of the persons participating in the supervisory process. (b) Supervision must reflect a review of all aspects of the occupational therapy assistant's practice. In any situation, the occupational therapist is ultimately responsible for all delegated services. Co-signature on occupational therapy service documentation, even if mandated by statute or rule, does not accurately satisfy supervision requirements. (c) Effectiveness of the supervision shall be regularly evaluated by both the occupational therapist and the occupational therapy assistant. **.0905 DELINEATION OF CLINICAL RESPONSIBILITIES** Regardless of the setting in which occupational therapy services are delivered, the occupational therapist and the occupational therapy assistant shall have the following responsibilities during client evaluation, intervention, and outcome evaluation: (1) Evaluations: (a) The occupational therapist shall; (i) Direct the evaluation process; (ii) Determine the need for services; (iii) Define the problems within the domain of occupational therapy that need to be addressed; (iv) Determine the client's goals and priorities in collaboration with the occupational therapy assistant and the client or caregiver; (v) Interpret the information provided by the occupational therapy assistant and integrate that information into the evaluation decision-making process; (vi) Establish intervention priorities; (vii) Determine specific future assessment needs; (viii) Determine specific assessment tasks that can be delegated to the occupational therapy assistant; and (ix) Initiate and complete the evaluation, interpret the data, and develop the intervention plan in collaboration with the occupational therapy assistant. (b) The occupational therapy assistant may contribute to the evaluation process by implementing assessments delegated by the occupational therapist. (2) Intervention Planning: (a) The occupational therapist shall develop the occupational therapy intervention plan. The plan may be developed collaboratively with the occupational therapy assistant and the client or caregiver; and (b) The occupational therapy assistant may provide input into the intervention plan. (3) Intervention implementation: (a) The occupational therapist:

	(i) Shall implement the occupational therapy intervention; (ii) May delegate aspects of the occupational therapy intervention to the occupational therapy assistant; and (iii) Shall supervise all aspects of intervention delegated to the occupational therapy assistant. (b) The occupational therapy assistant shall implement delegated aspects of intervention in which the occupational therapy assistant has established service competency; and (c) Occupational therapists shall not be subject to disciplinary action by the Board for refusing to delegate or refusing to provide the required training for delegation, if the occupational therapist determines that delegation may compromise client safety. (4) Intervention review: (a) The occupational therapist shall meet with each client who has been assigned to an occupational therapy assistant to further assess the client, to evaluate intervention, and, if necessary, to modify the individual's intervention plan; (b) The occupational therapist shall determine the need for continuing or discontinuing services; and (c) The occupational therapy assistant may contribute to the process of determining continuing or discontinuing services by providing information about the client's response to intervention to assist with the occupational therapist's decision making. (5) Documentation: (a) The occupational therapy practitioner shall document each evaluation, intervention, and discharge plan recognizing the requirements of practice settings, payors, and service delivery models. Documentation shall include the following elements: (i) Client name or identifiable information; (ii) Signature with occupational therapist or occupational therapy assistant designation of the occupational therapy practitioner who performed the service; (iii) Date of the evaluation, intervention, or discharge plan; (iv) Objective and measurable description of contact or intervention and client response; and (v) Length of time of intervention session or evaluation. (b) The occupational therapist shall determine the overall completion of the evaluation, intervention, or discharge plan; and (c) The occupational therapy assistant shall; (i) Document intervention, intervention response, and outcome; and (ii) Document client's level of function at discharge. (6) Discharge: (a) The occupational therapist shall determine the client's discharge from occupational therapy services; and (b) The occupational therapy assistant shall: (i) Report data for discharge summary; and (ii) Formulate discharge or follow-up plans under the supervision of the occupational therapist. (7) Outcome evaluation: (a) The occupational therapist is responsible for the selection, measurement, and interpretation of outcomes that are related to the client's ability to engage in occupations; and (b) The occupational therapy assistant must be knowledgeable about duties delegated by the occupational therapist that relate to the client's targeted occupational therapy outcome and provide information relating to outcome achievement.

North Dakota	**Statute: North Dakota Century Code §43-40-01 Definitions.** 4. "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy, under this chapter, who works under the supervision of an occupational therapist. **Regulation: North Dakota Administrative Code Title 55.5, Article 02** **Section 55.5-02-03-01 Supervision.** The occupational therapist and occupational therapy assistant shall exercise appropriate supervision over individuals who are authorized to practice only under supervision. Supervision is a cooperative process in which two or more people participate in a joint effort to establish, maintain, and elevate a level of competence and performance. Within the scope of occupational therapy practice, supervision is aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and development. Supervision involves guidance and oversight related to the delivery of occupational therapy services and the facilitation of professional growth and competence. It is the responsibility of the occupational therapist and the occupational therapy assistant to seek the appropriate quality and frequency of supervision to ensure safe and effective occupational therapy service delivery. **Section 55.5-02-03-01.1 Definitions.** For purposes of sections 55.5-02-03-01.2 and 55.5-02-03-01.3: 1. "Direct supervision" means face-to-face contact, including observation, modeling, cotreatment, discussions, teaching, and video teleconferencing. 2. "Indirect supervision" means other than face-to-face contact, including phone conversations, written correspondence, electronic exchanges, and other methods using secure telecommunication technology. **Section 55.5-02-03-01.2 Supervision of occupational therapy assistants.** An occupational therapy assistant must be supervised by an occupational therapist. 1. An occupational therapist may not supervise more than three occupational therapy assistants licensed or limited permitholders at the same time. 2. An occupational therapy assistant must be directly supervised as needed by evidence of clinical practice, and indirectly supervised as is necessary. In determining the methods, frequency, and content of supervision, an occupational therapist shall consider all of the following: a. Complexity of clients' needs. b. Number and diversity of clients. c. Skills of the occupational therapy assistant. d. Type of practice setting. e. Changes in practice settings. f. Requirements of the practice setting. g. Other regulatory requirements. 3. An occupational therapist and a supervised occupational therapy assistant shall make a written supervision plan, including all of the following: a. Documentation that the occupational therapy assistant is competent to perform the services provided. b. Documentation of the frequency, methods, and content of supervision. c. Documentation of periodic evaluation of the occupational therapy assistant's competence and the supervision necessary.

	4. An occupational therapist shall file with the board a substantiation of supervision form for each occupational therapy assistant supervised before the occupational therapy assistant may practice. If there is a change in supervisors, the new supervisor shall immediately file a new substantiation of supervision form. The form is available from the board. 5. An occupational therapist, who is unavailable to supervise an occupational therapy assistant for more than one day, shall arrange to have supervision available by another occupational therapist as necessary.
Ohio	**Statute: Ohio Revised Code §4755.04, Definitions.** (C) "Occupational therapy assistant" means a person who holds a license or limited permit to provide occupational therapy techniques under the general supervision of an occupational therapist. **Regulation: Ohio Administrative Code Chapter 4755:1-2 Code of Ethical Conduct and Practice Definition.** **4755:1-2-02 Occupational therapy practice defined.** For the purpose of Chapters 4755:1 of the Administrative Code, the following definitions apply: (B) "Occupational therapy assistant" means a person who holds a license to provide occupational therapy techniques under the general supervision of an occupational therapist. (H) "Unlicensed personnel" means any person who is on the job trained and supports the delivery of occupational therapy services by personally assisting the occupational therapist, occupational therapy assistant, student occupational therapist, and/or student occupational therapy assistant while the occupational therapist, occupational therapy assistant, student occupational therapist, and/or student occupational therapy assistant is concurrently providing services to the same client. (I) "Supervising occupational therapist" means the occupational therapist who is available to supervise the occupational therapy assistant, the student occupational therapist, student occupational therapy assistant, or unlicensed personnel. The supervising occupational therapist may be the occupational therapist who performed the initial evaluation or another occupational therapist with whom that occupational therapist has a documented agreement. (J) "Supervising occupational therapy assistant" means the occupational therapy assistant who is appropriately available to supervise the student occupational therapy assistant, the student occupational therapist who is completing the level I fieldwork experience, or unlicensed personnel. **4755:1-2-03 Roles and responsibilities.** (A) Occupational therapist. The occupational therapist must assume professional responsibility for the provision of all occupational therapy services, of which the following activities must not be wholly delegated, regardless of the setting in which the services are provided: (1) Interpretation of referrals or prescriptions for occupational therapy services; (2) Interpretation and analysis for evaluation purposes; (3) Development, interpretation, and modification of the treatment/intervention plan and the discharge plan. (B) Occupational therapy assistant. (1) The occupational therapy assistant may contribute to and collaborate in: (a) The evaluation process by gathering data, administering standardized tests and/or objective measurement tools, and reporting observations. (b) The preparation, implementation, and documentation of the treatment/intervention plan and the discharge plan. (c) Choosing the appropriate treatment interventions. (2) The occupational therapy assistant may independently:

(a) Select the daily modality of choice according to the established treatment/intervention plan.
(b) Document the progress and outcomes summary.
(3) The occupational therapy assistant may not evaluate independently or initiate treatment/intervention before the supervising occupational therapist performs an evaluation.

4755:1-2-04 Delegation.
(A) Occupational therapy assistant.
The occupational therapy assistant may implement the occupational therapy treatment/intervention plan established by the supervising occupational therapist. The supervising occupational therapist must consider the following when delegating to the occupational therapy assistant:
(1) The clinical complexity of the client;
(2) The competency of the occupational therapy assistant;
(3) The occupational therapy assistant's level of training in the treatment/intervention technique; and
(4) Whether continual reassessment of the client's status is needed during treatment/intervention.
(5) Notwithstanding paragraphs (A)(1) to (A)(4) of this rule, the occupational therapy assistant may respond to acute changes in the client's condition that warrant immediate action.
(D) Unlicensed personnel.
(1) Unlicensed personnel may only perform specific tasks which are neither evaluative, task selective, nor recommending in nature. The occupational therapist, occupational therapy assistant, student occupational therapist, or student occupational therapy assistant may delegate such tasks only after ensuring that the unlicensed personnel has been appropriately trained for the performance of the tasks.
(2) The occupational therapist, occupational therapy assistant, student occupational therapist, and student occupational therapy assistant must not delegate the following to unlicensed personnel:
(a) Performance of occupational therapy evaluative services;
(b) Initiation, planning, adjustment, modification, or performance of occupational therapy services;
(c) Making occupational therapy entries directly in the client’s official records; and
(3) The unlicensed personnel must not act independently on behalf of the occupational therapist, occupational therapy assistant, student occupational therapist, or student occupational therapy assistant in any matter related to occupational therapy treatment.

4755:1-2-05 Supervision.
(A) Supervision must ensure consumer protection. The supervising occupational therapist is ultimately responsible for all clients and is accountable and responsible at all times for the actions of persons supervised, including the:
(1) Occupational therapy assistant;
(2) Student occupational therapist;
(3) Student occupational therapy assistant; and
(4) Unlicensed personnel.
(B) The following factors must be considered by the supervising occupational therapist when determining the appropriate frequency, methods, and content of supervision:
(1) Complexity of the client needs;
(2) Number and diversity of clients;
(3) Skills of the occupational therapist and occupational therapy assistant;

	(4) Type and number of practice settings; (5) Requirements of the practice setting; and (6) Any other regulatory or administrative requirements. (C) Occupational therapy assistant. Supervision of the occupational therapy assistant, as defined in division (C) of section 4755.04 of the Revised Code, requires initial direction and periodic inspection of the service delivery and relevant in-service training. The supervising occupational therapist need not be on-site, but must be available for consultation with the occupational therapy assistant at all times. (1) The supervising occupational therapist must provide supervision at least one time per week for all occupational therapy assistants who are in their first year of practice. (2) The supervising occupational therapist must provide supervision at least one time per month for all occupational therapy assistants beyond their first year of practice. (3) Supervision requires an interactive process between the supervising occupational therapist and the occupational therapy assistant. The interactive process must include, but is not limited to, review of the following: (a) Client assessment; (b) Client reassessment; (c) Treatment/intervention plan; (d) Intervention; and (e) Discontinuation of treatment/intervention plan. (4) Co-signing client documentation alone does not meet the minimum level of supervision. (5) The supervising occupational therapy assistant is accountable and responsible at all times for the actions of all student occupational therapy assistants and unlicensed personnel supervised by the supervising occupational therapy assistant.
Oklahoma	**<u>Statute:</u> Oklahoma Statutes Title 59, Section 888.3, Definitions.** 3. "Occupational therapy assistant" means a person licensed to provide occupational therapy treatment under the general supervision of a licensed occupational therapist; **<u>Regulation:</u> Oklahoma Administrative Code Title 435, Chapter 30** **435:30-1-2. Definitions** The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly in-dictates otherwise: "Alternate supervisor" means an Oklahoma licensed Occupational Therapist who has signed a Form #5, Verification of Supervision, agreeing to provide supervision to the Occupational Therapy Assistant or applicant for licensure in the absence of the supervising Occupational Therapist. The alternate supervisor assumes all duties and responsibilities of the primary supervisor during that absence. "Direct supervision" means personal supervision and specific delineation of tasks and responsibilities by an Oklahoma licensed occupational therapist who has signed a Form #5, Verification of Supervision, agreeing to supervise the Occupational Therapy Assistant or applicant for licensure. Direct supervision shall include the responsibility for personally reviewing and interpreting the results of any habilitative or rehabilitative procedures conducted by the supervisee. It is the responsibility of the supervising occupational therapist to be onsite during treatment to ensure that the supervisee does not perform duties for which he is not trained.

"General supervision" means responsible supervision and control by an Oklahoma licensed occupational therapist who has signed a Form #5, Verification of Supervision, agreeing to supervise the Occupational Therapy Assistant or applicant for licensure. The supervising occupational therapist provides both initial direction in developing a plan of treatment and periodic inspection of the actual implementation of the plan. Such plan of treatment shall not be altered by the supervised individual without prior consultation with and approval of the supervising occupational therapist. The supervising occupational therapist need not always be physically present or on the premises when the assistant is performing services; however, except in cases of emergency, supervision shall require the availability of the supervising occupational therapist for consultation with and direction of the supervised individual. Supervision is an interactive process, more than a paper review or a co-signature, and requires direct in-person contact.

"Occupational therapist of record" means the occupational therapist who assumes responsibility for the provision and /or supervision of occupational therapy services for a client, and is held accountable for the coordination, continuation and progression of the plan of care

"Primary supervisor" means the Oklahoma licensed Occupational Therapist who has signed a Form #5, Verification of Supervision, agreeing to provide supervision to the Occupational Therapy Assistant or applicant for licensure. The Primary Supervisor must have access to the client's plan of care.

435:30-1-8. Licensure requirements specific to occupational therapy assistant

(a) An occupational therapy assistant is a person who assists in the duties usually performed by an occupational therapist under the general supervision of a licensed occupational therapist.

435:30-1-16. Responsible supervision

(a) An occupational therapist will not sign the Form #5, Verification of Supervision, to be the direct clinical supervisor for more than a total of four occupational therapy assistants or applicants for licensure regardless of the type of professional licensure or level of training.
(b) It shall be the responsibility of the occupational therapist to monitor the number of persons under his/her direct clinical supervision. It shall be the responsibility of the occupational therapy assistant to inquire of the occupational therapist in regards to the number of persons being directly supervised.
(c) On a case-by-case basis, an occupational therapist may petition the Committee to receive permission to supervise additional occupational therapy assistants or applicants.
(d) If responsible supervision is not practiced, both the occupational therapist and occupational therapy assistant are in violation of this rule.
(e) If the licensed occupational therapist agrees to supervise an occupational therapy assistant, the occupational therapist shall:

(1) determine the frequency and manner of consultations, taking into consideration the treatment settings being used, client rehabilitation status, and the competency of the occupational therapy assistant being supervised;
(2) maintain a record of all consultations provided;
(3) document in the client treatment record each time the occupational therapist supervising the occupational therapy assistant is physically present and directly supervises the treatment of a client by the occupational therapy assistant being supervised.
(4) make herself/himself available to the occupational therapy assistant in person or via telecommunication for consultation prior to implementation of any treatment program revisions; and

	(5) review with the occupational therapy assistant in person or via telecommunication the diagnosis of the condition to be treated, the authorization of the procedure, dismissal of the client, and evaluation of the performance of the treatment given. (f) The licensed occupational therapy assistant shall: (1) consult with the supervising occupational therapist in person or via telecommunication prior to any treatment program revision; and (2) notify the supervising occupational therapist of any significant changes in the physical, cognitive and/or psychological status of the client. Contact, or attempts to contact the supervising occupational therapist will be documented in the record. (g) Occupational therapy assistants with more than one employer must have a primary supervisor at each job who has completed a Form #5, Verification of Supervision. (h) The evaluating occupational therapist will document transfer of care to the occupational therapist of record. **435:30-1-17. Role of Occupational Therapy Assistants in evaluations** An Occupational Therapy Assistant's participation in evaluations is not independent. The Occupational Therapy Assistant works in collaboration with and under the supervision of an Occupational Therapist. It is the Occupational Therapists responsibility to give appropriate supervision and the Occupational Therapy Assistant's responsibility to seek appropriate supervision. The Occupational Therapy Assistant may have a role in the evaluation process and in the administration of assessment tools and instruments under the supervision of an Occupational Therapist after competency has been established. It is the Occupational Therapist who initiates the evaluation process and delegates the appropriate assessment to be carried out by the Occupational Therapy Assistant. The Occupational Therapy Assistant may administer and score these assessments. The Occupational Therapist interprets the results with input from the Occupational Therapy Assistant to establish a treatment plan.
Oregon	**Statute: Oregon Revised Statutes Chapter 675** As used in ORS 675.210 to 675.340, unless the context requires otherwise: (4) “Occupational therapy assistant” means a person licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist. **Regulation: Oregon Administrative Rules Chapter 339, Division 10** **339-010-0005 Definitions** (1) "Supervision," is a process in which two or more people participate in a joint effort to promote, establish, maintain and/or evaluate a level of performance. The occupational therapist is responsible for the practice outcomes and documentation to accomplish the goals and objectives. Levels of supervision: (a) "Close supervision" requires daily, direct contact in person at the work site; (b) "Routine supervision" requires the supervisor to have direct contact in person at least every two weeks at the work site or via telehealth as defined in OAR 339-010-0006(9) with interim supervision occurring by other methods, such as telephone or written communication; (c) "General supervision" requires the supervisor to have at least monthly direct contact in person with the supervisee at the work site or via telehealth as defined in OAR 339-010-0006(9) with supervision available as needed by other methods. **339-010-0035 Supervision of an Occupational Therapy Assistant** (1) Any person who is licensed as an occupational therapy assistant may assist in the practice of occupational therapy only under the supervision of a licensed occupational therapist.

	(2) Before an occupational therapy assistant assists in the practice of occupational therapy: (a) The OTA must log into their online license portal with the board and record the name of the licensed OT who will supervise them, the site where supervision will take place and the supervision start date. (b) The licensed occupational therapist whose name is recorded in the online license portal with the board must log into their online license portal and confirm their supervision of the OTA by updating the approval status to "approved". (3) An occupational therapy assistant always requires at least general supervision. (4) The supervising occupational therapist shall provide closer supervision where professionally appropriate. (5) The supervisor, in collaboration with the supervisee, is responsible for setting and evaluating the standard of work performed.
Pennsylvania	**Statute: Pennsylvania Unconsolidated Statutes, Act No. 140 of 1982, Section 3. Definitions.** The following words and phrases when used in this act shall have, unless the context clearly indicates otherwise, the meanings given to them in this section: "Occupational therapy assistant." A person licensed to assist in the practice of occupational therapy, under the supervision of an occupational therapist. **Regulation: Pennsylvania Code Section 42.22 Supervision of occupational therapy assistants.** (a) Section 3 of the act (63 P. S. § 1503) provides that licensed occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an occupational therapist. ''Under the supervision of an occupational therapist'' means that an occupational therapist currently licensed by the Board: (1) Evaluates the patient/client. (2) Prepares a written program plan. (3) Assigns treatment duties based on that program plan to an occupational therapy assistant currently licensed by the Board who has been specifically trained to carry out those duties. (4) Monitors the occupational therapy assistant's performance. (5) Accepts professional responsibility for the occupational therapy assistant's performance. (b) Supervision includes the following: (1) Communicating to the occupational therapy assistant the results of patient/client evaluation and discussing the goals and program plan for the patient/client. (2) Periodically reevaluating the patient/client and, if necessary, modifying the program plan. (3) Case management. (4) Determining program termination. (5) Providing information, instruction and assistance as needed. (6) Observing the occupational therapy assistant periodically. (7) Preparing on a regular basis, but at least annually, a written appraisal of the occupational therapy assistant's performance and discussing that appraisal with the assistant. (c) Notwithstanding subsections (a)(1) and (b)(2), the supervisor may assign to a competent occupational therapy assistant the administration of standardized tests, the performance of activities of daily living evaluations and other elements of patient/client evaluation and reevaluation that do not require the professional judgment and skill of an occupational therapist. (d) The supervisor shall have supervisory contact with the occupational therapy assistant at least 10% of the time worked by the assistant in direct patient care. ''Supervisory contact'' means face-to-face individual contact, telephone communication, contact through written reports or group conferences among a supervisor and two or more supervisees. Face-to-face individual contact shall occur onsite at least

	once a month and shall include observation of the assistant performing occupational therapy. The specific mode, frequency and duration of other types of supervisory contact depend on the treatment setting, the occupational therapy assistant's caseload, the condition of patients/clients being treated by the assistant and the experience and competence of the assistant as determined by the supervisor. The supervisor shall ensure, however, that supervisory contact within each calendar month includes a combination of face-to-face, telephone and written communication. (e) The supervisor shall maintain a supervisory plan and shall document the supervision of each occupational therapy assistant. Documentation shall include evidence of regular supervision and contact between the supervisor and the assistant. (f) A supervisor who is temporarily unable to provide supervision shall arrange for substitute supervision by an occupational therapist currently licensed by the Board. The substitute shall provide supervision that is as rigorous and thorough as that provided by the permanent supervisor. (g) Failure to comply with this section constitutes unprofessional conduct under section 16(a)(2) of the act (63 P. S. § 1516(a)(2)).
Puerto Rico	**Statute: Laws of Puerto Rico Title 20, Chapter 51, Section 1031 Definitions** (3) Assistant in occupational therapy. — The person who under the supervision of a licensed occupational therapist performs selective tasks or activities proper to occupational therapy. **Regulation: L. Num 137, § 1.3 (translation)** The occupational therapy assistant is the person who assists or helps the occupational therapist in selected tasks or activities that require neither the ability, judgement nor extensive knowledge required of occupational therapists. The occupational therapy assistant's work is made under the immediate direction of the occupational therapist.
Rhode Island	**Statute: Rhode Island General Laws Title 5, Chapter 40** **Section 5-40.1-3. Definitions.** (j) "Occupational therapy assistant" means a person licensed to practice occupational therapy under the provisions of this chapter and the rules and regulations authorized by this chapter. (k) "Supervision" means that a licensed occupational therapist or occupational therapy assistant is at all times responsible for supportive personnel and students. **Section 5-40.1-21 Supervision.** (a) A licensed occupational therapist shall exercise sound judgment and shall provide adequate care in the performance of duties. A licensed occupational therapist shall be permitted to supervise the following: occupational therapists, occupational therapy assistants, occupational therapy aides, care extenders, occupational therapy students, and volunteers. (b) A licensed occupational therapy assistant shall exercise sound judgment and shall provides adequate care in the performance of duties. A licensed occupational therapy assistant shall be permitted to supervise the following: occupational therapy aides, care extenders, students, and volunteers. (c) Subject to the requirements of this section, a licensed occupational therapy assistant may practice limited occupational therapy only under the supervision of a licensed occupational therapist. Supervision requires at a minimum that the supervising licensed occupational therapist meet in person with the licensed occupational therapy assistant to provide initial direction and periodic on-site supervision. The supervising licensed occupational therapist working with the licensed occupational therapy assistant shall determine the amount and type of supervision necessary in response to the experience and competence of the licensed occupational therapy assistant and the complexity of the treatment program. The supervisor and the licensed occupational therapy assistant shall be jointly responsible for maintaining records, including patient records, to document compliance with this regulation.

	(d) A licensed occupational therapy assistant: (1) May not initiate a treatment program until the patient has been evaluated and the treatment planned by the licensed occupational therapist; (2) May not perform an evaluation, but may assist in the data gathering process and administer specific assessments where clinical competency has been demonstrated, under the direction of the licensed occupational therapist; (3) May not analyze or interpret evaluation data; (4) May participate in the screening process by collecting data and communicate the information gathered to the licensed occupational therapist; (5) Monitors the need for reassessment and report changes in status that might warrant reassessment or referral under the supervision of the licensed occupational therapist; and (6) Immediately discontinues any treatment procedure, which appears harmful to the patient and immediately notifies the supervising occupational therapist. (e) (1) An occupational therapy aide shall be a worker trained on the job. A licensed occupational therapist or licensed occupational therapy assistant using occupational therapy aide personnel to assist with the provision of occupational therapy services must provide close supervision in order to protect the health and welfare of the consumer. (2) The primary function of an occupational therapy aide functioning in an occupational therapy setting shall be to perform designated routine tasks related to the operation of an occupational therapy service. These tasks may include, but are not limited to, routine department maintenance, transporting patients/clients, preparing or setting up treatment equipment and work area, assisting patients/clients with their personal needs during treatment, assisting in the construction of adaptive equipment, and carrying out a predetermined segment or task in the patient's care. (f) The licensed occupational therapist or occupational therapy assistant shall not delegate to an occupational therapy aide: (1) Performance of occupational therapy evaluation procedures; (2) Initiation, planning, adjustment, modification, or performance of occupational therapy procedures requiring the skills or judgment of a licensed occupational therapist or licensed occupational therapy assistant; (3) Making occupational therapy entries directly in patients' or clients' official records; and (4) Acting on behalf of the occupational therapist in any matter related to occupational therapy, which requires decision making or professional judgment. **<u>Regulation:</u> Rhode Island Code of Regulations Title 216, Chapter 40, Subchapter 05, Part 12** **12.2 Definitions** A. Wherever used in this Part the following terms shall be construed as follows: 8. “Occupational therapy assistant” means a person licensed to practice occupational therapy under the provisions of the Act and this Part. 10. "Supervision" means that a licensed occupational therapist or occupational therapy assistant shall at all times be responsible for supportive personnel and students. **12.6 Licensure of Occupational Therapists and Occupational Therapy Assistants** E. Supervision of occupational therapist assistants is pursuant to R.I. Gen. Laws § 5-40.1-21.

South Carolina	**Statute:** **South Carolina Code of Laws Title 40, Chapter 36** **Section 40-36-20. Definitions.** (4) "Direct supervision" means personal, daily supervision, and specific delineation of tasks and responsibilities by an occupational therapist and includes the responsibility for personally reviewing and interpreting the results of a supervisee on a daily basis. (9) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist. (12) "Supervision" means personal and direct involvement of an occupational therapist in a supervisee's professional experience which includes evaluation of the supervisee's performance with respect to each client treated by the supervisee. **Section 40-36-290. Responsibilities and duties of occupational therapists; records; discharge notes.** (A) An occupational therapist: (1) has the ultimate responsibility for occupational therapy treatment outcomes and for all occupational therapy services performed under the therapist's supervision; (2) at a minimum, shall provide supervision as required by this chapter; (3) shall communicate regularly with a supervisee regarding assignments, plan of care, and any changes in the client's status and shall document this communication; (4) shall reevaluate a client where therapy has been significantly interrupted before reassigning an occupational therapy assistant to the case; (5) only shall assign to a supervisee those duties and responsibilities for which the supervisee has been trained specifically and for which the supervisee is qualified to perform; (6) must be accessible to supervisee each working day; (7) shall perform the initial evaluation of and establish the treatment plan for each client; (8) shall make a consultation/reassessment visit every seven treatments or thirty days, whichever comes first. (B) An occupational therapist is responsible for the occupational therapy record of a client. The occupational therapy record shall consist of: (1) the initial evaluation including a written report signed and dated by the occupational therapist performing the evaluation; (2) a plan of care, including: (a) treatment to be rendered; (b) frequency and duration of treatment; (c) measurable goals. Progress notes must be signed and dated by the person rendering treatment. When progress notes are written by an occupational therapy student or an occupational therapy assistant student or examination candidate, the notes are to be countersigned and dated by the occupational therapist or occupational therapy assistant who is providing supervision. A discharge note containing a statement of the client's status at the last treatment session must be written, signed, and dated by the occupational therapist or occupational therapy assistant rendering services. In the case of the occupational therapy assistant, the occupational therapist must co-sign and consult on all discharge notes. **Section 40-36-300. Responsibilities and duties of occupational therapy assistants and aides; restrictions.** (A) An occupational therapy assistant only shall assist in the practice of occupational therapy under the supervision of a licensed occupational therapist and shall: (1) only accept those duties and responsibilities for which the assistant has been specifically trained and is qualified to perform;

	(2) consult with the supervising occupational therapist every seven treatments or thirty days, whichever is first, for each client; (3) inform the occupational therapist of any changes in a client that may require reevaluation or change in treatment; (4) contribute to a client evaluation by gathering data, administering structured tests, and reporting observations but may not evaluate a client independently or initiate treatment before a licensed occupational therapist's evaluation. **Regulation:** No relevant regulations.
South Dakota	**Statute: South Dakota Codified Laws §36-31-1, Definition of terms.** Terms used in this chapter mean: (6) "Occupational therapy assistant," any person licensed to assist in the practice of occupational therapy, under the supervision of or with the consultation of a licensed occupational therapist and whose license is in good standing; **Regulation: South Dakota Administrative Rules §20:64:01:01, Definitions.** (2) "Direct supervision," the physical presence of an occupational therapist or occupational therapy assistant in the immediate room when remediative tasks are being performed by an occupational therapy aide; (3) "Supervision," the shared responsibility between an occupational therapist and an occupational therapy assistant that occurs in person or by telecommunications while the occupational therapist assistant is treating patients. **Regulation: South Dakota Administrative Rules §20:64:03:02, Supervision of occupational therapy assistant.** An occupational therapy assistant with less than one year of experience in the assistant's present area of practice must receive a minimum of 10 hours of supervision from an occupational therapist for each 40 work hours or 25 percent of the total scheduled work hours. An occupational therapy assistant with more than one year of experience in the assistant's present area of practice must receive a minimum of 4 hours of supervision from an occupational therapist for each 40 work hours or 10 percent of the total scheduled work hours. The supervising occupational therapist shall evaluate each patient with input from the occupational therapy assistant as appropriate, prepare a written treatment plan outlining the tasks and responsibilities that may be performed by the occupational therapy assistant, monitor patient progress and reevaluate the treatment plan, and determine the termination of treatment. The frequency and manner of supervision is determined by the supervising licensed occupational therapist based on the condition of the patient or client, the proficiencies of the occupational therapy assistant, and the complexity of the therapy method. If the supervision agreement is terminated, the occupational therapy assistant must notify the board in writing within 15 days of such termination. In addition, the supervising occupational therapist must also notify the board in writing within 15 days if the supervision agreement is terminated.
Tennessee	**Statute: Tennessee Code Annotated Title 63, Chapter 13** **63-13-103 Definitions.** (8) "Occupational therapy assistant" means a person licensed to assist in occupational therapy practice under the supervision of an occupational therapist; **63-13-206 Supervision of an occupational therapy assistant by an occupational therapist.** (a) A licensed occupational therapy assistant shall practice under the supervision of an occupational therapist who is licensed in Tennessee. (b) The supervising occupational therapist is responsible for all services provided by the occupational therapy assistant, including, but not limited to, the formulation and implementation of a plan of occupational therapy services for each client, and has a continuing

	responsibility to follow the progress of each client and to ensure the effective and appropriate supervision of the occupational therapy assistant according to the needs of the client. (c) The supervising occupational therapist shall assign to the occupational therapy assistant only those duties and responsibilities that the occupational therapy assistant is qualified to perform. (d) The board shall adopt rules governing the supervision of occupational therapy assistants by occupational therapists. Those rules may address the following: (1) The manner in which the supervising occupational therapist oversees the work of the occupational therapy assistant; (2) The ratio of occupational therapists to occupational therapy assistants required under different conditions and in different practice settings; and (3) The documentation of supervision contacts between the supervising occupational therapist and the occupational therapy assistant. (e) The rules adopted by the board shall recognize that the frequency, methods and content of supervision of occupational therapy assistants by occupational therapists may vary by practice setting and are dependent upon the following factors, among others: (1) Complexity of the client's needs; (2) Number and diversity of clients; (3) Skills of the occupational therapy assistant and the supervising occupational therapist; (4) Type of practice setting; and (5) Requirements of the practice setting. **<u>Regulation:</u> Rules and Regulations of Tennessee Chapter 1150-02** **1150-02-01 Definitions.** As used in these rules, the terms and acronyms shall have the following meanings ascribed to them. (21) Licensed Occupational Therapy Assistant (OTA) - Any person who has met the qualifications for licensed occupational therapy assistant and holds a current, unsuspended or unrevoked, license which has been lawfully issued by the Board. Such person assists and works under the supervision of a licensed occupational therapist. (27) Supervision is defined as the following: (a) Continuous: Within sight of the individual being supervised. (b) Close: Daily direct contact at the site of treatment. (c) Routine: Direct contact at least every two (2) weeks at the site of treatment, with interim supervision occurring by other methods such as telephone or written communication. (d) General: At least monthly direct contact with supervision available as needed by other methods. (e) Minimal: 1. For supervision of occupational therapists, minimal supervision may be provided on an as-needed basis and may be less than monthly. 2. For supervision of occupational therapy assistants, minimal supervision is not appropriate. **1150-02.10 Supervision.** The Board adopts, as if fully set out herein, and as it may from time to time be amended, the current “Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services” issued by the American Occupational Therapy Association but only to the extent that it agrees with the laws of the state of Tennessee or the rules of the Board. If there are conflicts with state law or rules, the state law or rules govern the matter.

(3) Supervision of an Occupational Therapy Assistant with permanent licensure means initial direction and inspection of the service delivery and provision of relevant in-service training, according to the level of supervision the occupational therapy assistant requires. It is the responsibility of the occupational therapist and the occupational therapy assistant to seek the appropriate quality and frequency of supervision that ensures safe and effective occupational therapy service delivery. This decision is based on client's level of care, OTA caseload, experience and demonstrated performance competency.

(a) The frequency of the face to face collaboration between the Occupational Therapy Assistant and the supervising Occupational Therapist should exceed direct contact of once a month if the condition of the patient/client, complexity of treatment, evaluation procedures, and proficiencies of the person practicing warrants it.

(b) The Occupational Therapist shall be responsible for the evaluation of the patient and the development of the patient/client treatment plan. The Occupational Therapy Assistant may contribute information from observations and standardized test procedures to the evaluation and the treatment plans.

(c) The Occupational Therapy Assistant can implement and coordinate intervention plan under the supervision of the licensed Occupational Therapist.

(d) The Occupational Therapy Assistant can provide direct services that follow a documented routine and accepted procedure under the supervision of the Occupational Therapist.

(e) The Occupational Therapy Assistant can adapt activities, media, environment according to the needs to the patient/client, under the supervision of the licensed Occupational Therapist.

(f) Therapists must maintain documentation of each supervisory visit, and must identify a plan for continued supervision. Records must include, at a minimum, the following information:

1. Location of visit; a method of identifying clients discussed
2. Current plan for supervision (daily, weekly, bi-monthly, monthly, other)
3. Type of supervision provided. These include but are not limited to
    (i) In person
    (ii) Phone contact
    (iii) Electronic contact
4. Identification of type(s) of interventions observed. These include but are not limited to:
    (i) Interventions
    (ii) Training
    (iii) Consultations
5. Other supervisory actions. These include but are not limited to:
    (i) Discussion/recommendation for interventions and/or goals
    (ii) Discussion/training in documentation
    (iii) Demonstration/training in intervention techniques
    (iv) Assessment/re-assessment/discharge
    (v) Additional Comments
6. An agreement statement signed and dated by both parties, that the supervisory visit did occur and met the needs of the supervisor and supervisee.
7. It is the responsibility of the supervising occupational therapist to provide and the occupational therapy assistant to seek a quality and frequency of supervision that ensures safe and effective occupational therapy service delivery. Both

	parties (supervisor and supervisee) must keep copies of the supervisory records. Visit records must be maintained for three (3) years, and must be provided to the Board and/or its representative, upon request. (6) Supervision parameters (a) Supervision is a collaborative process that requires both the licensed occupational therapist and the licensed occupational therapy assistant to share responsibility. Appropriate supervision will include consideration given to factors such as level of skill, the establishment of service competency (the ability to use the identified intervention in a safe and effective manner), experience and work setting demands, as well as the complexity and stability of the client population to be treated. (b) Supervision is an interactive process that requires both the licensed occupational therapist and the licensed occupational therapy assistant or other supervisee to share responsibility for communication between the supervisor and the supervisee. The licensed occupational therapist should provide the supervision and the supervisee should seek it. An outcome of appropriate supervision is to enhance and promote quality services and the professional development of the individuals involved. (c) Supervision of occupational therapy services provided by a licensed occupational therapy assistant is recommended as follows: 1. Entry level occupational therapy assistants are persons working on initial skill development (less than 1 year of work experience) or who are entering new practice environments or developing new skills (one or more years of experience) and should require close supervision. 2. Intermediate level occupational therapy assistants are persons working on increased skill development, mastery of basic role functions (minimum one - three years of experience or dependent on practice environment or previous experience) and should require routine supervision. 3. Advanced level occupational therapy assistants are persons refining specialized skills (more than 3 years work experience, or the ability to understand complex issues affecting role functions) and should require general supervision. 4. Licensed occupational therapy assistants, regardless of their years of experience, may require closer supervision by the licensed occupational therapist for interventions that are more complex or evaluative in nature and for areas in which service competencies have not been established. 5. Certain occupational therapy assistants may only require minimal supervision when performing non-clinical administrative responsibilities.
Texas	**Statute: Texas Statutes Sec. 454.002. DEFINITIONS.** In this chapter: (6) "Occupational therapy assistant" means a person licensed by the board as an occupational therapy assistant who assists in the practice of occupational therapy under the general supervision of an occupational therapist. **Regulation: Texas Administrative Code Title 40, Part 12, Chapter 362, Section 362.1 Definitions.** The following words, terms, and phrases, when used in this part shall have the following meaning, unless the context clearly indicates otherwise. (27) Occupational Therapy Assistant (OTA)-- An individual who holds a license to practice or represent self as an Occupational Therapy Assistant in Texas and who is required to be under the general supervision of an OT. This definition includes an Occupational Therapy Assistant who is designated as a Certified Occupational Therapy Assistant (COTA®). (33) Occupational Therapy Practitioners--Occupational Therapists and Occupational Therapy Assistants licensed by this Board.

	Regulation: Texas Administrative Code Title 40, Part 12, Chapter 372, Section 372.1 Provision of Services (f) Plan of Care. (1) Only an occupational therapist may initiate, develop, modify, or complete an occupational therapy plan of care. It is a violation of the Occupational Therapy Practice Act for anyone other than the occupational therapist to dictate, or attempt to dictate, when occupational therapy services should or should not be provided, the nature and frequency of services that are provided, when the client should be discharged, or any other aspect of the provision of occupational therapy as set out in the Occupational Therapy Practice Act and Rules. (2) Modifications to the plan of care must be documented. (3) An occupational therapy plan of care may be integrated into an interdisciplinary plan of care, but the occupational therapy goals or objectives must be easily identifiable in the plan of care. (4) Only occupational therapy practitioners may implement the written plan of care once it is completed by the occupational therapist. (5) Only the occupational therapy practitioner may train non-licensed personnel or family members to carry out specific tasks that support the occupational therapy plan of care. (6) The occupational therapist is responsible for determining whether intervention is needed and if a referral is required for occupational therapy intervention. (7) Except where otherwise restricted by rule, the occupational therapy practitioner is responsible for determining whether any aspect of the intervention session may be conducted via telehealth or must be conducted in person. (8) The occupational therapy practitioner must have contact with the client during the intervention session. (A) The contact must be either: (i) synchronous audio and synchronous visual contact that is in person, via telehealth, or via a combination of in-person contact and telehealth; or (ii) synchronous audio contact, provided that the occupational therapy practitioner makes use of store-and-forward technology in preparation for or during the intervention session. The synchronous audio contact may be in person and/or via telehealth. In this subsection, “store-and-forward technology” means technology that stores and transmits or grants access to a client’s clinical information for review by an occupational therapy practitioner at a different physical location than the client. (B) Other telecommunications or information technology may be used to aid in the intervention session but may not be the primary means of contact or communication. (9) Except where otherwise restricted by rule, the supervising occupational therapist may only delegate to an occupational therapy assistant tasks that they both agree are within the competency level of that occupational therapy assistant.
Utah	**Statute: Utah Code Title 58, Chapter 42a, Part 1, Section 102 Definitions.** (5) "Occupational therapy assistant" means a person licensed under this chapter to practice occupational therapy under the supervision of an occupational therapist as described in Sections 58-42a-305 and 58-42a-306. **Statute: Utah Code Title 58, Chapter 42a, Part 3** **Section 305 Limitation upon occupational therapy services provided by an occupational therapy assistant and an occupational therapy aide.** (1) An occupational therapy assistant:

(a) may only perform occupational therapy services under the supervision of an occupational therapist as described in Section 58-42a-306;
(b) may not write an individual treatment plan;
(c) may not approve or cosign modifications to an individual treatment plan; and
(d) may contribute to and maintain an individual treatment plan.

Section 306 Supervision requirements.
An occupational therapist who is supervising an occupational therapy assistant shall:
(1) write or contribute to an individual treatment plan before referring a client to a supervised occupational therapy assistant for treatment;
(2) approve and cosign on all modifications to the individual treatment plan;
(3) meet face to face with the supervised occupational therapy assistant as often as necessary but at least once every two weeks in person or by video conference, and at least one time every month in person, to adequately provide consultation, advice, training, and direction to the occupational therapy assistant;
(4) meet with each client who has been referred to a supervised occupational therapy assistant at least once each month, to further assess the patient, evaluate the treatment, and modify the individual's treatment plan, except that if the interval of client care occurs one time per month or less, the occupational therapist shall meet with the client at least once every four visits;
(5) supervise no more than two full-time occupational therapy assistants at one time, or four part-time occupational therapy assistants if the combined work hours of the assistants do not exceed 40 hours per week, unless otherwise approved by the division in collaboration with the board;
(6) remain responsible for client treatment provided by the occupational therapy assistant; and
(7) fulfill any other supervisory responsibilities as determined by division rule.

Regulation: Utah Administrative Code R156-1-102a. Global Definitions of Levels of Supervision. (regulation is not occupational therapy-specific and applies to multiple professions)
(1) Under Subsection 58-1-106(1)(a), except as otherwise provided by statute or rule, the following global definitions of levels of supervision apply to supervision terminology in Title 58, Occupations and Professions, and Title R156, and shall be referenced and used to the extent practicable in those statutes and rules to promote uniformity and consistency.
(a) “Direct supervision” and “immediate supervision” means the supervising licensee is present and available for face-to-face communication with the person being supervised when and where professional services are being provided;
(b) "Indirect supervision" means the supervising licensee:
(i) has given either written or oral instructions to the person being supervised;
(ii) is present in the facility or located on the same premises where the person being supervised is providing services; and
(iii) is available to provide immediate face-to-face communication with the person being supervised as necessary.
(c) "General supervision" means that the supervising licensee:
(i) has authorized the work to be performed by the person being supervised;
(ii) is available for consultation with the person being supervised by personal face-to-face contact, or direct voice contact by electronic or other means, without regard to whether the supervising licensee is present in the facility or located on the same premises where the person being supervised is providing services;
(iii) can provide any necessary consultation within a reasonable time; and
(iv) personal contact is routine.

	(d) "Supervising licensee" means a licensee who under statute or rule has satisfied the requirements to act as a supervisor and has agreed to supervise an unlicensed individual or a licensee in a classification or licensure status that requires supervision. (2) Except as otherwise provided by statute or rule: (a) unlicensed personnel allowed to practice a regulated profession shall practice under an appropriate level of supervision as defined in this section, as specified by the profession's licensing act or rule; and (b) a license classification required to practice under supervision shall practice under an appropriate level of supervision as defined in this section, as specified by the profession's licensing act or rule.
Vermont	**<u>Statute:</u> Vermont Statutes Title 26, Chapter 71, Section 3351. Definitions** (2) "Occupational therapy assistant" means a person who is licensed to assist in the practice of occupational therapy under the supervision of an occupational therapist. **<u>Regulation:</u> Vermont Administrative Code §3.7, SUPERVISION STANDARDS.** (a) As used in this rule: "Supervision" means the responsible periodic review and inspection of all aspects of occupational therapy services by the appropriate licensed occupational therapist. "Close supervision" means daily, direct, face-to-face contact at the site of work and applies only to occupational therapists with initial skill development proficiencies or occupational therapy assistants, as appropriate for the delivery of occupational therapy services. "Routine supervision" means direct face-to-face contact at least every two weeks at the site of the work, with interim supervision occurring by other methods, such as telephonic, electronic, or written communication and applies only to occupational therapy assistants "General supervision" means at least monthly direct face-to-face contact, with interim supervision available as needed by other methods, and applies only to occupational therapists with increased skill development and mastery of basic role functions or occupational therapy assistants, as appropriate, for the delivery of occupational therapy services. (b) Supervision is a collaborative process that requires both the licensed occupational therapist and the licensed occupational therapy assistant to share responsibility. Appropriate supervision will include consideration given to such factors as level of skill, the establishment of service competency (the ability to use the identified intervention in a safe and effective manner), experience and work setting demands, as well as the complexity and stability of the client population to be treated. (c) The supervision of the occupational therapy assistant is a process that is aimed at ensuring the safe and effective delivery of occupational therapy services and fosters professional competence and development. (d) For effective supervision to occur that will ensure safety and effectiveness of service delivery and that will support the occupational therapy assistant's professional growth, a variety of types and methods of supervision should be used by the occupational therapist. Examples of methods or types of supervision include observation, co-treatment, dialogue/discussion, and teaching/instruction. (e) The occupational therapist develops a plan for supervision that includes input from the OTA in regard to the following: (1) the frequency of supervisory contact (2) the method(s) or type(s) of supervision (3) the content areas addressed

	(f) The supervisory plan is documented and a log of supervisory contacts is kept by both parties. The log includes the frequency and methods of supervision used. (g) Supervision of occupational therapy services provided by a licensed occupational therapy assistant shall be implemented as follows: (1) Entry level occupational therapy assistants are persons working on initial skill development (less than 1 year of work experience) or who are entering new practice environments or developing new skills (one or more years of experience) and shall require close supervision. (2) Intermediate level occupational therapy assistants are persons working on increased skill development, mastery of basic role functions (minimum one - three years of experience or dependent on practice environment or previous experience) and shall require routine supervision. (3) Advanced level occupational therapy assistants are persons refining specialized skills (more than 3 years work experience, or the ability to understand complex issues affecting role functions) and shall require general supervision. (4) Licensed occupational therapy assistants, regardless of their years of experience, may require closer supervision by the licensed occupational therapist for interventions that are more complex or evaluative in nature and for areas in which service competencies have not been established. (h) General statements regarding roles and responsibilities during the delivery of occupational therapy services: (1) The occupational therapist is responsible for the overall delivery of occupational therapy services and is accountable for the safety and effectiveness of the occupational therapy service delivery process. (2) The occupational therapy assistant delivers occupational therapy services under the supervision of the occupational therapist. (3) It is the responsibility of the occupational therapist to be directly involved in the delivery of services during the initial evaluation and regularly throughout the course of intervention. (4) Services delivered by the occupational therapy assistant are specifically selected and delegated by the occupational therapist. When delegating to the occupational therapy assistant, the occupational therapist considers the following factors: (A) the complexity of the client's condition and needs (B) the knowledge, skill, and competence of the occupational therapy assistant. (C) the nature and complexity of the intervention (5) Prior to delegation of any aspect of the service delivery process to the occupational therapy assistant, service competency must be demonstrated and documented between the occupational therapist and occupational therapy assistant. Service competency is demonstrated and documented for clinical reasoning and judgment required during the service delivery process as well as for the performance of specific techniques, assessments, and intervention methods used. Service competency must be monitored and reassessed regularly. (6) The role delineation and responsibilities of the occupational therapist and the occupational therapy assistant remain unchanged regardless of the setting in which occupational therapy services are delivered (i.e., traditional, non-traditional, or newly emerging practice settings). (i) An occupational therapist or occupational therapy assistant practicing under a temporary license must have daily, direct, on-site supervision by a licensed occupational therapist for the duration of the temporary license. The supervisor is available for advice and intervention, and will sign all notes entered into the patient's medical record.
Virginia	**<u>Statute:</u> Code of Virginia §54.1-2900 Definitions.** "Occupational therapy assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed occupational therapist to assist in the practice of occupational therapy.

	<u>Regulation:</u> Virginia Administrative Code Title 18, Agency 85, Chapter 80 **18 VAC 85-80-10 Definitions.** B. The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise: "Occupational therapy personnel" means appropriately trained individuals who provide occupational therapy services under the supervision of a licensed occupational therapist. **18 VAC 85-80-90 General Responsibilities.** B. An occupational therapy assistant renders services under the supervision of an occupational therapist that do not require the clinical decision or specific knowledge, skills and judgment of a licensed occupational therapist and do not include the discretionary aspects of the initial assessment, evaluation or development of a treatment plan for a patient. **18 VAC 85-80-110 Supervisory Responsibilities of an Occupational Therapist.** A. Delegation to an occupational therapy assistant. 1. An occupational therapist shall be ultimately responsible and accountable for patient care and occupational therapy outcomes under his clinical supervision. 2. An occupational therapist shall not delegate the discretionary aspects of the initial assessment, evaluation or development of a treatment plan for a patient nor shall he delegate any task requiring a clinical decision or the knowledge, skills, and judgment of a licensed occupational therapist. 3. Delegation shall only be made if, in the judgment of the occupational therapist, the task or procedures do not require the exercise of professional judgment, can be properly and safely performed by an appropriately trained occupational therapy assistant, and the delegation does not jeopardize the health or safety of the patient. 4. Delegated tasks or procedures shall be communicated to an occupational therapy assistant on a patient-specific basis with clear, specific instructions for performance of activities, potential complications, and expected results. B. The frequency, methods, and content of supervision are dependent on the complexity of patient needs, number and diversity of patients, demonstrated competency and experience of the assistant, and the type and requirements of the practice setting. The occupational therapist providing clinical supervision shall meet with the occupational therapy assistant to review and evaluate treatment and progress of the individual patients at least once every tenth treatment session or 30 calendar days, whichever occurs first. For the purposes of this subsection, group treatment sessions shall be counted the same as individual treatment sessions. C. An occupational therapist may provide clinical supervision for up to six occupational therapy personnel, to include no more than three occupational therapy assistants at any one time. D. The occupational therapy assistant shall document in the patient record any aspects of the initial evaluation, treatment plan, discharge summary, or other notes on patient care performed by the assistant. The supervising occupational therapist shall countersign such documentation in the patient record at the time of the review and evaluation required in subsection B of this section.
Washington	**<u>Statute:</u> Revised Code of Washington §18.59.020 Definitions.** (6) "Occupational therapy assistant" means a person licensed to assist in the practice of occupational therapy under the supervision or with the regular consultation of an occupational therapist. (7) "Occupational therapy practitioner" means a person who is credentialed as an occupational therapist or occupational therapy assistant.

	<u>Regulation:</u> Washington Administrative Code Title 246, Chapter 847 **WAC 246-847-010 Definitions.** (9) "Professional supervision" of an occupational therapy aide as described in RCW 18.59.020(5) means in-person contact at the treatment site by an occupational therapist or occupational therapy assistant licensed in the state of Washington. When client-related tasks are provided by an occupational therapy aide more than once a week, professional supervision must occur at least weekly. When client-related tasks are provided by an occupational therapy aide once a week or less, professional supervision must occur at least once every two weeks. (10) "Regular consultation with an occupational therapy assistant" means at least monthly contact with the supervising occupational therapist licensed in the state of Washington, with further supervision available as needed. **WAC 246-847-135 Standards of supervision.** The following are the standards for supervision of occupational therapy assistants, limited permit holders, and occupational therapy aides: (1) A licensed occupational therapy assistant must be in regular consultation, as defined by WAC 246-847-010, with an occupational therapist licensed in the state of Washington. Regular consultation must be documented and the documentation must be kept in a location determined by the supervising occupational therapist or occupational therapy assistant. (2) A limited permit holder: (a) Who is waiting to take the examination for licensure must work in association with an occupational therapist licensed in the state of Washington with a minimum of one year of experience. "In association with" includes consultation regarding evaluation, intervention, progress, reevaluation and discharge planning of each assigned patient at appropriate intervals and documented by cosignature of all notes by the supervising occupational therapist. (b) Who has failed the examination must be directly supervised by an occupational therapist licensed in the state of Washington with a minimum of one year of experience. Direct supervision must include consultation regarding evaluation, intervention, progress, reevaluation and discharge planning of each assigned patient at appropriate intervals and documented by cosignature of all notes by the supervising occupational therapist. (3) An occupational therapy aide must be supervised and trained by an occupational therapist or an occupational therapy assistant licensed in the state of Washington. Professional supervision must include documented supervision and training. (a) The occupational therapist or occupational therapy assistant shall provide professional supervision as defined in WAC 246-847-010 to the occupational therapy aide on client and nonclient related tasks. (b) When performing client related tasks, the occupational therapist or occupational therapy assistant must ensure the occupational therapy aide is trained and competent in performing the task on the specific client. (c) The documentation must be maintained in a location determined by the supervising occupational therapist or occupational therapy assistant.
West Virginia	**<u>Statute:</u> West Virginia Code Chapter 30, Article 28** **§30-28-3 Definitions** (e) "Direct supervision" means the actual physical presence of a licensed supervising occupational therapist or licensed occupational therapy assistant, and the specific delineation of tasks and responsibilities for personally reviewing and interpreting the results of any habilitative or rehabilitative procedures conducted by the limited permit holder, occupational therapy student, or aide. Direct supervision includes direct close supervision and direct continuous supervision. (f) "Direct close supervision" means the licensed supervising occupational therapist or licensed occupational therapy assistant is in the building and has daily direct contact at the site of work.

	(g) "Direct continuous supervision" means the licensed supervising occupational therapist or licensed occupational therapy assistant is physically present and in direct line of sight of the occupational therapy student or aide. (h) "General supervision" means initial direction and periodic inspection of the activities of a licensed occupational therapist assistant by the supervising licensed occupational therapist, but does not necessarily require constant physical presence on the premises while the activities are performed. (l) "Occupational Therapy Assistant" means a person licensed by the board under the provisions of this article to assist in the practice of occupational therapy under the general supervision of an Occupational Therapist. **§30-28-4 Scope of practice; license and supervision requirements.** (d) An occupational therapy assistant may assist in the practice of occupational therapy under the general supervision of an occupational therapist. **Regulation: West Virginia Code of State Rules Title 13, Series 1** **§13-1-2 Definitions.** As used in this rule: 2.6. "General Supervision" means initial direction and periodic inspection of the activities of a licensed occupational therapist assistant by the supervising licensed occupational therapist, but does not necessarily require constant physical presence on the premises while the activities are performed. 2.13. Occupational Therapy Assistant means a person licensed by the Board under the provisions of W. Va. Code §30-28 to assist in the practice of occupational therapy under the general supervision of an occupational therapist. **§13-1-12 Responsibilities and Supervision Requirements of the Occupational Therapist, Occupational Therapy Assistant, or Limited Permit Holder.** 12.2. 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 service delivery process involves evaluation, intervention planning, intervention implementation, intervention review, and outcome evaluation. 12.2.a. The occupational therapist must be directly involved through a face-to-face visit with the patient during the initial evaluation and establishment of the intervention plan, and prior to any change in the plan, such as adding, changing, renewing, or discontinuing occupational therapy goals. 12.3. The occupational therapy assistant is responsible for delivering occupational therapy services under the supervision of and in partnership with the occupational therapist. 12.4. It is the responsibility of the occupational therapist and the occupational therapy assistant to seek the appropriate quality and frequency of supervision to ensure safe and effective occupational therapy service delivery. 12.4.a. The specific frequency, methods, and content of supervision may vary by practice setting and are dependent upon the 12.4.a.1. Complexity of client needs, 12.4.a.2. Number and diversity of clients, 12.4.a.3. Skills of the occupational therapist and the occupational therapy assistant, 12.4.a.4. Type of practice setting, 12.4.a.5. Requirements of the practice setting, and 12.4.a.6. Other regulatory requirements.

	12.4.b It is the responsibility of the occupational therapist supervising an occupational therapy assistant with less than one year experience to provide general supervision with direct contact at least every two weeks at the site of work and supervision available as needed by telephonic, electronic, or written communication. Documentation by the occupational therapist must reflect that this supervision has occurred. 12.4.c. It is the responsibility of the occupational therapist supervising an occupational therapy assistant with increased skill development and mastery of basic role functions for the delivery of occupational therapy services to provide general supervision with monthly direct contact and supervision available as needed by telephonic, electronic, or written communication. Documentation by the occupational therapist must reflect that this supervision has occurred. 12.4.d. General Supervision is demonstrated through co-signatures on all paperwork or electronic notes pertaining to the practice of occupational therapy for the person requiring general supervision. All paperwork or electronic notes pertaining to the practice of occupational therapy must be signed and dated, electronically or otherwise, by the supervising licensed occupational therapist. The supervisor need not be present or on the premises at all times where the licensed occupational therapy assistant is performing the professional services.
Wisconsin	**Statute: Wisconsin Statutes 448.96, Definitions.** In this subchapter: (6) “Occupational therapy assistant" means an individual who is licensed by the affiliated credentialing board to assist in the practice of occupational therapy under the supervision of an occupational therapist. **Regulation: Wisconsin Administrative Code Chapter OT 1, OT 1.02 Definitions.** (26) “Supervision" is a cooperative process in which 2 or more people participate in a joint effort to establish, maintain, and elevate a level of competence and performance. One of the participants, the supervisor, possesses skill, competence, experience, education, credentials, or authority in excess of those possessed by the other participant, the supervisee. **Regulation: Wisconsin Administrative Code Chapter OT 4, OT 4.04 Supervision and practice of occupational therapy assistants.** (1) An occupational therapy assistant must practice under the supervision of an occupational therapist. Supervision is an interactive process that requires both the occupational therapist and the occupational therapy assistant to share responsibility for communication between the supervisor and the supervisee. The occupational therapist is responsible for the overall delivery of occupational therapy services and shall determine which occupational therapy services to delegate to the occupational therapy assistant or non−licensed personnel based on the establishment of service competence between supervisor and supervisee, and is accountable for the safety and effectiveness of the services provided. (2) Supervision of an occupational therapy assistant by an occupational therapist shall be either close or general. The supervising occupational therapist shall have responsibility for the outcome of the performed service. (3) When close supervision is required, the supervising occupational therapist shall have daily contact on the premises with the occupational therapy assistant. The occupational therapist shall provide direction in developing the plan of treatment and shall periodically inspect the actual implementation of the plan. The occupational therapist shall cosign evaluation contributions and intervention documents prepared by the occupational therapy assistant. (4) (ad) In this subsection, “direct contact” means face−to−face communication or communication by means of telephone, electronic communication, or group conference.

	(ah) When general supervision is allowed, the supervising occupational therapist shall, except as provided under par. (ap), have direct contact with the occupational therapy assistant and face−to−face contact with the client by every tenth session of occupational therapy and no less than once per calendar month. (ap) When general supervision is allowed, and occupational therapy services are provided to a client once per calendar month or less frequently than once per calendar month, the supervising occupational therapist shall have direct contact with the occupational therapy assistant and face−to−face contact with the client no less than every other session of occupational therapy. (at) Direct contact with the occupational therapy assistant under pars. (ah) and (ap) shall include reviewing the progress and effectiveness of treatment, and may occur simultaneously or separately from face−to−face contact with the client. (b) The occupational therapist shall record in writing a specific description of the supervisory activities undertaken for each occupational therapy assistant. The written record shall include client name, status and plan for each client discussed. (5) Close supervision is required for all rehabilitation, neonate, early intervention, and school system services provided by an entry level occupational therapy assistant. All other occupational therapy services provided by an occupational therapy assistant may be performed under general supervision, if the supervising occupational therapist determines, under the facts of the individual situation, that general supervision is appropriate using established professional guidelines.
Wyoming	**Regulation: Wyoming Administrative Rules, Occupational Therapy Board, Chapter 1, GENERAL PROVISIONS** Section 3. Definitions. The definitions set out in the Act are hereby incorporated by reference into these Rules. In addition, as used in these Rules, the following definitions shall apply: (d) “Close Supervision” means weekly, direct contact at the site of work and applies only to OTs with initial skill development proficiencies or OTAs, as appropriate, for the delivery of occupational therapy services. (j) “Routine Supervision” means direct contact at least every two weeks at the site of work, with interim supervision occurring by other methods, such as telephonic, electronic or written communication and applies only to OTAs. **Regulation: Wyoming Administrative Rules, Occupational Therapy Board, Chapter 3, Standards of Practice of Occupational Therapy** Section 2. Delineation of Roles. (a) An OT currently licensed by the Board: (i) Evaluates the client using the appropriate evaluation tool(s) for condition. (ii) Prepares a custom written program plan and provides treatment as appropriate within the licensees scope of practice and training. (iii) When applicable, assigns treatment duties based on that program plan to a licensed occupational therapy assistant currently licensed who has been specifically trained to carry out those duties. (iv) Monitors the occupational therapy assistant’s performance. (v) Accepts professional responsibility for the occupational therapy assistant’s performance. (b) An OTA currently licensed by the board assists in the practice of occupational therapy and performs treatment and delegated assessment commensurate with their education and training. Section 3. Supervision of Occupational Therapy Assistants. (a) A licensed OTA may assist in the practice of occupational therapy only under the supervision of an OT.

	(b) The supervising OT shall determine the level of supervision the OTA requires, based on the competency the OTA demonstrates. The supervisory guidelines are as follows: (i) An entry-level OTA is an individual working on initial skill development or entering a new practice area. At this level the OT shall provide close supervision, including weekly meetings and oversight, which could take place in person or virtually with a video and audio component. (ii) An intermediate-level OTA is an individual working on increased skill development and mastery of basic role functions and demonstrates ability to respond to situations based on previous experience. At this level the OT shall provide routine supervision, including bi-weekly meetings and oversight, which could take place in person or virtually with a video and audio component. (iii) An advanced-level OTA is an individual refining specialized skills with the ability to understand complex issues affecting role functions. At this level the OT shall provide general supervision, including bimonthly meetings and oversight, which could take place in person or virtually with a video and audio component. (c) Each supervising OT shall maintain a supervisory plan and shall document the supervision of each OTA using the supervision form provided by the Board. The supervising OT shall include evidence of regular supervision and contact between the supervisor and the assistant and the OT's supervision records may be subject to Board review upon request. The supervising OT shall maintain records related to their supervision for three (3) years. Supervision shall include: (i) Communicating to the OTA the results of patient or client evaluation and discussing the goals and program plan for the patient or client; (ii) Providing information, instruction and assistance as needed; (iii) Annually, or more often if warranted, preparing a written appraisal of the OTAs performance and discussing the appraisal with the OTA; (iv) Review of the Board's rules and the Wyoming Occupational Therapy Practice Act on an annual basis. (iv) A supervising OT after initial record review is performed may assign the administration of standardized tests, activities of daily living evaluations, or other elements of patient evaluation and re-evaluation that do not require the professional judgment and skill of an OT to an intermediate or advanced OTA. Assignment under this subsection must be consistent with OTA's education and training. (d) More frequent supervision may be necessary as determined by the OT or the OTA, dependent on the level of expertise displayed by the OTA, the setting and the population characteristics. (e) A supervisor who is temporarily unable to provide supervision shall arrange for substitute supervision by a licensed OT. The substitute shall provide supervision that is as rigorous and thorough as that provided by the permanent supervisor.