STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
2005 Evergreen Street, Suite 2050, Sacramento, CA 95815
P [916-263-2294] F [916-263-2701] | www.bot.ca.gov

TELECONFERENCE BOARD MEETING NOTICE & AGENDA

California Pacific Medical Center
Castro & Duboce Streets *
The Gazebo Room @ South Tower
San Francisco, CA 94114

Directions only: (415) 600-6000

Rancho Los Amigos National Rehabilitation Center
7601 E. Imperial Highway
CART Building Conference Room
Downey, CA 90242

Directions only: (562) 401-6800

December 1, 2011

9:30 am - Board Meeting

The public may provide comment on any issue before the committee at the time the matter is discussed.

1. Call to order, roll call, establishment of a quorum.
2. President's remarks. *(M. Evert)*
3. Board member updates/activities. (All Board members)
4. Approval of the September 7-8, 2011, Board meeting minutes.
5. Disaster Preparedness/Disaster Response Committee Report *(M. Evert)*
   A. Review and discussion Disaster Preparedness/Disaster Response Committee's Roles and Responsibilities.
   B. Future teleconference meeting date: January 24, 2012.
6. Enforcement Committee Report *(N. Michel)*
   A. Acceptance of February 9, 2011, Committee meeting minutes.
   B. Acceptance of April 27, 2011, Committee meeting minutes.
   C. Review and discussion of proposed amendments to the Board's Disciplinary Guidelines.
   D. Recommendation regarding proposed regulatory language to establish required actions against registered sex offenders.
   E. Future teleconference meeting date: January 26, 2012.
7. Legislative and Regulatory Affairs Committee Report *(L. Grangaard)*
   A. Recommended prioritization of previously approved legislative proposals, for the upcoming legislative session, including:
      - Amend Business and Professions Code (BPC) Section 146, Violations of specified authorization statutes as infractions; Punishment.
      - Amend BPC Section 149, Notice to cease advertising in telephone directory; Contest and hearing; Disconnection of service.

* For GPS use "45 Castro Street." The South Tower is adjacent to the parking garage.

- Amend BPC Section 2570.2, Definitions.
- Amend BPC Section 2570.3, Licensing requirement.
- Amend BPC Section 2570.16, Fees.
- Amend BPC Section 2570.18, Representation.
- Amend BPC 2570.27, Discipline; Initial license issued on probation.
- Add new BPC Section requiring mandatory reporting of employees who are terminated or suspended for cause, as specified, and consequences for failure to report.
- Add new BPC Section regarding limiting liability of occupational therapists providing services in an emergency, disaster, or state of war.
- Add new BPC Section establishing new language which would allow the Board to inspect records.
- Add new BPC Section establishing standards of practice for telehealth by occupational therapists.
- Add new BPC Section requiring the Board to perform a workforce study and authorize an appropriate expenditure for the study.

B. Future teleconference meeting date: January 24, 2012.

8. Practice Committee Report. *(L. Florey)*
   A. Recommended approval of revision to new language establishing a Retired Status.
   B. Discussion and review of Title 16, Division 39, California Code of Regulations, Section 4180, Supervision Definitions, and newly proposed Section 4187, Supervision Plan for an Occupational Therapist.
   C. Discussion and review of Title 16, Division 39, California Code of Regulations, Section 4150, Advanced Practice Definitions, regarding "post professional education and training."
   D. Discussion regarding whether the Occupational Therapy Practice Act requires a physician's referral for services.
   C. Future teleconference meeting date: February 9, 2012.

9. Consideration and adoption of proposed regulatory language to amend CCR Section 4180, Definitions, Section 4184, Delegations of Tasks to Aides, and establish section 4187, Supervision Plan for an Occupational Therapist.

10. Review and consideration of amending the Board's Administrative Manual.

11. Review of proposed Board Member Disciplinary Resource Manual.

12. Review and consideration of Board policy regarding hearing appealed cases.

13. Review and consideration of establishing Board policy regarding effective dates of disciplinary decisions.

14. Consideration of establishing ad-hoc committee of the Board to assist staff and provide oversight of the preparation of the upcoming Sunset Review report.

15. Executive Officer's report. *(H. Martin)*
    A. Budget information.
    B. Strategic Plan.
    C. Other informational items.

16. Enforcement data and reports. *(J. Hanson)*

17. Regulations Update report. *(H. Martin)*

18. Selection of 2012 meeting dates.

19. Election of Officers.

20. Public comment session for items not on the agenda.

21. Agenda Items for Next Meeting.

The Board may convene in CLOSED SESSION pursuant to Government Code Section 11126(c)(3) to deliberate on Disciplinary Decisions.

The Board may convene in CLOSED SESSION pursuant to Government Code Section 11126(a)(1) to discuss Evaluation of the Executive Officer.

Return to Open Session.

Adjournment.

ACTION MAY BE TAKEN ON ANY ITEM ON THE AGENDA.

Public comments will be taken on agenda items at the time the item is heard. Action may be taken on any item listed on the agenda. Agenda items may be taken out of order for convenience, to accommodate speakers or to maintain a quorum. For further information on this meeting and agenda, contact Tabatha Montoya at (916) 263-2294 or submit a written request to her at 2005 Evergreen Street, Suite 2050, Sacramento, California, 95815.

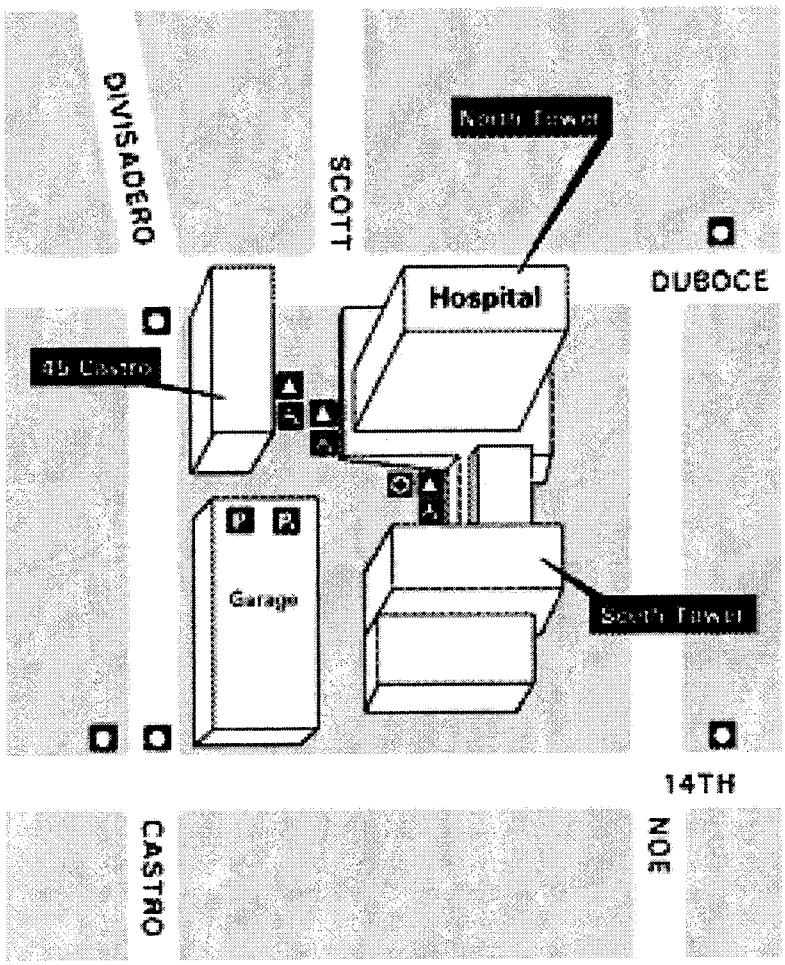
The meeting is accessible to the physically disabled. A person who needs disability related Accommodations or modifications in order to participate in the meeting shall make a request to Tabatha Montoya at (916) 263-2294 or by mailing a written request to 2005 Evergreen Street, Suite 2050, Sacramento, California, 95815. Providing at least five working days notice before the meeting will help ensure the availability of accommodations or modifications. This agenda as well as Board meeting minutes can be found at the Board's website at www.bot.ca.gov.

Location:

California Pacific Medical Center, South Tower, The Gazebo Room

The Gazebo is on the 1st floor of the South Tower. The South Tower is straight ahead as you enter the driveway. The driveway entrance is in the middle of Castro Street between 14th and Duboce Streets. You'll see the entrance to the campus on your left. It's the building that has the big lighted EMERGENCY ENTRANCE sign. If you enter on the ground floor, take the elevator UP to the first floor.

If you come by public transportation, take the N Judah to the Duboce Street stop and walk up towards Castro. If you drive, there's a parking lot at the end of the driveway on your right, or you can try to find someplace on the street before entering the driveway.



AGENDA ITEM 4

APPROVAL OF SEPTEMBER 7-8, 2011, BOARD MEETING MINUTES.

The draft minutes are attached for review.

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CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
TELECONFERENCE BOARD MEETING MINUTES

Wednesday, September 7-8, 2011

Board Members Present
Mary Evert, President
Linda Florey
Luella Grangaard
Nancy Michel
Bobbi Jean Tanberg
Eric Alegria

Board Members Absent
Kathay Lovell

Board Staff Present
Heather Martin, Executive Officer
Norine Marks, Legal Counsel
Jeff Hanson, Staff Services Manager
Jody Quesada, Office Technician

1. Call to order, roll call, and establishment of a quorum.

President Evert called the meeting to order at 9:41 am. Secretary Nancy Michel called the roll. Kathay Lovell was absent. A quorum of the Board was established.

2. Introductions.

President Evert introduced and welcomed a newly appointed member, Eric Alegria. Mr. Alegria is a public member appointed by the Speaker of the House. President Evert thanked Nancy Olsen OTR/L, the Academic Fieldwork Coordinator at Stanbridge College for hosting the meeting at the College.

3. President's remarks.

President Evert indicated that she and Ms. Martin have attended monthly teleconference reports with the Department of Consumer Affairs (DCA) Executive Office that include the state of our economy, state budget, travel, and hiring freezes. She told the Board Members that if they were interested in the written minutes of these meetings they should contact Ms. Martin.

President Evert reported that she had the honor of being the key note speaker at the graduation of the first master's level graduating class of Occupational Therapy from The University of St. Augustine.

4. Board member updates/activities.

Bobbi Jean Tanberg reported that she had the opportunity to present at The International Conference for Seniors and People with Disabilities in Seoul, Korea and visit the Occupational Therapy Department at Yonsei University. Ms. Tanberg reported spending time with the Director of the Korean Occupational Therapy Association who gave a presentation about Occupational Therapy and the role of Worker's Compensation.

Linda Florey reported she is totally retired from University of California, Los Angeles (UCLA) since the end of June.

Nancy Michel reported the Enforcement Committee has not been able to meet due to scheduling conflicts.

Luella Grangaard reported that her employer Eisenhower Medical Center opened a new in-patient clinic.

New member Eric Alegria reported he received his Master's degree in Public Administration from the University of Southern California (USC). Mr. Alegria stated he has managed two healthcare clinics in primary care and is currently managing two healthcare facilities in Long Beach. Mr. Alegria said he teaches government courses at El Camino College and is currently seeking one of the three open seats for the City Council of Rancho Palos Verdes.

5. Approval of the June 16, 2011, Board Meeting minutes.

- Luella Grangaard moved to approve the June 16, 2011, with two minor typographical edits.
- Nancy Michel seconded the motion.
- *The motion passed unanimously.*

6. Education/Outreach Committee Report.

A. Acceptance of the February 24, 2011, Committee meeting minutes.

Bobbi Jean Tanberg, the Chair of the Education/Outreach Committee, reported that the committee approved the February 24, 2011, meeting minutes as presented.

B. Recommendation(s) regarding development of marketing plan and materials to increase participation in Expert Reviewer and Expert Witness Programs.

Ms. Tanberg reported the committee discussed editing the roles and responsibilities of the committee. Ms. Tanberg proposed to amend the committee's role and responsibilities by deleting references to developing the Board's website by expanding its role to mean other various communication methods in addition to website development.

- Bobbi Jean Tanberg moved to amend the committee's roles and responsibilities for the Education Outreach Committee as proposed in the report.
- Nancy Michel seconded the motion.
- *The motion passed unanimously.*

C. Recommendations(s) regarding development of consumer-related informational brochures.

Ms. Tanberg reported the AOTA granted the Board permission to include a link to AOTA on their website. The Committee discussed that an informational brochure needs to be developed to explain the Board's role and provide contact information. Heather Martin agreed to present a draft of this brochure to the next meeting.

D. Recommendation(s) regarding accessible and informative Board and committee meetings.

Ms. Tanberg reported committee members discussed providing a toll-free number in which Board and Committee meetings can be heard in order to increase access. Online meetings, video conferencing and web casting were also discussed as a means to provide licensees an "on demand" experience. All options are still being explored and any new information will be presented to the Board.

E. Recommendation of proposed Fact Sheets and FAQs for individuals serving as Advanced Practice Reviewer and/or Expert Witness.

Ms. Tanberg reported committee members wanted to include in the Board's FAQs, statistics on how often an Expert Witness will be asked to review a case, a realistic time commitment and how common it would be for this witness to have to testify. There was a suggestion to change the term "Expert Witness" to "Practice Reviewer".

- ❖ Bobbi Jean Tanberg moved that the Board change the terminology from Expert Witness to Practice Reviewer for all materials related to that.
- ❖ Luella Grangaard seconded the motion.
- ❖ *The motion passed unanimously.*

F. Recommendation(s) regarding providing information via podcasts.

Ms. Tanberg reported that Ms. Martin confirmed "podcasts" could be posted to the Board's website. The committee suggested Ms. Martin collaborate with a past Expert Witness to record a short clip summarizing their experience as a reviewer. The committee felt this would be a more powerful reference in comparison to an instructional handout.

7. Legislative and Regulatory Affairs Committee Report

Luella Grangaard, Chair of the Legislative and Regulatory Committee, briefed the Board on the committee's activities and provided the following recommendations.

A. Review and discussion of Legislative and Regulatory Affairs Committee's Roles and Responsibilities and consideration of recommending changes to the Board.

This item will be brought to the Board at its December meeting.

B. Recommended positions on legislative proposals.

AB 171 (Beall), Autism

Ms. Grangaard reported the committee recommended that the Board support the bill because it increases access in coverage which would benefit the consumers and the licensees.

Discussion ensued about the present status of several of the bills. President Evert proposed to revisit this item later in the meeting to allow Ms. Martin time to check the internet for the current status of the bills and provide copies of any bill requiring immediate attention.

Ms. Martin informed the Board Members that Assembly Bill (AB) 415 was the only bill still alive on the floor. It was amended on September 2, 2011. The majority of the amendments have been about billing and reimbursement. Telemedicine is still in the Code of Federal Regulations so it will not be removed.

- ❖ Luella Grangaard moved to support AB 415.
- ❖ Bobbi Jean Tanberg seconded the motion.

Mr. Phipps confirmed OTAC is in support of AB 415.

- ❖ *The motion passed unanimously.*

Ms. Martin briefed the Board Members on the status of the remaining bills and it was determined that no immediate action was necessary on any of the remaining bills.

8. Practice Committee Report

A. Acceptance of the February 17, 2011 and April 7, 2011, meeting minutes.

Linda Florey, Chair of the Practice Committee reported the committee approved minutes as presented.

B. Recommended addition of Section 4171, Notification to Consumers regulations.

Ms. Florey reported that the committee blended the language of Section 4171 with the requirements of the Business and Professions code. Ms. Florey summarized that the section informs practitioners that name tags must be worn and should display in at least an 18-point font, the name, license type and license number to show the practitioner is licensed and regulated by the Board.

- ❖ Linda Florey moved that the Board adopt the new language of Section 4171.
- ❖ Bobbi Jean Tanberg seconded the motion.
- ❖ *The motion passed unanimously.*

Ms. Florey confirmed the next Practice Committee meeting is in November.

9. Review and Consideration of the Board's Strategic Plan

VISION STATEMENT

Ms. Grangaard stated that a few words were removed from the Vision statement.

- ❖ Luella Grangaard moved to adopt proposed Vision statement.
- ❖ Nancy Michel seconded the motion.
- ❖ *The motion passed unanimously.*

MISSION STATEMENT

Ms. Grangaard stated that the revision expands the Board's duties.

- ❖ Bobbi Jean Tanberg moved to adopt the proposed Mission statement.
- ❖ Nancy Michel seconded the motion.

Discussion ensued amongst the Board Members.

- Luella Grangaard moved to amend the proposed Mission statement by deleting the second sentence.
- Nancy Michel seconded the motion.
- *The motion passed unanimously.*

CORE VALUES

Ms. Grangaard stated the proposed statement should be labeled as A through F instead of F through K and that the proposed language mainly adds section C.

Ms. Michel suggested amending Section B., the word "enforce" to "enforcing" and Section C., the word "implement" to "implementing".

- Luella Grangaard moved the Board accept the proposed Core Values with amendments.
- Linda Florey seconded the motion.
- *The motion passed unanimously.*

STRATEGIC GOALS

Ms. Grangaard stated they compressed the current goals and removed as much routine Board operation from the goals.

- Luella Grangaard moved the Board accept the proposed Strategic Goals.
- Nancy Michel seconded the motion.
- *The motion passed unanimously.*

STRATEGIC OBJECTIVES

Goal 1
- Luella Grangaard moved to accept Goal 1.1 through 1.5 as amended.
- Nancy Michel seconded the motion.
- *The motion passed unanimously.*

Goal 2
- Luella Grangaard moved to accept the objectives under Goal 2.
- Bobbi Jean Tanberg seconded the motion.
- *The motion passed unanimously.*

Goal 3
- Luella Grangaard moved that objectives 3.1 through 3.6 be accepted by the Board.
- Linda Florey seconded the motion.

During discussion Ms. Martin suggested we replace "deliberations" with "business" in section 3.6 and strike the word "forms" in section 3.5.

President Evert asked all those in favor of Goal 3 with those two changes say "aye".

- *The motion passed unanimously.*

- Bobbi Jean Tanberg moved to strike the goals on page 3 and insert page 9 in its place.
- Nancy Michel seconded the motion.
- *The motion was adopted unanimously.*

Discussion ensued by the Board Members about revising the summary of Goal 3.

President Evert asked all those in favor of the revision of Goal 3 as a substitute for the previous vote say "aye".

- *The motion passed unanimously.*

Goal 4

- Luella Grangaard moved to accept the objectives as amended.
- Linda Florey seconded the motion.

Discussion ensued by Board members regarding changes and additions to the objectives of Goal 4.

President Evert asked all those in favor of the objectives as they have been amended say "aye".

- *The motion passed unanimously.*

- Luella Graangard moved that having voted on the prevailing side, I would like to bring back the motion on Goal 4 and I would like to substitute the goal 4 on page 3 with goal 4 on page 9.
- Nancy Michel seconded the motion.
- *The motion passed unanimously.*

Board members agreed the new Strategic Plan will be effective 2011 through 2014, actual counts of current Occupational Therapists and Occupational Therapy Assistants will be removed from the front page, Board staff will update the Strategic Plan and email it to the Board Members and have it posted on the website.

President Evert asked that each Committee Chairperson review the new Strategic Plan and identify where their activities work in underneath it. President Evert asked Ms. Tanberg include this information in her next report. Ms. Tanberg asked that the new Strategic Plan be sent in a format that allows them to see each committee and its specific objectives. Ms. Martin agreed to forward this format to the Board.

10. Review and Consideration of the Board's Administrative Manual

The Board members discussed adding a chapter to the manual explaining the relationship of the Board and DCA, having at least five members per committee as opposed to the current four, updating the agencies and organizations listed on the abbreviations list, notifying Ms. Martin as soon as possible in the event they will be absent so that quorum issues can be addressed, adding "and roll call votes when necessary" to the duties of the Secretary, clarifying the availability of the minutes, adding that the Board President consult with Office of Human Resources (OHR) regarding the Executive Officer Evaluation, clarifying the effective dates for those assuming office, including DCA and its offices as appropriate throughout the manual, and changing the manual to read "required" instead of "recommended" in the section titled Attendance at Committee Meetings.

Ms. Martin agreed to provide Board Members a sheet that they would be able to track the hours in which they work on Board business.

The Board Members directed Ms. Martin to bring back a copy of the proposed manual with the suggestions of the items reviewed. Ms. Martin agreed to include all changes in brackets.

11. Adoption of CCR Sections 4100, 4101, 4146, 4148, 4149, and 4149.1

A representative from the Center Public Interest Law (CPIL) stated that her Administrative Director wants to reinforce their support for section 4149. Ms. Martin indicated the only public comment received was

from CPIL, and referred to their letter from CPIL supporting the amendments to sections 4149, 4149(a), 4149(d), and 4149.1.

Board members discussed the provisions of section 4101 and decided to remove the "adoption of default decisions" from the authority delegated to the Executive Officer.

- Luella Grangaard moved to delete "default decisions" from section 4101 and notice the modified text for fifteen days.
- Nancy Michel seconded the motion.
- *The motion was adopted. The vote consisted of five ayes and one nay (Mary Evert).*

Board members discussed the inclusion of "alcohol" in to those incidents considered "substantially related to the qualifications, functions, or duties" set forth in section 4146(d)(3).

- Luella Graangard moved to add "or alcohol" to section 4146(d)(3) and notice the modified text for fifteen days.
- Bobbi Jean Tanberg seconded the motion.
- *The motion passed unanimously.*

- Luella Graangard moved to delegate to Ms. Martin the authority to make minor technical modifications as might be needed in the final rulemaking process in the absence of any negative comments.
- Eric Alegria seconded the motion.
- *The motion passed unanimously.*

- Luella Grangaard moved to adopt CCR 4100, 4148, 4149 and 4149.1 as presented.
- Nancy Michel seconded the motion.

- *The motion passed unanimously.*

12. Adoption of proposed regulatory language regarding Sponsored Free Health Care Events.

- Bobbi Jean Tanberg moved to adopt the language from the Free Health Care Events sections 4116, 4117, 4118 and 4119 as presented.
- Linda Florey seconded the motion.
- *The motion passed unanimously.*

13. Adoption of proposed amendments to Title 16 CCR Section 4155, Application for Approval in Advanced Practice Areas.

Ms. Martin informed the Board Members that we are reviewing the package to include the updated PAMs application.

- Bobbi Jean Tanberg moved to adopt the proposed amendment to Title 16, Section 4155 as provided.
- Nancy Michel seconded the motion.
- *The motion passed unanimously.*

14. Enforcement data and reports.

Mr. Hanson presented and discussed enforcement data spreadsheets to the Board Members.

15. Executive Officer's report.

Ms. Martin report the upcoming Committee meeting dates are:

Enforcement – September 28 or 29, 2011.
Legislative Regulatory Affairs – October 18, 2011.
Practice – November 4, 2011.
Education Outreach – November 10, 2011.

Ms. Martin reported that in order to keep BreEZe on track that the Board was asked and agreed to absorb some of the difference of the increased costs. The Board will absorb these costs for this fiscal year and next fiscal year.

Fiscal year 2011-2012 the first of two of the General Fund loan payments has to be repaid to us.

Ms. Martin reported that the Board's Disciplinary Guidelines went in to effect July 6, 2011.

Ms. Martin indicated she would work with Mr. Hanson to initiate a plan for noticing future regulatory packages that the Board will approve.

Ms. Martin disclosed that DCA still has an "acting" Director, however, a new Deputy Director of Board and Bureau Relations has been appointed. The Board is not fully staffed.

Ms. Martin agreed to email the Board Members a copy of the minutes from the Department's monthly meeting.

16. Public Comment

Mr. Phipps from AOTA questioned whether it has to be a physician's referral when Department of Motor Vehicles (DMV) orders a driving evaluation or if it's sufficient for DMV to refer for the evaluation. .

President Evert noted Mr. Phipps question and directed Ms. Martin to respond when the answer is obtained.

Mr. Phipps referenced the Board Meeting minutes from June 16, 2011, specifically the Board's inclusion of the information provided by Section 4125 of the CCR on our website. Ms. Martin confirmed that it was posted under general FAQ's.

17. Agenda Items for Next Meeting

Ms. Martin stated that the Board Member Disciplinary Reference Manual will be vetted by the Enforcement Committee, and then discussed at the next Board Meeting.

18. The Board will convene in CLOSED SESSION pursuant to Government Code Section 1126(c)(3) to deliberate on Disciplinary Decisions.

At approximately 3:43 p.m. the Board entered into Closed Session to deliberate on two (2) disciplinary matters.

At 4:03 p.m. the Board returned to Open Session and immediately adjourned.

Adjournment.

MEETING HELD THURSDAY, SEPTEMBER 8, 2011.

Administrative Hearing for Occupational Therapist licensee Sandra Ingram-Watson.

Call to order, roll call, and establishment of a quorum.

10:04 a.m. – President, Mary Evert called the meeting to order. Secretary, Nancy Michel called the roll. All Board members were present with the exception of Kathay Lovell; a quorum of the Board was established.

10:11 a.m. - The Administrative Hearing for Occupational Therapist applicant Sandra Ingram-Watson commenced.

The Honorable Vallera Johnson was the presiding Administrative Law Judge.

11:55 a.m. - The hearing concluded and the Board Members went directly in to closed session with the Honorable Vallera Johnson.

12:22 p.m. – The meeting returned to open session and was adjourned.

Administrative Hearing for Occupational Therapist licensee Kathleen Posuniak.

12:48 p.m. - Vice President, Bobbi Jean Tanberg called the meeting to order. Secretary, Nancy Michel called the roll. All Board members were present with the exception of Mary Evert and Kathay Lovell. A quorum of the Board was established.

12:49 p.m. – The Administrative Hearing for Occupational Therapist applicant Kathleen Posuniak commenced.

The Honorable Vallera Johnson was the presiding Administrative Law Judge.

3:29 p.m. – The hearing concluded and the Board Members went directly in to closed session with the Honorable Vallera Johnson.

4:03 p.m. – The hearing returned to open session and was adjourned

4:04 p.m. – Board Meeting Adjourned.

DISASTER PREPAREDNESS/RESPONSE COMMITTEE MEETING REPORT.

The following are attached for review:

- Committee report.
- Materials considered at Committee meeting.

ITEM
TO BE
PROVIDED

ENFORCEMENT COMMITTEE MEETING REPORT.

The following are attached for review:

A. Committee report.
B. February 9, 2011, Committee meeting minutes.
C. April 27, 2011, Committee meeting minutes.
D. Proposed amendments to the Board's Disciplinary Guidelines.
E. Recommendation regarding proposed regulatory language to establish required actions against registered sex offenders.

ITEM
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ENFORCEMENT COMMITTEE MEETING MINUTES

Wednesday, February 9, 2011

Committee Members Present
Nancy Michel, Board Member
Margaret Fuller
William Levanduski
Claudia Peyton

Board Staff Present
Heather Martin

A. Call to order, roll call, establishment of a quorum

Chairwoman Nancy Michel called the meeting to order at 4:10pm. Heather Martin called the roll and a quorum of the Committee was present.

B. Introductions

The committee members all introduced themselves and shared a little bit about their background and/or current place of employment.

C. Review of Committee Member Roster/Information.

Ms. Martin requested that committee members review the roster and provide any updates to her via email.

D. Review and discussion of Enforcement Committee's Roles and Responsibilities and consideration of recommending changes to the Board.

Ms. Martin referenced the Roles and Responsibilities document and indicated that it was drafted based on the Committee description in the Board's Administrative Manual. The committee members had no questions and agreed that it was a good starting point.

E. Discussion and consideration of prohibition of teaching continuing education courses when a practitioner's license is on probation.

Ms. Martin referenced Section 1887.10, Course Instructor Qualifications, from the Board of Behavioral Sciences' (BBS) regulations in the meeting materials. The Committee's discussion centered on the requirement of holding a license "free from restrictions due to disciplinary action by this board or any other health care regulatory board."

The Committee also reviewed a condition of probation from the BBS' Disciplinary Guidelines that prohibits licensees from being "an instructor of any coursework for continuing education credit by any license issued by the Board."

- Margaret Fuller moved to recommend to the Board that practitioners on probation are prohibited from teaching continuing education courses.
- Claudia Peyton seconded the motion.

After further discussion, Ms. Fuller rescinded her motion.

- Claudia Peyton moved to recommend to the Board that practitioners on probation be prohibited from being an instructor of any coursework for continuing competency, continuing education, presentations, workshops, in-services, institutes, or post-professional courses used to satisfy advanced practice requirements, during the first year of probation.
- Margaret Fuller seconded the motion.

- Motion passed.

F. Review of pending amendments to the Board's Disciplinary Guidelines and consideration of recommending changes to the Board.

Due to time constraints this item was tabled until the next meeting.

G. Selection of 2011 meeting dates/locations.

The Committee selected the following future meeting dates and locations: April 27th at Palomar Pomerado Hospital and June 1st , to be held via teleconference at CSU, Dominguez Hills in Carson, and Scripps Hospital in Encinitas.

H. Public comment on items not on agenda.

There was no public comment for items not on the agenda.

I. Adjournment

The meeting adjourned at 6:40 pm.

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ENFORCEMENT COMMITTEE MEETING MINUTES

Wednesday, April 27, 2011

Committee Members Present
Margaret Fuller
William Levanduski
Claudia Peyton

Committee Members Absent
Nancy Michel, Board Member

Board Staff Present
Heather Martin

A. Call to order, roll call, establishment of a quorum.

Ms. Martin called the meeting to order at 2:20 pm.

B. Approval of the February 9, 2011, Enforcement Committee meeting minutes.

The meeting minutes were not available and will be provided at the next meeting.

C. Discussion and consideration of prohibition of teaching continuing education or post-professional courses when a practitioner's license is on probation.

Ms. Martin advised the Committee members that this item was previously before the Committee. However, due to the way the item was previously noticed, the Board could not take action and the item was again before the Committee for consideration.

The Committee reviewed the language as presented. Claudia Peyton commented that the use of "post-professional" in the context of courses was not consistent with the American Occupational Therapy Association's 2010 glossary and recommended that the term "post-professional" not be used.

Ms. Martin indicated that post professional education is used in the advanced practice regulations. Section 4150 defines post professional education and training as "education and training obtained subsequent to the qualifying degree program or beyond current ACOTE standards for the qualifying degree program."

The Committee further discussed the use of "post-professional" as it relates to education.

- ❖ William Levanduski moved to recommend to the Board that practitioners on probation be prohibited from being an instructor of any coursework for continuing competency, continuing education, presentations, workshops, in-services, institutes, or post-professional courses used to satisfy advanced practice requirements, during the first year of probation.
- ❖ Claudia Peyton seconded the motion.

- ❖ Motion passed.

D. Discussion and consideration of amending post-professional education course instructor qualifications.

The Committee discussed the requirement of post-professional course instructors holding a license "free from restrictions due to disciplinary action by this board or any other health care regulatory board" and reviewed draft language provided by Board staff.

- ❖ Margaret Fuller moved to accept the language presented and recommend to the Board required instructors of post-professional courses must have a current and valid license, free from restrictions due to disciplinary action by this board or any other health care regulatory board or agency.
- ❖ William Levanduski seconded the motion.

- ❖ Motion passed.

E. Discussion and consideration of amending proposed regulatory language, Other Acts Constituting Unprofessional Conduct.

The Committee discussed the language presented that would set forth other actions constituting unprofessional conduct. The Committee discussed the various actions and agreed that the requirements were reasonable. However, the Committee felt that a traffic infraction with a fine of $500 was too low and suggested the amount be raised to $1,000.

- ❖ Claudia Peyton moved to accept the language with amendments and recommend the Board approve the language to move forward in the regulatory process.
- ❖ Margaret Fuller seconded the motion.

- ❖ Motion passed.

F. Review of pending amendments to the Board's Disciplinary Guidelines and consideration of recommending additional changes to Disciplinary Guidelines.

Ms. Martin explained that the Board was in the process of amending the Board's Disciplinary Guidelines. However, the recent revisions were to incorporate the new

Uniform Standards Related to Substance Abuse and the remaining content had not been reviewed since adopted in 2003.

The Committee began review, however, due to time constraints was unable to finish review of the Disciplinary Guidelines

G. Selection of future 2011 meeting dates/locations.

The Commitee agreed to meet August 3rd at Scripps Hospital in Encinitas.

H. Public comment on items not on agenda.

There was no public comment.

I. Agenda items for next meeting.

The Committee agreed that additional review of the Disciplinary Guidelines would be necessary at the next meeting.

California Board of Occupational Therapy

UNIFORM STANDARDS
RELATED TO SUBSTANCE ABUSE
AND
DISCIPLINARY GUIDELINES

~~July 2011~~

July 2012

Additional copies of this document may be obtained by contacting the Board at its office in Sacramento, California or from its web site at www.bot.ca.gov.

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY

UNIFORM STANDARDS RELATED TO SUBSTANCE ABUSE AND DISCIPLINARY GUIDELINES

TABLE OF CONTENTS

(*PLEASE NOTE:* **TABLE OF CONTENTS WILL NO LONGER MATCH DUE TO THE INSERTION OF ADDITIONAL LANGUAGE.)**

UNIFORM STANDARDS FOR THOSE LICENSEES WHOSE LICENSE IS ON PROBATION DUE TO A SUBSTANCE ABUSE PROBLEM

The following standards shall be adhered to in all cases in which a licensee's license is placed on probation due, in part, to a substance abuse problem. These standards are not guidelines and shall be followed in all instances, except that the Board may impose more restrictive conditions if necessary to protect the public.

Clinical Diagnostic Evaluations:

Whenever a licensee is ordered to undergo a clinical diagnostic evaluation, the evaluator shall be a licensed practitioner who holds a valid, unrestricted license which scope of practice authorizes him or her to conduct clinical diagnostic evaluations, has three (3) years experience in providing evaluations of health care professionals with substance abuse disorders, and is approved by the Board. The evaluations shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations.

Clinical Diagnostic Evaluation Report:

The clinical diagnostic evaluation report shall set forth, in the evaluator's opinion, whether the licensee has a substance abuse problem, whether the licensee is a threat to himself or herself or others, and recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice.

The evaluator shall not have a financial, personal, or business relationship with the licensee within the last five (5) years. The evaluator shall provide an objective, unbiased, and independent evaluation.

If the evaluator determines during the evaluation process that a licensee is a threat to himself or herself or others, the evaluator shall notify the board within 24 hours of such a determination.

For all evaluations, a final written report shall be provided to the board no later than ten (10) days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed 30 days.

The Board shall review the clinical diagnostic evaluation to help determine whether or not the licensee is safe to return to either part-time or full-time practice and what restrictions or recommendations should be imposed on the licensee based on the application of the following criteria:

License type, licensee's history, documented length of sobriety, scope and pattern of substance abuse, treatment history, medical history, current medical condition, nature, duration and severity of substance abuse problem, and whether the licensee is a threat to himself or herself or others.

When determining if the licensee should be required to participate in inpatient, outpatient or any other type of treatment, the Board shall take into consideration the recommendation of

the clinical diagnostic evaluation, license type, licensee's history, length of sobriety, scope and pattern of substance abuse, treatment history, medical history, current medical condition, nature, duration and severity of substance abuse and whether the licensee is a threat to himself or herself or others.

FACILITATED GROUP SUPPORT MEETINGS

If a board requires a licensee to participate in facilitated group support meetings, the following shall apply:

When determining the frequency of required facilitated group meeting attendance, the board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;
- the licensee's treatment history; and,
- the nature, duration, and severity of substance abuse.

Group Meeting Facilitator Qualifications and Requirements:

1. The meeting facilitator must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.
2. The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee in the last five (5) years.
3. The group meeting facilitator shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.
4. The facilitator shall report any unexcused absence within 24 hours.

WORK SITE MONITOR REQUIREMENTS:

If a Board determines that a worksite monitor is necessary for a particular licensee, the worksite monitor must meet the following requirements to be considered for approval by the Board:

The worksite monitor shall not have a current or former financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the Board; however, under no circumstances shall a licensee's worksite monitor be an employee or supervisee of the licensee.

The worksite monitor's license scope of practice shall include the scope of practice of the licensee who is being monitored or be another health care professional if no monitor with like scope of practice is available.

The worksite monitor shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

The worksite monitor shall sign an affirmation that he or she has reviewed the terms and

conditions of the licensee's disciplinary order and agrees to monitor the licensee as set forth by the Board.

The worksite monitor must adhere to the following required methods of monitoring the licensee:

a) Have face-to-face contact with the licensee in the work environment on as frequent a basis as determined by the Board, but at least once per week.
b) Interview other staff in the office regarding the licensee's behavior, if applicable.
c) Review the licensee's work attendance.

Reporting by the worksite monitor to the Board shall be as follows:

Any suspected substance abuse must be orally reported to the Board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the oral report must be within one (1) hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

The worksite monitor shall complete and submit a written report monthly or as directed by the board. The report shall include: the licensee's name; license number; worksite monitor's name and signature; worksite monitor's license number; worksite location(s); dates licensee had face-to-face contact with monitor; worksite staff interviewed, if applicable; attendance report; any change in behavior and/or personal habits; any indicators that can lead to suspected substance abuse.

The licensee shall complete the required consent forms and sign an agreement with the worksite monitor and the Board to allow the Board to communicate with the worksite monitor.

Major and Minor Violations

If a licensee commits a major violation, the Board shall order the licensee immediately to cease any practice of occupational therapy, immediately contact the licensee to inform him or her that he or she has been ordered to cease practice and that he or she may not practice unless notified by the Board, and refer the matter for disciplinary action or other action as determined by the Board.

Major Violations include, but are not limited to, the following:

1. Failure to complete a board-ordered program;
2. Failure to undergo a required clinical diagnostic evaluation;
3. Committing multiple minor violations of probation conditions and terms;
4. Treating a patient while under the influence of drugs or alcohol;
5. Committing any drug or alcohol offense that is a violation of the Business and Professions Code, or other state or federal law;
6. Failure to obtain biological testing for substance abuse when ordered;
7. Testing positive for a banned substance;
8. Failing to maintain a current account with drug-testing vendor;

~~8.~~ 9. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of alcohol or a controlled substance.

If a licensee commits a minor violation, the Board shall determine what action is appropriate.

Minor Violations include, but are not limited to, the following:

1. Failure to submit required documentation in a timely manner;
2. Unexcused attendance at required meetings;
3. Failure to contact a monitor as required;
4. Failure to contact or respond to Medical Review Officer;
5. Failure to make daily contact with drug-testing vendor as directed by the Board to determine if he or she must submit to drug testing;
6. Failure to maintain an adequate supply of chain of custody forms;
~~4.~~ 7. Any other violations that do not present an immediate threat to the licensee or to the public.

DRUG TESTING STANDARDS

If a licensee tests positive for a banned substance, the Board shall order that the licensee immediately cease any practice of occupational therapy, and immediately contact the licensee to inform him or her that he or she has been ordered to cease practice and that he or she may not practice until the Board determines that he or she is able to safely practice. The Board shall also immediately notify the licensee's employer that the licensee has been ordered to cease practice, and that he or she may not practice until the Board determines that he or she is able to safely practice.

The following drug testing standards shall apply to each licensee subject to drug testing:

1. Licensees shall be randomly drug tested at least 104 times per year for the first year or probation, and at any time as directed by the board. After the first year, licensees who are practicing, shall be randomly drug tested at least 50 times per year, and at any time as directed by the board.

2. Drug testing may be required on any day, including weekends and holidays.

3. Except as directed, the scheduling of drug tests shall be done on a random basis, preferably by a computer program.

4. Licensees shall be required to make daily contact as directed to determine if drug testing is required.

5. Licensees shall be drug tested on the date of notification as directed by the board.

~~6. Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S.~~

~~Department of Transportation.~~

~~7.~~ ~~Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.~~

~~8.~~ ~~Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.~~

6 ~~9.~~ Collection of specimens shall be observed.

7 ~~10.~~ Prior to vacation or absence, alternative drug testing location(s) must be requested by the licensee and approved in advance by the board.

~~11. Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.~~

8 ~~12.~~ A chain of custody form shall be used on all specimens.

~~A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven (7) days of receipt of the specimen. The Board will be notified of non-negative test results within one (1) business day and will be notified of negative test results within seven (7) business days.~~

DISCIPLINARY GUIDELINES

I. INTRODUCTION

To establish consistency in disciplinary penalties for similar offenses on a statewide basis, the California Board of Occupational Therapy (Board) has adopted these uniform disciplinary guidelines for particular violations. This document, designed for use by attorneys , administrative law judges, occupational therapists, occupational therapy assistants, others involved in the disciplinary process, and ultimately the Board, may be revised from time to time and shall be distributed to interested parties upon request.

These guidelines include general factors to be considered, probationary terms, and guidelines for specific offenses. The guidelines for specific offenses reference the applicable statutory and regulatory provision(s).

~~For purposes of this document, the term "license" includes the occupational therapy license and the occupational therapy assistant certificate.~~ The terms and conditions of probation are divided into two general categories:

(1) Standard Conditions are those conditions of probation which will generally appear in all cases involving probation as a standard term and condition; and
(2) Optional Conditions are those conditions which address the specific circumstances of the case and require discretion to be exercised depending on the nature and circumstances of a particular case.

Except as provided in the Uniform Standards Related to Substance Abuse, the Board recognizes that these recommended penalties and conditions of probation are merely guidelines and that mitigating or aggravating circumstances and other factors may necessitate deviations, as discussed herein. If there are deviations from the guidelines, the Board requests that the Administrative Law Judge hearing the matter include an explanation in the Proposed Decision so that the circumstances can be better understood and evaluated by the Board upon review of the Proposed Decision and before final action is taken.

The Board recognizes that these recommended penalties and conditions of probation are merely guidelines and that mitigating or aggravating circumstances and other factors may necessitate deviations, as discussed herein. If there are deviations from the guidelines, the Board requests that the Administrative Law Judge hearing the matter include an explanation in the Proposed Decision so that the circumstances can be better understood and evaluated by the Board upon review of the Proposed Decision and before final action is taken.

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II. GENERAL CONSIDERATIONS

The Board requests that Proposed Decisions following administrative hearings include the following:

a. Specific code sections violated with their definitions.

b. Clear description of the violation.
c. Respondent's explanation of the violation if he/she is present at the hearing.
d. Findings regarding aggravation, mitigation, and rehabilitation where appropriate.
e. When suspension or probation is ordered, the Board requests that the disciplinary order include terms within the recommended guidelines for that offense unless the reason for departure from the recommended terms is clearly set forth in the findings and supported by the evidence.

Factors to be Considered - In determining whether revocation, suspension or probation is to be imposed in a given case, factors such as the following should be considered:

1. Nature and severity of the act(s), offense(s), or crime(s) under consideration.
2. Actual or potential harm to any consumer, client or the general public.
3. Prior disciplinary record.
4. Number and/or variety of current violations.
5. Mitigation evidence.
6. Rehabilitation evidence.
7. In the case of a criminal conviction, compliance with terms of sentence and/or court-ordered probation.
8. Overall criminal record.
9. Time passed since the act(s) or offense(s) occurred.
10. Whether or not the respondent cooperated with the Board's investigation, other law enforcement or regulatory agencies, and/or the injured parties.
11. Recognition by respondent of his or her wrongdoing and demonstration of corrective action to prevent recurrence.

III. DEFINITION OF PENALTIES

Revocation: Loss of a license as the result of any one (1) or more violations of the Occupational Therapy Practice Act. Revocation of a license is permanent, unless the respondent takes affirmative action to petition the Board for reinstatement of his/her license and demonstrates to the Board's satisfaction that he/she is rehabilitated.

Suspension: Invalidation of a license for a fixed period of time, not to exceed one (1) year.

Stayed Revocation: Revocation of a license, held in abeyance pending respondent's compliance with the terms of his/her probation.

Stayed Suspension: Suspension of a license, held in abeyance pending respondent's compliance with the terms of his/her probation.

Probation: A period during which a respondent's discipline is stayed in exchange for respondent's compliance with specified conditions relating to improving his/her conduct or preventing the likelihood of a recurrence of the violation.

IV. DISCIPLINARY GUIDELINES

The offenses are listed by statute number in the Business and Professions Code. The standard terms of probation as stated herein shall be included for all probations. The optional conditions of probation as stated herein are to be considered and imposed along with any other optional conditions if facts and circumstances warrant. The number(s) in brackets listed after each condition of probation refers to the conditions listed on pages 8-14.

BUSINESS AND PROFESSIONS CODE SECTIONS – Occupational Therapy Practice Act

2570.185. – Patient Records

Maximum: Revocation
Minimum: Stayed revocation and 1 year probation on the following conditions:
a. Standard conditions [#1-#14]
b. Optional condition [28]

Section 2570.23 - Unlicensed Person Engaging in Practice - Sanctions

Applicant Maximum: Denial of application for a license

Applicant Minimum: Thirty (30) days actual suspension and three (3) years probation on the following conditions:
a. Standard conditions [#1- ~~#13~~ 14]
b. Optional conditions [# ~~26~~ 27 and # ~~30~~ 31]

Section 2570.28(a)(1),(2),or(3): Unprofessional Conduct – Incompetence, Gross Negligence, Repeated Negligent Acts, Conviction of Practicing Medicine

Maximum: Revocation
Minimum: Stayed revocation, thirty (30) days actual suspension and three (3) years probation on the following conditions:
a. Standard conditions [#1- ~~#13~~ 14]
b. Optional conditions ~~[#23, #25, # 26, #28, # 30]~~ [#24, #26, #27, #29, #31]

Section 2570.28(a)(4): Unprofessional Conduct – False Advertising

Maximum: Revocation
Minimum: Stayed revocation, thirty (30) days actual suspension and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~# 26 and #30~~ #27 and #31]

Section 2570.28(a)(5): Unprofessional Conduct – Discipline by Other Government Agency

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1- ~~#13~~ 14]

Section 2570.28(b): Procuring a License by Fraud, Misrepresentation, Mistake

Maximum: Revocation
Minimum: Stayed revocation, thirty (30) days actual suspension and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional condition [~~#23, #26, #28~~ #24, #27, #29]

Section 2570.28(c): Violating Any Provision of the Occupational Therapy Practice Act or Regulations

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. a. Standard conditions [#1 - ~~#13~~ 14]

Section 2570.28(d): False Statement on Application for License or Renewal

Maximum: Revocation
Minimum: Stayed revocation, thirty (30) days suspension and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~#26 and #30~~ #27 and #31]

Section 2570.28(e): Conviction of Crime Substantially Related to License

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~#26, #27, #28, #30~~ #27, #28, #29, #31]

Section 2570.28(f) or (g): Impersonating an Applicant or Acting as Proxy for Another in an Examination for Licensure, Impersonating a Licensee or Allowing Another Person to Use License

Maximum: Revocation
Minimum: Stayed revocation, thirty (30) days actual suspension and three (3) years probation on the following conditions:

a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~#26 and #30~~ #27 and #31]

Section 2570.28(h): Committing Fraud, Dishonest or Corrupt Act

Maximum: Revocation
Minimum: Stayed revocation, thirty (30) days actual suspension and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~#26 and #30~~ #27 and #31]

Section 2570.28(i): Committing Any Act Punishable as a Sexually Related Crime

Maximum: Revocation
Minimum: Stayed revocation, ninety (90) days actual suspension and five (5) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional Conditions [~~#15, #16, #24, #26, #30~~ #16, #17, #25, #27, #31]

Section 2570.28(j): Using Excessive Force, Mistreating or Abusing Patient

Maximum: Revocation
Minimum: Stayed revocation, ninety (90) days actual suspension and five (5) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional Conditions [~~#15, #16, #25, #26, 30~~ #16, #17, #26, #27, #31]

Section 2570.28(k): Falsifying, Making Grossly Incorrect, Inconsistent, or Unintelligible Entries in Patient/Hospital Record or any other record

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]

Section 2570.28(l): Changing the Prescription of Physician or Falsifying Verbal or Written Orders

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]

Section 2570.28(m): Failing to Maintain Patient Confidentiality

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]

Section 2570.28(n): Delegating Services that Require License to Unlicensed Person

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]

Section 2570.28(o): Committing Any Act that would be Grounds for Denial under Section 480

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]

Section 2570.28(p): Failing to Follow Infection Control Guidelines

Maximum: Revocation
Minimum: Stayed revocation and one (1) year probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]

Section 2570.29(a): Obtain, Possess, Administer to Self, Furnish or Administer to Others, Any Controlled Substance

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~#14, #17, #18, #19a and/or 19b or 19c, #20, #21, #22, #24, #31~~ #15, #18, #19, #20a and/or 20b or 20c, #21, #22, #23, #25, #32]

Section 2570.29(b)(1), (2) or (3): Use Controlled Substance, Dangerous Drug, Alcohol in Manner Dangerous, Injurious to Self or Others

Maximum: Revocation
Minimum: Stayed revocation and three (3) years probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~#14, #17, #18, #19a and/or 19b or 19c, #20, #21, #22, #24, #31~~ #15, #18, #19,

#20a and/or 20b or 20c, #21, #22, #23, #25, #32]

Section 2570.29(c): Conviction of Crime Involving Controlled Substance, Dangerous Drug, Alcohol or Falsifying a Record Involving Same

Maximum:	Revocation
Minimum:	Stayed revocation and three (3) years probation on the following conditions: a. Standard conditions [#1 - ~~#13~~ 14] b. Optional conditions [~~#14, #17, #18, #19a and/or 19b or 19c, #20, #21, #22, #24, #28, #31~~ #15, #18, #19, #20a and/or 20b or 20c, #21, #22, #23, #25, #29, #32]

Section 2570.29(d): Committed or Confined by Court for Intemperate Use of Controlled Substance, Dangerous Drug, Alcohol

Maximum:	Revocation
Minimum:	Stayed revocation and three (3) years probation on the following conditions: a. Standard conditions [#1 - ~~#13~~ 14] b. Optional conditions [~~#14, #17, #18, #19a and/or 19b or 19c, #20, #21, #22, #24, #28, #31~~ #15, #18, #19, #20a and/or 20b or 20c, #21, #22, #23, #25, #29, #32]

Section 2570.29(e): Falsify, Make Grossly Incorrect, Inconsistent, or Unintelligible Entries in Hospital/Patient Record involving Controlled Substance or Dangerous Drug

Maximum:	Revocation
Minimum:	Stayed revocation and three (3) years probation on the following conditions: a. Standard conditions [#1 - ~~#13~~ 14] b. Optional conditions [~~#14, #17, #18, #19a and/or 19b or 19c, #20, #21, #22, #24, #28, #31~~ #15, #18, #19, #20a and/or 20b or 20c, #21, #22, #23, #25, #29, #32]

2570.36. Required Reporting of Violations to the Board

Maximum:	Revocation
Minimum:	Stayed revocation and six (6) months' probation a. Standard conditions [#1 - # 14]

GENERAL PROVISIONS OF BUSINESS AND PROFESSIONS CODE

Section 119: Misdemeanor Pertaining to Use of a License

Maximum:	Revocation
Minimum:	Stayed revocation and one (1) year probation on the following conditions: a. Standard conditions [#1 - ~~#13~~ 14]

123. Conduct constituting subversion of licensing examination; penalties and damages

Maximum:	Denial of application for licensure or revocation
Minimum:	Stayed revocation and three (3) years probation on the following conditions: a. Standard conditions [#1 - #14]

Section 125: Misdemeanor Pertaining to Conspiring with Unlicensed Person for Use of a License

Maximum:	Revocation
Minimum:	Stayed revocation and one (1) year probation on the following conditions: a. Standard conditions [#1 - ~~#13~~ 14]

Section 125.6: Discrimination by Licensee

Maximum:	Revocation
Minimum:	Stayed revocation and one (1) year probation on the following conditions: a. Standard conditions [#1 - ~~#13~~ 14]

Section 480(a): Denial of Licenses

Maximum/Minimum: Denial of license

Section 480(c): Denial of Licenses

Maximum/Minimum: Denial of license

Section 496: Subversion of Licensing Examinations or Administration of Examinations.

Maximum:	Denial or revocation of license
Minimum:	Stayed revocation, thirty (30) days actual suspension and three (3) years probation on the following conditions: a. Standard conditions [#1 - ~~#13~~ 14] b. Optional conditions [~~#23, #26, #30~~ #24, #27, #31]

Section 498. Fraud, deceit or misrepresentation as grounds for action against license

Maximum:	Revocation
Minimum:	Stayed revocation and three (3) years probation on the following conditions: a. Standard conditions [#1 - #14]

Section 499. Action against license based on licentiate's actions regarding application of another

Maximum:	Revocation
Minimum:	Stayed revocation and two (2) years probation on the following conditions: a. Standard conditions [#1 - #14]

Section 581. Purchase or fraudulent alteration of diplomas or other writings

Maximum:	Revocation
Minimum:	Stayed revocation and three (3) years probation on the following conditions: a. Standard conditions [#1 - #14]

Section 582. Use of illegally obtained, altered, or counterfeit diploma, certificate, or transcript

Maximum:	Revocation
Minimum:	Stayed revocation and three (3) years probation on the following conditions: a. Standard conditions [#1 - #14]

Section 583. False statements in documents or writings

Maximum:	Revocation
Minimum:	Stayed revocation and two (2) years probation on the following conditions: a. Standard conditions [#1 - #14]

Section 584. Violation of examination

Maximum:	Revocation
Minimum:	Stayed revocation and three (3) years probation on the following conditions: a. Standard conditions [#1 - #14] b. Optional condition [#28]

Section 726: Sexual Abuse, Misconduct, or Relations with a Patient or Client

Maximum:	Revocation
Minimum:	Stayed revocation and one (1) year probation on the

following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~#25, #26, #30~~ #26, #27, #31]

Section 730: Performing Medical Evaluation Without Certification

Maximum: Revocation
Minimum: Stayed revocation and one (1) year probation on the following conditions:
a. Standard conditions [~~#1 - #13~~ 14]

Section 810: ~~Fraudulent Claims~~ Grounds for disciplinary action against health care professional

Maximum: Revocation
Minimum: Stayed revocation and one (1) year probation on the following conditions:
a. Standard conditions [#1 - ~~#13~~ 14]
b. Optional conditions [~~#26, #27, #30~~ #27, #28, #31]

Section 17500. False or misleading statements

Maximum: Revocation
Minimum: Stayed revocation and two (2) years probation on the following conditions:
a. Standard conditions [#1 - #14]

V. STANDARD CONDITIONS OF PROBATION
(To be included in ALL cases of probation)

1. **Obey All Laws**
   Respondent shall obey all federal, state and local laws ~~and regulations governing the practice of occupational therapy in California~~. Respondent shall submit, in writing, a full detailed account of any and all ~~violations of the law~~ arrests and convictions to the Board within five (5) days of occurrence.

   CRIMINAL COURT ORDERS: If Respondent is under criminal court orders by any governmental agency, including probation or parole, and the orders are violated, this shall be deemed a violation of probation and may result in the filing of an accusation or petition to revoke probation or both.

   OTHER BOARD OR REGULATORY AGENCY ORDERS: If Respondent is subject to any other disciplinary order from any other health-care related board or any professional licensing or certification regulatory agency in California or elsewhere, and violates any of the orders or conditions imposed by other agencies, this shall be deemed a violation of probation and may result in the filing of an accusation or petition to revoke probation or both.

2. **Compliance with Probation and Quarterly Reporting**
   Respondent shall fully comply with the terms and conditions of probation established by the Board and all requirements necessary to implement the conditions of probation. Respondent shall cooperate with representatives of the Board in its monitoring and investigation of the respondent's compliance with probation. Respondent shall respond to all requests and inquiries from the Board within the time period specified by the Board. Failure by respondent to accept and/or pick up any correspondence sent via express mail, certified mail or registered mail shall constitute a violation of probation.

   Respondent, within ten (10) days of completion of the quarter, shall submit quarterly written reports to the Board on a Quarterly Report of Compliance form obtained from the Board (Quarterly Written Report, rev. 4/2011).

3. **Personal Appearances**
   Upon reasonable notice by the Board, respondent shall report to and make personal appearances at times and locations as the Board may direct.

4. **Notification of Address and Telephone Number Change(s)**
   Respondent shall notify the Board staff and his or her Probation Monitor, in writing, within five (5) days of a change of residence or mailing address, of his/her new address and any change in work and/or home telephone numbers.

   Post Office Boxes are accepted for mailing purposes; however, the Respondent must also provide his or her physical residence address as well.

5. **Tolling for Out-of-State Practice, Residence or Extension of Probation for In-State Non-Practice.**

In the event respondent should leave California to reside or to practice outside the State for more than thirty (30) days, respondent shall notify the Board or its designee in writing within five (5) days of the dates of departure and return. All provisions of probation, other than the quarterly report requirements, examination requirements, ~~and~~ education requirements, address change and cost recovery requirements, shall be held in abeyance until respondent resumes practice and/or residence in California. All provisions of probation shall recommence on the effective date of resumption of practice in California, and the period of probation shall be extended for the period of time respondent was out of state.

Unless by Board order, in the event respondent is not engaging in the practice of occupational therapy while residing in California, respondent shall notify the Board or its designee in writing within five (5) days of the dates of cessation of practice and the expected return to practice. All provisions of probation shall remain in effect, and the period of probation shall be extended for the period of time respondent was not engaged in the practice of occupational therapy as required by other employment requirement of this order.

6. Notification to Employer(s)

Respondent shall request and obtain written approval from the Board:

- Within five days of the effective date of the Decision when currently employed,
- Prior to commencing employment, or
- Prior to entering into a contract to provide services.

When currently employed, applying for employment in any capacity, or contracted to provide occupational therapy services, Respondent shall provide a copy of the Board's Decision to each employer, supervisor, or contractor no later than the effective date of the Decision. Respondent shall notify any prospective employer, supervisor, or contractor of his/her probationary status with the Board prior to accepting such employment. This notification shall include a copy of the Board's Accusation, Statement of Issues, Stipulated Settlement, or Disciplinary Decision (whichever applies).

The respondent shall provide to the Board the names, physical addresses, mailing addresses, email addresses, fax numbers and telephone numbers of all employers, supervisors and contractors, and shall inform the Board in writing of the facility or facilities at which the person is providing occupational therapy services, the name(s) of the person(s) to whom the Board's decision was provided.

Respondent shall complete ~~the required~~ an authorization and consent form~~s and sign an agreement with the employer and supervisor, or contractor, and the Board,~~ to allow the Board to communicate with the employer and supervisor or contractor regarding issues including but not limited to the licensee's work status, attendance, performance, and on-going monitoring. (Authorization to Release Information. Dev. 11/2011).

Respondent shall cause each employer and supervisor or contractor to submit quarterly reports to the Board. The report shall be on a form provided by the Board, and shall include a performance evaluation and such other information as may be required by the Board (Work Performance Evaluation Form. Rev. 12/2010).

Reporting by the supervisor to the board shall be as follows:
Any suspected substance abuse must be orally reported to the Board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the oral report must be within four (4) hours of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

Respondent shall notify the Board, in writing, within five (5) days of any change in employment status. Respondent shall notify the Board, in writing, within five (5) days if he/she is terminated from any occupational therapy or health care related employment with a full explanation of the circumstances surrounding the termination.

7. Employment Requirements and Limitations

During probation, respondent shall work in his/her licensed capacity in the State of California. ~~This practice shall consist of no less than six (6) continuous months and of no less than twenty (20) hours per week.~~

While on probation, respondent shall not work for a registry or in any private duty position, except as approved, in writing, by the Board. Respondent shall work only on a regularly assigned, identified, and pre-determined work site(s) and shall not work in a float capacity except as approved, in advance and in writing, by the Board.

~~During probation, Respondent shall work in his or her capacity in the State of California.~~ *(duplicates 1st sentence)* If respondent is unable to secure employment in his or her capacity, is issued a cease practice order, or his or her license is temporarily suspended, the period of probation shall be extended for that period of time.

8. Supervision Requirements
Respondent shall obtain approval from the Board when continuing or before commencing any employment, regarding the level of supervision provided to the respondent while employed as an occupational therapist or occupational therapy assistant.

Respondent shall not function as a supervisor during the period of probation except as approved, in advance and in writing, by the Board.

9. Continuing Education Requirements
Respondent shall complete continuing education directly relevant to the violation as specified by the Board. Continuing education shall be completed within ~~a period of time designated by the Board~~, ~~which timeframe~~ six months of the effective date of the decision and shall be incorporated as a condition of ~~this~~ the probation period.

Continuing education shall be in addition to the professional development activities required for license renewal. The Board shall notify respondent of the course content and number of contact hours required. Within thirty (30) days of the Board's written notification of the assigned coursework, respondent shall submit a written plan to comply with this requirement. The Board shall approve such plan prior to enrollment

in any course of study.

Failure to satisfactorily complete the required continuing education as designated or failure to complete same no later than one year from the date of the Board's written notification shall constitute a violation of probation. Respondent is responsible for all costs of such continuing education. Upon successful completion of the course(s), respondent shall cause the instructor to furnish proof to the Board within thirty (30) days of course completion.

10. Maintenance of Valid License

Respondent shall, at all times while on probation, maintain an active current license with the Board including any period during which license is suspended or probation is tolled.

11. Cost Recovery Requirements

Where an order for recovery of costs is made, respondent shall make timely payment as directed in the Board's Decision pursuant to Business and Professions Code section 125.3. Respondent shall be permitted to pay these costs in a payment plan approved by the Board. Respondent must submit a proposed payment plan within 30 days of the effective date of the decision and be approved by a Board representative. Payments shall be completed no later than six (6) months prior to the end of the probation term. Failure to make payments in accordance with any formal agreement entered into with the Board or pursuant to any Decision by the Board shall be considered a violation of probation.

~~The Board may conditionally renew or reinstate, for a maximum of one (1) year, the license of any respondent who demonstrates financial hardship. Respondent shall enter into a formal agreement with the Board to reimburse the unpaid costs within that one (1) year period.~~

~~Except as provided above, t~~ The Board shall not renew or reinstate the license of any respondent who has failed to pay all the costs as directed in a Decision.

12. Instruction of Continuing Competency/Continuing Education Coursework

Respondent shall not be an instructor of any coursework for continuing competency, continuing education, presentations, workshops, in-services, institutes, or any courses used to satisfy advanced practice requirements, during the first year of probation.

~~12.~~ 13. Violation of Probation

If respondent violates probation in any respect, the Board, after giving respondent notice and opportunity to be heard, may revoke probation and carry out the disciplinary order which was stayed. If an accusation or a petition to revoke probation is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended and respondent shall comply with all probation conditions, until the matter is final.

~~13.~~ 14. Completion of Probation
Upon successful completion of probation, respondent's license will be fully restored.

VI. OPTIONAL CONDITIONS OF PROBATION

~~14.~~ 15. Examination by a Physician
Within ~~sixty (60)~~ forty-five (45) days of the effective date of the Decision, respondent shall submit to a physical examination by a physician and surgeon of his/her choice who meets minimum criteria ~~established~~ approved by the Board. The physician and surgeon shall be licensed in California and Medical Board Certified in Family Practice, Internal Medicine or a related specialty. The purpose of the examination shall be to determine respondent's ability to safely perform all professional duties with safety to self and to the public. Respondent shall provide the examining physician and surgeon with a copy of the Board's Disciplinary Order prior to the examination. Cost of such examination shall be paid by respondent.

Respondent shall cause the physician and surgeon to complete a written medical report to be submitted directly to the Board within ~~ninety (90)~~ sixty (60) days of the effective date of the Decision. If the examining physician and surgeon finds that respondent is not physically fit to practice or can only practice with restrictions the physician shall notify the Board, in writing, within five (5) working days. The Board shall notify respondent in writing of the physician and surgeon's determination of unfitness to practice and shall order the respondent to cease practice or place restrictions on respondent's practice. Respondent shall comply with any order to cease practice or restriction of his or her practice until the Board is satisfied of respondent's fitness to practice safely and has so notified respondent in writing. Respondent

~~15.~~ 16. Psychological Evaluation
Within ~~sixty (60)~~ forty-five (45) of the effective date of the Decision, respondent shall submit to a psychiatric/psychological evaluation. Within twenty (20) days of the effective date of the Decision, Respondent shall submit to the Board the name of one or more proposed evaluators for prior approval by the Board. The evaluation shall be performed by a physician and surgeon licensed in California and Board Certified in Psychiatry, or by a clinical psychologist licensed in California and approved by the Board. This evaluation shall be for the purpose of determining respondent's current mental, psychological and emotional fitness to safely perform all professional duties with safety to self and the public. Respondent shall provide the evaluator with a copy of the Board's Disciplinary Order prior to the evaluation. Cost of such evaluation shall be paid by respondent.

Respondent shall cause the evaluator to submit to the Board a written psychological report concerning respondent's status and progress as well as such other information as may be requested by the Board. This report shall be submitted within ~~ninety (90)~~ sixty (60) days from the effective date of the Decision.

If the evaluator finds that respondent is not psychologically fit to practice safely or can only practice with restrictions, the evaluator shall orally notify the Board within one (1)

working day, and then notify the Board, in writing, within five (5) working days. The Board shall notify the respondent in writing of the evaluator's determination of unfitness to practice and shall order the respondent to cease or restrict licensed activities as a condition of probation. Respondent shall comply with this condition until the Board is satisfied of respondent's fitness to practice safely and has so notified respondent. Respondent shall document compliance in the manner required by the Board.

If the evaluator finds that psychotherapy is required, respondent shall participate in a therapeutic program at the Board's discretion. Cost of such therapy shall be paid by respondent.

~~16.~~ 17. Psychotherapy

Within ~~sixty (60)~~ forty-five (45) days of the effective date of the Decision, respondent shall submit to the Board the name of one (1) or more proposed therapists for prior approval. Respondent shall participate in ongoing psychotherapy with a California licensed or legally registered mental health professional approved by the Board. Within ten (10) days of receiving notification of approval by the Board, Respondent shall commence psychotherapy. Respondent shall provide the therapist with a copy of the Board's Disciplinary Order no later than the first counseling session. Counseling shall be at least once a week unless otherwise determined by the Board. Respondent shall continue in such therapy at the Board's discretion. Cost of such therapy shall be paid by respondent.

Respondent shall cause the therapist to submit to the Board a written report concerning respondent's psychotherapy status and progress as well as such other information as may be requested by the Board. The initial psychotherapy report shall be submitted within ~~ninety (90)~~ sixty (60) days from the effective date of the Decision. Respondent shall cause the therapist to submit quarterly written reports to the Board concerning respondent's fitness to practice, progress in treatment and to provide such other information as may be required by the Board.

If the therapist finds that respondent is not fit to practice safely, or can only practice safely with restrictions, the therapist shall notify the Board, in writing, within five (5) working days. The Board shall notify respondent in writing of the therapist's determination of unfitness to practice and shall order the respondent to cease or restrict licensed activities as a condition of probation. Respondent shall comply with this condition until the Board is satisfied of respondent's fitness to practice safely and has so notified respondent. Respondent shall document compliance with this condition in the manner required by the Board.

~~17.~~ 18. Clinical Diagnostic Evaluation

Within twenty (20) days of the effective date of the Decision and at any time upon order of the Board, Respondent shall undergo a clinical diagnostic evaluation. Respondent shall provide the evaluator with a copy of the Board's Decision prior to the clinical diagnostic evaluation being performed.

Respondent shall cause the evaluator to submit to the Board a written clinical diagnostic evaluation report within ten (10) days from the date the evaluation was

completed, unless an extension, not to exceed thirty (30) days, is granted to the evaluator by the Board. Cost of such evaluation shall be paid by the Respondent.

Respondent is ordered to cease any practice of occupational therapy, beginning on the effective date of the Decision, pending the results of the clinical diagnostic evaluation. During this time, Respondent shall submit to random drug testing at least two (2) times per week. At any other time that Respondent is ordered to undergo a clinical diagnostic evaluation, he or she shall be ordered to cease any practice of occupational therapy for minimum of one month pending the results of a clinical diagnostic evaluation and shall, during such time, submit to drug testing at least two (2) times per week.

Upon any order to cease practice, Respondent shall not practice occupational therapy until the Board determines that he or she is able to safely practice either full-time or part-time and has had at least one-month of negative drug test results. Respondent shall comply with any terms or conditions made by the Board as a result of the clinical diagnostic evaluation.

~~18.~~ 19. Rehabilitation Program

Within thirty (30) days of the effective date of the Decision, respondent shall enter a rehabilitation and monitoring program specified by the Board. Respondent shall successfully complete such treatment contract as may be recommended by the program and approved by the Board.

Components of the treatment contract shall be relevant to the violation and to the respondent's current status in recovery or rehabilitation. The components may include, but are not limited to: restrictions on practice and work settings, random bodily fluid or other matter testing, abstention from drugs and alcohol, use of work site monitors, participation in chemical dependency rehabilitation programs or groups, psychotherapy, counseling, psychiatric evaluations and other appropriate rehabilitation or monitoring programs. Cost for participation in this program shall be paid by respondent.

~~19.~~ 20. Support Groups

~~19a.~~ 20a. Chemical Dependency Support/Recovery Groups

Within five (5) days of the effective date of the Decision, respondent shall begin attendance at a chemical dependency support group (e.g., Alcoholics Anonymous, Narcotics Anonymous), and continue as ordered by the Board or its designee. Verified documentation of attendance shall be submitted by respondent with each quarterly report. Respondent shall continue attendance in such a group for the duration of probation unless notified by the Board that attendance is no longer required.

When determining the frequency of required support group meeting attendance, the board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;

- the licensee's treatment history; and,
- the nature, duration, and severity of substance abuse.

~~19b.~~ 20b. Facilitated Support Group Meetings
Within thirty (30) days of the effective date of the Decision, respondent shall begin attendance at a facilitated support group, and continue as ordered by the Board or its designee. Verified documentation of attendance shall be submitted by respondent with each quarterly report. Respondent shall continue attendance in such a group for the duration of probation unless notified by the Board that attendance is no longer required.

When determining the frequency of required support group meeting attendance, the board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;
- the licensee's treatment history; and,
- the nature, duration, and severity of substance abuse.

Group Meeting Facilitator Qualifications and Requirements:

1. The meeting facilitator must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.
2. The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee in the last five (5) years.
3. The group meeting facilitator shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.
4. The facilitator shall report any unexcused absence within 24 hours.

~~19c.~~ 20c. Group Support/Recovery Meetings
Respondent shall begin and continue attendance at a support/recovery group (e.g., Alcoholics Anonymous, Narcotics Anonymous, or a facilitated group) as ordered by the Board or its designee. When determining the type and frequency of required support group

meeting attendance, the board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;
- the licensee's treatment history; and,
- the nature, duration, and severity of substance abuse.

Verified documentation of attendance shall be submitted by respondent with each quarterly report or as requested by the board staff. Respondent shall continue attendance in such a group for the duration of probation unless notified by the Board that attendance is no longer required.

If a facilitated group meeting is ordered, the group facilitator shall meet the following qualifications and requirements:

a. The meeting facilitator must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.
b. The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee in the last five (5) years.
c. The group meeting facilitator shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.
d. The facilitator shall report any unexcused absence within 24 hours.

***NOTE TO ALJ**: Condition ~~19c~~ 20c is not necessary if ~~19a~~ 20a or ~~19b~~ 20b is ordered.*

~~20.~~ 21. Abstain from Controlled Substances

Respondent shall completely abstain from the personal use or possession of controlled substances, as defined in the California Uniform Controlled Substances Act, and dangerous drugs as defined in sections 4021 and 4022 of the Business and Professions Code, except when lawfully prescribed by a licensed practitioner for a bona fide illness or condition.

If under such prescription, or when obtaining refills, Respondent shall cause to have sent to the Board, in writing and within fourteen (14) days, by the prescribing health professional, a report identifying the medication, dosage, the date the medication was prescribed, the Respondent's prognosis, the date the medication will no longer be required, and the effect on the recovery plan, if appropriate.

~~21.~~ 22. Abstain from use of Alcohol

Respondent shall completely abstain from the intake of alcohol during the period of probation.

~~22.~~ 23. Submit Biological Fluid or Specimen Samples

Respondent shall enroll in the Board's drug-testing program within two (2) business days of the effective date of Probation and shall comply with all contract requirements.

Respondent shall immediately submit to random and directed alcohol and/or drug testing at respondent's cost, upon request by the Board or its designee. The Respondent shall be subject to a minimum of one-hundred and four (104) random tests per year within the first year of probation, and a minimum of fifty (50) random tests per year thereafter, for the duration of the probationary term. If Respondent tests positive for a banned substance, Respondent shall be ordered by the Board to immediately cease any practice of occupational therapy, and may not practice unless and until notified by the Board. Any further analysis or review of a test that is positive for a banned substance shall be at respondent's costs. Respondent shall make daily contact as directed by the Board to determine if he or she must submit to drug testing. Respondent shall submit to his or her drug test on the same day that he or she is notified that a test is required. All alternative testing sites due to vacation or travel outside of California must be approved by the Board prior to the vacation or travel.

~~23.~~ 24. Take and Pass the Licensure Examination

Respondent shall take and pass the licensure examination currently required of new applicants for the license possessed by respondent. Respondent shall pay the established examination fees.

As a condition precedent to reinstatement of a license, respondent shall take and pass the licensure examination currently required of new applicants prior to resuming practice. Respondent shall pay the established examination and licensing fees.

All standard terms or other terms of probation shall be tolled until the respondent has successfully passed the licensure examination and notice of licensure has been mailed to respondent by the Board.

~~24.~~ 25. Worksite Monitor

Respondent shall submit the name of the proposed worksite monitor within 20 days of the effective date of the Decision. Respondent shall complete any required consent forms and sign an agreement with the worksite monitor and the Board regarding the Respondent and the worksite monitor's requirements and reporting responsibilities. Once a worksite monitor is approved, Respondent may not practice unless the monitor is present at the worksite. If the worksite monitor terminates the agreement with the Board and the Respondent, the Respondent shall not resume practice until another worksite monitor is approved by the Board.

Reporting by the worksite monitor to the board shall be as follows:
Any suspected substance abuse must be orally reported to the Board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the oral report must be within one (1) hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

The worksite monitor shall complete and submit a written report monthly or as directed by the board. The report shall include: the licensee's name; license number; worksite monitor's name and signature; worksite monitor's license number; worksite location(s); dates licensee had face-to-face contact with monitor; worksite staff interviewed, if applicable; attendance report; any change in behavior and/or personal habits; any indicators that can lead to suspected substance abuse.

The ~~licensee~~ consent form shall ~~complete the required consent forms and sign an agreement with the worksite monitor and the Board to~~ allow the Board to communicate with the worksite monitor. (Authorization and Consent Form. Dev. 10/2011).

~~25.~~ 26. Restriction on Licensed Practice

Respondent shall practice only with a specified client population, in a specified practice setting, or engage in limited occupational therapy services. These restrictions shall be specifically defined in the Decision and be appropriate to the violation. Respondent shall be required to document compliance in a manner required by the Board.

~~26.~~ 27. Suspension

Respondent is suspended from the practice of occupational therapy for _____ days beginning on the effective date of the Decision. Respondent shall be responsible for informing his or her employer of the Board's decision, the reasons for the length of suspension

~~27.~~ 28. Restitution

Within _____ days of the effective date of this Decision, respondent shall make restitution to _____ in the amount of $_____ and shall provide the Board with proof from _____ attesting that the full restitution has been paid. In all cases, restitution shall be made before the termination of probation.

~~28.~~ 29. Criminal Probation Reports

Respondent shall provide the Board with a copy of the standard conditions of the criminal probation, copies of all criminal probation reports and the name of his/her probation officer.

~~29.~~ 30. Relinquish License and Wall Certificate

Respondent shall relinquish and shall forward or deliver the license to practice and the wall certificate to the Board within ten (10) days of the effective date of the Decision and order.

~~30.~~ 31. Notification to Clients/Cessation of Practice

In orders that provide for a cessation or suspension of practice, respondent shall comply with procedures provided by the Board regarding notification to, and management of, clients.

~~31.~~ 32. Request for Modification

"Request" as used in this standard is a request made to the Board's designee, and is not under the Administrative Procedure Act.

The licensee shall demonstrate that he or she has met the following criteria before being granted a request to modify a practice restriction ordered by the Board:
a. Demonstrated sustained compliance with current recovery program.
b. Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information relating to the licensee's substance abuse.
c. Negative alcohol and drug screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of the program.

VII. REHABILITATION CRITERIA

When considering the denial of an occupational therapy practitioner license under section 480 of the Business and Professions Code, the Board, in evaluating the rehabilitation of the applicant and his/her present eligibility for a license will consider the following criteria:

(1) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.
(2) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial, which also could be considered as grounds for denial under section 480 of the Business and Professions Code.
The time that has elapsed since commission of the act(s) or crime(s) referred to in subdivision (1) or (2).
(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the applicant.
(5) Evidence, if any, of rehabilitation submitted by the applicant.

When considering the suspension or revocation of the license of an occupational therapy practitioner on the grounds that the person licensed has been convicted of a crime, the Board, in evaluating the rehabilitation of such person and his/her present eligibility for a license, shall consider the following criteria:

(1) The nature and severity of the act(s) or offense(s).
(2) Total criminal record.
(3) The time that has elapsed since commission of the act(s) or offense(s).
(4) The extent to which the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee.
(5) If applicable, evidence of expungement proceedings pursuant to section 1203.4 of the Penal Code.
(6) Evidence, if any, of rehabilitation submitted by the licensee.

PETITION FOR REINSTATEMENT/REDUCTION IN PENALTY

When considering a petition for reinstatement of the license or a petition for reduction in penalty, the Board shall evaluate evidence of rehabilitation submitted by the petitioner, considering those criteria specified in section ***VII.*** above.

RECOMMENDED LANGUAGE FOR ISSUANCE AND PLACEMENT OF A LICENSE ON PROBATION AND REINSTATEMENT OF LICENSE

[Reserved]

Section 4149.2 is added to Article 5.5 to read as follows:

§ 4149.2. Required Actions Against Registered Sex Offenders.

(a) Except as otherwise provided, if an individual is required to register as a sex offender pursuant to Section 290 of the Penal Code, or the equivalent in another state or territory, or military or federal law, the board shall:

(1) Deny an application by the individual for licensure.

(2) Revoke the license of the individual, and shall not stay the revocation nor place the license on probation.

(3) Not reinstate or reissue the individual's license.

(b) This section shall not apply to any of the following:

(1) An individual who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law or the law of the jurisdiction that required registration.

(2) An individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code; provided, however, that nothing in this paragraph shall prohibit the board from exercising its discretion to discipline a licensee under any other provision of state law based upon the licensee's conviction under section 314 of the Penal Code.

(3) Any administrative proceeding that is fully adjudicated prior to the effective date of this regulation shall not be subject to the provisions of this section. A petition for reinstatement of a revoked or surrendered license shall be considered a new proceeding for purposes of this paragraph, and the prohibition in subsection (a) against reinstating a license shall govern.

NOTE: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 2570.25, 2570.26, 2570.27, and 2570.28, Business and Professions Code.

AGENDA ITEM 7

LEGISLATIVE/REGULATORY AFFAIRS COMMITTEE MEETING REPORT.

The Committee report and copies of legislative proposals are attached for review.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.

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REPORT FROM THE LEGISLATIVE AND REGULATORY AFFAIRS COMMITTEE MEETING HELD NOVEMBER 2, 2011

The Committee discussed legislative proposals previously approved by the Board, in order to recommend to the Board a prioritization of the proposals for the upcoming legislative session. The language was reviewed and the committee discussed, among other things, the benefit, the costs, the likelihood of the language would be carried, and other financial or political considerations. The Committee agreed on ranking the proposals as a high priority, medium priority or low/not a priority; the recommendations are presented in priority order.

HIGH

1. Amend Business and Professions Code (BPC) Section 2570.2, Definitions.
2. Amend BPC Section 2570.3, Licensing requirement.
3. Amend BPC Section 2570.16, Fees.
4. Add new BPC Section requiring mandatory reporting of employees who are terminated or suspended for cause, as specified, and consequences for failure to report
5. Add new BPC Section regarding limiting liability of occupational therapists providing services in an emergency, disaster, or state of war.
6. Add new BPC Section establishing new language which would allow the Board to inspect records.
7. Add new BPC Section establishing standards of practice for telehealth by occupational therapists.

MEDIUM

1. Amend BPC 2570.27, Discipline; Initial license issued on probation.

LOW

1. Amend BPC Section 2570.18, Representation.
2. Add new BPC Section requiring the Board to perform a workforce study and authorize an appropriate expenditure for the study.

Two amendments to general provisions of the BPC were recommended for inclusion in DCA's omnibus bill or were otherwise considered low priority:

Section 146, Violations of specified authorization statutes as infractions; Punishment and Section 149, Notice to cease advertising in telephone directory; Contest and hearing; Disconnection of service.

Amend Business & Professions Code Section 2570.2(k)

(k) "~~Practice of~~ ~~o~~Occupational therapy" means the therapeutic use of ~~purposeful and meaningful goal-directed~~ everyday life activities (occupations) with individuals, groups, or populations to address participation and function in roles and situations in home, school, workplace, community and other settings. Occupational therapy services are provided for habilitation, rehabilitation, promoting and maintaining 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 life activities that affect physical and mental health, ~~which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and promote or maintain health,~~ well-being, and quality of life. Occupational therapy ~~services~~ encompasses research, education of students, occupational therapy ~~assessment~~ evaluation, treatment, education of, and consultation with~~, individuals who have been referred for occupational therapy services subsequent to diagnosis of disease or disorder (or who are receiving occupational therapy services as part of an Individualized Education Plan (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA)).~~ individuals, groups, programs, organizations, or communities.

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

(2) Occupational therapy includes, but is not limited to, performing as a clinician, supervisor of occupational therapy students and volunteers, researcher, scholar, consultant, administrator, faculty, clinical instructor, continuing education instructor and educator of consumers/clients. The term "client" is used to name the entity that receives occupational therapy services. Clients may be categorized as:

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

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

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

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

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

Amend Business & Professions Code Section 2570.3(k)

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

The board may approve a provider of post-professional education courses, that on or after January 1, 2015, submits an application to the Board and pays the fee set forth in section 2570.16. Each approved provider shall expire on June 30.2014, and biennially thereafter.

(l) On or after January 1, 2015, the board may approve a post-professional education course, when a provider approved under section (k) submits a post-professional education course application to the Board and pays the fee set forth in section 2570.16.

(original language was approved as "on or after January 1, *2012.*")

Amend Business and Professions Code Section 2570.16

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

(a) An application fee not to exceed fifty dollars ($50).
(b) A late renewal fee as provided for in Section 2570.10.
(c) A limited permit fee.
(d) A fee to collect fingerprints for criminal history record checks.
(e) A fee to query the National Practitioner Data Bank and the Healthcare Integrity Protection Data Bank.
(f) An initial application fee for providers of post-professional education courses shall be a non-refundable fee of three hundred dollars ($300).
(g) A biennial renewal fee for an approved post-professional education course provider shall be no less than three hundred dollars ($300), but no more than five hundred-fifty dollars ($550) per renewal cycle.
(h) A one-time, non-refundable fee for review of each post-professional educational course shall be no less than ninety dollars ($90) and no more than one hundred-fifty ($150) dollars per course.

Add new Business and Professions Code Section 2570.33

(a) Any employer of an occupational therapy practitioner shall report to the California Board of Occupational Therapy the suspension or termination for cause of any practitioner in their employ. The reporting required herein shall not act as a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800, and shall not be subject to discovery in civil cases.
(b) For purposes of the section, "suspension or termination for cause" is defined to mean suspension or termination from employment for any of the following reasons:
(1) Use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice occupational therapy.
(2) Unlawful sale of controlled substances or other prescription items.
(3) Patient neglect, physical harm to a patient, or sexual contact with a patient.
(4) Falsification of medical, treatment, client consultation or billing records.
(5) Incompetence or negligence.
(6) Theft from patients, other employees, or the employer.
(c) The first failure of an employer to make a report required by this section, shall result in a letter educating the employer of their reporting responsibilities. The second failure to make a report by this section shall be punishable by an administrative fine not to exceed one thousand dollars ($1,000). The third and any subsequent violations shall be punishable by an administrative fine not to exceed five thousand dollars ($5,000) per violation.

Add new Business and Professions Code Section 2570.35

(a) In addition to the reporting required under Section 2570.33, an employer shall also report to the board the name, professional licensure type and number, and title of the person supervising the licensee who has been suspended or terminated for cause, as defined in subdivision (b) of Section 2570.33. If the supervisor is a licensee under this chapter, the board shall investigate whether due care was exercised by that supervisor in accordance with this chapter. If the supervisor is a health professional, licensed by another licensing board under this division, the employer shall report the name of that supervisor and any and all information pertaining to the suspension or termination for cause of the person licensed under this chapter to the appropriate licensing board.
(b) The failure of an employer to make a report required by this section is punishable by an administrative fine not to exceed five thousand dollars ($5,000) per violation.

Add new Business and Professions Code Section

A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent.

An amendment to Government Code Section 8659(a)

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

Similar language

BPC §2727.5. Liability for emergency care

A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent.

BPC §3706. Immunity from liability for rendering emergency care; Exception

A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of employment shall not be liable for any civil damages as the result of acts or omissions by the person in rendering the emergency care. This section does not grant immunity from civil damages when the person is grossly negligent.

Add new Business and Professions Code Section

(a) Each member of the board, or a Any licensed occupational therapist appointed by the board, may inspect, or require reports from, a general or specialized hospital or any other facility providing occupational therapy treatment or services and the occupational therapy staff thereof, with respect to the occupational therapy treatment, services, or facilities provided therein, and may inspect occupational therapy patient records with respect to the care, treatment, services, or facilities. The authority to make inspections and to require reports as provided by this section shall not be delegated by a member of the board to any person other than an occupational therapist and shall be subject to the disclosure restrictions.
(b) The willful, unauthorized violation of professional confidence or unauthorized disclosure authorized by this section constitutes unprofessional conduct.

Add new Business and Professions Code Section 2572, Standards of Practice for Telehealth in Occupational Therapy

(a) The provision of telehealth is intended to provide equitable access or increased access to occupational therapy services, to promote independence, and to increase the quality and standards of care when a patient or client has a disability, illness, injury or has a need for consultative, preventative, diagnostic, wellness, or therapeutic services.
(b) The purpose of this section is to establish standards for the practice of telehealth by means of an interactive telecommunication system by an occupational therapist or occupational therapy assistant licensed under this chapter. The standard of care provided to patients is the same whether the patient is seen in-person, via telehealth or telerehabilitation, or other methods of electronically enabled occupational therapy, health care or education. Occupational therapists or occupational therapy assistants need not reside in California, as long as they have a valid, current and unrestricted California license.
(c) Occupational therapists must obtain verbal and written informed consent from the patient prior to delivering health care via telehealth, and also requires that this signed written consent statement becomes part of the patient's medical record.
(d) An occupational therapist or occupational therapy assistant licensed under this chapter conducting telehealth by means of an interactive telecommunication system must do all of the following:
(1) Provide services and/or treatment consistent with the practice of occupational therapy as defined in section 2570.2(k) of the Code,
(2) Interact with the patient maintaining the same ethical standards of practice required pursuant to Section 4170, California Code of Regulations;
(3) Comply with the supervision requirements for any licensed occupational therapy assistant providing services under this section;
(4) Provide and ensure appropriate client confidentiality and HIPAA compliance, establish secure connections, activate firewalls, and encrypt confidential information.
(e) For purposes of this section:
(1) "Telehealth" means the provision of health care, health information, or health education, using telecommunications technology, other technologies using interactive audio, video, or data communications when providing or using telerehabilitation, or via other specially adapted equipment.
(2) "Telerehabilitation" means the provision, at a distance, of telehealth-based rehabilitation services using various technologies including real-time videoconferencing, personal computer-based camera usage, videophones, home-applied technology for recording and submission of images, and includes the use of other technologies, including virtual reality videogame-based rehabilitation systems or other virtual reality systems with haptic interfaces.

Amend Business & Professions Code Section 2570.27

2570.27. (a) The board may discipline a licensee by any or a combination of the following methods:

(1) Placing the license on probation with terms and conditions.

(a) An administrative disciplinary decision imposing terms of probation may include, among other things, a requirement that the licensee-probationer pay the monetary costs associated with monitoring the probation.

(b) The board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section once a licensee has served his or her term of probation.

(2) Suspending the license and the right to practice occupational therapy for a period not to exceed one year.

(3) Revoking the license.

(4) Suspending or staying the disciplinary order, or portions of it, with or without conditions.

(5) Taking other action as the board, in its discretion, deems proper.

(b) The board may issue an initial license on probation, with specific terms and conditions, to any applicant who has violated any provision of this chapter or the regulations adopted pursuant to it, but who has met all other requirements for licensure.

Amend Business & Professions Code Section 2570.18

(a) On and after January 1, 2003, a person shall not represent to the public by title, education, or background, by description of services, methods, or procedures, or otherwise, that the person is authorized to practice occupational therapy in this state, unless authorized to practice occupational therapy under this chapter.
(b) Unless licensed to practice as an occupational therapist under this chapter, a person may not use the professional abbreviations "O.T.," "O.T.R.," or "O.T.R./L.," or "Occupational Therapist," or "Occupational Therapist Registered," or any other words, letters, or symbols with the intent to represent that the person practices or is authorized to practice occupational therapy.
(c) A licensed occupational therapist or licensed occupational therapy assistant who has earned a doctoral degree, granted by an institution accredited by the Western Association of Schools and Colleges, or a program accredited by the Accreditation Council on Occupational Therapy Education, or by an accrediting agency recognized by the National Commission on Accrediting or the United States Department of Education that the board determines is equivalent to the Western Association of Schools and Colleges, may do the following:
(1) In a written communication, use the initials conferred with that earned degree, as applicable, following the licensee's name.
(2) In a written communication, use the title "Doctor" or the abbreviation "Dr." preceding the licensee's name, and the licensee's name shall be immediately followed by an unabbreviated specification of the applicable earned doctoral degree held by the licensee, or the unabbreviated term occupational therapist or occupation therapy assistant, as applicable.
(3) In a spoken communication while engaged in the practice of occupational therapy, use the title "doctor" preceding the person's name, and the speaker specifies that he or she is an occupational therapist or occupational therapy assistant.
(d) A licensed occupational therapist or occupational therapy assistant who has been granted an honorary degree by an educational institution accredited by the Western Association of Schools and Colleges, the Accreditation Council on Occupational Therapy Education, or by an accrediting agency recognized by the National Commission on Accrediting or the United States Department of Education that the board determines is equivalent to the Western Association of Schools and College, may do the following:
(1) In a written communication, use the initials granted with that honorary degree, as applicable, followed by the designation "(Hon.)" or "(Honorary)," following the licensee's name.
(2) In a written communication, use the title "Doctor" or the abbreviation "Dr." preceding the licensee's name, and the licensee's name shall be immediately followed by an unabbreviated specification of the applicable honorary doctoral degree held by the licensee with the designation "(Hon.)" or "(Honorary)," and the unabbreviated term occupational therapist or occupational therapy assistant, as applicable.
(3) In a spoken communication when engaged in the practice of occupational therapy, use the title "doctor" preceding the person's name, and the speaker specifies that he or she has been granted an honorary degree and specifies that he or she is an occupational therapist or occupational therapy assistant.
~~(c)~~ (e) Unless certified to assist in the practice of occupational therapy as an occupational therapy assistant under this chapter, a person may not use the professional abbreviations "O.T.A.," "C.O.T.A.," "C.O.T.A./C." or "Occupational Therapy Assistant," or "Certified Occupational Therapy Assistant," or any other words, letters, or symbols, with the intent to represent that the person assists in, or is authorized to assist in, the practice of occupational therapy as an occupational therapy assistant.
~~(d)~~(f) The unauthorized practice or representation as an occupational therapist or as an occupational therapy assistant constitutes an unfair business practice under Section 17200 and false and misleading advertising under Section 17500.

Add new Business and Professions Code Section 2570.5, Workforce Study

(a) The board shall collect and analyze workforce data from its licensees for future workforce planning. The board may collect the data at the time of license renewal or from a scientifically selected random sample of its licensees. The board shall produce reports on the workforce data it collects, at a minimum, on a biennial basis. The board shall maintain the confidentially of the information it receives from licensees under this section and shall only release information in an aggregate form that cannot be used to identify an individual. The workforce data collected by the board shall include, at a minimum, employment information such as hours of work, number of positions held, time spent in direct patient care, clinical practice area, type of employer, and work location. The data shall also include future work intentions, reasons for leaving or reentering occupational therapy, job satisfaction ratings, and demographic data.

(b) Aggregate information collected pursuant to this section shall be placed on the board's Internet Web site.

(c) The board is authorized to expend the sum of fifty-five thousand dollars ($55,000) from the Occupational Therapy Fund for the purpose of implementing this section.

(d) This section shall be implemented by the board on or before January 1, 2014.

(original language was approved as "on or before July 1, *2009.*")

Amend Business & Professions Code Section 146

146. (a) Notwithstanding any other provision of law, a violation of any code section listed in subdivision (c) is an infraction subject to the procedures described in Sections 19.6 and 19.7 of the Penal Code when either of the following applies:
(1) A complaint or a written notice to appear in court pursuant to Chapter 5c (commencing with Section 853.5) of Title 3 of Part 2 of the Penal Code is filed in court charging the offense as an infraction unless the defendant, at the time he or she is arraigned, after being advised of his or her rights, elects to have the case proceed as a misdemeanor.
(2) The court, with the consent of the defendant and the prosecution, determines that the offense is an infraction in which event the case shall proceed as if the defendant has been arraigned on an infraction complaint.
(b) Subdivision (a) does not apply to a violation of the code sections listed in subdivision (c) if the defendant has had his or her license, registration, or certificate previously revoked or suspended.
(c) The following sections require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions regulated by this code:
(1) Sections 2052 and 2054.
(2) Section 2630.
(3) Section 2903.
(4) Section 3660.
(5) Sections 3760 and 3761.
(6) Section 4080.
(7) Section 4825.
(8) Section 4935.
(9) Section 4980.
(10) Section 4996.
(11) Section 5536.
(12) Section 6704.
(13) Section 6980.10.
(14) Section 7317.
(15) Section 7502 or 7592.
(16) Section 7520.
(17) Section 7617 or 7641.
(18) Subdivision (a) of Section 7872.
(19) Section 8016.
(20) Section 8505.
(21) Section 8725.
(22) Section 9681.
(23) Section 9840.
(24) Subdivision (c) of Section 9891.24.
(25) Section 19049.
(26) Section 2570.3.
(d) Notwithstanding any other provision of law, a violation of any of the sections listed in subdivision (c), which is an infraction, is punishable by a fine of not less than two hundred fifty dollars ($250) and not more than one thousand dollars ($1,000). No portion of the minimum fine may be suspended by the court unless as a condition of that suspension the defendant is required to submit proof of a current valid license, registration, or certificate for the profession or vocation which was the basis for his or her conviction.

Amend Business & Professions Code Section 149

149. (a) If, upon investigation, an agency designated in subdivision (e) has probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services, without being properly licensed by or registered with the agency to offer or perform those services, the agency may issue a citation under Section 148 containing an order of correction that requires the violator to do both of the following:
(1) Cease the unlawful advertising. .
(2) Notify the telephone company furnishing services to the violator to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.
(b) This action is stayed if the person to whom a citation is issued under subdivision (a) notifies the agency in writing that he or she intends to contest the citation. The agency shall afford an opportunity for a hearing, as specified in Section 125.9.
(c) If the person to whom a citation and order of correction is issued under subdivision (a) fails to comply with the order of correction after that order is final, the agency shall inform the Public Utilities Commission of the violation and the Public Utilities Commission shall require the telephone corporation furnishing services to that person to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.
(d) The good faith compliance by a telephone corporation with an order of the Public Utilities Commission to terminate service issued pursuant to this section shall constitute a complete defense to any civil or criminal action brought against the telephone corporation arising from the termination of service.
(e) Subdivision (a) shall apply to the following boards, bureaus, committees, commissions, or programs:
(1) The Bureau of Barbering and Cosmetology.
(2) The Cemetery and Funeral Bureau.
(3) The Veterinary Medical Board.
(4) The Landscape Architects Technical Committee.
(5) The California Board of Podiatric Medicine.
(6) The Respiratory Care Board of California.
(7) The Bureau of Electronic and Appliance Repair, Home Furnishings, and Thermal Insulation.
(8) The Bureau of Security and Investigative Services.
(9) The Bureau of Automotive Repair.
(10) The California Architects Board.
(11) The Speech-Language Pathology and Audiology Board.
(12) The Board for Professional Engineers and Land Surveyors.
(13) The Board of Behavioral Sciences.
(14) The Structural Pest Control Board within the Department of Pesticide Regulation.
(15) The Acupuncture Board.
(16) The Board of Psychology.
(17) The California Board of Accountancy.
(18) The Naturopathic Medicine Committee.
(19) The Physical Therapy Board of California.
(20) The Bureau for Private Postsecondary Education.
(21) The California Board of Occupational Therapy.

PRACTICE COMMITTEE REPORT.

The following are attached for review:

- Committee report.
- Recommended revisions to Retired Status language.
- Recommended revisions to the OT Supervision Language.
- Materials considered at Committee meeting.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.

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REPORT FROM THE PRACTICE COMMITTEE MEETING HELD NOVEMBER 4, 2011

The Committee discussed the following items:

A. Recommended approval of revision to new language establishing a Retired Status.

The Board previously approved the language establishing a Retired Status. However, staff identified several scenarios that were not addressed by the language as approved. Thus, staff recommended the Committee review proposed changes to the language. The Committee made several clarifying changes to the language and is recommending approval by the Board.

Recommended language follows report.

B. Discussion and review of Title 16, Division 39, California Code of Regulations, Section 4180, Supervision Definitions, and newly proposed Section 4187, Supervision Plan for an Occupational Therapist.

This language was noticed for public comment. However, it was noted that the proposed language was inconsistent with Title 22 regulations regarding the OT Service Unit of a skilled nursing facility. Thus, the Committee reviewed the proposed language and made several clarifying changes to the language and is recommending the Board issued a notice of Modified Text to effect the these changes.

Recommended language follows report.

C. Discussion and review of Title 16, Division 39, California Code of Regulations, Section 4150, Advanced Practice Definitions, regarding "post-professional education and training."

The Committee reviewed the definition of "post-professional education and training" as it relates to Advanced Practices (A/P). Discussion surrounded what course content is considered "beyond ACOTE standards" as standards have changed and will continually change. The group consensus was:
1) courses taken as part of an academic program that also cover the content required of an advanced practice area, will satisfy the Board's A/P educational requirements; and

2) if the educational program arranges for Level II fieldwork for students in an advanced practice area, and the student follows the reporting/documentation requirements, the fieldwork will satisfy the A/P training requirement.

The group also felt that there should be an outreach effort to notify the educational programs that if the course content and fieldwork they offer to students meets the Board's advanced practice requirements, upon completion, the student(s) will satisfy the requirements for advanced practice approval.

The Committee then recommend the definition of "post-professional education and training" with regard to qualifying for advanced practice credit be re-evaluated; the Committee requests the Board assign this definition to the Committee for further consideration.

D. Discussion regarding whether the Occupational Therapy Practice Act requires a physician's referral for services.

To facilitate discussion of this item, the Committee reviewed several items, including the statutory definition of occupational therapy, the American Occupational Therapy Association's documents entitled "Standards of Practice of Occupational Therapy" and "Scope of Practice."

The Committee discussed several terms, including referral and diagnosis and determined language was clear; no further discussion or action is recommended.

E. Future teleconference meeting date: February 9, 2012.

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY

PROPOSED AMENDED REGULATORY LANGUAGE
Title 16, Division 39, California Code of Regulations

Retired Status

(a) A holder of an occupational therapy or occupational therapy assistant license that is current and active, ~~or capable of being renewed pursuant to Business and Professions Code Section 2510 and California Code of Regulations (CCR) Sections 4120 through 4130~~, and whose license is not suspended, revoked, or otherwise restricted by the board or subject to discipline, may apply for a retired license, upon application and payment of a twenty-five dollar ($25) fee.
(b) The application shall be on a form prescribed by the board and contain a certification statement from the licensee whether he or she has been disciplined by another public agency or been convicted or pled nolo contendere to any violation of any statute in the United States or foreign country.
(c) Submission of a complete application and payment of the retirement fee shall not result in an update to the expiration date of the license.
~~(b)~~ (d) The holder of a retired license shall not engage in any activity for which an active license is required.
~~(c)~~ (e) An occupational therapist holding a retired license shall be permitted to use the title "occupational therapist, retired" or "retired occupational therapist." An occupational therapy assistant holding a retired license shall be permitted to use the title "occupational therapy assistant, retired" or "retired occupational therapy assistant." The designation of retired shall not be abbreviated in any way.
~~(d)~~ (f) The holder of a retired license shall not be required to renew that retired license.
~~(e)~~ (g) In order for the holder of a retired license issued pursuant to this section to restore his or her license to active status, ~~he or she shall comply with BPC Section 2570.14~~ the following conditions must be met:
(1) The holder's license shall not have expired for a period in excess of five (5) years.
(2) The holder shall submit a renewal application and pay all accrued back renewal fees and a delinquent fee.
(3) The holder shall have completed twenty four (24) PDUs within the two-year period immediately preceding the date the renewal application is filed.
(h) The holder of a retired license whose license has expired for a period in excess of five (5) years shall not be permitted to renew the license, the holder must submit a new application for licensure and shall comply with BPC Section 2570.14.
(i) The holder of a retired license that has expired for a period in excess of five (5) years shall be permitted to use the titles specifies in subsection (e). The board shall not purge a retired license record from its licensing data system in order to maintain a public record that the retired license holder is permitted to use the titles specified in subsection (e).

Authority cited: Sections 462, 700, 701, 702, 703, 704, 2570.10, and 2570.11, Business and Professions Code; Reference: Sections 2570.14, 2570.16 and 2570.17, Business and Professions Code.

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
PROPOSED AMENDED REGULATORY LANGUAGE
Title 16, Division 39, California Code of Regulations

Proposed amendments are shown by strikeout for deleted text and underline for new text.

Article 9. Supervision of Occupational Therapy Assistants, Limited Permit Holders, Students, and Aides

§ 4180. Definitions

In addition to the definitions found in Business and Professions Code sections 2570.2 and 2570.3 the following terms are used and defined herein:
(a) "Client related tasks" means tasks performed as part of occupational therapy services rendered directly to the client.
(b) "Level I student" means an occupational therapy or occupational therapy assistant student participating in activities designed to introduce him or her to fieldwork experiences and develop an understanding of the needs of clients.
(c) "Level II student" means an occupational therapy or occupational therapy assistant student participating in delivering occupational therapy services to clients with the goal of developing competent, entry-level practitioners.
(d) "Level II fieldwork educator" means a licensed occupational therapist or occupational therapy assistant who has a minimum of one year of practice experience following issuance of a license or other authorization to practice issued by another state regulatory board.
(e) "Non-client related tasks" means clerical and secretarial activities; transportation of patients/clients; preparation or maintenance of treatment equipment and work area; taking care of patient/client personal needs during treatments; and assisting in the construction of adaptive equipment and splints.
(f) "Periodic" means at least once every 30 days.
(g) "Clinical supervision," as used in this article, refers to those activities included in the American Occupational Therapy Association's document entitled "Standards of Practice for Occupational Therapy" (Adopted 2010), incorporated herein by reference.

Note: Authority cited: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.3, 2570.4, 2570.5, 2570.6, and 2570.13, Business and Professions Code.

§ 4184. Delegation of Tasks to Aides.

(a) The primary function of an aide in an occupational therapy setting is to perform routine tasks related to occupational therapy services. Non-client related tasks may be delegated to an aide when the supervising occupational therapy practitioner has determined that the person has been appropriately trained and has supportive documentation for the performance of the services.
(b) Client related tasks that may be delegated to an aide include specifically selected routine aspects of an intervention session. In addition to the requirements of Code section 2570.2, subdivisions (a) and (b), the following factors must be present when an occupational therapist delegates a selected aspect of an intervention to an aide:

(1) The outcome anticipated for the aspects of the intervention session being delegated is predictable.
(2) The situation of the client and the environment is stable and will not require that judgment or adaptations be made by the aide.
(3) The client has demonstrated previous performance ability in executing the task.
(4) The aide has demonstrated competence in the task, routine and process.
(c) The supervising occupational therapist shall not delegate to an aide the following tasks:
(1) Performance of occupational therapy evaluative procedures;
(2) Initiation, planning, adjustment, or modification of treatment procedures.
(3) Acting on behalf of the occupational therapist in any matter related to occupational therapy treatment that requires decision making.
~~(d) All documented client related services shall be reviewed and cosigned by the supervising occupational therapist.~~

Note: Authority cited: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.4 and 2570.13, Business and Professions Code

§ 4187. Supervision Plan for an Occupational Therapist
An occupational therapy assistant serving in an administrative or supervisory role related to the provision of occupational therapy services, unless in conflict with other laws, shall only provide administrative services pursuant to a documented plan for the clinical supervision of any occupational therapy practitioner providing those occupational therapy services. This document shall include provisions for ongoing and formal evaluation of clinical performance, and must be available at time of hire, contract negotiation, and upon request.

Note: Authority: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.4 and 2570.13, Business and Professions Code.

22 CA ADC § 72417

22 CCR § 72417

Cal. Admin. Code tit. 22, § 72417

Barclays Official California Code of Regulations Currentness
Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies (Refs & Annos)
Chapter 3. Skilled Nursing Facilities
Article 4. Optional Services

➡§ 72417. Occupational Therapy Service Unit -Staff.

(a) The occupational therapy service unit shall be under the direction of an occupational therapist.

(b) An occupational therapy assistant shall work only under the supervision of an occupational therapist.

(c) There shall be occupational therapists and occupational therapy assistants in the number to meet the identified needs of the patients.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 72417, 22 CA ADC § 72417
This database is current through 10/14/11 Register 2011, No. 41
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22 CA ADC § 72415

22 CCR § 72415

Cal. Admin. Code tit. 22, § 72415

Barclays Official California Code of Regulations Currentness
Title 22. Social Security
Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies (Refs & Annos)
Chapter 3. Skilled Nursing Facilities
Article 4. Optional Services

➡§ 72415. Occupational Therapy Service Unit -Policies and Procedures.

(a) Each occupational therapy service unit shall have written policies and procedures for the management of the occupational therapy service.

(b) The policies and procedures shall be established and implemented by the patient care policy committee in consultation with an occupational therapist.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

22 CCR § 72415, 22 CA ADC § 72415
This database is current through 10/14/11 Register 2011, No. 41
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§ 4150. Definitions

For the purpose of this article:
(a) "ACOTE" means the Accreditation Council for Occupational Therapy Education.
(b) "Post professional education and training" means education and training obtained subsequent to the qualifying degree program or beyond current ACOTE standards for the qualifying degree program.
(c) "Contact hour" means sixty (60) minutes of coursework or classroom instruction.
(d) "Semester unit" means fifteen (15) contact hours.
(e) "Quarter unit" means ten (10) contact hours.
(f) "Rehabilitation of the hand, wrist, and forearm" as used in Code section 2570.2(l) refers to occupational therapy services performed as a result of surgery or injury to the hand, wrist, or forearm.
(g) "Upper extremity" as used in Code section 2570.3(e) includes education relating to the hand, wrist, or forearm.
(h) "Swallowing" as used in Code section 2570.3 is the passage of food, liquid, or medication through the pharyngeal and esophageal phases of the swallowing process.
(i) "Instrumental evaluation" is the assessment of any aspect of swallowing using imaging studies that include, but are not limited to, endoscopy and videofluoroscopy.
(1) "Endoscopic evaluation of swallowing" or "endoscopy" is the process of observing structures and function of the swallowing mechanism to include the nasopharynx, oropharynx, and hypopharynx.
(2) "Videofluoroscopic swallowing study" or "videofluoroscopy" is the fluoroscopic recording and videotaping of the anatomy and physiology of the oral cavity, pharynx, and upper esophagus using a variety of bolus consistencies to assess swallowing function. This procedure may also be known as videofluorography, modified barium study, oral-pharyngeal motility study and videoradiography.

Note: Authority Cited: Sections 2570.3 and 2570.20, Business and Professions Code. Reference: Sections 2570.2 and 2570.3, Business and Professions Code

ACCREDITATION STANDARDS FOR A DOCTORAL-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST (Effective 1/1/08)		ACCREDITATION STANDARDS FOR A MASTER'S-DEGREE-LEVEL EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPIST (Effective 1/1/08)		ACCREDITATION STANDARDS FOR AN EDUCATIONAL PROGRAM FOR THE OCCUPATIONAL THERAPY ASSISTANT (Effective 1/1/08)	
B.5.13.	Explain the use of superficial thermal and mechanical modalities as a preparatory measure to improve occupational performance, including foundational knowledge, underlying principles, indications, contraindications, and precautions. Demonstrate safe and effective application of superficial thermal and mechanical modalities.	B.5.13.	Explain the use of superficial thermal and mechanical modalities as a preparatory measure to improve occupational performance, including foundational knowledge, underlying principles, indications, contraindications, and precautions. Demonstrate safe and effective application of superficial thermal and mechanical modalities.	B.5.13.	Recognize the use of superficial thermal and mechanical modalities as a preparatory measure to improve occupational performance. Based on the intervention plan, demonstrate safe and effective administration of superficial thermal and mechanical modalities to achieve established goals while adhering to contraindications and precautions.
SKILLS, KNOWLEDGE, AND COMPETENCIES FOR ENTRY-LEVEL PRACTICE ARE DERIVED FROM AOTA PRACTICE DOCUMENTS AND NBCOT PRACTICE ANALYSIS STUDIES. SUPERFICIAL THERMAL MODALITIES INCLUDE, BUT ARE NOT LIMITED TO, HYDROTHERAPY/WHIRLPOOL, CRYOTHERAPY (COLD PACKS, ICE), FLUIDOTHERAPY™, HOT PACKS, PARAFFIN, WATER, AND INFRARED. MECHANICAL MODALITIES INCLUDE, BUT ARE NOT LIMITED TO, VASOPNEUMATIC DEVICES AND CONTINUOUS PASSIVE MOTION (CPM). *THE WORD "DEMONSTRATE" DOES NOT REQUIRE THAT A STUDENT ACTUALLY PERFORMS THE TASK TO VERIFY KNOWLEDGE AND UNDERSTANDING. THE PROGRAM MAY SELECT THE TYPES OF LEARNING ACTIVITIES AND ASSESSMENTS THAT WILL INDICATE COMPLIANCE WITH THE STANDARD.* *FOR THOSE INSTITUTIONS IN STATES WHERE REGULATIONS RESTRICT THE USE OF PHYSICAL AGENT MODALITIES, IT IS RECOMMENDED THAT STUDENTS BE EXPOSED TO THE MODALITIES OFFERED IN PRACTICE TO ALLOW STUDENTS KNOWLEDGE AND EXPERIENCE WITH THESE MODALITIES IN PREPARATION FOR THE NBCOT EXAMINATION AND FOR PRACTICE OUTSIDE OF THE STATE IN WHICH THE EDUCATIONAL INSTITUTION RESIDES.*					
B.5.14.	Explain the use of deep thermal and electrotherapeutic modalities as a preparatory measure to improve occupational performance, including indications, contraindications, and precautions.	B.5.14.	Explain the use of deep thermal and electrotherapeutic modalities as a preparatory measure to improve occupational performance, including indications, contraindications, and precautions.		
SKILLS, KNOWLEDGE, AND COMPETENCIES FOR ENTRY-LEVEL PRACTICE ARE DERIVED FROM AOTA PRACTICE DOCUMENTS AND NBCOT PRACTICE ANALYSIS STUDIES. DEEP THERMAL MODALITIES INCLUDE, BUT ARE NOT LIMITED TO, THERAPEUTIC ULTRASOUND AND PHONOPHORESIS. ELECTROTHERAPEUTIC MODALITIES INCLUDE, BUT ARE NOT LIMITED TO, BIOFEEDBACK, NEUROMUSCULAR ELECTRICAL STIMULATION, FUNCTIONAL ELECTRICAL STIMULATION, TRANSCUTANEOUS ELECTRICAL NERVE STIMULATIO, ELECTRICAL STIMULATION FOR TISSUE REPAIR, HIGH-VOLTAGE GALVANIC STIMULATION, AND IONTOPHORESIS.					
B.5.15.	Develop and promote the use of appropriate home and community programming to support performance in the client's natural environment and participation in all contexts relevant to the client.	B.5.15.	Develop and promote the use of appropriate home and community programming to support performance in the client's natural environment and participation in all contexts relevant to the client.	B.5.14.	Promote the use of appropriate home and community programming to support performance in the client's natural environment and participation in all contexts relevant to the client.
B.5.16.	Demonstrate the ability to educate the client, caregiver, family, significant others, and communities to facilitate skills in areas of occupation as well as prevention, health maintenance, and safety.	B.5.16.	Demonstrate the ability to educate the client, caregiver, family, and significant others to facilitate skills in areas of occupation as well as prevention, health maintenance, and safety.	B.5.15.	Demonstrate the ability to educate the client, caregiver, family, and significant others to facilitate skills in areas of occupation as well as prevention, health maintenance, and safety.

FULL-TIME EQUIVALENT: a position for a full-time faculty member (as defined by the institution) responsible for contributing to the functioning of the program through a variety of mechanisms, including, but not limited to, teaching, advising, and committee work.

HABITS: "autonomic behavior that is integrated into more complex patterns that enable people to function on a day to day basis..." (Neidstadt & Crepeau, 1998).

HIGHER EDUCATION: includes all degree-granting institutions at levels beyond high school. These institutions are generally divided into community (two year) colleges, colleges, and universities.

> **COMMUNITY COLLEGE**: these institutions offer two year programs, generally in applied areas. Students who complete the prescribed curriculum are awarded an associate's degree. Occupational therapy assistant programs are generally housed in community colleges and students typically receive an Associate of Applied Science (AAS) degree or an Associate of Science (AS) degree.
>
> **COLLEGE**: these institutions offer primarily four year programs leading to baccalaureate degrees. They may offer some master's programs, the first post-graduate degree level. Entry-level master's programs lead to the degree of Master of Science, Master of Arts in Occupational Therapy, or Master of Occupational Therapy depending upon the institution and the curriculum.
>
> **UNIVERSITIES**: these institutions award baccalaureate and master's degrees (and some may have some associate degree programs). In addition, they offer programs at the doctoral level.
>
> **PUBLIC VS. PRIVATE INSTITUTIONS**: public institutions receive a considerable portion of their operating budget from the state or county in which they are located and are subject to control by governmental bodies. Private institutions receive their funding from tuition and fund raising. They are subject to less governmental control.
>
> **VICE PRESIDENT FOR ACADEMIC AFFAIRS**: the chief academic officer of the campus. A member of the President's cabinet; working with the faculty and having responsibility for setting academic directions. Other units, related to the academic area (e.g., library, academic advising, academic computing, registrar) may also report to the VPAA, but this varies from campus to campus. Sometimes the academic area is headed by a person called a Provost; the position is generally similar to that described here.

ACADEMIC DEANS: if the college or university is large, it may be divided into academic divisions or schools (clusters of related departments). Each division is headed by a dean; the deans report to the Vice President for Academic Affairs.

MENTORING: a relationship between two people in which one person (the mentor) is dedicated to the personal and professional growth of the other (the mentee). A mentor has more experience and knowledge than the mentee.

MISSION: the statement which explains the unique nature of the program and how it helps fulfill or advances the mission of the sponsoring institution.

MODALITIES: application of a therapeutic agent, usually a physical agent modality.

> **DEEP THERMAL MODALITIES**: include therapeutic ultrasound and phonophoresis.
>
> **ELECTROTHERAPEUTIC MODALITIES**: include biofeedback, neuromuscular electrical stimulation, functional electrical stimulation, transcutaneous electrical nerve stimulation, electrical stimulations for tissue repair, high-voltage galvanic stimulation, and iontophoresis.
>
> **MECHANICAL MODALITIES**: include vasopneumatic devices and continuous passive motion.
>
> **SUPERFICIAL THERMAL MODALITIES**: include hydrotherapy, whirlpool, cryotherapy, fluidotherapy, hot packs, paraffin, water, and infrared.

Business and Professions Code Section 2570.2

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

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

STANDARDS OF PRACTICE FOR OCCUPATIONAL THERAPY

This document defines minimum standards for the practice of occupational therapy. The practice of occupational therapy means the therapeutic use of everyday life activities (occupations) with individuals, groups, organizations, and populations for the purpose of participation in roles and situations in the home, school, workplace, community, or 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 physical, cognitive, psychosocial, sensory, communication, and other areas of performance in various contexts and environments in everyday life activities that affect health, well-being, and quality of life (American Occupational Therapy Association [AOTA], 2004). The overarching goal of occupational therapy is "to support [people's] health and participation in life through engagement in occupations" (AOTAa, 2008, p. 626).

The *Standards of Practice for Occupational Therapy* are requirements for occupational therapists and occupational therapy assistants for the delivery of occupational therapy services. *The Reference Manual of Official Documents of the American Occupational Therapy Association, Inc.* (current version as of press time, AOTA, 2009b) contains documents that clarify and support occupational therapy practice, as do various issues of the *American Journal of Occupational Therapy.* These documents are reviewed and updated on an ongoing basis for their applicability.

Education, Examination, and Licensure Requirements

All occupational therapists and occupational therapy assistants must practice under federal and state law.

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®) 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.

Definitions

The following definitions are used in this document:

- ***Activity (Activities):*** A class of human behaviors that are goal directed.
- ***Assessment:*** Specific tools or instruments that are used during the evaluation process.
- ***Client:*** The entity that receives occupational therapy services. Clients may include (1) individuals and other persons relevant to the individual's life, such as family, caregivers, teachers, employers, and others who also may help or be served indirectly; (2) organizations such as business, industry, or agencies; and (3) populations within a community (Moyers & Dale, 2007).
- ***Evaluation:*** The process of obtaining and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results.
- ***Intervention:*** The 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.
- ***Occupation:*** "Goal-directed pursuits that typically extend over time, have meaning to their performance, and involve multiple tasks" (Christiansen, Baum, & Bass-Haugen, 2005, p. 548); "all the things that people want, need, or have to do, whether of a physical, mental, social, sexual, political, spiritual, or any other nature, including sleep and rest activities." (Wilcock & Townsend, 2009, p. 193); "activities of everyday life named, organized, and given meaning by individuals and a culture" (Law, Polatajko, Baptiste, & Townsend, 1997, p. 32).
- ***Outcomes:*** What occupational therapy actually achieves for the client. Changes desired by the client that can focus on any area of the client's occupational performance.
- ***Re-evaluation:*** The process of critical analysis of client response to intervention. This analysis enables the therapist to make any necessary changes to intervention plan in collaboration with the client.
- ***Screening:*** Obtaining and reviewing data relevant to a potential client to determine the need for further evaluation and intervention.

- ***Transitions:*** Transitions are "actions coordinated to prepare for or facilitate a change, such as from one functional level to another, from one life [change] to another, from one program to another, or from one environment to another"(AOTA, 1998, p. 866).

Standard I. Professional Standing and Responsibility

1. An occupational therapy practitioner (occupational therapist or occupational therapy assistant) delivers occupational therapy services that reflect the philosophical base of occupational therapy and are consistent with the established principles and concepts of theory and practice.
2. An occupational therapy practitioner is knowledgeable about and delivers occupational therapy services in accordance with AOTA standards, policies, and guidelines and state, federal, and other regulatory and payer requirements relevant to practice and service delivery.
3. An occupational therapy practitioner maintains current licensure, registration, or certification as required by law or regulation.
4. An occupational therapy practitioner abides by the *Occupational Therapy Code of Ethics* (AOTA, 2005a).
5. An occupational therapy practitioner abides by the *Standards for Continuing Competence* (AOTA, 2005b) by establishing, maintaining, and updating professional performance, knowledge, and skills.
6. An 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 (AOTA, 2009a).
7. An occupational therapy assistant is responsible for providing safe and effective occupational therapy services under the supervision of and in partnership with the occupational therapist and in accordance with laws or regulations and AOTA documents (AOTA, 2009a).
8. An occupational therapy practitioner maintains current knowledge of legislative, political, social, cultural, societal, and reimbursement issues that affect clients and the practice of occupational therapy.
9. An occupational therapy practitioner is knowledgeable about evidence-based research and applies it ethically and appropriately to provide occupational therapy services consistent with best practice approaches.
10. An occupational therapy practitioner respects the client's sociocultural background and provides client-centered and family-centered occupational therapy services.

Standard II. Screening, Evaluation, and Re-evaluation

1. An occupational therapist is responsible for all aspects of the screening, evaluation, and re-evaluation process.

2. An occupational therapist accepts and responds to referrals in compliance with state or federal laws, other regulatory and payer requirements, and AOTA documents.

3. An occupational therapist, in collaboration with the client, evaluates the client's ability to participate in daily life by considering the client's history, goals, capacities, and needs; the activities and occupations the client wants and needs to perform; and the environments and context in which these activities and occupations occur.

4. An occupational therapist initiates and directs the screening, evaluation, and re-evaluation process and analyzes and interprets the data in accordance with federal and state law, other regulatory and payer requirements, and AOTA documents.

5. An occupational therapy assistant contributes to the screening, evaluation, and re-evaluation process by implementing delegated assessments and by providing verbal and written reports of observations and client capacities to the occupational therapist in accordance with federal and state laws, other regulatory and payer requirements, and AOTA documents.

6. An occupational therapy practitioner uses current assessments and assessment procedures and follows defined protocols of standardized assessments during the screening, evaluation, and re-evaluation process.

7. An occupational therapist completes and documents occupational therapy evaluation results. An occupational therapy assistant contributes to the documentation of evaluation results. An occupational therapy practitioner abides by the time frames, formats, and standards established by practice settings, federal and state law, other regulatory and payer requirements, external accreditation programs, and AOTA documents.

8. An occupational therapy practitioner communicates screening, evaluation, and re-evaluation results within the boundaries of client confidentiality and privacy regulations to the appropriate person, group, organization, or population.

9. An occupational therapist 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.

10. An occupational therapy practitioner educates current and potential referral sources about the scope of occupational therapy services and the process of initiating occupational therapy services.

Standard III. Intervention

1. An occupational therapist has overall responsibility for the development, documentation, and implementation of the occupational therapy intervention based on the evaluation, client goals, best available evidence, and professional and clinical reasoning.

2. An occupational therapist ensures that the intervention plan is documented within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, state and federal law, and other regulatory and payer requirements.

3. An occupational therapy practitioner collaborates with the client to develop and implement the intervention plan, on the basis of the client's needs and priorities, safety issues, and relative benefits and risks of the interventions.

4. An occupational therapy practitioner coordinates the development and implementation of the occupational therapy intervention with the intervention provided by other professionals, when appropriate.

5. An occupational therapy practitioner uses professional and clinical reasoning to select the most appropriate types of interventions, including therapeutic use of self, therapeutic use of occupations and activities, consultation, education, and advocacy.

6. An occupational therapy assistant selects, implements, and makes modifications to therapeutic interventions that are consistent with the occupational therapy assistant's demonstrated competency and delegated responsibilities, the intervention plan, and requirements of the practice setting.

7. An occupational therapist modifies the intervention plan throughout the intervention process and documents changes in the client's needs, goals, and performance.

8. An occupational therapy assistant contributes to the modification of the intervention plan by exchanging information with and providing documentation to the occupational therapist about the client's responses to and communications throughout the intervention.

9. An occupational therapy practitioner documents the occupational therapy services provided within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, federal and state laws, other regulatory and payer requirements, and AOTA documents.

Standard IV. Outcomes

1. An occupational therapist is responsible for selecting, measuring, documenting, and interpreting expected or achieved outcomes that are related to the client's ability to engage in occupations.

2. An occupational therapist is responsible for documenting changes in the client's performance and capacities and for transitioning the client to other types or intensity of service or discontinuing services when the client has achieved identified goals, reached maximum benefit, or does not desire to continue services.

3. An occupational therapist prepares and implements a transition or discontinuation plan based on the client's needs, goals, performance, and appropriate follow-up resources.

4. An occupational therapy assistant contributes to the transition or discontinuation plan by providing information and documentation to the supervising occupational therapist related to the client's needs, goals, performance, and appropriate follow-up resources.

5. An occupational therapy practitioner facilitates the transition or discharge process in collaboration with the client, family members, significant others, other professionals (e.g., medical, educational, or social services), and community resources, when appropriate.

6. An occupational therapist is responsible for evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.

7. An occupational therapy assistant contributes to evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.

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Note. These standards are intended as recommended guidelines to assist occupational therapy practitioners in the provision of occupational therapy services. These standards serve as a minimum standard for occupational therapy practice and are applicable to all individual populations and the programs in which these individuals are served.

SCOPE OF PRACTICE

Statement of Purpose

The purpose of this document is to define the scope of practice in occupational therapy in order to

1. delineate the domain of occupational therapy practice that directs the focus and actions of services provided by occupational therapists and occupational therapy assistants;
2. delineate the dynamic process of occupational therapy evaluation and intervention services to achieve outcomes that support the participation of clients in their everyday life activities (occupations);
3. describe the education and certification requirements to practice as an occupational therapist and occupational therapy assistant; and
4. 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) document *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002) and on the *Philosophical Base of Occupational Therapy*, which states that "the understanding and use of occupations shall be at the central core of occupational therapy practice, education, and research" (AOTA, 2003a, Policy 1.11). Occupational therapy is a dynamic and evolving profession that is responsive to consumer needs and to emerging knowledge and research.

This scope of practice document is designed to support and be used in conjunction with the *Definition of Occupational Therapy Practice for the Model Practice Act* (AOTA, 2004a). While this scope of practice document helps support state laws and regulations that govern the practice of occupational therapy, it does not supercede those existing laws and other regulatory requirements. Occupational therapists and occupational therapy assistants are required to abide by statutes and regulations when providing occupational therapy services. State laws and other regulatory requirements typically include statements about educational requirements to practice occupational therapy, procedures to practice occupational therapy legally within the defined area of jurisdiction, the definition and scope of occupational therapy practice, and supervision requirements.

AOTA (1994) states that a referral is not "required for the provision of occupational therapy services" (p. 1034); however, a referral may be indicated by some state laws and other regulatory requirements. The AOTA 1994 document *Statement of Occupational Therapy Referral* states that "occupational therapists respond to requests for services, whatever their sources. They may accept and enter cases at their own professional discretion and based on their own level of competency" (p. 1034). Occupational therapy assistants provide services under the supervision of an occupational therapist. State laws and other regulatory requirements should be viewed as minimum criteria to practice occupational therapy. Ethical guidelines that ensure safe and effective delivery of occupational therapy services to clients always influence occupational therapy practice (AOTA, 2000).

Definition of Occupational Therapy

AOTA's *Definition of Occupational Therapy for the Model Practice Act* defines occupational therapy as

> 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" (AOTA, 2004a).

Scope of Practice—The Domain and Process

The scope of practice includes the domain and process of occupational therapy services. These concepts are intertwined with the domain defining the focus of occupational therapy (see Figure 1) and the process defining the delivery of occupational therapy (see Figure 2). The domain of occupational therapy is the everyday life activities (occupations) that people find meaningful and purposeful. Within this domain, occupational therapy services enable clients to engage (participate) in their everyday life activities in their desired roles, context, and life situations. Clients may be individuals, groups, communities, or populations. The occupations in which clients engage occur throughout the life span and include

- activities of daily living (self-care activities);
- education (activities to participate as a learner in a learning environment);
- instrumental activities of daily living (multistep activities to care for self and others, such as household management, financial management, and childcare);
- leisure (nonobligatory, discretionary, and intrinsically rewarding activities);
- play (spontaneous and organized activities that promote pleasure, amusement, and diversion);
- social participation (activities expected of individuals or individuals interacting with others); and
- work (employment-related and volunteer activities)

DOMAIN OF OCCUPATIONAL THERAPY

Engagement in Occupation to Support Participation in Context or Contexts

Performance in Areas of Occupation

Activities of Daily Living (ADL)*
Instrumental Activities of Daily Living (IADL)
Education
Work
Play
Leisure
Social Participation

Performance Skills	**Performance Patterns**
Motor Skills	Habits
Process Skills	Routines
Communication/Interaction Skills	Roles

Context	**Activity Demands**	**Client Factors**
Cultural	Objects Used and Their Properties	Body Functions[1]
Physical	Space Demands	Body Structures[2]
Social	Social Demands	
Personal	Sequencing and Timing	
Spiritual	Required Actions	
Temporal	Required Body Functions	
Virtual	Required Body Structures	

*Also referred to as basic activities of daily living (BADL) and personal activities of daily living (PADL).

(AOTA, 2002, p. 611)
[1]Body Functions (e.g., neuromuscular, sensory, visual, perceptual, cognitive, mental)
[2]Body Structures (e.g., cardiovascular, digestive, integumentary systems)

Figure 1

Within this domain of practice, occupational therapists and occupational therapy assistants consider the repertoire of occupations in which the client engages, the performance skills and patterns the client uses, the contexts influencing engagement, the features and demands of the activity, and the client's body functions and structures. Occupational therapists and occupational therapy assistants use their knowledge and skills to help clients "attain and resume daily life activities that support function and health" throughout the lifespan (AOTA, 2002, p. 610). Participation in activities and occupations that are meaningful to the client involves emotional, psychosocial, cognitive, and physical aspects of performance. This participation provides a means to enhance health, well-being, and life satisfaction.

The domain of occupational therapy practice complements the World Health Organization's (WHO) conceptualization of participation and health articulated in the *International Classification of Functioning, Disability and Health (ICF)* (WHO, 2001). Occupational therapy incorporates the basic constructs of ICF, including environment, participation, activities, and body structures and functions, when addressing the complexity and richness of occupations and occupational engagement.

The process of occupational therapy relates to service delivery (see Figure 2) and includes evaluating, intervening, and targeting outcomes. Occupation remains central to the occupational therapy process. It is client-centered, involving collaboration with the client throughout each aspect of service delivery. During the evaluation, the therapist develops an occupational profile, analyzes the client's ability to carry out everyday life activities, and determines the client's occupational needs, problems, and priorities for intervention. Evaluation and intervention may address one or more of the domains (see Figure 1) that influence occupational performance. Intervention includes planning and implementing occupational therapy services and involves therapeutic use of self, activities, and occupations, as well as consultation and education. The occupational therapist and occupational therapy assistant utilize occupation-based theories, frames of reference, evidence, and clinical reasoning to guide the intervention (AOTA, 2002).

The outcome of occupational therapy intervention is directed toward "engagement [of the client] in occupations that support participation in [daily life situations] (AOTA, 2002, p. 618). Outcomes of the intervention determine future actions with the client. Outcomes include the client's occupational performance, role competence and adaptation, health and wellness, quality of life and satisfaction, and prevention initiatives (AOTA, 2002, p. 619).

COLLABORATIVE PROCESS MODEL

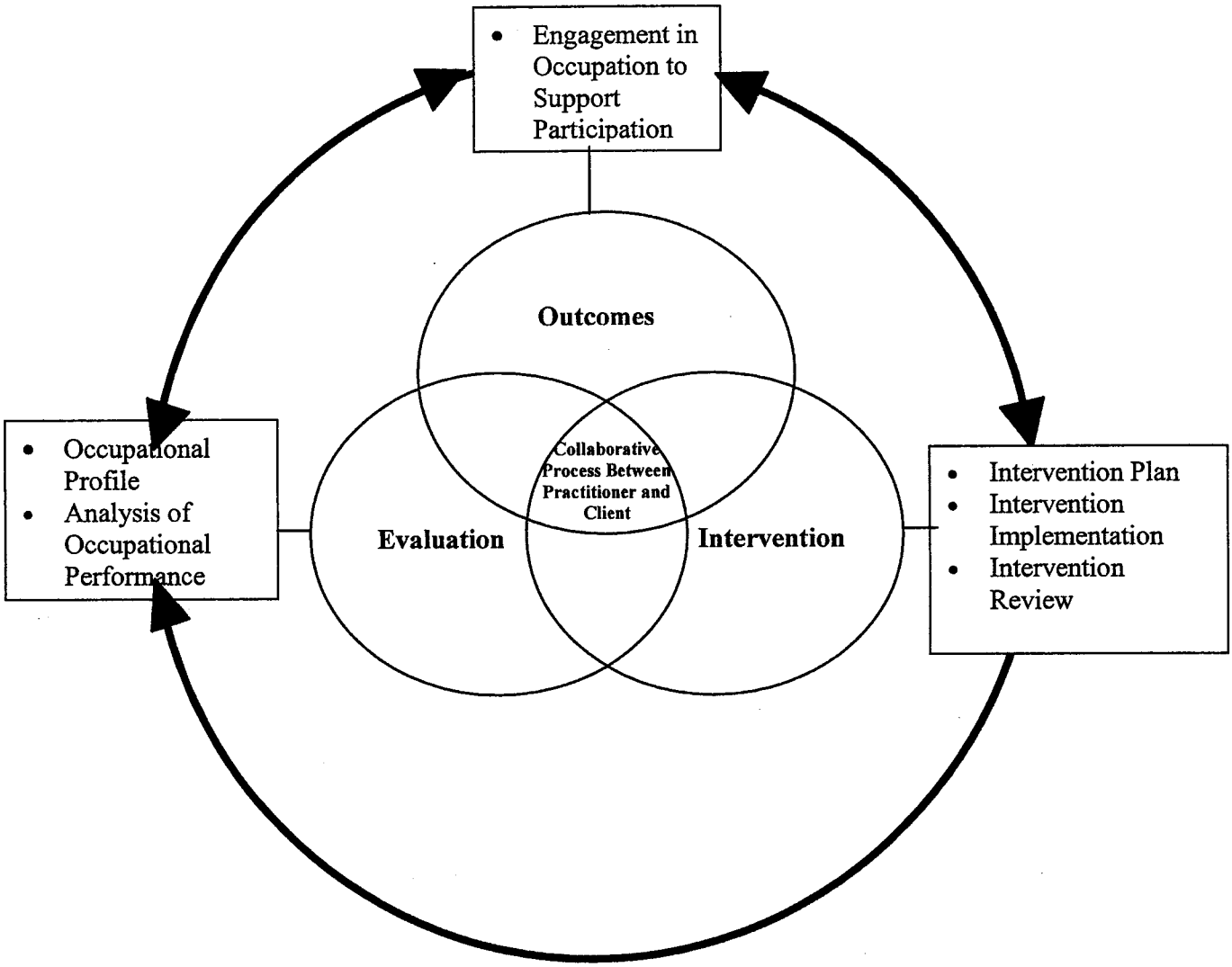

Figure 2: Illustration of the framework emphasizing client–practitioner interactive relationship and interactive nature of the service delivery process (AOTA 2002, 614).

Occupational Therapy Practice

Occupational therapists and occupational therapy assistants are experts at analyzing the performance skills and patterns necessary for people to engage in their everyday activities in the context in which those activities and occupations occur. The occupational therapist assumes responsibility for the delivery of all occupational therapy services and for the safety and effectiveness of occupational therapy services provided. The occupational therapy assistant delivers occupational therapy services under the supervision of and in partnership with the occupational therapist (AOTA, 2004b).

The practice of occupational therapy includes

A. Strategies selected to direct the process of interventions, such as
   1. Establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired.
   2. Compensation, modification, or adaptation of activity or environment to enhance performance.
   3. Maintenance and enhancement of capabilities without which performance in everyday life activities would decline.
   4. Health promotion and wellness to enable or enhance performance in everyday life activities.
   5. 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
   1. Client factors, including body functions (e.g., neuromuscular, sensory, visual, perceptual, cognitive) and body structures (e.g., cardiovascular, digestive, integumentary, genitourinary systems).
   2. Habits, routines, roles, and behavior patterns.
   3. Cultural, physical, environmental, social, and spiritual contexts and activity demands that affect performance.
   4. 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
   1. Therapeutic use of occupations, exercises, and activities.
   2. Training in self-care, self-management, home management, and community/work reintegration.
   3. Development, remediation, or compensation of physical, cognitive, neuromuscular, sensory functions, 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 individuals, including family members, caregivers, and others.
   6. Care coordination, case management, and transition services.
   7. Consultative services to groups, programs, organizations, or communities.
   8. Modification of environments (home, work, school, or community) 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 wheelchair management.
11. Driver rehabilitation and community mobility.
12. Management of feeding, eating, and swallowing to enable eating and feeding performance.
13. Application of physical agent modalities, and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills.

(AOTA, 2004a)

Site of Intervention

Along the continuum of service, occupational therapy services may be provided to clients throughout the life span in a variety of settings. The settings may include, but are not limited to, the following:

- Institutional settings (inpatient) (e.g., acute rehabilitation, psychiatric hospital, community and specialty focused hospitals, nursing facilities, prisons)
- Outpatient settings (e.g., hospitals, clinics, medical and therapy offices)
- Home and community settings (e.g., home care, group homes, assisted living, schools, early intervention centers, day-care centers, industry and business, hospice, sheltered workshops, wellness and fitness centers, community mental health facilities)
- Research facilities

Education and Certification Requirements

To practice as an occupational therapist, the individual

- must have graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE®) or predecessor organizations[1], and
- must have 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 organization (AOTA, 2003b, Policy 5.3).
- must have successfully passed the national certification examination for occupational therapists and/or met state requirements for licensure/registration.

To practice as an occupational therapy assistant, the individual

- must have graduated from an associate- or certificate-level occupational therapy assistant program accredited by ACOTE® or predecessor organizations, and

[1] Foreign educated graduates of occupational therapy programs approved by the World Federation of Occupational therapy (WFOT) may also be eligible for certification/licensure as an occupational therapist provided additional requirements are met.

- must have 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 (AOTA, 2003b, Policy 5.3).
- must have successfully passed the national certification examination for occupational therapy assistants and/or met state requirements for licensure/registration.

AOTA supports licensure of qualified occupational therapists and occupational therapy assistants (AOTA, 2003b, Policy 5.3). State and other legislative or regulatory agencies may impose additional requirements to practice as an occupational therapist and occupational therapy assistants in their area of jurisdiction.

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Adopted by the Representative Assembly 2004C23
Edited by the Commission on Practice 2005

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STANDARDS OF PRACTICE FOR OCCUPATIONAL THERAPY

Preface

This document defines minimum standards for the practice of occupational therapy. The *Standards of Practice for Occupational Therapy* are requirements for occupational therapists and occupational therapy assistants for the delivery of occupational therapy services. *The Reference Manual of Official Documents* contains documents that clarify and support occupational therapy practice (American Occupational Therapy Association [AOTA, 2004]). These documents are reviewed and updated on an ongoing basis for their applicability.

Education, Examination, and Licensure Requirements

All occupational therapists and occupational therapy assistants must practice under federal and state law.

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®) 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 associate- or certificate-level 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.

Definitions

Assessment. Specific tools or instruments that are used during the evaluation process.

Client. A person, group, program, organization, or community for whom the occupational therapy practitioner is providing services.

Evaluation. The process of obtaining and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results.

Screening. Obtaining and reviewing data relevant to a potential client to determine the need for further

evaluation and intervention.

Standard I: Professional Standing and Responsibility

1. An occupational therapy practitioner (occupational therapist or occupational therapy assistant) delivers occupational therapy services that reflect the philosophical base of occupational therapy and are consistent with the established principles and concepts of theory and practice.

2. An occupational therapy practitioner is knowledgeable about and delivers occupational therapy services in accordance with AOTA standards, policies, and guidelines, and state and federal requirements relevant to practice and service delivery.

3. An occupational therapy practitioner maintains current licensure, registration, or certification as required by law or regulation.

4. An occupational therapy practitioner abides by the AOTA *Occupational Therapy Code of Ethics* (AOTA, 2000).

5. An occupational therapy practitioner abides by the AOTA *Standards for Continuing Competence* (AOTA, 1999) by establishing, maintaining, and updating professional performance, knowledge, and skills.

6. An 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.

7. An occupational therapy assistant is responsible for providing safe and effective occupational therapy services under the supervision of and in partnership with the occupational therapist and in accordance with laws or regulations and AOTA documents.

8. An occupational therapy practitioner maintains current knowledge of legislative, political, social, cultural, and reimbursement issues that affect clients and the practice of occupational therapy.

9. An occupational therapy practitioner is knowledgeable about evidence-based research and applies it ethically and appropriately to the occupational therapy process.

Standard II: Screening, Evaluation, and Re-evaluation

1. An occupational therapist accepts and responds to referrals in compliance with state laws or other regulatory requirements.

2. An occupational therapist, in collaboration with the client, evaluates the client's ability to participate in daily life activities by considering the client's capacities, the activities, and the environments in which these activities occur.

3. An occupational therapist initiates and directs the screening, evaluation, and re-evaluation process and analyzes and interprets the data in accordance with law, regulatory requirements, and AOTA documents.

4. An occupational therapy assistant contributes to the screening, evaluation, and re-evaluation process by implementing delegated assessments and by providing verbal and written reports of observations and client capacities to the occupational therapist in accordance with law, regulatory requirements, and AOTA documents.

5. An occupational therapy practitioner follows defined protocols when standardized assessments are used.

6. An occupational therapist completes and documents occupational therapy evaluation results. An occupational therapy assistant contributes to the documentation of evaluation results. An occupational therapy practitioner abides by the time frames, formats, and standards established by practice settings, government agencies, external accreditation programs, payers, and AOTA documents.

7. An occupational therapy practitioner communicates screening, evaluation, and re-evaluation results within the boundaries of client confidentiality to the appropriate person, group, or organization.

8. An occupational therapist 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.

9. An occupational therapy practitioner educates current and potential referral sources about the scope of occupational therapy services and the process of initiating occupational therapy services.

Standard III: Intervention

1. An occupational therapist has overall responsibility for the development, documentation, and implementation of the occupational therapy intervention based on the evaluation, client goals, current best evidence, and clinical reasoning.

2. An occupational therapist ensures that the intervention plan is documented within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, and payers.

3. An occupational therapy assistant selects, implements, and makes modifications to therapeutic activities and interventions that are consistent with the occupational therapy assistant's demonstrated competency and delegated responsibilities, the intervention plan, and requirements of the practice setting.

4. An occupational therapy practitioner reviews the intervention plan with the client and appropriate others regarding the rationale, safety issues, and relative benefits and risks of the planned interventions.

5. An occupational therapist modifies the intervention plan throughout the intervention process and documents changes in the client's needs, goals, and performance.

6. An occupational therapy assistant contributes to the modification of the intervention plan by exchanging information with and providing documentation to the occupational therapist about the client's responses to and communications throughout the intervention.

7. An occupational therapy practitioner documents the occupational therapy services provided within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, payers, and AOTA documents.

Standard IV: Outcomes

1. An occupational therapist is responsible for selecting, measuring, documenting, and interpreting expected or achieved outcomes that are related to the client's ability to engage in occupations.

2. An occupational therapist is responsible for documenting changes in the client's performance and capacities and for discontinuing services when the client has achieved identified goals, reached maximum benefit, or does not desire to continue services.

3. An occupational therapist prepares and implements a discontinuation plan or transition plan based on the client's needs, goals, performance, and appropriate follow-up resources.

4. An occupational therapy assistant contributes to the discontinuation or transition plan by providing information and documentation to the supervising occupational therapist related to the client's needs, goals, performance, and appropriate follow-up resources.

5. An occupational therapy practitioner facilitates the transition process in collaboration with the client, family members, significant others, team, and community resources and individuals, when appropriate.

6. An occupational therapist is responsible for evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.

7. An occupational therapy assistant contributes to evaluating the safety and effectiveness of the occupational therapy processes and interventions within the practice setting.

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Adopted by the Representative Assembly 2005C218

NOTE: This document replaces the 1998 *Standards of Practice for Occupational Therapy*. These standards are intended as recommended guidelines to assist occupational therapy practitioners in the provision of occupational therapy services. These standards serve as a minimum standard for occupational therapy practice and are applicable to all individual populations and the programs in which these individuals are served.

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AGENDA ITEM 9

CONSIDERATION AND ADOPTION OF PROPOSED REGULATORY LANGUAGE TO AMEND CCR SECTION 4180, DEFINITIONS, SECTION 4184, DELEGATIONS OF TASKS TO AIDES, AND ESTABLISH SECTION 4187, SUPERVISION PLAN FOR AN OCCUPATIONAL THERAPIST

The following are attached for review:

- Notice
- Proposed Text
- Initial Statement of Reasons
- *Proposed* Modified Text

TITLE 16. CALIFORNIA BOARD OF OCCUPATIONAL THERAPY

NOTICE IS HEREBY GIVEN that the California Board of Occupational Therapy (CBOT) is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments relevant to the proposed action in writing. Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 pm on November 28, 2011, or must be received by the CBOT at the hearing.

The CBOT does not intend to hold a hearing in this matter. If any interested party wishes that a hearing be held, he or she must make the request in writing to the board. The request must be received in the board office not later than 5:00 pm. on November 14, 2011.

The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the action substantially as described below or may modify such action if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified action will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the action.

Authority and Reference: Pursuant to the authority vested by sections 2570.13 and 2570.20 of the Business and Professions Code (BPC), and to implement, interpret or make specific sections 2570.2, 2570.3 2570.4, 2570.5, 2570.6, and 2570.13, the Board is proposing changes to Division 39, Title 16 of the California Code of Regulations (CCR) as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Existing law, Business and Professions Code (BPC) section 2570.20, authorizes the Board to adopt rules in accordance with the Administrative Procedures Act relating to the professional conduct of occupational therapy practitioners to carry out its regulatory purpose. Existing law sets forth the supervision requirements for occupational therapy aides and assistants. The proposed regulations are designed to define and clarify the roles and responsibilities of occupational therapists, occupational therapy assistants, and occupational therapy aides, delivering professional services.

The following regulatory changes are proposed:

- Amend CCR section 4180. Definitions (pertaining to Supervision of Occupational Therapy Assistants, Limited Permit Holders, Students, and Aides).

  The proposed amendment adds a new definition for "Clinical Supervision" by incorporating by reference the American Occupational Therapy Association's "Standards of Practice for Occupational Therapy".

- Amend CCR section 4184. Delegation of Tasks to Aides

  The proposed amendment deletes subsection (d) that states "All documented client related services shall be reviewed and cosigned by the supervising occupational therapist." The proposed amendment is intended to delete any reference or authority that an aide is authorized to document client record under any circumstance. The proposed regulation eliminates conflict with newly enacted statutory language contained in Business and Professions Code section 2570.2(a) which states in pertinent part "The occupational therapist or occupational therapy assistant is responsible for documenting the client's record regarding the patient related tasks that are performed by the aide.

- Add CCR section 4187. Supervision Plan for Occupational Therapist

  The proposed regulation would add a new subsection that would require a documented plan be established for the clinical supervision of an occupational therapist(s) who is employed in facilities or businesses that are owned by an occupational therapy assistant or have an occupational therapy assistant functioning in an administrative, management, or directive role over the clinical services provided by the business or facility. It is the intent of the Board to allow occupational therapy assistants to function in administrative, management, and lead positions. However, the Board seeks to make it clear that an occupational therapy assistant functioning in these roles is not in any way, authorized to practice beyond his or her scope of practice as an occupational therapy assistant. Furthermore, it is not proper for an assistant functioning as an administrator, manager, or other directive role, to evaluate the clinical performance of an occupational therapist.

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: None

Non-discretionary Costs/Savings to Local Agencies: None

Local Mandate: None

Cost to Any Local Agency or School District for Which Government Code Sections 17500-17630 Requires Reimbursement: None

Business Impact: The amendment to proposed section 4187 may have a cost impact to businesses or facilities that provide occupational therapy services that are owned by or whose services are administered or managed by an occupational therapy assistant. In cases where a business or facility only has one occupational therapist on staff, the regulations would require that another occupational therapist be hired or contracted to evaluate the clinical performance of the occupational therapist employed by the business or facility. The Board does not have data that indicates how many occupational therapy assistants own or operate their own practice. The Board does not have data regarding the number of facilities that employ an occupational therapy assistant in a supervisory, management, or clinical director capacity who oversees the delivery of occupational therapy services provided by the occupational therapists. This regulation is not thought to have a significant statewide adverse economic impact directly affecting businesses including the ability of California businesses to compete with businesses from other states.

Impact on Jobs/New Businesses:

The Board has determined that this regulatory proposal will not have an impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business: The Board has determined that there may be a cost impact to occupational therapy practices that are owned by or operated by an occupational therapy assistant. In such cases the owner operator would be required to hire or contract with another occupational therapist to evaluate the clinical services of the therapist who conducts the businesses assessments and develops the treatment plans. In cases where a facility that employs multiple occupational therapists that are managed or supervised by an occupational therapy assistant, the business would be required to designate one of the

occupational therapists as the clinical evaluator. It is anticipated that the cost impact would be minimal.

Effect on Housing Costs: None

EFFECT ON SMALL BUSINESS
The Board has determined that there would be fiscal impact to an occupational therapy assistant that owns and operates his/her own private practice. Please refer to the Business Impact statement above.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative considered by it or that has otherwise been identified and brought to its attention would either be more effective in carrying out the purpose for which the action is proposed or would be as effective as and less burdensome to affected private persons than the proposal described in this Notice. Adoption of the proposed regulatory action is consistent with the Board's mandate to coordinate, administer, and regulate the practice of occupational therapy.

TEXT OF PROPOSAL AND INITIAL STATEMENT OF REASONS AND INFORMATION

The Board has prepared an initial statement of reasons that sets forth the reasons for the proposed action and has all the information upon which the proposal is based.

Copies of the exact language of the proposed regulation and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained from our website as listed below or upon written request from the contact person listed below.

AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE

All the information upon which the proposed regulation is based is contained in the rulemaking file, which is available for public inspection by contacting the person named below.

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named below or by accessing the Board's website as listed below.

CONTACT PERSON

Inquiries or comments concerning the proposed rulemaking action may be addressed to:

Jeff Hanson
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Website Access: All materials regarding this proposal can be found on-line at **www.bot.ca.gov > Laws and Regulations > Proposed Regulations.**

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
PROPOSED AMENDED REGULATORY LANGUAGE
Title 16, Division 39, California Code of Regulations

Proposed amendments are shown by strikeout for deleted text and underline for new text.

Article 9. Supervision of Occupational Therapy Assistants, Limited Permit Holders, Students, and Aides

§ 4180. Definitions

In addition to the definitions found in Business and Professions Code sections 2570.2 and 2570.3 the following terms are used and defined herein:
(a) "Client related tasks" means tasks performed as part of occupational therapy services rendered directly to the client.
(b) "Level I student" means an occupational therapy or occupational therapy assistant student participating in activities designed to introduce him or her to fieldwork experiences and develop an understanding of the needs of clients.
(c) "Level II student" means an occupational therapy or occupational therapy assistant student participating in delivering occupational therapy services to clients with the goal of developing competent, entry-level practitioners.
(d) "Level II fieldwork educator" means a licensed occupational therapist or occupational therapy assistant who has a minimum of one year of practice experience following issuance of a license or other authorization to practice issued by another state regulatory board.
(e) "Non-client related tasks" means clerical and secretarial activities; transportation of patients/clients; preparation or maintenance of treatment equipment and work area; taking care of patient/client personal needs during treatments; and assisting in the construction of adaptive equipment and splints.
(f) "Periodic" means at least once every 30 days.
(g) "Clinical supervision," as used in this article, refers to those activities included in the American Occupational Therapy Association's document entitled "Standards of Practice for Occupational Therapy" (Adopted 2010), incorporated herein by reference.

Note: Authority cited: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.3, 2570.4, 2570.5, 2570.6, and 2570.13, Business and Professions Code.

§ 4184. Delegation of Tasks to Aides.

(a) The primary function of an aide in an occupational therapy setting is to perform routine tasks related to occupational therapy services. Non-client related tasks may be delegated to an aide when the supervising occupational therapy practitioner has determined that the person has been appropriately trained and has supportive documentation for the performance of the services.
(b) Client related tasks that may be delegated to an aide include specifically selected routine aspects of an intervention session. In addition to the requirements of Code section 2570.2, subdivisions (a) and (b), the following factors must be present when an occupational therapist delegates a selected aspect of an intervention to an aide:

(1) The outcome anticipated for the aspects of the intervention session being delegated is predictable.
(2) The situation of the client and the environment is stable and will not require that judgment or adaptations be made by the aide.
(3) The client has demonstrated previous performance ability in executing the task.
(4) The aide has demonstrated competence in the task, routine and process.
(c) The supervising occupational therapist shall not delegate to an aide the following tasks:
(1) Performance of occupational therapy evaluative procedures;
(2) Initiation, planning, adjustment, or modification of treatment procedures.
(3) Acting on behalf of the occupational therapist in any matter related to occupational therapy treatment that requires decision making.
~~(d) All documented client related services shall be reviewed and cosigned by the supervising occupational therapist.~~

Note: Authority cited: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.4 and 2570.13, Business and Professions Code

§ 4187. Supervision Plan for an Occupational Therapist
An occupational therapy assistant in an administrative role related to the provision of occupational therapy services shall only provide administrative services pursuant to a documented plan for the clinical supervision of any occupational therapy practitioner providing those occupational therapy services. This document shall include provisions for ongoing and formal evaluation of clinical performance, and must be available at time of hire, contract negotiation, and upon request.

Note: Authority: Sections 2570.13 and 2570.20, Business and Professions Code. Reference: Sections 2570.2, 2570.4 and 2570.13, Business and Professions Code.

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY

INITIAL STATEMENT OF REASONS

Subject Matter of Proposed Regulation: Regulations pertaining to the Supervision of Occupational Therapy Assistants, Limited Permit Holders, Students, and Aides

Sections Affected: Title 16, Division 39, Sections 4180, 4184, and 4187

Introduction:

The California Board of Occupational Therapy (Board) is the state governmental agency that regulates the practice of occupational therapy. The Board's highest priority in exercising its licensing, regulatory, and disciplinary functions is to protect and promote the health, safety and welfare of California consumers. The Board also administers, coordinates, and enforces the provisions of the laws and regulations pertaining to occupational therapy.

The proposed regulations are intended to establish, clarify and implement practice and supervision standards relating to the delivery of occupational therapy services.

Specific Purpose of each adoption, amendment or repeal:

Amend Section 4180 (Definitions)

The proposed regulation adds a new definition for "Clinical Supervision" by incorporating by reference the American Occupational Therapy Association's (AOTA's) "*Standards of Practice for Occupational Therapy* (adopted 2010)".

Although the *Standards of Practice for Occupational Therapy* does not specifically provide a definition for "clinical supervision" it clarifies practice standards and defines the roles and responsibilities between occupational therapists and occupational therapy assistants.

The *Standards of Practice for Occupational Therapy* also describes and defines the practice of occupational therapy. It provides education, examination, and licensure requirements that are fundamental to the profession and consistent with California's licensure requirements. The *Standards of Practice for Occupational Therapy* also contains other professional responsibilities and provides definitions for terms used in the document pertaining to: Activity, Assessment, Client, Evaluation, Intervention, Occupation, Outcomes, Re-evaluation, and Screening.

The *Standards of Practice for Occupational Therapy* clarifies, enhances, and supports supervision requirements already established by the Board by breaking down the roles and responsibilities in four areas pertaining to the delivery of services. The four areas and a summary of the duties and responsibilities for practitioners follows:

(1) Professional Standing and Responsibility
This section clarifies that the delivery of occupational therapy services should reflect the philosophical base of occupational therapy and be consistent with established principals and concepts of theory. It specifies that an occupational therapy practitioner must be knowledgeable about the standards, policies, and guidelines of federal, state, and the profession pertaining to the delivery of services. It specifies that occupational therapy practitioners maintain current licensure as required by law, and specifies that occupational therapy practitioners shall abide by the Occupational Therapy Code of Ethics (AOTA 2005). It specifies occupational therapy practitioners are responsible for maintaining and updating their knowledge and skills and are responsible and accountable for the safety and effectiveness of delivered services.

This section specifies that occupational therapy assistants are responsible for providing safe and effective services under the supervision of an occupational therapist. It specifies occupational therapy practitioners be knowledgeable about legislative, political, social, cultural, societal, and reimbursement issues affecting occupational therapy practice. It specifies occupational therapy practitioners be knowledgeable about evidence-based research and apply it ethically and with a best practices approach. It specifies occupational therapy practitioners respect a client's sociocultural background and provide client-centered and family-centered occupational therapy services.

(2) Screening, Evaluation, and Re-evaluation
This section clarifies that an occupational therapist is responsible for all aspects of the screening, evaluation, and re-evaluation processes. It specifies an occupational therapist accepts and responds to referrals in compliance with federal and state laws, and other regulatory and payer requirements. It specifies that an occupational therapist is to collaborate with the client in the screening, evaluation, and re-evaluation processes. It specifies that an occupational therapist is responsible for initiating and directing the screening, evaluation, and re-evaluation processes. It specifies that an occupational therapy assistant may contribute to the screening, evaluation, and re-evaluation processes. It specifies occupational therapy practitioners use current assessments and assessment procedures and follows protocols during the screening, evaluation, and re-evaluation process. It specifies occupational therapy practitioners document the screening, evaluation, and re-evaluation in accordance with federal and state laws, and other regulatory and payer entities. It specifies occupational therapy practitioners respect a client's confidentiality and privacy. It specifies that occupational therapy practitioners shall make appropriate referrals based on a client's needs. It specifies that occupational therapy practitioners shall educate current and potential referral sources about occupational therapy services and processes for initiating services.

(3) Intervention
This section requires an occupational therapist be responsible for the development, documentation, and implementation of therapeutic intervention based on the evaluation, client goals, best available evidence, and professional and clinical reasoning; specifies an occupational therapist is responsible for ensuring the intervention plan is documented in accordance with federal and state laws, and other regulatory and payer

entity requirements. It specifies an occupational therapy practitioners collaborate with clients on developing and implementing an intervention plan and coordinate the intervention plan with other professionals when appropriate. It specifies occupational therapy practitioners use professional and clinical reasoning to select appropriate types of interventions in the delivery of services.

(4) Outcome.
This section clarifies that an occupational therapist is responsible for selecting, measuring, documenting, and interpreting expected or achieved outcomes. It specifies an occupational therapist is responsible for documenting changes in the client's performance and capabilities and for transitioning the client to other types or intensity of service or discontinuing services when the client has achieved identified goals, reached maximum benefit, or does not desire to continue services. It specifies an occupational therapist prepares and implements, and an occupational therapy assistant contributes to, a transition or discontinuation plan based on the client's needs, goals, performance, and appropriate follow up resources. It specifies an occupational therapy practitioner shall facilitate the transition or discharge process by collaborating with the client, family members, significant others, and other professionals when appropriate. It specifies an occupational therapist is responsible for, and an occupational therapy assistant contributes to, evaluating the safety of occupational therapy processes and interventions.

Factual Basis/Rationale:
Adoption of the proposed regulations would enhance the Board's ability to administer, coordinate, and enforce professional standards for occupational therapy. Incorporation of AOTA's Standards for Occupational Therapy Practice is designed to establish and clarify additional detail surrounding the roles, duties, functions, and responsibilities of practitioners providing services to the public. Incorporation of AOTA's Standards for Occupational Therapy Practice would align California practice standards with national standards. Incorporation of the AOTA's Standards for Occupational Therapy Practice would enhance the Board's ability to take disciplinary action against practitioners for deviations in practice standards. Incorporation of AOTA's Standards for Occupational Therapy Practice enhance and clarify existing similar regulations by providing specific examples and situations that occur in the delivery of occupational therapy services. The proposed regulations would serve to protect the public by ensuring occupational practitioners act in accordance with, and within, their scope of practice.

Delete Section 4184(d) (Delegation of Tasks to Aides)

The proposed regulation would delete current regulatory language that allows aides to document client related services.

Factual Basis/Rationale:
The regulatory language should be deleted as it conflicts with Business and Professions Code (BPC) section 2570.2(a) which states in pertinent part "The occupational therapist or occupational therapy assistant is responsible for documenting the client's record concerning the delegated client-related tasks performed by the aide."

When the Board first adopted the current regulatory language that allows an aide to document a client record it was done so essentially for the convenience of the occupational therapist. It was believed that that since the supervising occupational therapist was required to have the aide providing services directly in their line of sight, the therapist could verbally direct the aide what to document in the record (the aide was essentially transcribing the therapist's own entry) and the therapist would then co-sign the record.

Deletion of the regulatory language will eliminate any confusion regarding an aide's ability to document a client record. It is the intent of the Board that, consistent with BPC section 2570.2(a), only licensees (an occupational therapist or occupational therapy assistant) shall be responsible for documenting a client record.

Add Section 4187 (Supervision Plan for Occupational Therapist)

The proposed language requires that a documented plan be established for the supervision of clinical performance of an occupational therapist who is employed in facilities, settings, or by businesses that are owned by or have an occupational therapy assistant functioning in an administrative, management, leadership, or directive role in the facility or business.

Factual Basis/Rationale:
The Board is concerned with ethical implications that derive from situations where an owner, administrator, or director, of a facility or business who is an occupational therapy assistant evaluates the clinical performance of an occupational therapist(s), who is under their administrative supervision. The purpose of this regulation is to make certain that it would be improper for an occupational therapy assistant to evaluate the clinical performance of an occupational therapist. Some examples of implementing the proposed regulations are as follows:

Facility or business owned by an occupational therapist with one occupational therapist as an employee or contractor would require that the occupational therapy assistant owner/operator hire or contract with another occupational therapist to evaluate the performance of the occupational therapist employed or contracted to provide services for the facility/business.

Facility or business that has an occupational therapy assistant functioning as a rehabilitation director that employs or contracts with two or more occupational therapists to provide services would require that the documented plan specify the occupational therapist that is designated to perform the clinical evaluation of occupational therapist(s) employed or contracted at the facility.

BUSINESS IMPACT
The proposed amendment to Section 4180 would have minimal cost impact to businesses in that it sets forth standards for practice for occupational therapy practitioners. Any practitioner that violates these standards potentially could be disciplined by the Board resulting in revocation of the license thereby resulting in loss of income to the licensee.

The proposed deletion to Section 4184 would have no cost impact to an employer due to the fact that current law requires that an occupational therapist must be present when an aide provides therapeutic services to a client. The proposed regulations simply require that the occupational therapist document the client's record.

Adoption of proposed Section 4187 may have a cost impact to businesses or facilities that provide occupational therapy services that are owned by or whose rehabilitation services are supervised, managed, or administered by an occupational therapy assistant. The proposed regulation would require that another occupational therapist be employed or contracted to evaluate the clinical performance of the occupational therapist that is employed at the facility that is owned by an occupational therapy assistant or facility that managed or administered by an occupational therapy assistant. In cases where a business or facility employs more than two occupational therapists one of the therapists could be designated to provide the clinical evaluations.

UNDERLYING DATA

We relied on the American Occupational Therapy Association's documents entitled "Standards of Practice for Occupational Therapy" (adopted 2010) and "Occupational Therapy Code of Ethics and Ethics Standards" (adopted 2010). These documents are available upon request.

SPECIFIED TECHNOLOGIES OR EQUIPMENT

This regulation does not mandate the use of specific technologies or equipment.

CONSIDERATION OF ALTERNATIVES

No reasonable alternative to the regulation would be either more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons and businesses than the proposed regulation.

AGENDA ITEM 10

REVIEW AND CONSIDERATION OF AMENDING THE BOARD'S ADMINISTRATIVE MANUAL.

The current manual is attached for review.

Introduction

Overview

The California Board of Occupational Therapy (Board) was established on January 1, 2001 (Senate Bill 1046, Chapter 697, Statutes of 2000) to protect the health, safety, and welfare of California consumers by regulating the practice of occupational therapists and occupational therapy assistants. It is one of several boards, bureaus, commissions and committees under the umbrella of the Department of Consumer Affairs (DCA), which provides administrative oversight and support services. The Board is autonomous and sets its own policies, procedures and regulations.

Strategic Plan

The Board's mission, vision, goals, objectives and action plans are in its Strategic Plan which was originally adopted in July 2004. The Strategic Plan will be reviewed annually and revised as needed.

Abbreviations

Agencies

CBOT	California Board Occupational Therapy
CDA	California Department of Aging
CDCR	California Department of Corrections & Rehab
CDE	California Department of Education
CDPH	California Department of Public Health
DCA	Department of Consumer Affairs
DDS	Department of Developmental Services
DHCS	Department of Health Care Services
DMH	Department of Mental Health
DSS	Department of Social Services
DVA	Department of Veterans Affairs
OAH	Office of Administrative Hearings
OAL	Office of Administrative Law
PTBC	Physical Therapy Board of California
SCSA	State and Consumer Services Agency
SLA & HAD	Speech Language and Audiology & Hearing Aide Dispensers Board

Codes

BPC	Business and Professions Code
~~CAC~~	~~California Administrative Code~~
CCR	California Code of Regulations
CFR	Code of Federal Regulations
CEC	California Education Code
CGC	California Government Code
HSC	Health and Safety Code
WIC	Welfare and Institutions Code

Abbreviations (Cont.)

Organizations

ACOTE	Accreditation Council for Occupational Therapy Education of the American Occupational Therapy Association
APTA	American Physical Therapy Association
AOTA	American Occupational Therapy Association
ASHA	American Speech-Language-Hearing Association
ASHT	American Society of Hand Therapists
CAMFT	California Association of Marriage & Family Therapists
CLEAR	Council on Licensure, Enforcement and Regulation
CPIL	Center for Public Interest Law
CPTA	California Physical Therapy Association
FARB	Federation of Associations of Regulatory Boards
HTCC	Hand Therapy Certification Commission
NBCOT	National Board for Certification in Occupational Therapy
OTAC	Occupational Therapy Association of California
RESNA	Rehabilitation Engineering Society of North America
WFOT	World Federation of Occupational Therapy

Titles

AG	Attorney General
ALJ	Administrative Law Judge
CHT	Certified Hand Therapist
COTA	Occupational Therapy Assistant Certified by NBCOT
DA	District Attorney
DAG	Deputy Attorney General
EO	Executive Officer
OT	Occupational Therapist
OTA	Occupational Therapy Assistant
OTR	Occupational Therapist Registered with NBCOT

Chapter 1. Board

Composition

(B&P section 2570.19)

The Board is composed of seven members of which, by law, includes:

- Four practitioners, including three occupational therapists and one occupational therapy assistant
- Three public members

The Governor appoints the four practitioners and one of the public members. One public member is appointed by the Assembly Speaker, and one public member is appointed by the Senate Rules Committee. Board members may serve up to two consecutive four-year terms.

Officers

(Board Policy – February 21, 2008)

The Board shall elect from its members a President, Vice President, and a Secretary to hold office for one calendar year or until their successors are duly elected.

Elections shall take place at the last meeting of the Board held annually. New officers shall assume office at the first meeting held in the next calendar year following the Officer elections. All officers may be elected on one motion or ballot as a slate of officers unless objected to by a Board member.

If the office of President becomes vacant, an election shall be held at the next scheduled Board meeting. Elected officers shall then serve the remainder of the term.

Officer Duties

(Board Policy – February 21, 2008)

The President shall preside over the meetings, and supervise the Executive Officer.

The Vice President acts in the President's absence.

The Secretary shall be responsible for taking roll and taking roll call vote when necessary.

Meetings

(B&P section 2570.19)

The Board will meet a minimum of three times a year and may meet more often as it determines necessary.

The Board will hold meetings in the cities of Sacramento, Los Angeles, and San Francisco and different geographic areas throughout the state as a convenience to the public and licensees.

Board Member Attendance at Board Meetings

(Board Policy – February 21, 2008)

Board members shall attend each meeting of the Board. If a member is unable to attend, he/she is requested to promptly contact the Executive Officer, to address quorum issues.

Quorum

(Common Law)

Four members of the Board constitute a quorum of the Board for the transaction of business. (A majority of the statutory number of members, BPC 2570.19, not a majority of the appointees.)

Agenda Items

(Board Policy – February 21, 2008)

Any Board member may submit items for a Board meeting agenda to the Board President or Executive Officer. Items shall be requested during a Board meeting or at least 21 days prior to the meeting.

The Board meeting agenda package will be sent to Board members 10 or more days prior to the meeting.

Record of Meetings

(Board Policy – Adopted date*)*

The minutes are a summary, not a transcript, of each Board meeting.

The minutes ~~and Assignments of Board Directives~~ shall be prepared by Board staff and submitted for review by the Board President within 20 working days after the Board meeting and then distributed to members of the Board.

Board minutes shall be approved at the next scheduled Board meeting and serve as the official record of the meeting.

Once draft Board minutes ~~and Assignments of Board Directives~~ are distributed to Board members, they ~~can~~ will be included in any Board and Committee agenda package ~~with the understanding that the draft minutes shall not be circulated but will be used for committee work~~.

Approved minutes of the open session are available for distribution to the public and shall be posted on the Board's website.

Tape Recording

(Board Policy – February 21, 2008)

Public Board meetings are tape-recorded. Tape recordings shall be retained until the minutes are adopted; the tape(s) shall then be destroyed. Closed session proceedings shall be taped at the discretion of the Board.

Meeting Rules

(Board Policy – February 21, 2008)

Board meetings will be conducted under Robert's Rules of Order to the extent that it does not conflict with the Bagley-Keene Open Meeting Act or any other section of law.

Communication

(Board Policy – February 21, 2008)

The Board President, his/her designee or the Executive Officer shall serve as spokesperson to the media on Board actions or policies.

Any written or oral communications concerning Board matters of a sensitive nature shall be made only by the Board President, his/her designee or the Executive Officer.

Staff shall provide Board members with Committee and Board member contact information on a quarterly basis.

Correspondence

(Board Policy – February 21, 2008)

Originals of all correspondence received shall be maintained in the Board's office files consistent with the record retention schedule. Only copies of such correspondence shall be given to the Executive Officer and/or Board members as required.

Executive Officer Evaluation

(CGC section 11126(a)(4))

(Board Policy – February 21, 2008)

Each Board Member shall provide input to the Board President regarding the performance appraisal and salary administration of the Executive Officer.

The performance appraisal of the Executive Officer shall be presented in draft form to the Board by the Board President at the annual election meeting.

The Board President may consult with the Office of Human Resources (OHR).

Matters relating to the performance of the Executive Officer shall be discussed in closed session unless he or she requests that it be discussed in open session.

Board Member Training

(CGC section 11146 et seq.)

(Board Policy – February 21, 2008)

New and continuing Board members shall complete training in accordance with the law and DCA procedures. The Executive Officer shall ensure compliance by annually reviewing the training completed by Board members.

Required training topics include, at a minimum:

- Diversity
- Ethics
- Sexual Harassment Prevention
- Privacy Protection/Identity Theft, and
- Board Member Orientation

Chapter 2. Board President

The duties of the Board President include, but are not limited to:

Supervision of Executive Officer

(Board Policy – February 21, 2008)

The Board President means President or President's designee. The President is the immediate supervisor of the Executive Officer. Specific instructions for work on Board policy matters by the Executive Officer from board members shall be coordinated through the Board President.

The incoming Board President shall assume all ~~delegated~~ duties at the ~~close of the annual~~ next meeting, including supervision of the Executive Officer.

Performance Appraisal of Executive Officer

(CGC section 11126(a)(4))

(Board Policy – February 21, 2008)

The Board President shall request from each Board Member input to the performance appraisal and consult with OHR salary administration of the Executive Officer prior to his/her draft preparations.

The performance appraisal of the Executive Officer shall be presented in draft form to the Board by the Board President at the annual election meeting.

Matters relating to the performance of the Executive Officer shall be discussed in closed session unless he or she requests that it be discussed in open session.

Chapter 3. Board Members

Per Diem Salary

(B&P Section 103)

Business and Professions Code Section 103 regulates compensation in the form of per diem salary and reimbursement of travel and other related expenses for Board members. In relevant part, this section provides for the payment of per diem salary for Board members "for each day actually spent in the discharge of official duties," and provides that the Board member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

Business and Professions Code Section 103 also states, "Notwithstanding any other provision of law, no public officer or employee shall receive per diem salary compensation for serving on those boards, commissions, committees, or the Consumer Advisory Council on any day when the officer or employee also received compensation for his or her regular public employment."

(Board Policy – February 21, 2008)

Accordingly, the following general guidelines shall be adhered to in the payment of per diem salary, or reimbursement for travel:

1. Board members shall be paid ~~salary~~ per diem salary for attendance at official Board and Committee meetings of which they are members. Board members cannot claim per idem salary for time spent traveling to and form a Board or Committee meeting. ~~Salary~~ pPer diem salary shall not be paid for preparation time for Board of Committee meetings, which would include such things as reading the meeting materials.

   Where it is necessary fore a Board member to leave early from a meeting, the Board President shall determine if the member has provided a substantial service during the meeting and, if so, shall authorize payment of salary per diem and reimbursement for travel-related expenses.

2. Board members shall be paid ~~salary~~ per diem salary for attendance at education and outreach events, or other events including but not limited to hearings, conferences or meetings other than official Board or Committee meetings that are approved in advance by the Board President and consistent with a "substantial service" as defined. The Executive Officer shall be notified of the event prior to the Board member's

Per Diem Salary (Cont.)

attendance. Board members will be compensated for actual time spent attending events other than official Board of Committee meetings, and preparation time for said events, based on submission of an approved attendance form. Per diem salary shall be paid upon evidencing six (6) hours of actual time spent. Hours may be accumulated over several events to meet this requirement.

3. Board-specified work and performance of state roles or additional assigned duties, Board members will be compensated for actual time spent performing work authorized in advance by the Board President based on submission of an approved attendance form. Per diem salary shall be paid upon evidencing six (6) hours of actual time spent. Hours may be accumulated for Board-specified assignments to meet this requirement.

Chapter 4. Executive Officer

Appointment

(B&P section 2570.21)

The Board appoints an Executive Officer who serves at the pleasure of the Board. He/She may be terminated at any time for any reason whatsoever, with or without good cause, and notwithstanding any representation to the contrary by any individual board member.

Role

(CCR Section 4101)

(Board Policy – February 21, 2008)

The Executive Officer is the Board's chief administrative officer. He/sShe implements the policies developed by the Board.

Recruitment

(Board Policy – February 21, 2008)

The Board shall institute an open recruitment plan to obtain a pool of qualified Executive Officer candidates. It shall also utilize proven equal employment opportunity and personnel recruitment procedures. The Board shall also work with the Department of Consumer Affairs' OHR and Deputy Director for Board relations in its recruitment process.

Selection

(Board Policy – February 21, 2008)

A qualified candidate for Executive Officer must demonstrate abilities that include the supervision of employees, conflict resolution and complaint mediation, public speaking and effective written and verbal communication skills. The candidate must have knowledge and expertise in the areas of administration, licensing, enforcement, legislation and budget.

(CGC section 11125)

The selection of a new Executive Officer shall be included as an item of business, which must be included in a written agenda and transacted at a public meeting.

Board Staff

(Board Policy – February 21, 2008)

The Board delegates all authority and responsibility for management of the civil service staff to the Executive Officer, including the annual evaluation and appraisal.

Performance Appraisal of Executive Officer

(CGC section 11126(a)(4))

(Board Policy – February 21, 2008)

The Board shall evaluate the performance of the Executive Officer on no less than an annual basis.

Matters relating to the performance of the Executive Officer shall be discussed in closed session unless he or she requests that it be discussed in open session.

Chapter 5. Committees

Standing Committees

(Board Policy – February 21, 2008)

The Board has six standing committees subject to the Open Meetings Act:

- Administrative Committee
- Disaster Preparedness/Disaster Response Committee
- Education and Outreach Committee
- Enforcement Committee
- Legislative and Regulatory Affairs Committee
- Practice Committee

Internal organization of each committee is at its discretion, except as specified in this manual, and shall be approved by the Board.

Member terms shall be two years, and members shall serve a maximum of two full, consecutive terms.

Meetings shall be held two or three times per year or as work requires.

Administrative Committee

(Board Policy – February 21, 2008)

The Administrative Committee consists of the President and Vice President.

~~Terms shall be two years, and m~~Members shall serve a maximum of two full, consecutive terms.

Meetings shall be held two or three times per year or as work requires.

The purpose of the Administrative Committee is to annually update the Strategic Plan, respond to items identified in an internal audit and provide guidance to staff in fulfillment of the audit staff's recommendations, provide guidance to staff for the budgeting and organizational components of the Board (i.e., sunset review, sunrise projects, budget change proposals, out-of-state trip requests, contracts, meeting agendas and preparations) and other duties as required.

Disaster Preparedness/ Disaster Response Committee

(Board Policy – February 21, 2008)

The Disaster Preparedness/Disaster Response Committee shall consist of ~~four~~ five members, at least one of whom shall be a Board member.

The Committee ~~members shall elect a~~ chairperson, the assigned Board member, shall be responsible for overseeing the meeting(s) and work with the Executive Officer in development of agenda packet materials. The Board member will be responsible for providing the Committee report at the Board meeting.

~~Member terms shall be two years, and members shall serve a maximum of two full, consecutive terms.~~

~~Meetings shall be held two or three times per year or as work requires.~~

The ~~purpose of the~~ Disaster Preparedness/Disaster Response Committee is assigned to identify and provide input into reducing barriers to occupational therapy roles in disaster preparedness and response, review the current laws and regulations to ensure consistency, be responsible for the development and maintenance of the Board's Disaster Response plan, and provide input into updates of the Board's Continuity of Operations and Continuation of Government (COOP/COG) report.

Members may be asked to represent the Board at meetings held regarding emergency/disaster response (i.e., meetings held by the California Department of Public Health, the Governor's Office of Emergency Services, local government, etc.)

Education and Outreach Committee

(Board Policy – February 21, 2008)

The Education and Outreach Committee shall consist of ~~four~~ five members, at least one of whom shall be a Board member.

The Committee ~~members shall elect a~~ chairperson, the assigned Board member, shall be responsible for overseeing the meeting(s) and work with the Executive Officer in development of agenda packet materials. The Board member will be responsible for providing the Committee report at the Board meeting.

~~Member terms shall be two years, and members shall serve a maximum of two full, consecutive terms.~~

~~Meetings shall be held two or three times per year or as work requires.~~

Education and Outreach Committee

The ~~purpose of the~~ Education and Outreach Committee is assigned to develop consumer and licensee outreach projects, including the Board's newsletter, website, e-government initiatives and outside organization presentations.

Members may be asked to represent the Board at meetings, conferences, health, career or job fairs, or at the invitation of outside organizations and programs.

Enforcement Committee

(Board Policy – February 21, 2008)

The Enforcement Committee shall consist of ~~four~~ five members, at least one of whom shall be a Board member.

The Committee ~~members shall elect a~~ chairperson, the assigned Board member, shall be responsible for overseeing the meeting and work with the Executive Officer in development of agenda packet materials. The Board member will be responsible for providing the Committee report at the Board meeting.

~~Terms shall be two years, and members shall serve a maximum of two full, consecutive terms.~~

~~Meetings shall be held two or three times per year or as work requires.~~

The purpose of the Enforcement Oversight Committee is to continually seek ways to improve the Board's enforcement activities, develop and review enforcement policies, review enforcement and discipline-related regulatory proposals, review enforcement and discipline-related forms, review and make recommendations regarding the Board's disciplinary guidelines and to assist in identifying situations where enforcement procedures might be improved.

Please note: Members will not review individual enforcement cases.

Legislative/Regulatory Affairs Committee

(Board Policy – February 21, 2008)

The Legislative/Regulatory Affairs Committee shall consist of ~~four~~ five members, at least one of whom shall be a Board member.

The Committee ~~members shall elect a~~ chairperson, the assigned Board member, shall be responsible for overseeing the meeting(s) and work with the Executive Officer in development of agenda packet materials. The Board member will be responsible for providing the Committee report at the Board meeting.

~~Terms shall be two years, and members shall serve a maximum of two full, consecutive terms.~~

~~Meetings shall be held two or three times per year or as work requires.~~

The ~~purpose of the~~ Legislative/Regulatory Affairs Committee is assigned to provide information and/or make recommendations to the Board and committees of the Board on matters relating to legislation and regulations affecting the regulation of Occupational Therapists, Occupational Therapy Assistants and other items in the public interest or affecting Board operations.

The Committee's goals and objectives are to:

- Monitor current legislation on behalf of the Board and make position recommendations to the Board at each Board meeting.
- Serve as a resource to other Board committees on legislative and regulatory matters.
- Serve as a resource for the Board to implement proposed revisions to the Act and Board regulations.

The classification system to be used by the Legislative/ Regulatory Affairs Committee in recommending Board positions is:

- Support:
  The Board supports the current version of the bill. This designation commits the Board to full involvement in the legislative process including sending letters to key people, conferring with key people prior to committee hearings and testifying at hearings by Board members, Legislative Committee members or senior staff.

Legislative/Regulatory Affairs Committee (Cont.)

- Support if Amended:
  The Board generally supports the concept or intent of the bill. Technical flaws need to be corrected before the Board will fully support the bill. The Board identifies the amendments or requirements that must be met in order for support to be obtained. Should the requested amendments or requirements be accepted, the Board's position will change to support. This designation commits the Board to full involvement in the legislative process as discussed above.

- Oppose:
  The Board is opposed to the current version of the bill. This designation commits the Board to involvement in the legislative process as discussed above.

- Oppose Unless Amended:
  The Board is opposed to the bill but is willing to work with the author and sponsor of the bill to resolve the Board's concerns about the bill. The Board identifies the amendments or requirements that must be met to remove the Board's opposition. Should the requested amendments or requirements be accepted, the Board will adopt a support position.
- Watch
  The Board has some interest in the bill because it potentially may affect the work of the Board. This designation requires careful tracking through the legislative process.
- Neutral
  The Board takes no official position.

Practice Committee

(Board Policy – February 21, 2008)

The Practice Committee shall consist of ~~seven~~ no less than five members, one of whom shall be a Board member. The members shall include a diverse representation for a variety of work settings.

The Committee ~~members shall elect a~~ chairperson, the assigned Board member, shall be responsible for overseeing the meeting(s) and work with the Executive Officer in development of agenda packet materials. The Board member will be responsible for providing the Committee report at the Board meeting.

~~Terms shall be two years, and members shall serve a maximum of two full, consecutive terms.~~

~~Meetings shall be held two or three times per year or as work requires.~~

The purpose of the Practice Committee is to review and provide recommendations to staff on Applications for Advanced Practice Post-Professional Education courses; review and provide recommended responses to the Board on various practice issues/questions submitted by licensees and consumers; provide guidance to staff on continuing competency audits; review and provide recommendations to the Board on practice-related proposed regulatory amendments; and review and provide recommendations to Board staff on revisions to various applications and forms used by the Board.

Ad Hoc Committees

(Board Policy – February 21, 2008)

The Board may establish ad hoc committees as needed for the Board and its standing Committees.

Advisory Capacity

(Board Policy – February 21, 2008)

Committee recommendations and reports shall be submitted to the Board in a timely manner for consideration and possible action.

Agendas

(Board Policy – February 21, 2008)

Agendas shall focus on the specific tasks assigned by the Board and include:

- Public comment
- Time for committee members to recommend new areas of study to be brought to the Board's attention for possible assignment.
- Only those information items dealing with subjects assigned or delegated to the respective committee.

Committee chairs shall confer with the Board President prior to including any agenda item that is not clearly within that committee's assigned purview.

If more than two Board members will attend a Committee meeting, the agenda shall contain the statement: "~~Notice of a Board meeting indicates that three or more members of the Board are present. While the law requires the Board to notice this also as a Board meeting, it is not the intent to take action as a Board at this meeting~~ A quorum of the board may be present at the committee meeting. Board members who are not members of the committee

may observe but no participate or vote."

Appointments

(Board Policy – Adopted date*)*

At the last meeting before the end of the fiscal year, standing committees shall make recommendations for possible members.

The Board President shall appoint, ~~subject to the approval of the Board~~, the members to fill positions with expired terms of each standing committee and appoint members to ad hoc committees.

Attendance at Committee Meetings

(Board Policy – February 21, 2008)

Board members who are not members of the committee may attend a committee meeting and observe but not participate or vote.

It is ~~recommended~~ required that non-Committee Board members sit in the audience and not participate in the meeting discussion.

Dual Membership

(Board Policy – February 21, 2008)

A non-Board member cannot serve concurrently on more than two standing advisory committees.

Meeting Rules

(Board Policy – February 21, 2008)

Meetings will be conducted under Robert's Rules of Order to the extent that it does not conflict with the Bagley-Keene Open Meeting Act or any other section of law.

Minimum Qualifications

(Board Policy – February 21, 2008)

The minimum qualifications for a licensee member of a standing advisory committee are:

- Five years of professional experience
- Current California licensure as an occupational therapist or occupational therapy assistant, without restriction,
- No pending or prior disciplinary action.

Record of Meetings

(Board Policy – February 21, 2008)

The minutes are a summary, not a transcript of each committee meeting. The minutes shall be prepared by Board staff and submitted for review by Committee members within 20 working days of the meeting.

Committee minutes shall be approved at the next scheduled Committee meeting and serve as the official record of the meeting.

Approved minutes of the open session are available to the public, upon request, and shall be posted on the Board's website.

Recruitment

(Board Policy – February 21, 2008)

The Board shall recruit interested persons to serve on appropriate committees.

Reimbursement of Travel-related Expenses

(Board Policy – February 21, 2008)

Committee members are entitled to be reimbursed for all travel-related expenses to attend Committee meetings.

Residence Requirement

(Board Policy – February 21, 2008)

A member of a standing advisory committee must be a California resident.

Staff Participation

(Board Policy – February 21, 2008)

Board staff provides advice, consultation and support to committees.

Tape Recording

(Board Policy – February 21, 2008)

Committee meetings are tape-recorded. Tape recordings shall be retained until the minutes are adopted; the tape(s) shall then be destroyed.

Chapter 6. Travel Procedures

Travel Approval

(Board Policy – February 21, 2008)

Board members shall have the Board President's approval for all travel except for regularly scheduled Board and Committee meetings to which the Board member is assigned.

~~If a Board member requests within the 10-day notice period to attend a meeting of a committee of which he or she is not a member and such request requires the meeting to be noticed also as a Board meeting, the request may not be approved.~~

Arrangements for Board member travel are made by Board members or the Board's staff.

Arrangements for Committee member travel are made by the Board's staff.

If a conference is held out of state, the President and/or Executive Officer may only attend if an Out of State Travel Request has been approved by the Department of Finance. If the conference is not an approved OST, there will be no reimbursement for travel-related expenses and the individual may not represent the Board.

Claims for Reimbursement of Travel-related expenses

(Board Policy – February 21, 2008)

Board members shall have the Board President's approval for all travel except for regularly scheduled Board and Committee meetings to which the Board member is assigned.

Chapter 7. Security Procedures

Request for Records Access

(Board Policy – February 21, 2008)

No Board member may access a licensee's or applicant's file without the Executive Officer's knowledge and approval of the conditions of access except as consistent with the Public Records Act, Information Practices Act, and other relevant sections of law. A notation of the Board member's access to the record shall be entered in the file. Records or copies of records shall not be removed from the Board's office.

Contact with Applicants, Licensees, Complainants, and Respondents

(Board Policy – February 21, 2008)

Board members shall not intervene on behalf of a applicant, ~~or~~ licensee, or complainant for any reason. They ~~should~~ shall forward all contacts or inquiries to the Executive Officer or Board staff.

Board members shall not directly participate in complaint handling and resolution or investigations. If a Board member is contacted by a respondent or his/her attorney, he/she shall refer the individual to the Executive Officer or Board staff.

Gifts from Applicants

(Board Policy – February 21, 2008)

Gifts of any kind to Board members or staff from applicants for licensure, applicants or other interested organizations with the Board shall not be permitted.

[Legal Counsel to provide more language regarding Fair Political Practice Committee requirements]

Chapter 8. Affiliation With The Department of Consumer Affairs (DCA)

Overview of DCA

(Board Policy – February 21, 2008)

The Department of Consumer Affairs (DCA) is mandated to protect and serve California consumers while ensuring a competent and fair marketplace. DCA helps consumers learn how to protect themselves from unscrupulous and unqualified individuals. The Department also protects professionals from unfair competition by unlicensed practitioners.

The Department of Consumer Affairs includes 40 regulatory entities (nine bureaus, one program, twenty-five boards, three committees, one commission, and one office). These entities establish minimum qualifications and levels of competency for licensure. They also license, register, or certify practitioners, investigate complaints and discipline violators. The committees, commission and boards are semiautonomous bodies whose members are appointed by the Governor and the Legislature. DCA provides them administrative support. DCA's operations are funded exclusively by license fees.

Pursuant to B&P Code Section 127 the director may require reports from any board, commission, examining committee, or other similarly constituted agency within the department as he deems reasonably necessary on any phase of their operations.

Chapter 9. Affiliation With Other Organizations

AOTA

(Board Policy – February 21, 2008)

The Board shall maintain membership in the American Occupational Therapy Association (AOTA). The President, President's designee, and/or Executive Officer shall represent the Board at AOTA's Annual Conference. If AOTA's Annual Conference is held out of state, the President and/or Executive Officer may only attend if an Out of State Travel Request has been approved by the Department of Finance. If the conference is not an approved OST, there will be no reimbursement for travel-related expenses.

CLEAR

(Board Policy – February 21, 2008)

The Board may maintain membership in the Council on Licensure, Enforcement and Regulation (CLEAR). If CLEAR's Annual Conference is held out of state, the President and/or Executive Officer may only attend if an Out of State Travel Request has been approved by the Department of Finance. If the conference is not an approved OST, there will be no reimbursement for travel-related expenses.

NBCOT

(Board Policy – February 21, 2008)

The Board may maintain membership in the National Board for Certification in Occupational Therapy (NBCOT). If NBCOT's Annual Conference is held out of state, the President and/or Executive Officer may only attend if an Out of State Travel Request has been approved by the Department of Finance. If the conference is not an approved OST, there will be no reimbursement for travel-related expenses.

OTAC

(Board Policy – February 21, 2008)

The Board shall maintain membership in the Occupational Therapy Association of California (OTAC). The Board shall ensure representation by attending OTAC Annual Conference and other events as operationally practicable.

Chapter 10. Information

Disciplinary Actions

(Board Policy – February 21, 2008)

All final decisions by the Board following formal disciplinary proceedings of alleged violations of the Act shall be published on the Board's website after the effective date of the decision.

Conclusion

This Board Member Administrative Procedure Manual serves as reference for important laws, regulations, Department of Consumer Affairs' policies and Board policies in order to guide the actions of the Board members and ensure Board effectiveness and efficiency.

References

The procedures in this manual are specific to the Board. Suggested references for additional important information are:

Board Member Orientation and Reference Manual, DCA

Business and Professions Code, sections 103, 106, 106.5, 2570-2571, 17500

California Code of Regulations, sections 4100-4184

California Government Code, sections 1750, 11120 et seq., 11146 et seq.

State Administrative Manual, section 700 et seq.

AGENDA ITEM 11

REVIEW OF PROPOSED BOARD MEMBER DISCIPLINARY RESOURCES MANUAL.

The draft manual is attached for review.

ITEM
TO BE
PROVIDED

AGENDA ITEM 12

REVIEW AND CONSIDERATION OF BOARD POLICY REGARDING HEARNG APPEALED CASES.

The policy is attached for review.

STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF OCCUPATIONAL THERAPY
2205 Evergreen Street, Suite 2050, Sacramento, CA 95811
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E-mail: cbot@dca.ca.gov Web: www.bot.ca.gov

SUBJECT:	POLICY #	DATE ADOPTED:
Hearings in Contested Cases After Denial of Licensure Alleging the Unlicensed Practice of Occupational Therapy	E – 10-02	~~TBD~~ **July 28, 2010**
DISTRIBUTION: All Staff Jan Lachman, DAG Office of Administrative Hearings	APPROVED BY: Board of Occupational Therapy	

Policy

Where an applicant for licensure has been denied a license based upon allegations the he or she has practiced occupational therapy without a license for a period of more than one year, and the denied individual requests, has a right to, and has not waived a hearing pursuant to Business & Professions Code section 485, the Board of Occupational Therapy (Board) will hear the contested case pursuant to sections 11512 and 11517(a) of the Government Code. The Board will attempt to schedule as many hearings as possible on the same day in the same location for greater efficiency.

Background

The unlicensed practice by occupational therapy practitioners continues to be an issue requiring immediate attention. Requiring denied applicants to appear before the Board will help ensure a more consistent and efficient handling of hearings after an application for licensure has been denied.

Implementation

TBD

Attachments

Government Code sections 11512, 11517

AGENDA ITEM 13

REVIEW AND CONSIDERATION OF ESTABLISHING POLICY REGARDING EFFECTIVE DATES OF DISCIPLINARY DECISIONS.

The following are attached for review:

- Background/briefing paper
- Proposed policy

STATE OF CALIFORNIA
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DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
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Date: November 18, 2011

From: Jeff Hanson

Subject: Request for Approval of Policy Establishing Disciplinary Order Effective Dates

BACKGROUND

The purpose of the Consumer Protection Enforcement Initiative (CPEI) is to improve the processing time of enforcement cases and streamline the investigation and disciplinary functions. The Board's staff has been encouraged to think outside the box to implement processes that further promote the CPEI.

The intent of this proposed policy is to streamline enforcement processes in a manner that facilitates prompt resolution, provides consumer protection and does not infringe on any rights that are afforded to a respondent.

This policy will provide consistency in handling of cases and eliminates the necessity of staff modifying mail ballots to outline different options. This policy will eliminate the need for staff to seek clarification regarding the effective date of a Decision after the Board's deliberation of discipline cases in closed session.

To delve into more of the rationale of this proposal we will address each of the potential situations as follows:

Default Decision

In this scenario the respondent has either failed to request a hearing (file a Notice of Defense) or has failed to appear for a hearing after having been served notice of the date, time, and location of their hearing. Pursuant to Government Code Section 11520(c), a respondent may file a motion to vacate a Default Decision; this must be done within seven days of service of the Decision.

Stipulated Settlements

In this scenario the respondent has agreed to the terms and conditions contained in the Order. Since a respondent enters into these agreements freely and they waive further appeal rights, such as the right to reconsideration, it makes no sense to delay the effective date until 30-days after the date of service.

In some cases the settlement agreement may have been signed by respondent a month prior, or even more, before the Board has the opportunity adopt the settlement agreement. Making the Decision effective ten (10) days after service provides a respondent reasonable notice of the effective date of the decision (or the start of the terms to which they previously agreed.)

Proposed Decisions
These are cases that went to an administrative hearing. In this scenario the Board would render a Decision on whether to adopt the ALJ's Proposed Decision as its Decision in the matter. In this scenario Board staff would make the effective date the Decision effective 30-days after the service of the Decision to respondent. This standard allows the respondent and Board staff the opportunity to file a request or petition for reconsideration of all or part of the case.

PROPOSED POLICY

All Disciplinary Orders adopted by the Board, including Default Decisions, Stipulated Settlement Agreements and Proposed Decisions issued by an Administrative Law Judge, shall be effective as follows:

Default Decisions
A Default Decision that is adopted by the Board shall be effective **10-days** from the date of service of the decision to the Respondent.

Stipulated Settlement Agreements
A stipulated settlement agreement that is adopted by the Board (or if regulations granting authority for the Executive Officer to approve settlement agreements for revocation or surrender of a license is adopted in regulation) shall be effective **10-days** from the date of service of the decision to Respondent.

Proposed Decisions
A Proposed Decision adopted by the Board shall be effective **30-days** from the date of service of the decision to the Respondent.

When serving a Default Decision or Proposed Decision, Board staff ensures that the appeal date shall not fall on a Saturday, Sunday, or State holiday.

STATUTORY UTHORITIES

Government Code Section 11519(a) states:

The decision shall become effective within 30-days after it is delivered or mailed to respondent unless: a reconsideration is ordered within that time, **or the agency itself orders that the decision shall become effective sooner**, or a stay of execution is granted.

Government Code Section 11520(c) states:

Within seven days after service on the respondent of a decision based on the respondent's default, the respondent may serve a written motion requesting that the decision be vacated and stating the grounds relied on. The agency in its discretion may vacate the decision and grant a hearing on a showing of good cause. As used in the subdivision, good cause includes, but is not limited to, any of the following:

(1) Failure of the person to receive notice served pursuant to Section 11505.
(2) Mistake, inadvertence, surprise, or excusable neglect.

Note: Section 11505 requires the Accusation be served by certified mail.

Government Code Section 11521 states:

(a) The agency itself may order a reconsideration of all or part of the case on its own motion or on petition of any party. The agency shall notify a petitioner of the time limits for petitioning for reconsideration. The power to order a reconsideration shall expire 30 days after the delivery or mailing of a decision to a respondent, or on the date set by the agency itself as the effective date of the decision if that date occurs prior to the expiration of the 30-day period or at the termination of a stay of not to exceed 30 days which the agency may grant for the purpose of filing an application for reconsideration. If additional time is needed to evaluate a petition for reconsideration filed prior to the expiration of any of the applicable periods, an agency may grant a stay of that expiration for no more than 10 days, solely for the purpose of considering the petition. If no action is taken on a petition within the time allowed for ordering reconsideration, the petition shall be deemed denied.

(b) The case may be reconsidered by the agency itself on all the pertinent parts of the record and such additional evidence and argument as may be permitted, or may be assigned to an administrative law judge. A reconsideration assigned to an administrative law judge shall be subject to the procedure provided in Section 11517. If oral evidence is introduced before the agency itself, no agency member may vote unless he or she heard the evidence.

DEFINITIONS

Default Decision
When a Respondent fails to file a Notice of Defense (written notice requesting a hearing) to contest the charges or provide mitigating evidence in a hearing; or fails to appear for a scheduled hearing, the Attorney General prepares a Default Decision. Default Decisions are designed to bring finality to cases after giving the respondent notice and opportunity to be heard or "have their day in court". A Default Decision can be summarized as an uncontested case which results in revocation.

Proposed Decision
When an administrative hearing is held, the administrative law judge (ALJ) that presided over the hearing drafts a proposed decision for the Board to consider as its Decision in the matter.

Settlement Agreement/Stipulated Settlement
When Accusations are served on a licensee, they are advised they may avoid the lengthy timeframe, uncertainty, and costs associated with an administrative by inquiring about potential settlement terms. If the case warrants, Board staff coordinates appropriate terms and conditions with the assigned DAG. When appropriate, this provides a more expeditious resolution for both parties.

The terms and conditions incorporated in settlement agreements should be consistent with the Board's Disciplinary Guidelines; although Board staff has in the past been able to secure terms and conditions that are stronger or more stringent than what would be anticipated if the case had proceeded to hearing. Once adopted by the Board, settlement agreements are designed to be complete, final, and an exclusive embodiment of the agreement between the respondent and Board.

Therefore, the respondent waives all further appeal rights associated with discipline, including the right to reconsideration. A respondent is not obligated to accept the terms and conditions proposed, in which case they retain their right to a hearing.

Serve
Board staff or the AGO mails the notice (e.g. the Accusation, Notice of Hearing, etc.) by regular and certified mail to the licensee's last known address of record.

Stay
An order that delays (stays) the effective date, or an action, of a Disciplinary Decision. A stay would be ordered in the event the Board granted a request or petition for reconsideration to review all or a part of a Decision. The purpose of stay would be to allow the Board to meet and discuss additional material or evidence that is provided.

Vacate Decision
In accordance with Government Code Section 11520(c) the Board may grant a respondent's motion, on a showing of good cause, to vacate a Default Decision revoking the license. The purpose is to allow the respondent the opportunity to have an administrative hearing.

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SUBJECT	Disciplinary Order Effective Dates
NUMBER	2011-01
SUPERSEDES	NEW
ISSUE DATE	December 1, 2011

These are general guidelines to provide Enforcement staff with direction and provide consistency in serving Disciplinary Orders.

PURPOSE

This policy is designed to standardize the effective dates of Final Decisions pertaining to disciplinary actions that are consistent with the Department of Consumer Affairs' Consumer Enforcement Protection Initiative (CPEI) and the rights afforded to licensees.

This policy will provide consistency in handling of case and eliminates the necessity of staff modifying mail ballots to outline different options. This policy will eliminate the need for staff to seek clarification regarding the effective date of a Decision after the Board's deliberation of discipline cases in closed session.

POLICY

All Disciplinary Orders adopted by the Board, including Default Decisions, Stipulated Settlement Agreements and Proposed Decisions issued by an Administrative Law Judge, shall be effective as follows:

Default Decisions

A Default Decision that is adopted by the Board shall be effective **10-days** from the date of service of the decision to the Respondent.

Stipulated Settlement Agreements

A stipulated settlement agreement that is adopted by the Board (or if regulations granting authority for the Executive Officer to approve settlement agreements for revocation or surrender of a license is adopted in regulation) shall be effective **10-days** from the date of service of the decision to Respondent.

Proposed Decisions

A Proposed Decisions adopted by the Board shall be effective **30-days** from the date of service of the decision to the Respondent.

When serving a Default Decision or Proposed Decision, Board staff ensures that the appeal deadline shall not fall on a Saturday, Sunday, or State holiday.

APPLICABILITY

This policy shall apply to all Disciplinary Orders of the Board.

AGENDA ITEM 14

CONSIDERATION OF ESTABLISHING AD-HOC COMMITTEE OF THE BOARD TO ASSIST STAFF AND PROVIDE OVERSIGHT OF THE PREPARATION OF THE UPCOMING SUNSET REVIEW REPORT.

The Sunset Review Schedule is attached for review.

DCA Boards and Bureaus: Sunset Dates and Review Cycles

Board	(BPC Code Sections)	Sunset Dates	Review Cycle	Last Reviewed
Accountancy, Board of	(5000, 5015.6)	1/1/16	2014/15	2010/11
Acupuncture Board	(4928, 4934)	1/1/13	2011/12	2004/05
Architects Board, California	(5510, 5517)	1/1/16	2014/15	2010/11
Landscape Architects Technical Committee	(5620, 5621, 5622)	1/1/16	2014/15	2010/11
Automotive Repair, Bureau of	(9882)	None	2013/14	2003/04 (2005/06 monitor report)
Athletic Commission	(18602, 18613)	1/1/14	2012/13	2010/11
Board of Barbering and Cosmetology	(7303)	1/1/14	2012/13	2005/06
Behavioral Sciences, Board of	(4990, 4990.4)	1/1/13	2011/12	2004/05
Cemetery and Funeral Bureau	(7602)	None	2013/14	2004/05
Chiropractic Board	(1000 & Chiropractic Act of 1922)	None	2011/12	2005/06
Common Interest Development Managers	(11506)	1/1/15	2013/14	Never reviewed (New)
Contractors State License Board	(7000.5, 7011)	1/1/16	2014/15	2010/11
Court Reporters Board	(8000, 8005, 8030.2, 8030.4, 8030.5, 8030.6, 8030.8)	1/1/13	2011/12	2004/05
Dental Hygiene Committee of California	(1901, 1903)	1/1/15	2013/14	2003/04
Dental Board of California	(1601.1, 1616.5)	1/1/16	2014/15	2010/11
Electronic and Appliance Repair, Home Furnishings and Thermal Insulation	(9810, 19030)	None	2013/14	Never reviewed
Engineers, Land Surveyors & Geologists	(6710, 6714, 8710)	1/1/16	2014/15	2010/11
Guide Dogs for the Blind, Board of	(7200, 7215.6)	1/1/14	2012/13	2000/01
Interior Design, Certification Organization	(5810)	1/1/14	2012/13	2002/03
Massage Therapists Organization	(4620)	1/1/15	2013/14	Never reviewed (New)
Medical Board of California	(2001, 2020)	1/1/14	2012/13	2004/05
Occupational Therapy, California Board of	(2570.19)	1/1/14	2012/13	2005/06
Optometry, Board of	(3010.5, 3014.6)	1/1/14	2012/13	2001/02

Updated: November 2011

Board	(BPC Code Sections)	Sunset Dates	Review Cycle	Last Reviewed
Osteopathic Medical Board of California	(2450 & Osteopathic Act)	None	2012/13	2004/05
Naturopathic Medicine Committee	(2450.3, 3685, 3686)	1/1/13, 1/1/14	2012/13	Never reviewed (New)
Pharmacy, Board of	(4001, 4003)	1/1/13	2011/12	2002/03
Physical Therapy Board of California	(2602, 2607.5)	7/1/13 & 1/1/14	2011/12	2005/06
Physician Assistant Committee	(3504, 3512)	7/1/13	2011/12	2001/02
Podiatric Medicine, Board of	(2460)	1/1/13	2011/12	2001/02
Private Postsecondary Education, Bureau of	(Education Code 94874.1, 94950)	1/1/15, 1/1/16	2013/14	2005/06
Professional Fiduciaries Bureau	(6510)	1/1/15	2013/14	2010/11
Psychology, Board of	(2920, 2933)	1/1/13	2011/12	2004/05
Registered Dispensing Opticians (with Med Board)	(2569)	1/1/14	2012/13	2004/05
Registered Nursing, Board of	(2701, 2708)	1/1/12	2010/11	2010/11
Respiratory Care Board	(3710, 3716)	1/1/14	2012/13	2001/02
Security and Investigative Services, Bureau of	(7501)	None	2013/14	Never reviewed
Speech-Language Pathology, Audiology & Hearing Aid Dispensers Board	(2531, 2531.75)	1/1/14	2012/13	1998
Structural Pest Control Board	(8520, 8528)	1/1/15	2013/14	2004/05
Tax Preparer Education Council	(22259)	1/1/15	2013/14	2003/04
Veterinary Medical Board	(4800, 4804.5)	1/1/14	2012/13	2003/04
Vocational Nursing and Psychiatric Technicians, Board of	(2841, 2847, 4501, 4503)	1/1/16	2014/15	2010/11

KEY: Blue = 2011/12 sunset review (Sunset Date – January 1, 2013)
Black = 2012/13 sunset review (Sunset Date – January 1, 2014)
Green = 2013/14 sunset review (Sunset Date – January 1, 2015)
Red = 2014/15 sunset review (Sunset Date – January 1, 2016)

Updated: November 2011

DCA Boards and Bureaus Sunset Dates for Review

2011/2012	2012/2013	2013/14	2014/2015
Acupuncture Board	Athletic Commission	Automotive Repair, Bureau of	Accountancy Board
Behavioral Sciences Board	Barbering and Cosmetology Board	Cemetery and Funeral Bureau	Architects Board Landscape Architects Technical Committee
Chiropractic Board	Guide Dogs for the Blind	Common Interest Development Managers	Contractors State License Board
Court Reporters Board	Interior Design Certification Organization	Dental Hygiene Committee	Dental Board
Pharmacy Board	Medical Board of California	Electronic, Appliance Repair, Home Furnishings and Thermal Insulation Bureau	Engineers, Land Surveyors and Geologists
Physical Therapy Board	Occupational Therapy Board	Massage Therapist Organization	Registered Nursing Board
Physician Assistant Committee	Optometry Board	Private Postsecondary Education Bureau	Vocational Nursing and Psychiatric Technicians Board
Podiatric Medicine Board	Osteopathic Medical Board	Professional Fiduciaries Bureau	
Psychology Board	Naturopathic Medicine Committee	Security and Investigative Services Bureau	
	Registered Dispensing Opticians	Structural Pest Control Board	
	Respiratory Care Board	Tax Preparer Education Council	
	Speech-Language Pathology, Audiology, Hearing Aid Dispensers Board		
	Veterinary Medical Board		

Updated: November 2011

Date: November 18, 2011

To: CBOT Board Members

From: Heather Martin

Subject: Executive Officer Report – December Board Meeting

All Committee selected a future meeting date in early 2012. After the Board selects its 2012 meeting dates, the committees will select their meeting dates for the duration of 2012 at their first meeting. The Committee Meeting dates are as follows

Committee	Meeting Date
Disaster Preparedness/Response Committee	January 24, 2012
Education/Outreach Committee	January 19, 2012
Enforcement Committee	January 26, 2012
Legislative/Regulatory Affairs Committee	January 24, 2012
Practice Committee	February 9, 2012

BreEZe Project (formerly I-Licensing Project):
The board is in Release Two of the new system which will integrate applicant, licensee, and enforcement information and provides for submission of initial applications, advanced practice applications, and renewal applications on-line and accepts payment by credit/debit card.

Our budget will be augmented by: our share of the BreEZe development/deployment and maintenance costs and estimated credit card processing costs which are as follows:

Year	2011-12	2012-13	2013-14	2014-15
BrEZe	$ 21	$ 33	$ 45	$ 40
Credit Card		7	13	13

** Dollars in thousands

Budget
Materials under item 15A include a Fiscal Month (FM) 3 Budget report (with hand-written notes), workload and revenue projections for Fiscal Years (FY) 2001-12 and 2012-13; and an updated fund condition.

Our budget for the year will be between $1.447 -1.459m. Any unspent funds will be considered a 'reversion' and will affect our fund condition.

Agenda Item 15

Also, the Governor's Budget for FY 2011/12 includes a General Fund (GF) loan repayment of $640k (monies loaned to GF in FY 2003/04). Depending upon our 2011/12 revenue and expenditures, additional monies from the 2009/10 GF loan may need to be repaid in 20013/14. (Updated information will be available at the Spring 2012 Board meeting)

Staff

The Board currently has only 10 staff. Vacancies include 2.5 permanent positions and 2.5 two-year limited (CPEI) positions that could not be filled due to the hiring freeze. Freeze exemptions have been submitted to DCA for the permanent Staff Services Manager and 1.5 clerical staff clerical positions (1.0 in Administration and .5 position in Enforcement). Due to the hiring freeze, the 2.5 two-year limited term (CPEI) positions were vacant for more than six months and the positions were abolished. However, we will be submitting requests to re-establish the positions and exempt them from the hiring freeze for recruitment purposes. This will allow more flexibility in the recruitment process.

Please note – the Hiring Freeze has not been lifted, however, the process has been simplified. Due to acceptance of spending plan reductions, now Freeze Exemptions must only go though DCA and SCSA.

Strategic Plan

Materials under item 15B include the revised Strategic Plan that was sent to you all via email and a version provided by DCA's Office of Publication has provided been provided for your review. (A couple of "cover sheet" versions follow.)

Other Informational Items

Materials under item 15C include several reports.

FISMA Report

Government Code section 13400 - 13407, known as the Financial Integrity and State Manager's Accountability Act of 1983 (FISMA), was enacted to reduce the waste of resources and strengthen accounting and administrative control. FISMA requires each state agency to maintain effective systems of internal accounting and administrative control, to evaluate the effectiveness of these controls on an ongoing basis, and to biennially review and prepare a report on the adequacy of the agency's systems of internal accounting and administrative control.

In order to comply with the FISMA report due 12/31/2011, the DCA executive office asked the Boards to identify the risks that are prevalent within our board. DCA's goal is to identify the most significant risks in the department (as a whole) and implement a plan (using existing resources) to reduce or mitigate those risks.

Our FISMA report submission is attached at end of this report.

Agenda Item 15

Enforcement Improvement Plan Report
In light of the attention and priority given to the Boards enforcement efforts, DCA requested boards provide an updated Enforcement Improvement Plan Report. Our response is attached at the end of this report.

Issues Affecting Licensees

Cease Practice Orders
Pursuant to authority under Business and Professions Code Section 315.2 and the Board's Uniform Standards Related to Substance Abuse and Disciplinary Guidelines (Guidelines) the Board has began issuing Cease Practice Orders to those probationers ordered to undergo biological fluid testing and abstain from alcohol and controlled substances, who *test positive* for a banned substance. In September, we issued two such orders. The Order is sent to the licensee and copies were also provided to the employers.

We were the first board to Order a licensee to Cease Practice under this statute and allowed under our Guidelines. As such, in order to ensure full disclosure on the Web License Lookup, we were successful in getting the system updated to reflect this new status as "Cease Practice Order Issued."

Also, licensees are advised the following:

In order for the Board to consider a request from you to return to practice, you must:

1. Undergo a clinical diagnostic evaluation, the cost of which be paid by you, and a final written report shall be provided to the Board.

2. You shall submit to random drug testing at least two (2) times per week and demonstrate at least one-month of negative drug test results.

    a. You are required to call in (or log in) daily to FirstLab to determine if you have been selected for testing, and submit to random drug testing when selected.
    b. A missed test will be considered a positive test. In the event you miss a scheduled test or test positive for a banned substance, your one-month "counter" will be reset from that date.

The Board will review the clinical diagnostic evaluation to help determine whether or not you are safe to return to either part-time or full-time practice and/or what restrictions or recommendations should be imposed on your license. This determination will be based on your license type, license history, documented length of sobriety, scope and pattern of substance abuse, treatment history, medical history, current medical condition, nature, duration and severity of substance abuse problem, and whether you are considered a threat to yourself or others.

(Unfortunately, neither individual has been successful yet in meeting these requirements.)

Agenda Item 15

Also, DCA and the Senate Business, Professions and Economic Development Committee (Senate B&P) have expressed concerns that the healing arts boards were not moving forward with implementing the Uniform Standards as required; however, these concerns did not apply to this board. (We're in compliance.)

As a result, Senate B&P requested a Legislative Counsel opinion regarding whether the healing arts boards are required to adopt the Uniform Standards. The Legislative Counsel opinion is attached at end of this report.

License Suspensions for Unpaid Taxes
Effective January 1, 2012, we are required to suspend the license of anyone who owes the Franchise Tax Board (FTB) or Board of Equalization (BOE) in excess of $100,000. The BOE will provide the listing of individuals four times per year; the FTB will provide the it two times per year. The DCA has agreed to take the lead on this issue as they have with those individual whose license has been granted "temporarily" for 150 days due to non-compliance with a support order.

2011 FISMA REPORT – California Board of Occupational therapy

1. **DCA Human Resources**

   Long processing times, inconsistent instructions and answers, and employee turn-over/re-assignments, have adversely impacted the Board's ability to obtain necessary information, establish positions and recruit for and fill vacancies. This has hampered the Board's ability to efficiently conduct its business adversely affected processing timeframes or timely protect consumers. The CBOT has been forced to take on a more proactive approach and monitor requests more intensively thereby expending more time and energy monitoring HR related issues.

2. **Lengthy Processing Times Associated with Adjudication of Disciplinary Cases (AG & OAH)**

   Recent focus on investigative processing times with DOI and Board desk investigations has resulted in improvements in processing times. Improvements in the investigative processes are diminished if the adjudication processing times increase or do not reflect improvement. Vacancies or inadequate staffing with the Attorney Generals' Office and Office of Administrative Hearings significantly hamper the Board's efforts at improving the overall processing times of disciplinary cases. CBOT enforcement staff has taken on a more proactive approach in instructing and monitoring the prosecution aspect of cases to facilitate prompt attention to cases.

   (Specific Example: Accusation was filed Feb 2, 2011. DAG, Defense Attorney, & OAH could not coordinate a hearing until March 27, 2012. CBOT asked that another DAG be assigned from the SD office that could put on the case sooner. Ultimate outcome, hearing was re-scheduled to January 12, 2012). DCA Board efforts to improve disciplinary processing times will not be fully realized until a coordinated effort with all involved agencies can be accomplished.

3. **Expert Witness Program (Review of enforcement cases involving incompetence or negligence)**

   The CBOT lacks an established pool of qualified individuals to serve as Experts. The practice of Occupational Therapy is diverse and covers many areas of practice. The problem is exacerbated by a relatively small licensing population. The Board has a handful of individuals it relies upon for general practice and advanced practice areas (hand therapy, swallowing evaluation, assessment, and intervention, and physical agent modalities). However, the Board is hard-pressed to provide Experts in other practice

areas such as pediatrics, special-education, early intervention services, mental health, adult day health, and other community-based programs.

This lack of available Experts has the potential for causing a delay in the investigation, enforcement or prosecution of cases. The Board's Education and Outreach Committee is working on strategies for developing a pool of experts. For the time being, the Committee Members have advised staff that if a case warrants a particular skill for expert review they will take it upon themselves to use contacts within the profession to refer staff to an appropriate qualified individual.

4. **Incomplete and Updated Procedure Manuals**

While the CBOT staff can reference procedures for major functions of Board business, the procedures would benefit from updating and re-organization. It is the intent and priority of Board management to complete comprehensive and complete manuals regarding Board functions but routine/daily business has hindered this goal. Completion/updating of the manuals will be a priority of the Board during Spring 2012.

ITEM TO BE PROVIDED

LEGISLATIVE
COUNSEL
BUREAU

October 27, 2011

Honorable Curren D. Price Jr.
Room 2053, State Capitol

HEALING ARTS BOARDS: ADOPTION OF UNIFORM STANDARDS - #1124437

Dear Senator Price:

You have asked two questions with regard to the adoption of uniform standards by the Substance Abuse Coordination Committee pursuant to Section 315 of the Business and Professions Code. You have asked whether the Substance Abuse Coordination Committee is required to adopt the uniform standards pursuant to the rulemaking procedures under the Administrative Procedure Act (Ch. 3.5 (commencing with Sec. 11340), Pt. 1, Div. 3, Title 2, Gov. C.). You have also asked, if the uniform standards are properly adopted by the Substance Abuse Coordination Committee, whether the healing arts boards are required to implement them.

By way of background, Section 315 of the Business and Professions Code[1] provides as follows:

> "315. (a) For the purpose of determining uniform standards that will be used by healing arts boards in dealing with substance-abusing licensees, there is established in the Department of Consumer Affairs the Substance Abuse Coordination Committee. The committee shall be comprised of the executive officers of the department's healing arts boards established pursuant to Division 2 (commencing with Section 500), the State Board of Chiropractic Examiners, the Osteopathic Medical Board of California, and a designee of the State Department of Alcohol and Drug Programs. The Director of Consumer Affairs shall chair the committee and may invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee.

[1] All further section references are to the Business and Professions Code, unless otherwise referenced.

"(b) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Division 3 of Title 2 of the Government Code).

"(c) By January 1, 2010, the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program:

"(1) Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

"(2) Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in paragraph (1) and any treatment recommended by the evaluator described in paragraph (1) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

"(3) Specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status and condition.

"(4) Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomness, method of notice to the licensee, number of hours between the provision of notice and the test standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

"(5) Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

"(6) Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

"(7) Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

"(8) Procedures to be followed when a licensee tests positive for a banned substance.

"(9) Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

"(10) Specific consequences for major violations and minor violations. In particular, the committee shall consider the use of a deferred prosecution stipulation similar to the stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency unless or until the licensee commits a major violation, in which case it is revived and the license is surrendered.

"(11) Criteria that a licensee must meet in order to petition for return to practice on a full-time basis.

"(12) Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

"(13) If a board uses a private-sector vendor that provides diversion services, standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation; standards for the vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and standards for a licensee's termination from the program and referral to enforcement.

"(14) If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

"(15) If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor' performance in adhering to the standards adopted by the committee.

"(16) Measurable criteria and standards to determine whether each board' method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term." (Emphasis added.)

Thus, the Legislature has established in the Department of Consumer Affairs (hereafter department) the Substance Abuse Coordination Committee (subd. (a), Sec. 315; hereafter committee). The committee is comprised of the executive officers of each healing arts board within the department,[2] the State Board of Chiropractic Examiners, and the

[2] The department's healing arts boards are those boards established under Division 2 (commencing with Section 500) to license and regulate practitioners of the healing arts. Those boards include, among others, the Dental Board of California, the Medical Board of California, the Veterinary Medical Board, and the Board of Registered Nursing.

Osteopathic Medical Board of California (hereafter, collectively, healing arts boards), and a designee of the State Department of Alcohol and Drug Programs (Ibid.). The Director of Consumer Affairs chairs the committee and is authorized to invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee (Ibid.).

The committee is required to formulate uniform and specific standards in each of 16 areas provided by the Legislature, but otherwise has discretion to adopt the uniform standards each healing arts board shall use in dealing with substance-abusing licensees (subd. (c), Sec. 315). The committee adopted its initial set of uniform standards in April 2010, and revised those initial standards as recently as April 2011.[1] Although the committee has adopted the uniform standards pursuant to its own procedures, it has yet to adopt those standards pursuant to the rulemaking procedures of the Administrative Procedure Act (Ch. 3.5 (commencing with Sec. 11340), Pt. 1, Div. 3, Title 2, Gov. C.; hereafter APA).

You have asked whether the committee is required to adopt the uniform standards pursuant to the rulemaking procedures of the APA.

The APA establishes basic minimum procedural requirements for the adoption, amendment, or repeal of administrative regulations by state agencies (subd. (a), Sec. 11346, Gov. C.). The APA is applicable to the exercise of any quasi-legislative power conferred by any statute (Ibid.). Quasi-legislative powers consist of the authority to make rules and regulations having the force and effect of law (*California Advocates for Nursing Home Reform v. Bonta* (2003) 106 Cal.App.4th 498, 517; hereafter *California Advocates*). The APA may not be superseded or modified by any subsequent legislation except to the extent that the legislation does so expressly (subd. (a), Sec. 11346, Gov. C.).

The term "regulation" is defined for purposes of the APA to mean "every rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure" (Sec. 11342.600, Gov. C.; emphasis added). The APA provides that a state agency shall not issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation under the APA, unless properly adopted under the procedures set forth in the APA, and the Office of Administrative Law is empowered to determine whether any such guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule is a regulation under the APA (Sec. 11340.5, Gov. C.).

In *Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 571 (hereafter *Tidewater*), the California Supreme Court found as follows:

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[1] See http://www.dca.ca.gov/about_dca/sacc/index.shtml (as of September 20, 2011).

> "A regulation subject to the APA thus has two principal identifying characteristics. (See *Union of American Physicians & Dentists v. Kizer* (1990) 223 Cal.App.3d 490, 497 [272 Cal.Rptr. 886] [describing two-part test of the Office of Administrative Law].) First, the agency must intend its rule to apply generally, rather than in a specific case. The rule need not, however, apply universally: a rule applies generally so long as it declares how a certain class of cases will be decided. (*Roth v. Department of Veterans Affairs* (1980) 110 Cal.App.3d 622, 630 [167 Cal.Rptr. 552].) Second, the rule must 'implement, interpret, or make specific the law enforced or administered by [the agency], or ... govern [the agency's] procedure.' (Gov. Code, § 11342, subd. (g).)"

If a policy or procedure falls within the definition of a "regulation" within the meaning of the APA, the adopting agency must comply with the procedures for formalizing the regulation, which include public notice and approval by the Office of Administrative Law (*County of Butte v. Emergency Medical Services Authority* (2010) 187 Cal.App.4th 1175, 1200). The Office of Administrative Law is required to review all regulations adopted pursuant to the APA and to make its determinations according to specified standards that include, among other things, assessing the necessity for the regulation and the regulation's consistency with the agency's statutory obligation to implement a statute (subd. (a), Sec. 11349.1, Gov. C.).

Applying these principles to the question presented, the uniform standards are subject to the rulemaking procedures of the APA if the following criteria are met: (1) Section 315 does not expressly preclude application of the APA, (2) the committee is a state agency under the APA, (3) the uniform standards are regulations subject to the APA, and (4) no exemption applies under the APA.

With respect to the first criterion, Section 315 is silent on the application of the APA. Thus, Section 315 does not expressly preclude application of the APA, and the APA will apply to any regulation adopted under Section 315.

We turn next to the second criterion, and whether the committee is an "agency" for purposes of the APA. The word "agency" is defined, for purposes of the APA, by several separate provisions of law. For purposes of the rulemaking procedures of the APA, "agency" is defined to mean a state agency (Sec. 11342.520, Gov. C.). That reference to state agency is defined elsewhere in the Government Code to include every state office, officer, department, division, bureau, board, and commission (subd. (a), Sec. 11000, Gov. C.). The APA does not apply to an agency in the judicial or legislative branch of the state government (subd. (a), Sec. 11340.9, Gov. C.).

Along those lines, the APA is applicable to the exercise of any quasi-legislative power conferred by any statute (subd. (a), Sec. 11346, Gov. C.). Quasi-legislative powers consist of the authority to make rules and regulations having the force and effect of law (*California Advocates*, supra, at p. 517). Thus, for purposes of our analysis, we think that an "agency" means any state office, officer, department, division, bureau, board, or commission that exercises quasi-legislative powers.

Here, the committee is a state office comprised of executive officers of the healing arts boards and the Director of Consumer Affairs. Although the Legislature has set forth 16 areas in which the committee is required to adopt standards, the committee itself is required to exercise quasi-legislative powers and adopt uniform standards within those areas. Those standards shall have the force and effect of law, since the healing arts boards, as discussed more extensively below, are required to use the standards in dealing with substance-abusing licensees and the standards are required to govern matters such as when a licensee is temporarily removed from practice or subject to drug testing or work monitoring (paras. (2), (4), and (7), subd. (c), Sec. 315). Accordingly, we think the committee is an agency to which the APA applies.

As to the third criterion, two elements must be met for the uniform standards at issue to be a regulation: they must apply generally and they must implement, interpret, or make specific a law enforced or administered by the agency or that governs its procedures (*Tidewater*, supra, at p. 571; Sec. 11342.600, Gov. C.). Section 315 requires the committee to formulate uniform and specific standards in specified areas that each healing arts board within the department shall use when dealing with substance-abusing licensees, whether or not the board chooses to have a formal diversion program. The uniform standards will not be limited in application to particular instances or individuals but, instead, will apply generally to those licensees. Further, under this statutory scheme, the uniform standards will implement Section 315 and will be enforced and administered by, and will govern the procedures of, each healing arts board that is a member of the committee. Thus, the uniform standards are, in our view, a regulation under the APA.

Lastly, we turn to the fourth criterion, and whether the regulation is exempt from the APA. Certain policies and procedures are expressly exempted by statute from the requirement that they be adopted as regulations pursuant to the APA. In that regard, Section 11340.9 of the Government Code provides as follows:

> "11340.9. This chapter does not apply to any of the following:
>
> "(a) An agency in the judicial or legislative branch of the state government.
>
> "(b) A legal ruling of counsel issued by the Franchise Tax Board or State Board of Equalization.
>
> "(c) A form prescribed by a state agency or any instructions relating to the use of the form, but this provision is not a limitation on any requirement that a regulation be adopted pursuant to this chapter when one is needed to implement the law under which the form is issued.
>
> "(d) A regulation that relates only to the internal management of the state agency.
>
> "(e) A regulation that establishes criteria or guidelines to be used by the staff of an agency in performing an audit, investigation, examination, or inspection, settling a commercial dispute, negotiating a commercial

arrangement, or in the defense, prosecution, or settlement of a case, if disclosure of the criteria or guidelines would do any of the following:

"(1) Enable a law violator to avoid detection.

"(2) Facilitate disregard of requirements imposed by law.

"(3) Give clearly improper advantage to a person who is in an adverse position to the state.

"(f) A regulation that embodies the only legally tenable interpretation of a provision of law.

"(g) A regulation that establishes or fixes rates, prices, or tariffs.

"(h) A regulation that relates to the use of public works, including streets and highways, when the effect of the regulation is indicated to the public by means of signs or signals or when the regulation determines uniform standards and specifications for official traffic control devices pursuant to Section 21400 of the Vehicle Code.

"(i) A regulation that is directed to a specifically named person or to a group of persons and does not apply generally throughout the state."

None of the exemptions contained in the APA can be reasonably construed to apply to the committee or the uniform standards to be used by the healing arts boards. In addition, we are aware of no other applicable exemption.

Thus, because all four of the criteria are met, it is our opinion that the Substance Abuse Coordination Committee is required to adopt the uniform standards pursuant to the rulemaking procedures under the Administrative Procedure Act (Ch. 3.5 (commencing with Sec. 11340), Pt. 1, Div. 3, Title 2, Gov. C.).

Having reached this conclusion, we next turn to whether the healing arts boards are required to use the uniform standards if those standards are properly adopted. In addressing that question, we apply certain established rules of statutory construction. To ascertain the meaning of a statute, we begin with the language in which the statute is framed (*Leroy T. v. Workmen's Comp. Appeals Bd.* (1974) 12 Cal.3d 434, 438; *Visalia School Dist. v. Workers' Comp. Appeals Bd.* (1995) 40 Cal.App.4th 1211, 1220). Significance should be given to every word, and construction making some words surplusage is to be avoided (*Lambert Steel Co. v. Heller Financial, Inc.* (1993) 16 Cal.App.4th 1034, 1040). In addition, effect should be given to statutes according to the usual, ordinary import of the language employed in framing them (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 388).

As set forth above, subdivision (c) of Section 315 provides that "the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program" (emphasis added). Section 19 provides that "shall" is mandatory and "may" is permissive. The word "may" is ordinarily construed as permissive, whereas the word "shall" is ordinarily construed as mandatory (*Common Cause v. Board of Supervisors* (1989) 49 Cal.3d 432, 443).

Here, in Section 315, the Legislature uses the term "shall" rather than "may" in providing that each healing arts board "shall use" the specific and uniform standards adopted by the committee when dealing with substance-abusing licensees. The Legislature uses the term "shall use" as compared to "shall consider," "may consider," or "may use." The Legislature's use of the term "shall" indicates that the healing arts boards are required to use the standards adopted by the committee rather than being provided the discretion to do so. Moreover, as employed in this context, the word "use" implies that the healing arts boards must implement and apply those standards rather than merely considering them. Finally, the use of the term "uniform" suggests that the Legislature intended each board to apply the same standards. If the healing arts boards were not required to use the standards as adopted by the committee, the standards employed by these boards would vary rather than being "uniform."

Notwithstanding the plain meaning of Section 315, one could argue that the enactment of Section 315.4 indicates that the Legislature intended that implementation of the uniform standards by the boards be discretionary. Section 315.4, which was added by Senate Bill No. 1172 of the 2009-10 Regular Session (Ch. 517, Stats. 2010; hereafter S.B. 1172), provides that a healing arts board "may adopt regulations authorizing the board to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation pursuant to the uniform and specific standards adopted and authorized under Section 315." Section 315.4 could be read to imply that a healing arts board is not required to implement those uniform standards because the board was given discretion to adopt the regulations that would allow that board to implement the standards, if necessary.

It is a maxim of statutory construction that a statute is to be construed so as to harmonize its various parts within the legislative purpose of the statute as a whole (*Wells v. Marina City Properties, Inc.* (1981) 29 Cal.3d 781, 788). As discussed above, we believe that the plain meaning of Section 315 requires the healing arts boards to implement the uniform standards adopted by the committee. Thus, whether Section 315.4 indicates, to the contrary, that the Legislature intended the boards to have discretion in that regard depends upon whether there is a rational basis for harmonizing the two statutes.

In harmonizing Sections 315 and 315.4, we note that S.B. 1172 did not make any changes to Section 315, such as changing the term "shall" to "may" in subdivision (c) of Section 315 or deleting any subdivisions of Section 315. S.B. 1172 did not diminish the scope of the authority provided to the committee to adopt the uniform standards. In fact, the analysis of the Senate Committee on Business, Professions and Economic Development for S.B. 1172, dated April 19, 2010 (hereafter committee analysis), describes the purpose of S.B. 1172 and the enactment of Section 315.4, as follows:

> "The Author points out that pursuant to SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008), the DCA was required to adopt uniform guidelines on sixteen specific standards that would apply to substance abusing health care licensees, regardless of whether a board has a diversion program. Although most of the adopted guidelines do not need additional statutes for

> implementation, there are a couple of changes that must be statutorily adopted to fully implement these standards. This bill seeks to provide the statutory authority to allow boards to order a licensee to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program, if a major violation is committed and while undergoing clinical diagnostic evaluation." (Committee analysis, at p. 4.)

The committee analysis further provides that the purpose of S.B. 1172 was to grant specific authority to implement those standards and "provide for the full implementation of the Uniform Standards" (committee analysis, at p. 11). The committee analysis at no time implies that the Legislature intended the Section 315 uniform standards to be revised or repealed by S.B. 1172 or that, in enacting Section 315.4, the Legislature intended that the implementation of the uniform standards be subject to the discretion of each healing arts board.

Thus, in our view, Section 315.4 may be reasonably construed in a manner that harmonizes it with Section 315. Specifically, we think that the intent of the Legislature in enacting Section 315.4 was not to make the uniform standards discretionary but to "provide for the full implementation of the Uniform Standards" by providing the authority to adopt regulations where the Legislature believed that further statutory authority was needed. Accordingly, we think implementation by the various healing arts boards of the uniform standards adopted under Section 315 is mandatory.[4]

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[4] Although Section 108 and Division 2 (commencing with Section 500) authorize the healing arts boards to set standards and adopt regulations (see, for example, Secs. 1224, 1614, 2018, 2531.95, 2615, 2715, 2854, 2930, 3025, 3510, and 3546), it is an axiom of statutory construction that a particular or specific provision takes precedence over a conflicting general provision (Sec. 1859, C.C.P.; *Agricultural Labor Relations Bd. v. Superior Court* (1976) 16 Cal.3d 392, 420, app. dism. *Kubo v. Agricultural Relations Bd.* (1976) 429 U.S. 802; see also Sec. 3534, Civ. C.). Thus, in our view, the specific requirement under Section 315 that the uniform standards be adopted supersedes any general provision authorizing the boards to set standards and adopt regulations.

Thus, it is our opinion that, if the uniform standards are properly adopted by the Substance Abuse Coordination Committee, the healing arts boards are required to implement them.

Very truly yours,

Diane F. Boyer-Vine
Legislative Counsel

By
Lisa M. Plummer
Deputy Legislative Counsel

LMP:syl

BUDGET INFORMATION.

The following are attached for review:

- Fiscal Month (FM) 3 Budget Report
- Fiscal Year (FY) 2011-12 and 2012-13 Revenue projections
- Fund Condition

DEPARTMENT OF CONSUMER AFFAIRS

CA BD OF OCCUPATIONAL THERAPY

BUDGET REPORT

AS OF 9/30/2011

RUN DATE 10/12/2011

PAGE 1

FM 03

Have not received final Budget yet.

CA BD OF OCCUPATIONAL THERAPY

These #'s are estimates

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PERSONAL SERVICES								
SALARIES AND WAGES								
003 00	CIVIL SERVICE-PERM	0	22,846	68,538	0	68,538	(68,538)	
033 04	TEMP HELP (907)	0	4,845	13,101	0	13,101	(13,101)	
063 00	STATUTORY-EXEMPT	0	5,868	17,603	0	17,603	(17,603)	
TOTAL	SALARIES AND WAGES 552,354	0	33,559	99,242	0	99,242	(99,242)	0.00%
STAFF BENEFITS								
103 00	OASDI	0	1,921	5,763	0	5,763	(5,763)	
104 00	DENTAL INSURANCE	0	170	511	0	511	(511)	
105 00	HEALTH/WELFARE INS	0	2,709	8,128	0	8,128	(8,128)	
106 01	RETIREMENT	0	5,267	15,800	0	15,800	(15,800)	
125 15	SCIF ALLOCATION COST	0	343	776	0	776	(776)	
134 00	OTHER-STAFF BENEFITS	0	2,245	6,715	0	6,715	(6,715)	
135 00	LIFE INSURANCE	0	13	38	0	38	(38)	
136 00	VISION CARE	0	52	156	0	156	(156)	
137 00	MEDICARE TAXATION	0	477	1,411	0	1,411	(1,411)	
TOTAL	STAFF BENEFITS 253,704	0	13,198	39,299	0	39,299	(39,299)	0.00%
TOTAL	**PERSONAL SERVICES** 806,058	0	46,757	138,541	0	138,541	(138,541)	0.00%
OPERATING EXPENSES & EQUIPMENT								
FINGERPRINTS								
213 04	FINGERPRINT REPORTS	0	1,275	2,907	0	2,907	(2,907)	
TOTAL	FINGERPRINTS	0	1,275	2,907	0	2,907	(2,907)	0.00%
GENERAL EXPENSE								
207 00	FREIGHT & DRAYAGE	0	96	96	0	96	(96)	
TOTAL	GENERAL EXPENSE	0	96	96	0	96	(96)	0.00%
PRINTING								
244 00	OFFICE COPIER EXP	0	0	0	2,214	2,214	(2,214)	
TOTAL	PRINTING	0	0	0	2,214	2,214	(2,214)	0.00%
COMMUNICATIONS								
252 00	CELL PHONES,PDA,PAGE	0	19	79	0	79	(79)	
257 01	TELEPHONE EXCHANGE	0	0	3	0	3	(3)	
TOTAL	COMMUNICATIONS	0	19	82	0	82	(82)	0.00%

CA BD OF OCCUPATIONAL THERAPY

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
POSTAGE								
263 05	ALLOCATED POSTAGE-DC	0	650	2,323	0	2,323	(2,323)	
263 06	ALLOCATED POSTAGE-ED	0	1,245	1,582	0	1,582	(1,582)	
TOTAL POSTAGE		0	1,895	3,905	0	3,905	(3,905)	0.00%
TRAVEL: IN-STATE								
292 00	PER DIEM-I/S	0	0	308	0	308	(308)	
294 00	COMMERCIAL AIR-I/S	0	306	1,011	0	1,011	(1,011)	
296 00	PRIVATE CAR-I/S	0	0	189	0	189	(189)	
297 00	RENTAL CAR-I/S	0	0	59	0	59	(59)	
TOTAL TRAVEL: IN-STATE		0	306	1,567	0	1,567	(1,567)	0.00%
TRAINING								
332 00	TUITN/REGISTRATN FEE	0	90	90	0	90	(90)	
TOTAL TRAINING		251,914 0	90	90	0	90	(90)	0.00%
FACILITIES OPERATIONS								
343 00	RENT-BLDG/GRND(NON S	0	4,384	13,151	39,453	52,604	(52,604)	
347 00	FACILITY PLNG-DGS	0	82	164	0	164	(164)	
TOTAL FACILITIES OPERATIONS		0	4,466	13,315	39,453	52,768	(52,768)	0.00%
CENTRAL ADMINISTRATIVE SERVICES								
438 00	PRO RATA	0	0	18,089	0	18,089	(18,089)	
TOTAL CENTRAL ADMINISTRATIVE SERVICES		0	0	18,089	0	18,089	(18,089)	0.00%
EXAMINATIONS								
404 03	C/P SVS - EXT SUB MA	~~0~~ 0	619	675	0	675	(675)	
TOTAL EXAMINATIONS		0	619	675	0	675	(675)	0.00%
ENFORCEMENT								
396 00	ATTORNEY GENL-INTERD	0	20,348	~~34,408~~ 67,588	0	34,408	(34,408)	
397 00	OFC ADMIN HEARNG-INT	0	3,908	3,908	0	3,908	(3,908)	
414 31	EVIDENCE/WITNESS FEE	0	400	959	0	959	(959)	
418 97	COURT REPORTER SERVS	0	160	330	0	330	(330)	
TOTAL ENFORCEMENT		169,073 0	24,816	39,604	0	39,604	(39,604)	0.00%
TOTAL OPERATING EXPENSES & EQUIPMEN		0	33,581	80,332	41,667	121,999	(121,999)	0.00%
CA BD OF OCCUPATIONAL THERAPY		0	80,337	218,873	41,667	260,540	(260,540)	0.00%

+ DCA Pro Rata

Est. Total Budget: 1,443,000

DEPAR Γ OF CONSUMER AFFAIRS
SCHEDULE OF WORKLOAD AND REVENUE STATISTICS

BOARD/FUND: BOARD OF OCCUPATIONAL THERAPY (3017)

LICENSE CATEGORY: SUMMARY

Account Number	Revenue Category	Actual workload				Est. Workload		Fees		Est. Revenue	
		07-08	08-09	09-10	10-11	11-12	12-13	11-12	12-13	11-12	12-13
125600	Other Regulatory Fees	117	137	127	418	151	166	$15.00	$15.00	$34,400	$42,625
125700	Licenses and Permits	975	940	633	895	500	935	varies	varies	$127,500	$131,250
125800	Renewal Fees	6,519	5,315	5,166	5,180	5,100	5,705	$150.00	$150.00	$755,675	$789,275
125900	Delinquent Renewal Fees	347	218	177	205	213	220	$75.00	$75.00	$15,900	$16,725
141200	Sales of Documents									$0	$0
142500	Miscellaneous Services to the Public									$6,750	$6,750
164300	Penalty Assessments									$12,000	$13,500
150300	Income from Surplus Money Investments	$135,000	$70,000	$10,000	$4,900	N/A	N/A	N/A	N/A	$4,500	$1,000
	Total Workload	142,958	76,610	16,103	11,598	5,964				$956,725	$1,001,125
	Total Revenue Collected	$1,013,120	#REF!	#REF!	$956,725	$1,001,125					
	Total Number of Licensees	10,266	12,666		13,426	14,232					

ENY: 11 FFY: 11
SECTION: 11 CA BD OF OCCUPATIONAL THERAPY
SUB-SECTION: 00
UNIT: 00
SUB-UNIT: 00
SUB-SUB-UNIT: 00
INDEX: 1475 CA BD OF OCCUPATIONAL THERAPY

Budget Doc's not finalized yet; all figures are ESTIMATES

PROGRAM
PG EL CMP TSK PCA DESCRIPTION

REF	SOURCE	ASRC	DESCRIPTION	PLANNED RECEIPTS	ACTUAL RECEIPTS CURRENT MONTH	ACTUAL RECEIPTS YEAR-TO-DATE	BALANCE
67 00 000 000 73017			REIMB - CA BD OF OCCUPATIONAL THERAPY				
001	991937	01	FINGERPRINT REPORTS	0.00	1,479.00	4,080.00	4,080.00-
001	991937	02	EXTERNAL/PRIVATE/GRANT	0.00	0.00	1,175.00	1,175.00-
*TOTAL SOURCE 991937				0.00	1,479.00	5,255.00	5,255.00-
*TOTAL PROG 67				0.00	1,479.00	5,255.00	5,255.00-
*TOTAL REFERENCE 001				0.00	1,479.00	5,255.00	5,255.00-
67 00 000 000 83017			REVENUE CA BD OF OCCUPATIONAL THERAPY				
980	125600	CU	OTA DUP LIC FEE-$15.00	0.00	240.00	600.00	600.00-
980	125600	CV	OTA DUP CERT FEES-$15.00	0.00	0.00	90.00	90.00-
980	125600	18	CITATION & FINE FEE COLLECTED-VAR	0.00	1,773.00	4,698.00	4,698.00-
*TOTAL SOURCE 125600				34,400 0.00	2,013.00	5,388.00	5,388.00-
980	125700	OC	OT INITIAL LIC FEE-$VAR	0.00	6,400.00	26,891.00	26,891.00-
980	125700	OD	OTA INITIAL CERT FEE-$VAR	0.00	2,019.00	5,271.00	5,271.00-
980	125700	OE	OT LIMITED PERMIT-$75.00	0.00	975.00	2,175.00	2,175.00-
980	125700	OJ	OTA LIMITED PERMIT $75.00	0.00	150.00	600.00	600.00-
980	125700	90	OVER/SHORT FEES	0.00	7.00	91.00	91.00-
980	125700	91	SUSPENDED REVENUE	0.00	0.00	225.00	225.00-
980	125700	92	PRIOR YEAR REVENUE ADJUSTMENT	0.00	0.00	287.00-	287.00
*TOTAL SOURCE 125700				127,500 0.00	9,551.00	34,966.00	34,966.00-
980	125800	BM	OT ANNUAL RENEWAL FEE- $150.00	0.00	0.00	150.00	150.00-
980	125800	BP	OT INACTIVE RENEWAL LIC FEE-$25.0	0.00	750.00	1,800.00	1,800.00-
980	125800	BQ	OTA INACTIVE RENEWAL CERT FEE-$25	0.00	125.00	375.00	375.00-
980	125800	C1	AUTOMATED REVENUE REFUND CLAIM	0.00	140.00-	323.00	323.00-
980	125800	2W	BIENNIAL RENEWAL-OT $150	0.00	102,725.00	253,800.00	253,800.00-
980	125800	2X	BIENNIAL RENEWAL-OTA $150	0.00	16,800.00	42,600.00	42,600.00-
980	125800	90	OVER/SHORT FEES	0.00	0.00	5.00	5.00-

DEPT OF CONSUMER AFFAIRS - REGULATORY BOARDS
RECEIPTS BY ORGANIZATION AND SOURCE
AS OF 09/30/11

ENY: 11 FFY: 11
SECTION: 11 CA BD OF OCCUPATIONAL THERAPY
SUB-SECTION: 00
UNIT: 00
SUB-UNIT: 00
SUB-SUB-UNIT: 00
INDEX: 1475 CA BD OF OCCUPATIONAL THERAPY

PROGRAM
PG EL CMP TSK PCA DESCRIPTION

REF	SOURCE	ASRC	DESCRIPTION	PLANNED RECEIPTS		ACTUAL RECEIPTS CURRENT MONTH	ACTUAL RECEIPTS YEAR-TO-DATE	BALANCE
*TOTAL SOURCE 125800				755,675	0.00	120,260.00	299,053.00	299,053.00-
980	125900	A4	OT DELINQ RENEWAL FEE-$75.00		0.00	0.00	75.00	75.00-
980	125900	TM	DELINQ BIENNIAL-OT $75		0.00	300.00	2,625.00	2,625.00-
980	125900	TN	DELINQ BIENNIAL-OTA $75		0.00	0.00	525.00	525.00-
*TOTAL SOURCE 125900				15,900	0.00	300.00	3,225.00	3,225.00-
980	142500	90	MISC. SER TO PUBLIC - GENERAL		0.00	705.00	2,220.00	2,220.00-
*TOTAL SOURCE 142500				6,750	0.00	705.00	2,220.00	2,220.00-
980	161000	02	REVENUE CANCELLED WARRANTS		0.00	37.00	337.00	337.00-
*TOTAL SOURCE 161000					0.00	37.00	337.00	337.00-
980	161400	91	DISHONORED CHECK FEE-VAR		0.00	0.00	125.00	125.00-
*TOTAL SOURCE 161400					0.00	0.00	125.00	125.00-
980	164300	99	PENALTY ASSESSMENTS	12,000	0.00	796.11	3,047.81	3,047.81-
*TOTAL SOURCE 164300					0.00	796.11	3,047.81	3,047.81-
*TOTAL PROG 67					0.00	133,662.11	348,361.81	348,361.81-
*TOTAL REFERENCE 980					0.00	133,662.11	348,361.81	348,361.81-
*TOTAL INDEX 1475				est. interest 4,506	0.00	135,141.11	353,616.81	353,616.81-
*TOTAL SEC 11					0.00	135,141.11	353,616.81	353,616.81-

956,725

3017 - Board of Occupational Therapy
Analysis of Fund Condition

Prepared 11/15/2011

(Dollars in Thousands)

FY 2010-11 Month 13 Actuals	Actual 2010-11	CY 2011-12	Governor's Budget BY 2012-13	BY+1 2013-14	BY+2 2014-15
BEGINNING BALANCE	$ 1,029	$ 893	$ 1,032	$ 705	$ 333
Prior Year Adjustment	$ -1	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 1,028	$ 893	$ 1,032	$ 705	$ 333
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	$ 42	$ 34	$ 42	$ 42	$ 42
125700 Other regulatory licenses and permits	$ 101	$ 128	$ 131	$ 131	$ 131
125800 Renewal fees	$ 790	$ 756	$ 789	$ 789	$ 789
125900 Delinquent fees	$ 15	$ 16	$ 17	$ 17	$ 17
141200 Sales of documents	$ -	$ -	$ -	$ -	$ -
142500 Miscellaneous services to the public	$ 7	$ 7	$ 7	$ 7	$ 7
150300 Income from surplus money investments	$ 5	$ 4	$ 1	$ -	$ -
160400 Sale of fixed assets	$ -	$ -	$ -	$ -	$ -
161000 Escheat of unclaimed checks and warrants	$ 1	$ 1	$ 1	$ 1	$ 1
161400 Miscellaneous revenues	$ -	$ -	$ -	$ -	$ -
164300 Penalty Assessments	$ 12	$ 12	$ 14	$ 14	$ 14
Totals, Revenues	$ 973	$ 958	$ 1,002	$ 1,001	$ 1,001
Transfers from Other Funds					
F00001 GF loan per item 1475-011-3017 BA of 2003 (repay)	$ -	$ 640	$ -	$ -	$ -
F00002 GF loan per BA of 2009 (repay)	$ -	$ -	$ -	$ -	$ -
Transfers to Other Funds					
T00001 GF loan per 1475-011-3017 BA of 2003	$ -	$ -	$ -	$ -	$ -
T00002 GF loan per BA of 2009	$ -	$ -	$ -	$ -	$ -
T00001 GF loan repayment per Ch 697/00					
Totals, Revenues and Transfers	$ 973	$ 1,598	$ 1,002	$ 1,001	$ 1,001
Totals, Resources	$ 2,001	$ 2,491	$ 2,034	$ 1,706	$ 1,334
EXPENDITURES					
Disbursements:					
8880 FSCU (State Operations)	$ -	$ -	$ -	$ -	$ -
0840 SCO (State Operations)	$ -	$ -	$ -	$ -	$ -
1110 Program Expenditures (State Operations)	$ 1,108	$ 1,438	$ 1,289	$ 1,315	$ 1,341
BreEZe SPR Funding	$ -	$ 21	$ 33	$ 45	$ 40
Credit Card BCP (BreEZe)	$ -	$ -	$ 7	$ 13	$ 13
	$ 1,108	$ 1,459	$ 1,329	$ 1,373	$ 1,394
FUND BALANCE					
Reserve for economic uncertainties	$ 893	$ 1,032	$ 705	$ 333	$ -60
Months in Reserve	7.3	9.3	6.2	2.9	-0.5

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2009-10 AND ON-GOING.

B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR.

STRATEGIC PLAN

The following are attached for review:

- Plain text version of Strategic Plan adopted at 9/2011 meeting.
- Strategic Plan (same) to be published - w/graphics

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY

STRATEGIC PLAN 2011 - 2014

INTRODUCTION

The California Board of Occupational Therapy (Board), established on January 1, 2001 (Senate Bill 1046, Chapter 697, Statutes of 2000), protects the health, safety, and welfare of California consumers by regulating the practice of occupational therapists and occupational therapy assistants. Board members meet four – six times annually to set policy, develop legislation and regulations that identify education, experience and examination requirements for licensure and establish and enforce professional standards of practice.

VISION

The California Board of Occupational Therapy is a model organization for occupational therapy state regulatory boards, ensuring consumer protection and quality occupational therapy.

MISSION

The mission of the California Board of Occupational Therapy is to regulate occupational therapy by serving and protecting California's consumers and licensees.

CORE VALUES

The California Board of Occupational Therapy will strive for the highest possible quality throughout all of its programs making it a progressive and responsive organization by:

A. Providing excellent customer service to consumers, licensees, employers and other stakeholders;
B. Promoting, applying, and enforcing ethical standards of occupational therapy;
C. Implementing fair and consistent application of the laws and regulations governing occupational therapy;
D. Recognizing and supporting the diverse practice settings and roles in occupational therapy;
E. Encouraging active participation by stakeholders through access to the Board;
F. Ensuring a high level of professionalism, efficiency, and effectiveness by the Board members and staff.

STRATEGIC GOALS

The following strategic goals were identified:

Goal 1: Enforce the laws and regulations governing occupational therapy by effectively investigating complaints, non-compliance, and irregularities, and concluding with an appropriate response.

Goal 2: Ensure those seeking licensure meet professional standards of conduct, education, fieldwork, and examination.

Goal 3: Monitor evolving trends and standards in occupational therapy, modify statutes and regulations as needed and promptly inform licensees of these changes, secure necessary funding and ensure responsive staff processes.

Goal 4: Inform the public and other entities about occupational therapy requirements, evidence-based practices, standards and trends through accessible "green" communication methods.

STRATEGIC GOALS AND OBJECTIVES

Goal 1: Enforce the laws and regulations governing occupational therapy by effectively investigating complaints, non-compliance, irregularities, and conclude with an appropriate response.

1.1 Fully audit no less than 5% of renewing licensees, to determine if continuing competency requirements are met.
1.2 Establish and maintain a pool of 20 Practice Reviewers to review enforcement cases.
1.3 Target 90% of complaints investigated by Board staff to be completed in 90 days or less.
1.4 Ensure the enforcement program is sufficiently funded and staffed to ensure consumer protection with prompt actions.
1.5 Promptly post disciplinary process on Board's website.

Goal 2: Ensure those seeking licensure meet professional standards of conduct, education, fieldwork, and examination.

2.1 Research the implications of revised (2008) Accreditation Council for Occupational Therapy Education (ACOTE) standards and determine relevance to and impact on Advanced Practice requirements by 2013.
2.2 Investigate the value and cost of developing a jurisprudence examination on professional standards of conduct.

Goal 3: Monitor evolving trends and standards in occupational therapy, modify statutes and regulations as needed and promptly inform licensees of these changes, secure necessary funding, and ensure responsive staff processes.

3.1 Practice Committee will identify and track changes in areas of occupational therapy practice, education and research, and advise the Board.
3.2 The Legislative and Regulatory Review Committee will identify and track legislation and review regulations which affect occupational therapy practice and advise the Board.
3.3 Annually review continuing competency requirements relevant to identified best practices, standards and trends.
3.4 Send quarterly notifications to advise and update practitioners of laws and regulations.
3.4.a Educate practitioners of laws and regulations impacting occupational therapy scope of practice.
3.5 Through on-line licensure (BreEze), 80% of the license renewals and initial licensure applications will be completed via the Internet.
3.6 Provide at least two Board meetings annually and committee meetings when possible via electronic communication to increase accessibility to Board business.

Goal 4: Inform the public and other entities about occupational therapy requirements, evidence-based practices, standards and trends through accessible "green" communication methods.

4.1 Increase education and outreach efforts to consumers regarding laws and regulations affecting occupational therapy.

4.1.a. Develop and make available consumer-related informational brochures (i.e. 'What is OT?' and 'The Complaint Process.')

4.1.b. Participate in at least four community programs and public events annually to educate the public about occupational therapy, subject to travel restrictions and available funding.

4.2 Active collaboration with other health care professionals (i.e. physical therapists, speech-language pathologists and audiologists, nurses, physicians, social workers and other mental-health practitioners, etc.) to ensure that those professions and the public are informed about occupational therapy, and that the occupational therapy regulations and enforcement procedures are applicable, adequate and relevant.

4.3 Active collaboration with the Department of Health Care Services, the Department of Public Health, the Department of Mental Health, the Department of Aging, the Department of Social Services, the Department of Education, the Department of Veteran's Affairs, the Department of Corrections and Rehabilitation, the legislative bodies and other governmental entities, and ensure they are adequately informed about occupational therapy and that their respective laws and regulations are updated appropriately.

CALIFORNIA BOARD OF
OCCUPATIONAL THERAPY

Strategic Plan 2011–2014

NEW GRAPHIC TO BE ADDED HERE

Introduction

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PLAN
IDEA
STRATEGY
TACTICS
VISION

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STRATEGIC GOALS

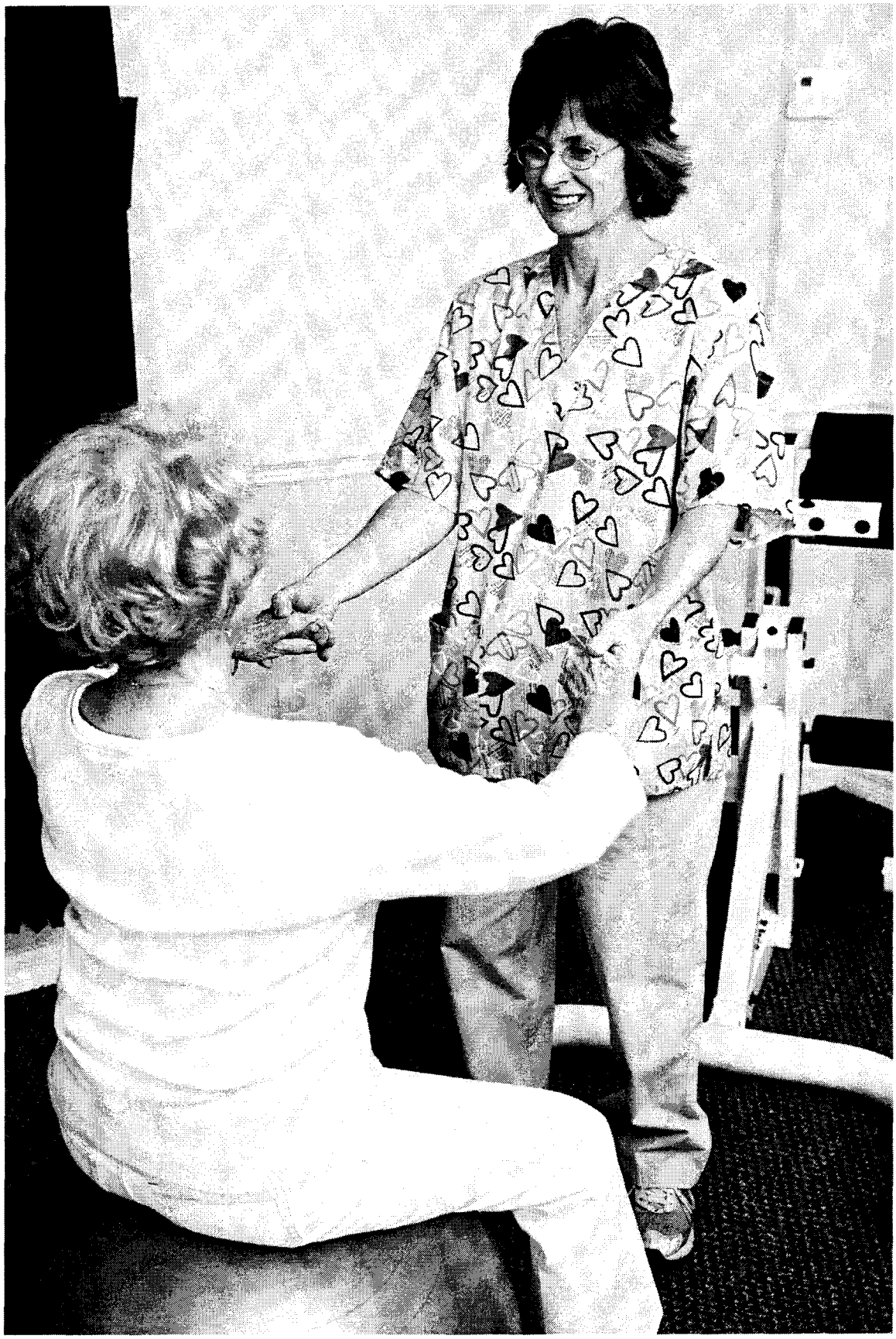
The following strategic goals were identified:

Goal 1:
enforce the laws and regulations governing occupational therapy by effectively investigating complaints, non-compliance, and irregularities, and concluding with an appropriate response.

Goal 2:
ensure those seeking licensure meet professional standards of conduct, education, fieldwork, and examination.

Goal 3:
monitor evolving trends and standards in occupational therapy, modify statutes and regulations as needed, and promptly inform licensees of these changes, secure necessary funding and ensure responsive staff processes.

Goal 4:
inform the public and other entities about occupational therapy requirements, evidence-based practices, standards and trends through accessible "green" communication methods.



Goal 1:

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Goal 2:

Ensure those seeking licensure meet professional standards of conduct, education, fieldwork, and examination.

2.1 Research the implications of revised (2008) accreditation council for occupational therapy education (acote) standards and determine relevance to and impact on advanced practice requirements by 2013.

2.2 Investigate the value and cost of developing a jurisprudence examination on professional standards of conduct.

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3.4 Send quarterly notifications to advise and update practitioners of laws and regulations.

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Goal 4:

Inform the public and other entities about occupational therapy requirements, evidence-based practices, standards and trends through accessible "green" communication methods.

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4.1.a. Develop and make available consumer-related informational brochures (i.e. 'what is ot?' And 'the complaint process.')

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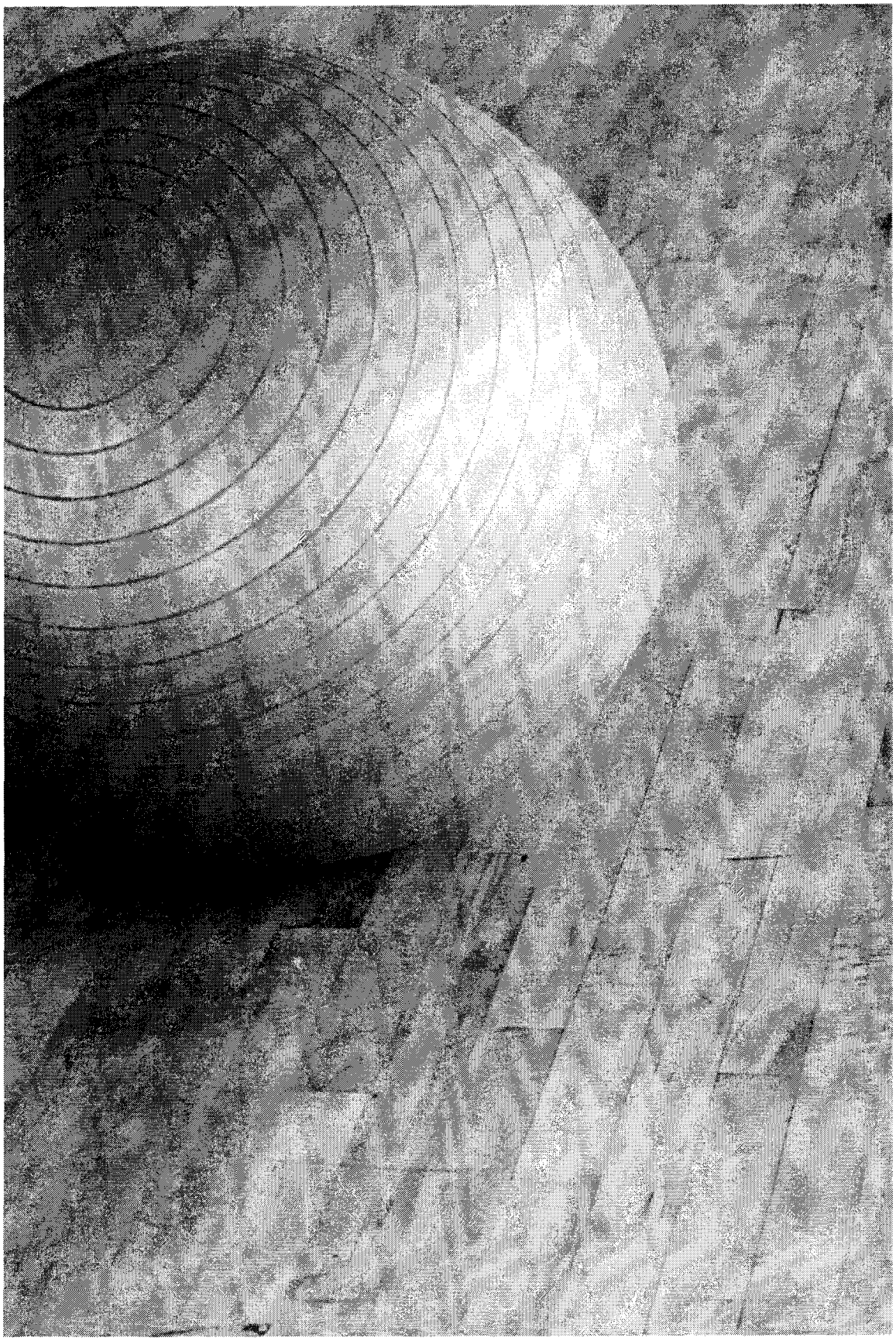
4.2 Active collaboration with other health care professionals (i.e. physical therapists, speech-language pathologists and audiologists, nurses, physicians, social workers and other mental-health practitioners, etc.) to ensure that those professions and the public are informed about occupational therapy, and that the occupational therapy regulations and enforcement procedures are applicable, adequate and relevant.

4.3 Active collaboration with the department of health care services, the department of public health, the department of mental health, the department of aging, the department of social services, the department of education, the department of veteran's affairs, the department of corrections and rehabilitation, the legislative bodies and other governmental entities, and ensure they are adequately informed about occupational therapy and that their respective laws and regulations are updated appropriately.



CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
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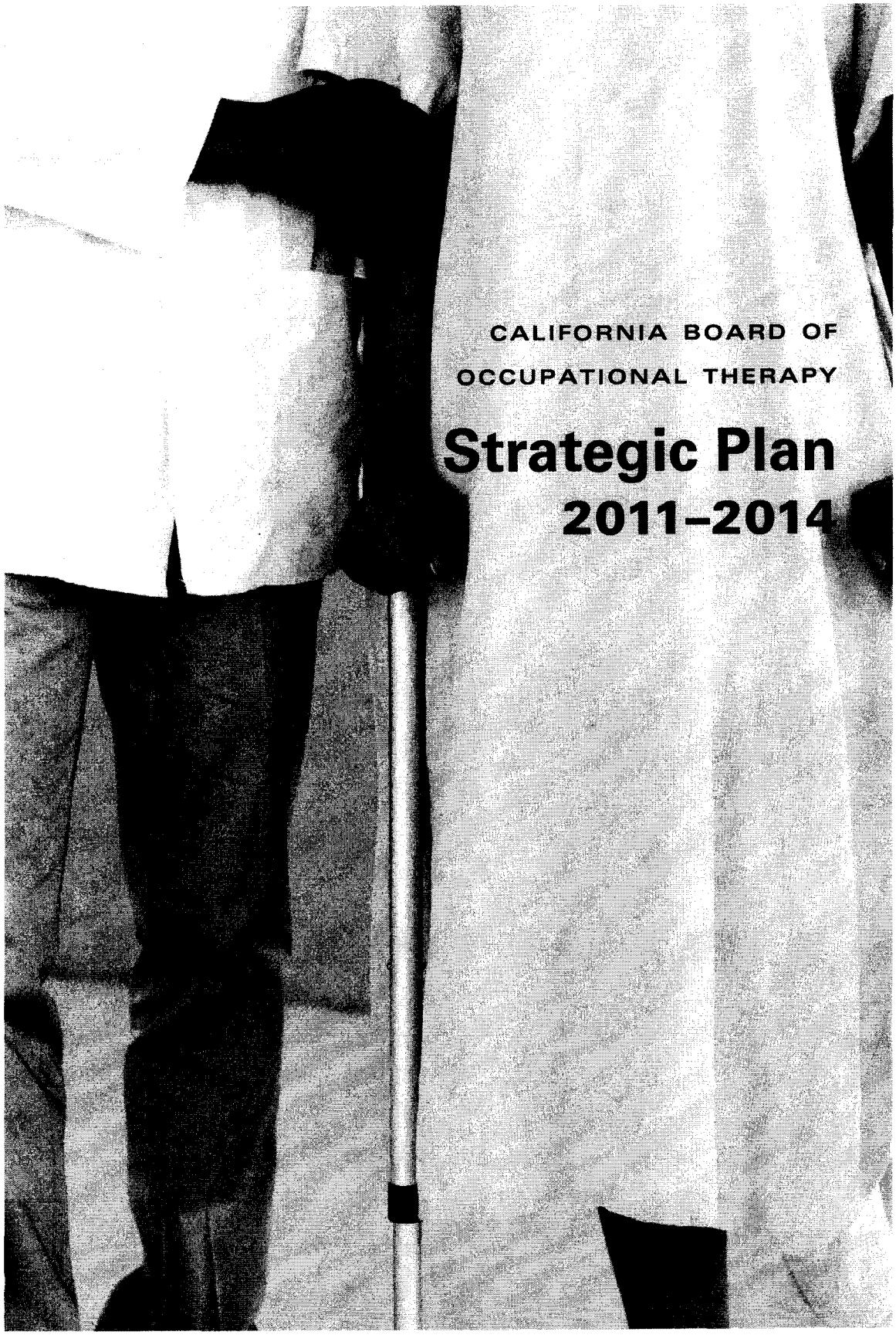
CALIFORNIA BOARD OF
OCCUPATIONAL THERAPY

Strategic Plan 2011–2014



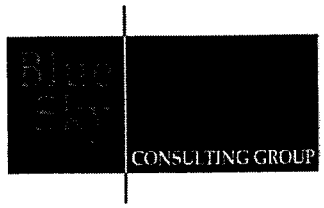
CALIFORNIA BOARD OF
OCCUPATIONAL THERAPY

Strategic Plan
2011–2014

OTHER INFORMATIONAL ITEMS.

The following are attached for review:

- Report entitled "*Fiscal Impact of AF 415: Potential Cost Savings from Expansion of Telehealth.*"
- CMS Telehealth Credentialing Rule
- Report entitled "*Credentialing Under Medicare and Accreditation Porgrams: Implications for Telehealth Practitioners.*"



Fiscal Impact of AB 415: Potential Cost Savings from Expansion of Telehealth

Prepared for

Center for Connected Health Policy

Prepared by

Matthew Newman
Trisha McMahon
The Blue Sky Consulting Group

September 30, 2011

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Executive Summary

The use of information and communication technologies to deliver health care remotely, referred to as telehealth, has been reimbursable under California law since 1996. However, telehealth technologies and applications have advanced over the last decade and a half, leaving the current reimbursement laws outdated. In fact, the law now often serves as a hindrance to further adoption of telehealth. As such, Assembly Bill 415 (AB 415) has been introduced in the California Legislature to modernize reimbursement law, and to help clear the path for the increased use of telehealth in California.

The purpose of this report is to analyze the fiscal impact of AB 415 on the State of California, primarily focusing on the Medi-Cal program. In addition, we describe the fiscal effects that expanded use of telehealth (as envisioned by AB 415) could bring to other health services payers in California. Given this focus, the report does not address what are some of the primary benefits of telehealth, such as improved patient satisfaction, reduced patient travel times and costs, and other patient benefits. It does, however, draw upon the academic literature to qualitatively summarize how California could experience cost savings through less costly interventions, better care, and increased access to timely, cost-saving interventions.

This study also attempts to provide a quantitative estimate of the cost savings that California could experience, to the extent that telehealth is adopted more broadly, consistent with the goals of AB 415. Given that the majority of the research on telehealth has sought to establish its clinical effectiveness, and not its cost-effectiveness, as well as the fact that telehealth technology and practice are evolving rapidly, there is not a way to estimate conclusively the fiscal impact on a health care system that has completely integrated telehealth. However, we utilize current published research to identify areas where telehealth has the potential to save money, and then model the potential savings for the State of California should telehealth be more fully adopted in these areas.

AB 415 does not specify which areas of telehealth should be promoted (nor does it require adoption in any particular area); however, we believe the health care marketplace will encourage development of telehealth primarily in areas where cost advantages can be demonstrated. Thus, we have estimated the potential savings from telehealth in areas that have current demonstrated cost savings based on published studies; other areas are likely to show cost savings as they are more thoroughly investigated, and the technology and practice advance.

According to our analysis of the existing published telehealth literature, home monitoring for chronic diseases is one of the areas where telehealth has the greatest potential to reduce health care costs. By applying the findings from several published studies of the impact of telehealth for home monitoring of patients with heart failure and diabetes, we estimate that telehealth has the potential to produce savings to the Medi-Cal program of as much as several hundred million dollars annually. These estimates cover just one area of potential telehealth expansion. Additional savings are possible from other areas of telehealth, such as reduced need for costly

medical transports or more timely access to specialists. Therefore, while evidence for the cost-effectiveness of telehealth continues to emerge, existing studies do point to the potential for telehealth to produce savings.

Introduction: What is Telehealth?

Telehealth is a mode of delivering health care services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health providers.[1] Telehealth can be delivered synchronously via videoconferencing technologies – where patients and providers interact with each other simultaneously – and asynchronously via store and forward technologies – when information such as X-rays or photographs are collected and transmitted, to be analyzed at a later time. Applications of telehealth are diverse, ranging from home monitoring for chronic diseases to specialty consultations with rural clinic patients to time-sensitive assessments in an emergency room or intensive care unit (ICU). Telehealth can utilize a variety of technologies, including digital cameras, video cameras, structured online questionnaires, telephone call centers, measurement devices, and movement sensors. These technologies are often combined, and their costs can differ greatly. Thus, while many speak of three specific types of telehealth – home monitoring, videoconferencing, and store and forward – in reality, telehealth can and does incorporate a variety of communication technologies that are continually advancing and becoming less costly.[2]

Although many telehealth projects and initiatives have been undertaken, barriers exist to widespread adoption and integration into routine health care. These include process issues, such as technology purchase, integration, training, and maintenance; legal issues, such as networking with practitioners with out-of-state licensure, confidentiality, and liability; and financial issues, due to restrictive and non-standardized reimbursement policies by public and private insurers.

Telehealth in California

Telehealth is already covered by public and private payers – to a degree – in California. A 1996 law set forth rules for telehealth reimbursement by both Medi-Cal and commercial payers. In addition, federal legislation has enabled Medicare to reimburse for certain telehealth activities. However, both the state and federal laws circumscribe the types of telehealth that can be reimbursed. Below, we examine how current law enables Medi-Cal, Medicare, and commercial payers to reimburse for telehealth.

Medi-Cal currently reimburses videoconferencing and some store and forward services for patients with a barrier to in-person care. Store and forward is limited to teleophthalmology, teledermatology, and teleoptometry. These services are only allowed to be used in physician or practitioner offices, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Clinics (FQHCs). Medi-Cal does not pay for consultation provided by telephone or email. Moreover, providers have additional paperwork to file if they utilize

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[1] Center for Connected Health Policy, "Advancing California's Leadership in Telehealth Policy: A Telehealth Model Statute and Other Policy Recommendations", February 2011.

[2] María E. Dávalos et al., "Economic Evaluation of Telemedicine: Review of the Literature and Research Guidelines for Benefit–Cost Analysis," *Telemedicine and e-Health* 15, no. 10 (December 2009): 933-948.

telemedicine: they must document the barrier to in-person care and obtain written proof of a patient's informed consent.

Medicare has similarly restrictive reimbursement policies. Medicare allows payment of videoconferencing for *rural* Medicare beneficiaries; these beneficiaries must seek care in a rural Health Professional Shortage Area or in a county outside of a Metropolitan Statistical Area. Relative to Medi-Cal, a broader range of originating sites is allowed; this includes physician or practitioner offices, hospitals, Critical Access Hospitals (CAH), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Skilled Nursing Facilities (SNFs), hospital-based renal dialysis centers, and community mental health centers.[3] However, Medicare does not explicitly allow for store and forward technology except in demonstration programs in Alaska and Hawaii. Yet, Medicare allows payment for some services provided through a manner similar to store and forward, such as radiology, pathology, cardiology, physician team consultations, and other services.[4]

Finally, commercial payers are required to cover telehealth when it's "appropriately provided." The 1996 California law that authorized Medi-Cal reimbursement also required that commercial payers shall not require "face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine."[5] Given the flexibility of the language, some commercial providers have adopted Medicare's telehealth restrictions, limiting coverage to rural areas or to be provided in the limited list of originating sites.[6] In addition, like Medi-Cal, private plans do not have to pay for consultations provided by telephone or email, and doctors are required to obtain verbal and written informed consent from the patient.

The impact of these reimbursement policies has been to limit telehealth to certain technologies and patient populations. For example, advances in technology (such as iPads and smart phones) blur the distinctions among email, telephone and videoconferencing, but the law still lives by the old boundaries. In addition, home monitoring of chronic diseases has been shown to be an effective intervention, but would not be reimbursed under current law, because the practice does not originate at one of the approved originating sites, and often uses technologies and services not explicitly allowed. Finally, only patient populations that have a barrier to care qualify for telehealth services, even though telehealth may be able to offer less costly care to populations that do not have trouble accessing health care services. The same goes for using telehealth in traditional locations such as community hospitals and nursing homes, as well as untraditional sites, such as schools, for which Medi-Cal does not currently reimburse.

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[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Telehealth Services", March 2011, https://www.cms.gov/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf.

[4] Center for Connected Health Policy, "Advancing California's Leadership in Telehealth Policy: A Telehealth Model Statute and Other Policy Recommendations."

[5] California Health and Safety Code Section 1374.13.

[6] Center for Connected Health Policy, "Advancing California's Leadership in Telehealth Policy: A Telehealth Model Statute and Other Policy Recommendations."

AB 415: Reducing Barriers to Telehealth Reimbursement

AB 415 updates Medi-Cal and private payer reimbursement rules so that telehealth services are treated as equal to in-person services, regardless of service purpose, location, or type of patient. The law does not mandate specific reimbursement rates, thereby allowing payers to determine the relative value of telehealth in comparison to traditional care, and to encourage or discourage telehealth adoption, depending on where they determine that cost savings or other factors warrant. Generally, AB 415 allows payers to figure out where telehealth offers the most promise, and to adapt as technology changes. Below, we indicate the specific changes to current law that are made by AB 415, and briefly highlight their impacts. AB 415:

- Updates the term "telemedicine" used in current law to "telehealth" to reflect changes in technologies, settings, and applications, for medical and other purposes;
- Includes the asynchronous (store and forward) application of technologies in the definition of telehealth, and removes the 2013 sunset date for Medi-Cal reimbursement of teledermatology and teleophthalmalogy services;
- Removes restrictions in current law that prohibit telehealth services provided via email and telephone;
- Specifies that any service otherwise covered under standard contract terms (e.g., covered benefit, medically necessary) must be covered, whether provided in-person or via telehealth;
- Eliminates the current Medi-Cal requirement to document a barrier to an in person visit for coverage of services provided using telehealth;
- Requires private health care payers and Medi-Cal to cover encounters between licensed health practitioners and enrollees irrespective of the setting of the enrollee and provider(s);
- Removes the current requirement necessitating an additional written informed consent waiver be obtained prior to any telehealth service being rendered.

Currently, telehealth must overcome several obstacles in order to provoke widespread payer reimbursement. Yet, without widespread demand for telehealth from providers and patients, payers have little incentive to revisit existing reimbursement policies. Thus, what AB 415 essentially does is break what William Leach, writing for the California Telemedicine and eHealth Center, calls "the self-reinforcing relationship between telemedicine reimbursement and adoption by physicians and patients."[7]

[7] William D. Leach, "If You Bill It, They Will Come: A Literature Review on Clinical Outcomes, Cost-Effectiveness, and Reimbursement for Telemedicine" (California Telemedicine and eHealth Center, January 2009), http://www.cteconline.org/_pdf/Literature-Review.pdf.

How Telehealth Can Save Money

Expanded use of telehealth has the potential to reduce health care costs in three principal ways. The first is by producing the same medical results through a less costly medical interaction. For example, a patient receives care via videoconferencing in an emergency room, and avoids a transfer to another hospital, which has the needed specialist available, thereby saving the transportation costs. The second is by producing better patient outcomes than traditional care. For example, home monitoring of a chronic disease can lead to decreased hospitalizations. Finally, telehealth can increase access to care and lower long run health care costs. For example, telehealth can provide rural residents with timely stroke care that can decrease disability and its associated life-long health care, income support, and other related costs.

What the Academic Literature Says

A significant body of academic literature has developed on telehealth. Indeed, literally hundreds of studies have been published. Reflecting the nature of the issue, however, this literature is rapidly evolving, complicating its careful study. In most instances, the literature is focused on evaluating how telehealth outcomes compared to those from traditional care. And, many studies have concluded that telehealth outcomes are in fact equivalent or superior to outcomes from traditional care. Rigorous economic evaluation of telehealth programs, however, remains relatively less common.[8] One major reason for the relative lack of conclusive research is that the cost side of the equation continues to evolve rapidly, with equipment costs steadily on the decline. Thus, what was not cost-effective in the past may well become cost-effective in the near future.[9] In addition, the way in which cost outcomes are studied has not been standardized, so that cost findings are not comprehensive, and therefore often not directly comparable. Moreover, most studies cover relatively short periods (generally one year), essentially only measuring short-term cost findings, while ignoring longer-term effects. Further complicating matters, most of the available literature compares telehealth to traditional medicine, rather than to a no treatment alternative. Consequently, instances where telehealth's benefits stem from increased access to care are not well studied.[10]

Despite these issues, some research has emerged which supports the idea that telehealth can reduce health care costs by providing more efficient care, by achieving better patient outcomes, or by providing care in a more timely manner. Thus, while there is not yet a consensus among researchers that telehealth, taken as a whole, saves money, there is evidence to support the claim that expanded use of telehealth can lead to cost savings.

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[8] Leach, William D. et. al., "If You Bill It, They Will Come: A Literature Review of Clinical Outcomes, Cost-Effectiveness, and Reimbursement for Telemedicine." California Telemedicine and eHealth Center (January 2009) p. 3.

[9] Dávalos et al., "Economic Evaluation of Telemedicine."

[10] Leach, "If You Bill It, They Will Come: A Literature Review on Clinical Outcomes, Cost-Effectiveness, and Reimbursement for Telemedicine."

Efficiency Outcomes

Telehealth can lower health care costs by delivering the same level of care more efficiently. One way in which telehealth can be more efficient is through a decrease in unnecessary laboratory tests. For example, Maria Davalos and her colleagues found that most studies agree that telemedicine reduces the use of unnecessary services, such as laboratory tests. [11] Moreover, Eric Pan and his colleagues at the Center for Informational Technology Leadership theorize that telehealth can be more efficient due to "bi-directional information sharing," a term that describes the early involvement of specialists, and their ability to order targeted testing for their patient's condition, or to review results ordered by the primary care provider. This can result in improved outcomes or lower cost, relative to a traditional in-person consultation.[12]

Another efficiency gain can be found through decreased consultation times. For example, a physician's review of store and forward information takes less time than an in-person consultation. Similarly, a follow-up videoconference in a patient's home takes less time than a follow-up in-person visit.[13,14] The largest efficiency gains, however, may come from a reduction in unnecessary patient transports. Studies on telehealth interventions in pediatric cardiology, trauma, stroke, and burn care show that telehealth interventions in acute care settings like emergency rooms can remove the need to have some patients transferred to receive specialty care in other hospitals. For example, Victoria Wade and her colleagues at the University of Adelaide found that a majority of studies on telehealth for rural inpatient care found cost savings due to reduced transports and reduced time of transport. [15] Similarly, Jeffrey Saffle and his colleagues at the University of Utah's Intermountain Burn Center found that some acute burn victims studied had air transportation charges in excess of their hospital charges, and concluded that use of telehealth could avoid the need for costly transports.[16] In addition, remote visits to patients in skilled nursing facilities, for wound care for example, can result in avoided transport costs. For example, in their review of 53 geriatric applications of telehealth in the *Journal of Telemedicine and Telecare*, P. Jennett and his fellow researchers wrote that the results indicated that telephone consultation for the provision of medical advice to geriatric patients and video consultations regarding chronic wounds can be cost-saving because they reduce the use of hospital/nursing home services, and limit the need for patients to be transported. [17] A study by Ratliff and Forch at the University of Virginia Health System found that a telehealth intervention in a long-term community care setting replaced patient transport to a local wound care clinic.[18] Finally, use of telehealth can avoid the need for providers to travel to remote patients, either at their homes or at

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[11] Dávalos et al., "Economic Evaluation of Telemedicine."

[12] Eric Pan et al., "The value of provider-to-provider telehealth," *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association* 14, no. 5 (June 2008): 446-453.

[13] Dávalos et al., "Economic Evaluation of Telemedicine."

[14] Lanis L Hicks, David A Fleming, and Adam Desaulnier, "The application of remote monitoring to improve health outcomes to a rural area," *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association* 15, no. 7 (September 2009): 664-671.

[15] Victoria A Wade et al., "A systematic review of economic analyses of telehealth services using real time video communication," *BMC Health Services Research* 10 (2010): 233.

[16] Jeffrey R Saffle, Linda Edelman, and Stephen E Morris, "Regional air transport of burn patients: a case for telemedicine?," *The Journal of Trauma* 57, no. 1 (July 2004): 57-64; discussion 64.

[17] P A Jennett et al., "The socio-economic impact of telehealth: a systematic review," *Journal of Telemedicine and Telecare* 9, no. 6 (2003): 311-320.

[18] Catherine R Ratliff and Windy Forch, "Telehealth for wound management in long-term care," *Ostomy/Wound Management* 51, no. 9 (September 2005): 40-45.

other health facilities. For example, research on a telehealth intervention utilized by a home health agency found that telehealth reduced the number of home visits by nurses from 8.2 to 5.8 per month.[19]

Effectiveness Outcomes

Another way in which telehealth can produce cost savings is through the provision of better care, which reduces the amount or cost of subsequent health care services. In this case, telehealth provides care that decreases the need for services such as hospitalizations, emergency room visits, and outpatient visits. For example, Guy Pare et. al.'s review in the *Journal of the American Medical Informatics Association* of studies on chronic disease home telemonitoring found that the majority of the studies involving patients with pulmonary and cardiac diseases demonstrated a significant decrease in hospital admissions, emergency department visits, and hospital length of stay.[20] A study of home care for indigent diabetic patients found that diabetes-related outpatient visits decreased by 49 percent.[21] In addition, telehealth is being investigated as a way to keep elderly patients in their homes longer prior to transfer to long-term care or skilled nursing facilities, thereby reducing long-term care costs. For example, the Veterans Health Administration has systematically implemented home monitoring of elderly patients with chronic conditions, and views it as a way to delay transfers into skilled nursing facilities.[22]

Finally, telehealth can provide quicker access to needed care, perhaps preventing adverse outcomes. For example, a review of teledermatology studies in the *Journal of the American Academy of Dermatology* by Erin Warshaw and her fellow researchers found that time to dermatology opinion was significantly shorter in the telehealth groups as compared to those that received traditional care, thereby accelerating time to biopsy, time to surgery or time to other definitive interventions.[23] As Davalos et al. write, this timely diagnosis and treatment can indirectly lead to reduced transfers or referrals, fewer physicians office visits, reduced hospitalization rates, or fewer emergency room visits.[24]

Access Outcomes

By increasing access to care, particularly in rural areas, telehealth has the potential to lower long-term health care costs. For example, access to rehabilitation services is more difficult for rural residents due to distance to facilities, transportation problems, rural poverty, and lack of rural

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[19] Sue Myers et al., "Impact of Home-Based Monitoring on the Care of Patients with Congestive Heart Failure," *Home Health Care Management & Practice* 18, no. 6 (October 1, 2006): 444 -451.

[20] Guy Paré, Mirou Jaana, and Claude Sicotte, "Systematic review of home telemonitoring for chronic diseases: the evidence base," *Journal of the American Medical Informatics Association: JAMIA* 14, no. 3 (June 2007): 269-277.

[21] Julie Cheitlin Cherry et al., "Diabetes disease management program for an indigent population empowered by telemedicine technology," *Diabetes Technology & Therapeutics* 4, no. 6 (2002): 783-791.

[22] Adam Darkins et al., "Care Coordination/Home Telehealth: the systematic implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic conditions," *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association* 14, no. 10 (December 2008): 1118-1126.

[23] Erin M Warshaw et al., "Teledermatology for diagnosis and management of skin conditions: a systematic review," *Journal of the American Academy of Dermatology* 64, no. 4 (April 2011): 759-772.

[24] Dávalos et al., "Economic Evaluation of Telemedicine."

service providers. This lack of access to specialty services and new technologies prevents rural patients from receiving the appropriate level of care. Now, tele-rehabilitation programs for stroke, brain injuries, cardiac procedures, and spinal cord injuries have the potential to increase access to appropriate care.[25,26] In the long run, proper treatment could lessen disability and its associated medical costs. For example, two studies on tele-stroke care found long-term cost savings due to decreased nursing home and rehabilitation costs.[27,28,29]

A study of the impact of telehealth in a federally funded demonstration project also found that telehealth has the potential to lower health care costs.[30] In this project, a network was developed that linked three hospitals, a federally qualified health care clinic, a county dental clinic, and patient homes. The project reported outcomes for congestive heart failure, diabetes, and tele-dental health, concluding that "the diabetes disease management program increased the number of diabetics who brought their blood sugar under control... [and that] the national cost of care for CHF hospitalizations could be reduced from 8 billion dollars to 4.2 billion dollars."

Increased access also has the potential to result in lower costs for other state programs outside of Medi-Cal. For example, a study conducted by the Blue Sky Consulting Group for the California Health Care Foundation on tele-ophthalmology demonstrated that, for each diabetic patient examined for retinopathy via store and forward telemedicine, state cost savings would total nearly $2,500 over the patient's lifetime relative to the no treatment case due to early detection of retinopathy and reduced disabling blindness. Savings would stem from decreased use of Medi-Cal, State Supplemental Payment, In-Home Supportive Services, Cash Assistance Program for Immigrants, and blindness rehabilitation provided through the state Department of Rehabilitation.

Specific Examples of Demonstrated Cost Savings

While no consensus among researchers has yet emerged with respect to the cost-effectiveness of telehealth overall, two areas have emerged with the strongest evidence of overall cost savings: home monitoring and acute care telemedicine. For example, in their 2010 systematic review of economic evaluations of videoconferencing, Wade et al. concluded that "synchronous video delivery is cost-effective for home care, and for on-call hospital specialists, and it can be cost-

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[25] George Demiris, Cheryl L. Shigaki, and Laura H. Schopp, "An Evaluation Framework for a Rural Home-Based Telerehabilitation Network," *Journal of Medical Systems* 29, no. 6 (December 2005): 595-603.

[26] Dahlia Kairy et al., "A systematic review of clinical outcomes, clinical process, healthcare utilization and costs associated with telerehabilitation," *Disability & Rehabilitation* 31, no. 6 (January 2009): 427-447.

[27] Bart M Demaerschalk, Ha-Mill Hwang, and Grace Leung, "Cost analysis review of stroke centers, telestroke, and rt-PA," *The American Journal of Managed Care* 16, no. 7 (July 2010): 537-544.

[28] Lars Ehlers et al., "National use of thrombolysis with alteplase for acute ischaemic stroke via telemedicine in Denmark: a model of budgetary impact and cost effectiveness," *CNS Drugs* 22, no. 1 (2008): 73-81.

[29] Here we note that relatively little research on the effects of telehealth on the long-term cost savings of increased access has been done. In general, studies compare telehealth to usual care, not to "no care." In addition, most of the studies we identified tended to investigate short-run outcomes.

[30] Dimmick, SL, et. al., "Outcomes of an integrated telehealth network demonstration project," *Telemed J E Health.* 2003 Spring;9(1):13-23.

effective for regional and rural health care, depending upon the particular circumstances of the service."[31]

Chronic Disease Home Monitoring

In addition to the Wade et. al. meta analysis, several systematic reviews of the literature on chronic disease home monitoring have found that it produces cost savings to the health payer. For example, a 2008 meta-analysis of home monitoring in *Telemedicine Journal and e-Health* by Vergara Rojas and Marie-Pierre Gagnon found that it was the cost-effective alternative in 21 out of 23 studies, the vast majority of which focused on chronic disease care.[32] In addition, they found that the main benefits from monitoring programs were decreased hospital utilization, improved patient compliance with treatment plans, improved patient satisfaction with health services, and improved quality of life. A 2008 review of economic data on telemonitoring for heart failure by Emily Seto found that all nine studies identified cost reductions from telemonitoring compared to usual care, with savings ranging between 1.6 percent and 68.3 percent. These cost savings were mainly attributed to a reduction in the high re-hospitalization rates from heart failure.[33]

Two other meta-analyses found less robust findings on costs, but still concluded that evidence is emerging on the promise of home monitoring for specific chronic diseases. Most recently, a 2011 meta-analysis of congestive heart failure telemonitoring studies found that of the six studies that evaluated costs, four of them concluded that costs were reduced, while two found no significant difference compared to usual care.[34] Secondly, a 2009 review of studies on home monitoring for chronic respiratory conditions found that "despite minimal existing evidence at this level, preliminary analyses showed promising results and affordability of this approach, especially with technology advancement and decreased cost over the years."[35]

Other meta-analyses, while not conclusively demonstrating cost savings, nevertheless suggest that home monitoring is a potentially promising area. For example, Pare et. al.'s meta-analysis on chronic disease telemonitoring found the quality and rigor of the analyses reviewed limited, but nevertheless labels chronic disease monitoring as a "promising patient management approach that produces accurate and reliable data, empowers patients, influences their attitudes and behaviors, and potentially improves their medical conditions."[36]

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[31] Victoria A Wade et al., "A systematic review of economic analyses of telehealth services using real time video communication," *BMC Health Services Research* 10 (2010): 233.

[32] Stephanie Vergara Rojas and Marie-Pierre Gagnon, "A systematic review of the key indicators for assessing telehomecare cost-effectiveness," *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association* 14, no. 9 (November 2008): 896-904.

[33] Emily Seto, "Cost comparison between telemonitoring and usual care of heart failure: a systematic review," *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association* 14, no. 7 (September 2008): 679-686.

[34] Malcolm Clarke, Anila Shah, and Urvashi Sharma, "Systematic review of studies on telemonitoring of patients with congestive heart failure: a meta-analysis," *Journal of Telemedicine and Telecare* 17, no. 1 (2011): 7-14.

[35] Mirou Jaana, Guy Paré, and Claude Sicotte, "Home telemonitoring for respiratory conditions: a systematic review," *The American Journal of Managed Care* 15, no. 5 (May 2009): 313-320.

[36] Paré, Jaana, and Sicotte, "Systematic review of home telemonitoring for chronic diseases."

A study of a home monitoring in a public program setting also found convincing evidence of cost effectiveness. In this study, 17,025 participants in the Veterans Health Administration used an electronic messaging device to communicate with care coordinators who remotely monitored their condition. The study found that inpatient hospital admissions fell by 19.7 percent and inpatient hospital days fell by 25.3 percent.[37]

Acute Care Telehealth

The inability of local hospitals to provide specialist care for certain acute care patients, such as a stroke or head trauma victims, often leads to transfers to hospitals with the appropriate specialists. A reduction in these and other types of medical transports can mean significant savings. In fact, a study by Rifat Latifi and his colleagues at the University of Arizona found that the savings from one avoided transport alone can cover the cost of establishing a telehealth system.[38] In this 2009 study, researchers found that the around-the-clock trauma and emergency management telemedicine network prevented 17 unnecessary transfers and saved an estimated $104,852 in transfer costs alone. The model built by Pan et. al. estimated that a national expansion of telehealth could save $537 million annually by avoiding such emergency transports.[39]

A 2010 review of acute stroke telemedicine in the *International Journal of Technology Assessment in Health Care* by Tim Johansson and Claudia Wild found that telehealth likely saved money through the increase of rt-PA interventions, which decreased long-term nursing home and rehabilitation costs.[40,41] They also found that 12 of 18 studies reported the system's impact on patient transport even if they did not provide cost information. Of these, half of the studies showed a decrease in patient transport while the other half showed the same level of transfer. Often in tele-stroke, hospitals will still transport patients to a stroke center after they have been given the rt-PA intervention.

An Estimate of Savings from AB 415

The broadest application of telehealth likely comes from home monitoring for chronic diseases. And while there is not yet a consensus among researchers that telehealth is generally cost-effective, published research does suggest that use of telehealth in this area has the potential to generate significant cost savings. In order to provide policy makers with an estimate of the potential savings that could result from more widespread use of telehealth, we used results from

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[37] AHRQ, "Care Coordinators Remotely Monitor Chronically Ill Veterans via Messaging Device, Leading to Lower Inpatient Utilization and Costs," http://www.innovations.ahrq.gov/content.aspx?id=3006.

[38] Rifat Latifi et al., "Initial experiences and outcomes of telepresence in the management of trauma and emergency surgical patients," *The American Journal of Surgery* 198, no. 6 (December 2009): 905-910.

[39] Eric Pan et al., "The value of provider-to-provider telehealth," *Telemedicine Journal and E-Health: The Official Journal of the American Telemedicine Association* 14, no. 5 (June 2008): 446-453.

[40] Tim Johansson and Claudia Wild, "Telemedicine in Acute Stroke Management: Systematic Review," *International Journal of Technology Assessment in Health Care* 26, no. 2 (2010): 149-155.

[41] The intravenous infusion of recombinant tissue plasminogen activator, or rt-PA, is the only treatment approved by the US Food and Drug Administration for acute ischemic stroke. It is a thrombolytic used to improve neurologic recovery and reduce the incidence of disability.

the published literature to estimate the savings that would accrue to the Medi-Cal program if telehealth was adopted for home monitoring of two chronic conditions: heart failure and diabetes. Although we specifically estimate the savings for the Medi-Cal program, the cost reductions presented would apply to other health care payers as well.

To estimate the potential savings from broader application of telehealth, we searched the published academic literature for meta-analyses on home monitoring cost outcomes. We then reviewed and catalogued the cost findings from the included studies, as well as more recent non-meta studies, which were not published in time for inclusion in a meta-review. In total, we catalogued 42 studies on chronic disease home monitoring.

To model the savings we estimated the decrease in health care costs based on the literature. We then used administrative and survey data to estimate what the current Medi-Cal costs for a population comparable to the subjects of the included studies. Next, we combined these two data points to produce an estimate of Medi-Cal savings.

Chronic Disease Savings

The literature on chronic disease telehealth is extremely diverse and has hindered meta-analyzers in their efforts to estimate an average savings associated with use of telehealth for a specific disease, let alone across various chronic diseases. Studies differ in how the intervention is managed; for example, in telehealth technology, monitoring frequency, and educational components. Different studies also compare telehealth to different types of "usual care," which can be a specific disease management program, home health care, scheduled clinic visits, or unstandardized physician care. Moreover, studies measure costs in different ways. Some only look at the costs for specific outcomes such as hospitalizations, while others look at costs more broadly. Not all studies take into consideration the cost of the intervention itself, but instead rely just on changes in the outcomes measured.

Given that the majority of chronic disease patients receive care for their illnesses at clinics, hospitals, or other outpatient facilities (in addition to hospital inpatient care), we decided to focus on savings to this population (i.e., we excluded studies that examined changes in home health care costs). Therefore, we looked for studies that compared home monitoring to standard outpatient chronic disease care. Of 18 studies we identified that examined chronic diseases and reported cost findings, 11 of them compared telehealth to chronic disease care that was not provided via a home health agency.[42]

In addition, because telehealth can have a complex impact on health care utilization (for example, in the short run, outpatient costs may increase while inpatient hospital costs decrease[43]), we sought to measure the overall decrease in health care costs from an intervention, including both inpatient and outpatient care. Most studies, however, looked at a subset of cost outcomes. For example, seven studies looked only at hospitalization and/or emergency room

[42] Of the 42 catalogued studies, eighteen were deemed qualified because they had a usable cost outcome, reported on an intervention that qualified as telehealth, and studied one the primary chronic diseases.

[43] Barbara Johnston et al., "Outcomes of the Kaiser Permanente Tele-Home Health Research Project," *Arch Fam Med* 9, no. 1 (January 1, 2000): 40-45.

costs. Ultimately, we identified three studies of chronic disease home monitoring that reported broad-based measures of health care cost, including inpatient and outpatient costs. Two of them reported overall cost savings for congestive heart failure, while the remaining study focused on diabetes.

In the sections that follow, we present the results of estimation models for chronic disease monitoring for these two conditions. These models present the savings that California could experience to the extent that telehealth home monitoring for Medi-Cal patients with heart failure and diabetes becomes widely adopted.

Heart Failure

To estimate the impact of more widespread use of telehealth for home monitoring of heart failure patients, we relied on published research to estimate the percentage reduction in overall health care costs, and then applied these reductions to estimates of the size and costs associated with the Medi-Cal population of patients with heart failure.

Multiple studies have found savings associated with application of telehealth for home monitoring of heart failure patients. For example, we identified seven studies that compared telehealth to traditional outpatient care, with savings estimates ranging from 17 percent to 75 percent.[44,45,46,47,48,49,50] On average, these studies reported a 42 percent reduction in measured costs.

As noted previously, we sought to rely on studies with broad-based measures of cost, including both inpatient and outpatient costs. We identified two studies with such a broad-based measure. The first, by Paul Heidenrich of the Cardiology Section of the Department of the Veterans Affairs Medical Center in Palo Alto and his colleagues examined the impact of a telephone-based home monitoring and patient education intervention. Each patient in the study group received a digital scale and an automatic blood pressure cuff. Each day the enrolled patients called an automated phone system and entered blood pressure, pulse, weight, and any symptoms. If values were outside of established ranges, the phone system called a nurse and appropriate

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[44] Mary Bondmass, Nadine Bolger, and Gerard Castro, "The Effect of Physiologic Home Monitoring and Telemanagement on Chronic Heart Failure Outcomes.," *The Internet Journal of Advanced Nursing Practice* 3, no. 2 (1999).

[45] Jerome Vaccaro et al., "Utilization Reduction, Cost Savings, and Return on Investment for the PacifiCare Chronic Heart Failure Program, 'Taking Charge of Your Heart Health'," *Disease Management* 4, no. 3 (September 2001): 131-142.

[46] Carmela Maiolo et al., "Home telemonitoring for patients with severe respiratory illness: the Italian experience," *Journal of Telemedicine and Telecare* 9, no. 2 (2003): 67-71.

[47] S Scalvini et al., "Effect of home-based telecardiology on chronic heart failure: costs and outcomes," *Journal of Telemedicine and Telecare* 11 Suppl 1 (2005): 16-18.

[48] Daniel Benatar et al., "Outcomes of chronic heart failure," *Archives of Internal Medicine* 163, no. 3 (February 10, 2003): 347-352.

[49] Barbara H Southard, Douglas R Southard, and James Nuckolls, "Clinical trial of an Internet-based case management system for secondary prevention of heart disease," *Journal of Cardiopulmonary Rehabilitation* 23, no. 5 (October 2003): 341-348.

[50] A Giordano et al., "Multicenter randomised trial on home-based telemanagement to prevent hospital readmission of patients with chronic heart failure," *International Journal of Cardiology* 131, no. 2 (January 9, 2009): 192-199.

follow-up care was pursued. Patients also participated in a patient education program. The study measured the impact of the program on a comprehensive measure of overall health care costs, including both inpatient and outpatient care for the treatment and a matched control group over a two year period.[51] According to the study results, medical claims for the treatment group decreased from an average of $8,500 in the year prior to the intervention, to $7,400 during the year of the telehealth intervention; claims for the control group increased from an average of $9,200 to $18,800. By adjusting for the costs of the telehealth program and differences in the initial level of average claims, we calculate that the treatment group had average total claims that were 30 percent less than those for the control group that relied on usual physician care.

The second study we relied upon was written by Jeremy Nobel and Gordon Norman of the Harvard School of Public Health. They reported the results of a telehealth-based disease management program aimed at reducing costs for heart failure patients. Patients in the study utilized an electronic, home-based weight measurement device linked to a care coordination center used by a large managed care plan. When unexpected weight changes or symptoms were reported, patients were urged to seek same day or emergency care. In addition to the telehealth home monitoring, nurses assessed patients' understanding of their condition and treatment, self-care skills, diet, and medication compliance.

The researchers found that average per member per month costs decreased by 44 percent for patients over 65 and by 27 percent for patients under 65, compared to a control group.[52] Because patients over 65 are likely to be covered by Medicare, we relied upon the lower 27 percent figure. When averaged with the previous study's finding, we calculate that average patient costs would decrease by 28 percent as a result of the implementation of a telehealth-based home monitoring program.

To apply this cost-savings estimate to Medi-Cal, we estimated the percent of the Medi-Cal population that has heart failure using data from the 2009 California Health Interview Survey (CHIS). According to CHIS, approximately 1.75 percent of the Medi-Cal population has heart failure. However, a large fraction of these recipients are non-citizens, who likely would be eligible for emergency services only and so would not qualify to receive a home monitoring telehealth intervention. Adjusting the population from the CHIS data to count just the Medi-Cal enrolled citizens with heart failure resulted in an estimate of 1.4 percent.[53]

Next, we estimated the amount of total claims for our population of interest. First, we estimated the average annual expenditure for a Medi-Cal beneficiary by dividing annual Medi-Cal expenditures by average enrollment.[54,55,56] Because heart failure patients are more expensive to

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[51] As the researchers note, rather than relying on heart failure claims alone, the cost of all claims was used "because of inaccuracies in coding of diagnoses." The result is a comprehensive measure of healthcare costs suitable for our analysis.

[52] Jeremy J Nobel and Gordon K Norman, "Emerging information management technologies and the future of disease management," *Disease Management: DM* 6, no. 4 (2003): 219-231.

[53] *California Health Interview Survey 2009* (UCLA Center for Health Policy Research, May 2011).

[54] To account for fluctuations in the Medi-Cal budget, we relied on annual averages over the previous several years for both expenditures and enrollment. Budget data from California Department of Finance, *Governor's Proposed Budget: Department of Health Care Services Budget 2009-10 through 2011-12.*

care for than the average patient, we adjusted the per beneficiary average using an analysis of annual health care costs per capita for chronic disease patients prepared by the California HealthCare Foundation.[57] This analysis utilized data from the Medical Expenditure Panel Survey (MEPS) and found that heart disease patients had an annual cost per capita that was five times higher than average. While heart disease is a larger category of diagnosis that contains heart failure, the average should be representative of heart failure cost, based on a review of the data compiled by the American Heart Association.[58,59] Consequently, we adjusted the Medi-Cal per beneficiary average expenditure by the amount indicated from the California HealthCare Foundation report.

Applying the average cost reduction finding from the research, we calculate that telehealth for home monitoring of heart failure patients has the potential to produce savings in the Medi-Cal program of up to $929 million annually. Since the state is only responsible for approximately 31 percent of Medi-Cal expenditures (with the federal government paying the remaining share), we estimate that the total general fund savings could total up to $281 million annually, to the extent that this type of telehealth home monitoring was widely adopted.[60] While the extent to which telehealth will be adopted depends on a host of factors, the potential exists for Medi-Cal to save approximately $8,600 per beneficiary annually for many of the estimated 107,000 Medi-Cal beneficiaries with heart failure.

Diabetes

To estimate the potential impact of home monitoring for diabetes patients, we followed an approach similar to the one used for our heart failure estimates. Specifically, we estimated the extent of the potential savings based on the published literature. Then, we applied these savings to Medi-Cal expenditures for a comparable population.

In a study entitled "Diabetes Disease Management Program for an Indigent Population Empowered by Telemedicine Technology," Julie Cherry and her colleagues examined the impact of a home monitoring system used with a population of indigent or economically disadvantaged adults with diabetes.[61] Study participants were given a blood glucose monitor as well as a small

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[55] We note that the amount budgeted for Medi-Cal may contain expenditures that are not directly for patients such as county administration.

[56] California Department of Health Care Services, *Trend in Medi-Cal Program Enrollment - Most Recent 24 Months, 2009-08 - 2011-07* (July 2011).

[57] California HealthCare Foundation, "Chronic Disease in California: Facts and Figures," California HealthCare Foundation (2006).

[58] A review of cost and prevalence data on heart diseases compiled by the American Heart Association showed that heart failure's per person average was higher than the average for total cardiovascular disease and equal to coronary heart disease.

[59] Donald Lloyd-Jones et al., "Heart disease and stroke statistics--2009 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee," *Circulation* 119, no. 3 (January 27, 2009): 480-486.

[60] The state share of 30 percent is a four year average of the ratio of general fund to total funding for Medi-Cal from: California Department of Finance, *Governor's Proposed Budget: Department of Health Care Services Budget 2009-10 through 2011-12.*

[61] Cherry et al., "Diabetes disease management program for an indigent population empowered by telemedicine technology."

appliance called a "Health Buddy," which has a large screen and four buttons which patients use to answer personalized daily health questions. Responses were sent via telephone line to a data center, where case managers were alerted and responded as needed.

The researchers measured each patient's utilization of health care services, including inpatient admissions, emergency room visits, post-discharge care visits, and outpatient visits, as well as total diabetes-related charges for health care services. According to their analysis, the telehealth intervention resulted in a reduction in diabetes-related charges of 9 percent.

To apply this cost-savings estimate to the Medi-Cal population, we estimated the fraction of the Medi-Cal population that has diabetes, again using 2009 CHIS data. As with the heart failure population, we again adjusted the results to include just citizens. According to the CHIS data, approximately 6 percent of Medi-Cal beneficiaries have been diagnosed with diabetes.[62,63]

Next, we estimated total diabetes-related claims for these beneficiaries, by calculating the average per-beneficiary expenditures and adjusting the result to account for the higher-than-average costs associated with caring for a patient with diabetes. As with the heart failure calculations, we relied on the California HealthCare Foundation analysis of the MEPS data to estimate the cost differential between a patient with diabetes and the average patient. This analysis found that diabetes patients had an annual cost per capita that was three times higher than average. In addition, because the cost measure used in the Cherry study was diabetes-related claims (as opposed to all claims), we needed to estimate the fraction of these annual costs that was related to diabetes. According to the literature, diabetes-related medical problems were responsible for 57 percent of total medical costs incurred by people with diabetes (with the remaining visits being for chief complaints other than diabetes).[64]

Using the average expenditures per beneficiary, the estimated number of beneficiaries, the diabetes cost differential and the fraction of costs for diabetes patients related to their diabetes, we calculated that the average annual Medi-Cal expenditure for diabetes related care was nearly $10,500 per beneficiary. Applying the 9 percent cost reduction finding from the research, we estimate that utilizing home monitoring for diabetes could result in savings for the Medi-Cal program of up to $417 million annually. Since the state is only responsible for 31 percent of Medi-Cal funding, general fund savings could be up to $127 million each year, depending on the extent to which this form of telehealth intervention is adopted, or approximately $939 for each of the estimated 444,000 Medi-Cal recipients with diabetes.[65]

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[62] *California Health Interview Survey 2009.*

[63] We restrict our analysis to citizens, since non-citizens receive only emergency care. If we do not restrict citizenship status, diabetes prevalence increases to 8 percent.

[64] American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2007," *Diabetes Care* 31, no. 3 (March 2008): 596 -615.

[65] The state share of 30 percent is a four year average of the ratio of general fund to total funding for Medi-Cal from: California Department of Finance, *Governor's Proposed Budget: Department of Health Care Services Budget 2009-10 through 2011-12.*

Summary of Results

Treatment of chronic diseases such as heart failure and diabetes is responsible for a disproportionate share of health care costs. Furthermore, a substantial fraction of the care for these diseases comes from hospital admissions or readmissions, as well as other costly medical interventions that potentially can be avoided through better disease management, such as can be produced with the telehealth-based interventions discussed above.

According to the estimates we developed, based on findings from the published literature, utilizing home monitoring for chronic disease patients could yield substantial savings if fully implemented. We estimate that total general fund savings could total up to $408 million, although the amount of the actual savings would depend on the extent to which telehealth is adopted. It is reasonable to assume that this type of intervention would not be suitable for the entire population of Medi-Cal patients with heart failure or diabetes. However, even if these interventions were instituted with a quarter of the eligible population, annual general fund savings would exceed $102 million a year, according to our application of the published research findings.

The potential savings modeled here present an indication of the potential for telehealth-based home monitoring of just two chronic conditions. Additional savings for patients with chronic obstructive pulmonary disease (COPD) and other chronic diseases may also be achievable. In addition, a growing body of research has shown that telehealth has the potential to reduce costs in several other areas, notably including acute care telehealth.

Conclusion

Although telehealth has been the subject of hundreds of studies, the potential cost savings associated with telehealth have been the subject of less rigorous analysis relative to studies on its medical effectiveness. Analysis of the fiscal effects of telehealth are complicated by the fact that telehealth is a rapidly evolving area of health care, with technological innovations arriving at a rapid pace and technology costs falling as equipment and information transfer costs are lowered throughout the economy.

Given this rapid pace of change, it is not surprising that a consensus has yet to emerge on the cost-effectiveness of telehealth overall. Nevertheless, studies do point to areas of potential cost savings. And, given that AB 415 does not mandate specific reimbursement rates for telehealth services, it is likely that payers will choose to reimburse telehealth services more generously in areas where cost savings can be demonstrated while discouraging expansion of telehealth (via lower reimbursement rates or refusal to pay for technology costs) in areas where it has not proven to be cost-effective.

The analysis of published research findings presented here suggests that broad application of telehealth in the area of home monitoring for congestive heart failure and diabetes has the potential to produce substantial savings for the State of California. In addition, telehealth has the potential to reduce health care costs in many other areas, such as by reducing medical transportation costs, reducing home health care costs, or increasing access to cost-effective

treatments such as retinopathy screening or more timely care for stroke patients. Taken as a whole, the potential cost savings from telehealth could be quite significant. By reducing several of the barriers to more widespread adoption of telehealth, AB 415 can encourage adoption of telehealth in areas where payers, providers, and patients determine that it is effective, cost-effective, and appropriate.

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CMS Telehealth Credentialing Rule

The Centers for Medicare and Medicaid Services has implemented new rules that make it easier for hospitals to establish medical credentials for telehealth professionals.

These new rules, which go into effect July 5, 2011, will revise the Medicare Conditions of Participation to allow hospitals and CMS-designated Critical Access Hospitals (CAH) to provide medical credentials to telehealth providers by relying on the review of those providers by another hospital in a separate location, a process termed "privileging by proxy."

The new rules allow a hospital (an originating site, in CMS terminology) to grant practice privileges to telehealth providers at a second hospital (termed a distant site) by accepting the distant-site hospital's credentialing and privileging approvals for those providers.

In addition, the new rules allow sites other than hospitals, such as physician offices and ambulatory centers, which provide telehealth services, to receive privileging by proxy approvals for telehealth services, as long as those services meet the hospital's conditions of practice.

These new regulations have important implications for telehealth services in California. They will promote the use of telehealth to improve access to care, reduce costs, and increase the availability and quality of services in medically underserved communities, both urban and rural. Reducing administrative burdens on hospitals for the credentialing of telehealth practitioners will encourage hospitals to utilize telehealth services.

The regulations are vitally important to California's 352 hospitals, which includes 34 rural hospitals and 28 CAHs, and to many of the state's 264 Rural Health Clinics.

CCHP collaborated with the California Association of Rural Health Clinics, California Rural Indian Health Board, and California State Rural Health Association, in supporting the rule change. The collaborating organizations sent a **comment letter** to CMS in July, 2010.

Why Was the Rule Change Necessary?

To participate in the Medicare or Medicaid programs, a hospital must be certified as complying with CMS's Conditions of Participation. CMS certifies hospitals in two ways—through a survey conducted by a state agency on behalf of CMS, or by a CMS-granted "deeming authority" to a hospital accrediting organization, such as The Joint Commission (TJC).

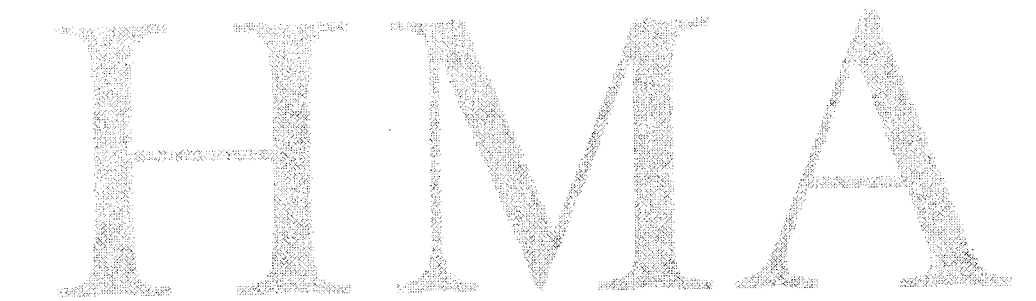
In the past, TJC-accredited hospitals were deemed to have met CMS's Medicare requirements. This included TJC rules that accredited hospitals could use the privileging by proxy process to credential telehealth providers.

However, TJC's deeming authority was revoked with the passage of the Medicare Improvements for Patients and Providers Act of 2008. The statute required TJC to reapply for CMS certification. In addition, CMS had determined that TJC's privileging by proxy process was inconsistent with CMS's hospital and CAH Conditions of Participation requirements.

This rule change reinstated the privileging by proxy process.

A 2010 **CCHP report** provides background on provider credentialing under Medicare and accreditation programs, prior to the release of the proposed rule change.

Report Included



HEALTH MANAGEMENT ASSOCIATES

Credentialing Under Medicare and Accreditation Programs: Implications for Telehealth Practitioners

DRAFTED FOR THE
CENTER FOR CONNECTED HEALTH POLICY
MARCH 2010

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Table of Contents

I. Overview

The Center for Connected Health Policy (CCHP) has asked Health Management Associates (HMA) to examine recent changes to The Joint Commission's (TJC's) credentialing standards for telehealth providers to determine the impact on hospitals, rural health clinics (RHCs), federally-qualified health centers (FQHCs), and clinics operated by the Indian Health Service (IHS). In addition, CCHP asked HMA to examine whether any changes also govern telehealth care provided to Medi-Cal and private pay patients, as well as to identify the risks of noncompliance with Medicare Conditions of Participation (CoPs).

Medicare CoPs set forth the conditions for participating in (receiving reimbursement from) the Medicare program. Providers may choose to be eligible for Medicare participation by seeking deemed status designation through meeting accreditation standards established by an approved accrediting body.

Hospitals having deemed status through the TJC's accreditation program are concerned about changes to the TJC standards for credentialing professionals who are engaged in providing telehealth services. TJC was required to change its credentialing and privileging by proxy requirements to conform to hospital Medicare CoPs. The Center for Medicare and Medicaid Services (CMS) requires telehealth service providers to be credentialed by each hospital that uses telehealth services. Many believe this requirement to be cumbersome, time-consuming and outdated given today's use of telehealth for delivering healthcare services.

Achieving a sensible, nation-wide credentialing/privileging standard for telehealth practitioners requires a fundamental regulatory solution that is embraced by CMS and by all committed to promoting telehealth services, recognizes the importance of telehealth in today's health care delivery system, and develops uniform standards that do not overly-burden hospitals providers.

This paper was prepared using readily-available resources and does not constitute a legal opinion.

II. CMS Medicare Conditions of Participation, Accreditation and Deemed Status

Medicare Conditions of Participation

Medicare CoPs are the minimum health and safety requirements that providers must meet in order to participate in the Medicare program. Compliance with these CoPs are determined through either a survey conducted by the State Survey Agency (SSA) or through verification of compliance by an AO whose standards and processes have been formally approved by CMS as meeting or exceeding the minimum Medicare CoPs (deemed status). CoPs have specific standards related to each condition. CMS has provided interpretive guidelines and survey procedures to clarify these requirements for both providers and SSAs.

Accrediting Organizations

Accrediting organizations (AOs) offer providers an opportunity to have external quality assurance oversight of their governance and operations. Achieving accreditation status identifies providers as having met standards established by these AOs. Accreditation can be a condition of contracting with a managed care organization or other insurer, obtaining preferred status for liability insurance rate purposes, obtaining financial loans, or qualification for certain grants or other reimbursements. AOs may also apply to CMS to be designated as an AO for "deemed status" purposes.

Deemed Status Designation by CMS

Section 1865(b) of the Social Security Act permits providers and suppliers accredited by an approved national accrediting body to be *"deemed"* to meet Medicare CoPs. To receive approval, AOs must demonstrate to CMS that their requirements meet or exceed the Medicare CoPs. AOs seeking this designation must submit an application to CMS for approval. CMS conducts a review of the survey and accrediting process to determine if these requirements meet or exceed the Medicare CoPs.

Section 1865 (a)(3)(A) of the Social Security Act requires that CMS's review of deeming applications is completed within 210 calendar days after the date of receipt of the application. Within 60 days of receiving the application, CMS must publish a notice in the Federal Register that identifies the accrediting body, and the nature of the request, and provides at least 30 days for public comment about the application. At the end of the 210-day period, CMS must publish an approval or a denial of the application in the Federal Register with the effective and expiration dates of the approval.

Accreditation by an AO is voluntary on the part of the provider or supplier, and it is not required for participation in the Medicare program. A provider may opt for routine surveys by

an SSA to determine if it meets Medicare requirements in lieu of requesting deemed status through the accreditation process.[1]

Federal regulations permit participation via deemed status for certain categories of providers and suppliers.[2] To date, AOs have applied for and been approved by CMS for hospitals, critical access hospitals, ambulatory surgical centers, home health agencies and hospices. There are three AOs that are approved for hospitals: The Joint Commission, American Osteopathic Association's Health Facilities Accreditation Program (AOA/HFAP), and Det Norske Veritas Healthcare's National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO).

There are no AOs that have applied for or are currently recognized by CMS for purposes of certifying compliance with Medicare CoPs for RHCs, FQHCs or clinics operated by the IHS. These providers and suppliers may choose to be accredited for quality assurance purposes, but they currently cannot be "deemed" to meet the Medicare CoPs by meeting the standards of an AO.

Process for Obtaining Deemed Status through Accreditation

If a provider seeks to obtain deemed status recognition from CMS, accreditation alone will not provide that recognition. A provider can be accredited by an AO, but not deemed. Providers seeking deemed status recognition for their accreditation must document that they are accredited under the AOs CMS-recognized deemed status accreditation program, and the AO must recommend to CMS that certification be granted via deemed status.

Providers must first apply to the Medicare Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC) for Medicare certification. The AO may not conduct the initial accreditation survey until the FI/MAC has completed its initial review of the provider's application for certification (CMS Form 855A) and has made a recommendation to CMS for approval. A copy of the CMS 855A is also sent to the SSA. The AO may proceed with the accreditation survey once the FI/MAC has recommended approval. Once the AO has conducted the accreditation survey and has determined compliance, the AO is required to notify CMS (both the Central Office and the Regional Office) and also provides a copy of this notification to the provider. The provider must provide a copy of this notice of compliance with the accreditation standards to the SSA. The SSA then sends the certification package, with documentation of approval by the

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[1] Thomas Hamilton, Director, Centers for Medicare and Medicaid Services (CMS) Survey and Certification Group, *S&C-09-02: Approval of Deeming Authority of Det Norske Veritas Healthcare, Inc. for Hospitals*, October 3, 2008.

[2] 42 CFR §§ 488.5 and 488.6: Ambulatory surgical centers; comprehensive outpatient rehabilitation facilities; critical access hospitals; home health agencies; hospices; hospitals; clinics, rehabilitation agencies or public health agencies providing outpatient physical therapy, occupational therapy or speech pathology services; psychiatric hospitals; religious non-medical health care institutions; rural health clinics; screening mammography services; skilled nursing facilities; and transplant centers, except for kidney transplant center.

HMA, along with the AO notice of compliance and other documentation, to the CMS Regional Office for review and approval for Medicare certification via deemed status. The CMS Regional Office makes the final determination for deemed status approval.

III. Importance of Credentialing

> "Credentialing is the process of obtaining, verifying and analyzing information to assess the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare entity. Credentialing involves evaluating the provider's licensure, current competency, education, training and ability to determine the practitioner's qualifications to perform the clinical activities he or she desires."[3]

Each hospital's governing body is responsible for the credentialing process and delegates certain responsibilities to the hospital medical staff for implementation. Verifying qualifications to provide care and treatment to hospital patients includes but is not limited to: confirmation of current professional license and board specialty certifications, checking with the National Practitioner Data Bank (NPDB), the Healthcare Integrity Protection Data Bank (HIPDB), DEA Active Controlled Substances Act (CSA) Registration Database and other similar databases, confirmation of schooling and degrees, and confirmation of membership in professional associations.

Hospital credentialing criteria can vary from hospital to hospital, but there are core criteria for medical staff selection imposed by CMS as a condition of participating in Medicare, and by standards established by AO. Hospital credentialing practices may exceed these core requirements. These criteria are individual character, competence, training, experience, and judgment.[4]

Credentialing is considered to be a patient protection measure to allow only those providers who meet particular high standards to treat patients. Credentialing is also a risk management activity.

> "If a patient suffers an adverse outcome at a hospital and the physician is at fault, the patient or patient's family can hold the hospital liable. If an investigation reveals that the hospital did not meet the industry standard for credentialing and privileging the provider, a court may find that the hospital was negligent in their credentialing practices."[5]

Credentialing is also used to comply with accreditation and regulatory entities. All three hospital AOs that have deemed status approval from CMS require hospitals to credential medical staff. CMS Medicare CoPs require hospital medical staff credentialing as a condition of participation in the Medicare program. Most states, including California, have some hospital credentialing requirements as a condition of licensure.

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[3] Kathy Matzke, COMSM, CPCS, Contributing Editor, *2010 Credentials Verification Desk Reference,* Credentialing Resource Center, HCPro, 2010.

[4] 42 CFR 482.12 (a)(6)

[5] Matzke, 2010.

In 2007, twenty-eight states' high courts upheld negligent credentialing claims where patients sued hospitals for allegedly granting privileges to doctors with questionable credentials. Two states' high courts rejected negligent credentialing claims.[6]

No instances of negligent credentialing involving telehealth providers were identified during the research for this paper. It is unknown if a hospital would be found liable, if the hospital holds telehealth providers to a lesser or different standard than medical staff providing service at the hospital, and if that different standard is identified as contributing to a patient's injury, illness or death.

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[6] American Medical Association, American Medical News, *Hospital can be sued for credentialing doctor with questionable qualifications, Minnesota high court rules, 10/15/2007,* http://www.ama-assn.org/amednews/2007/10/15/prsa1015.htm State courts permitting claims: Alabama, Alaska, California, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Michigan, Minnesota, Mississippi, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, & Vermont. State courts rejecting claims: Delaware & Kansas.

IV. Medicare Conditions of Participation vs. Accreditation: Standards, Oversight and Risks of Noncompliance

This section summarizes the credentialing standards established by CMS Medicare Conditions of Participation, AOs, and California licensure for hospitals and clinics, as well as the risks of noncompliance.

A: Hospitals: Acute Care Hospitals

Medicare Hospital Conditions of Participation and Verification of Compliance: Medicare hospital CoPs are established in regulations as authorized by federal statute.[7] These CoPs include requirements for the governing body, which is responsible for the overall operations and governance and medical staff. The governing body delegates some credentialing and privileging functions to the medical staff but retains responsibility for:

- Appointing the members of the medical staff based on medical staff recommendations;
- Approving medical staff bylaws and requirements;
- Ensuring that the medical staff is accountable to the governing body for providing quality patient care; and
- Ensuring that the selection criteria used for medical staff membership are based on character, competency, experience, training, and judgment.[8]

The CoPs require that the hospital medical staff is responsible for:

- Periodically conducting appraisals of medical staff members;
- Examining credentials of candidates for medical staff membership and make recommendations to the governing body for medical staff appointment;
- Enforcing medical staff bylaws and establish the duties and privileges for each category of medical staff (active, courtesy, etc.);
- Describing qualifications of medical staff; and
- Establishing criteria for privileges granted to individual practitioners.

CMS publishes State Operations Manuals (SOMs) for each provider or supplier category for which Medicare benefits are provided. These SOMs provide the text of the regulations, and also

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[7] 42 CFR 482.

[8] 42 CFR 482.12.

provide Interpretive Guidelines (IGs) for both providers and SSAs to know how CMS is interpreting the regulatory requirements. In addition, CMS provides Survey Procedures to instruct SSAs on what to look for to verify compliance with regulations and the interpretation of the regulations during the course of conducting a survey.

The Interpretive Guidelines and Survey Procedures for both the Condition of Governing Body (42 CFR 482.12) and Medical Staff (42 CFR 482.22) contain information on CMS's interpretation and survey procedures used to determine compliance with federal Medicare hospital regulations (CoPs).

Relevant portions of the SOM that factor into the conflict between a credentialing/privileging by proxy process for medical staff and the CMS Medicare CoPs are included in Appendix A. While the excerpts in Appendix A are central to the subject of this paper, the entire CoPs for governing body and medical staff provide valuable context on this issue. Of particular note are the interpretive guidelines that state: there must be a single medical staff that is responsible to the governing body of the hospital for providing quality care to patients; and any criteria for credentialing or privileging must be equally-applied to all practitioners. CMS Medicare hospital CoPs do not have unique conditions or standards for the credentialing of telehealth practitioners.

Consequences of noncompliance for non-accredited hospitals:
Hospitals that are not accredited are under the jurisdiction of the SSA for purposes of verifying compliance with Medicare CoPs. CMS has established a system of prioritizing workload that the SSA performs on behalf of CMS. The highest priority workload is "Tier 1" and the lowest priority workload is "Tier 4". SSAs are expected to be able to complete all of higher priority workload in any given year, and are not to work on lower priority workload unless completion of higher priority workload is assured. CMS considers the receipt of a complaint with a high potential for immediate jeopardy to patient to be a Tier 1 workload. CMS requires the SSA to survey non-accredited hospitals no less than once every 5 years (Tier 2 workload), or no less than once every 4-5 years (Tier 3 workload), or no less than once every 3 years (Tier 4 workload) if all other higher priority workload has been accomplished.

Should the SSA find that a condition of participation is not met, it recommends to the CMS RO that the Medicare agreement be terminated. The hospital has an opportunity to correct the deficient practice and have compliance verified by a revisit from the SSA. The timeframe within which the hospital must take the corrective action depends on the severity of the deficient practice. Immediate jeopardy situations permit only 23 days, but most situations provide six months for corrective action. Actual decertification of a hospital is rare. Should a hospital's Medicare agreement be terminated, the hospital's Medi-Cal agreement is also terminated. (See Section V, page 20 for more detail on the relationship between Medicare and Medi-Cal standards.)

Hospital Accreditation and Deemed Status:

Deemed status through accreditation for hospitals is approved by CMS for three accreditation organizations: The Joint Commission (TJC), American Osteopathic Association's Health Facilities Accreditation Program (AOA/HFAP), and most recently, Det Norske Veritas Healthcare's National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO). The number of California hospitals that are accredited and non-accredited is summarized in the following chart:

ACCREDITATION TYPE/STATUS	NUMBER OF CALIFORNIA HOSPITALS (Excluding Critical Access Hospitals)
The Joint Commission	370
American Osteopathic Association	21
Det Norske Veritas Healthcare	0
Non-accredited	20
Total	**411**

Information from the California Department of Public Health, Licensing and Certification, and accreditation organization websites. (3/10)

The Joint Commission

In 1965, federal law granted approval for the Joint Commission hospital accreditation program to have deemed status. The vast majority of California's hospitals are accredited by The Joint Commission. In the past, CMS did not have oversight of TJC's standards because of TJC's statutory authority to have its accreditation program be approved for deemed status designation. Other AOs were, and are, required to submit an application to CMS for deemed status approval for their accreditation programs.

In 2001, TJC released new standards by which a Joint Commission-accredited hospital with deemed status could accept a "privileging by proxy" process with another Joint Commission-accredited hospital. This was viewed by many as a step toward recognizing the changing health care delivery system's use of telehealth, while preserving patient health and safety through using a standardized credentialing process.

The Medicare Improvements for Patients and Providers Act (MIPPA) enacted July 15, 2008, removed the statutory status of the Joint Commission's hospital accreditation program effective July 15, 2010. CMS now has the authority to review TJC's accreditation program and confirm that it meets or exceeds Medicare CoPs.

The Joint Commission was required to submit an application for approval to CMS to determine if TJC standards meets or exceeds federal Medicare hospital Conditions of Participation. As a part of this application process, CMS notified the TJC that the credentialing and privileging requirement by proxy did not meet the minimum Medicare hospice Conditions of Participation standard for medical staff credentialing. TJC was required to conform its accreditation standards to meet or exceed the CMS Medicare hospital Conditions of Participation, for those

hospitals seeking deemed status through accreditation. TJC was granted deemed status approval for its hospital accreditation program effective November 27, 2009, through July 15, 2014.[9]

The Joint Commission released a statement in October 2009 that, although TJC continues to engage CMS and members of Congress regarding the issue of credentialing and privileging by proxy as it related to telemedicine providers and users, TJC must survey to the current Medicare requirements and has changed the requirements for hospitals seeking deemed status through accreditation. These changes will be effective July 15, 2010.[10] These "Revised Hospital Requirements for Telemedicine" for hospitals seeking deemed status through accreditation include:

> LD.04.03.09, EP 4: Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body. All licensed independent practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site. (See also MS.13.01.01, EP 1; LD.04.03.09, EP 9)
>
> LD.04.03.09, EP9: Note: For hospitals that use Joint Commission accreditation for deemed status purposes: All licensed independent practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site. (See also MS.13.01.01, EP 1 and LD.04.03.09, EP 4)
>
> MS.13.01.01, EP 1: For hospitals that use Joint Commission accreditation for deemed status purposes: All licensed independent practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site, according to standards MS.06.01.03 through MS.06.01.13. Note: If the distant site is a Medicare-participating hospital, the originating site's medical staff may use a copy of the distant site's credentialing packet for privileging purposes. This packet includes a list of all privileges granted to the licensed independent practitioner by the distant site and an attestation signed by the distant site indicating that the packet is complete, accurate, and up to date.

Hospitals not seeking accreditation for deemed status purposes are not required to comply with these sections. TJC has alternative requirements for telemedicine for accreditation-only

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[9] The Joint Commission press release, *The Joint Commission's Hospital Accreditation Recognized by CMS*, November 30, 2009.

[10] The Joint Commission Perspectives, *Credentialing and Privileging by Proxy and Telemedicine*, October 2009

providers. However, if a hospital chooses not to apply for deemed status designation by CMS, the SSA has jurisdiction for routine, periodic surveys of the hospital to determine compliance with Medicare CoPs.

American Osteopathic Association/Health Facilities Accreditation Program
Hospitals accredited by the AOA/HFAP are not permitted to accept the credentialing and privileging decision of another organization (credentialing/privileging by proxy). This standard is regardless of whether the hospital seeks a deemed status by accreditation. The hospital must:

- Use the same credentialing process as required for all other providers
- Complete specified qualifications review
- Ensure that each telemedicine provider is approved using the medical staff credentialing process.[11]

Det Norske Veritas Healthcare National Integrated Accreditation for Healthcare Organizations (DNV)
There are no California hospitals currently accredited by DNV. Unlike the AOA/HFAP and TJC, DNV does not have separate standards for telemedicine credentialing and privileging. However, DNV's credentialing standards are consistent with federal Medicare hospital CoPs.

Consequences of Non-compliance for Accredited Hospitals: Accredited hospitals with deemed status, are not under the jurisdiction of the SSA for routine Medicare certification surveys. The AO conducts the routine survey. However, the SSA retains the authority to investigate complaints. Should a complaint investigation reveal such serious problems that the SSA believes that Medicare CoPs may not be met, the SSA will request CMS for permission to do a "complaint validation survey" to determine whether or not the hospital meets the CoPs.

Hospitals with deemed status may also be surveyed by the SSA under other circumstances. CMS has instructed the SSA to conduct "sample validation surveys" by selecting 10% of all accredited hospitals each year to validate whether these hospitals continue to meet the Medicare CoPs.

A finding that CoPs are not met will result in the same recommendation that the Medicare agreement be terminated, with the hospital having a specific timeframe within which they must take corrective action to come back into compliance. In addition, the hospital may lose it's deemed status while undertaking corrective action, which puts the hospital under the authority of the SSA. Deemed status may be restored by CMS after corrective action has been verified.

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[11] NCPro, *2010 Credentials Verification Desk Reference,* p. 51.

Accreditation and deemed status does not mean that a hospital no longer needs to comply with Medical hospital CoPs. Deemed status only means that the SSA does not conduct the routine verification of compliance with federal CoPs.

California State Licensing Requirements for General Acute Care Hospitals: California hospital licensing regulations for medical staff credentialing and privileging are somewhat general, and would not necessarily conflict with either the more stringent CMS Medicare medical staff credentialing standards, or the more flexible credentialing and privileging by proxy requirements established by TJC for hospitals that are not seeking accreditation for deemed status purposes.

> Title 22, § 70203. Medical Service General Requirements.
>
> (a) A committee of the medical staff shall be assigned responsibility for:
>
> > (1) Recommending to the governing body the delineation of medical privileges.
> >
> > (2) Developing, maintaining and implementing written policies and procedures in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate....
>
> (d) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

California State licensing requirements indicate a hospital must comply with its own policies and procedures. These include the hospital bylaws and other policies and procedures that govern the hospital credentialing and privileging processes.

The California SSA conducts periodic state licensing surveys once every three years as a part of a consolidated licensing survey with TJC. Joining the SSA are physician surveyors from the California Medical Associations Institute for Medical Quality (CMA/IMQ) to review medical staff, peer review processes and medical staff minutes. It is rare for the SSA to revoke a hospital license. However, there have been occasions where a temporary suspension order is issued to immediately suspend (and close operations of) a hospital.

As is the case with enforcement of federal certification standards, hospitals are provided an opportunity to correct deficient practices. It is more likely that, upon identification of a state licensing requirement with serious implications for patient health and safety, that the SSA will request of CMS approval to use federal authority to require corrective action. The threat of losing Medicare and Medicaid funding is a more immediate threat to a hospital's "bottom line" than the process for revoking a licensing, which can take 12 months or more. Regardless of

whether the deficient practice is identified under state or federal law, hospitals are very sensitive to any deficient findings and quickly take corrective action in the vast majority of cases.

B. Critical Access Hospitals

Critical Access Hospital (CAH) designation applies to small hospitals which have met certain criteria, thereby qualifying for a higher level of Medicare reimbursement (cost plus 1%). A facility that meets the following criteria may be designated by CMS as a CAH:

- Is located in a State that has established with CMS a Medicare rural hospital flexibility program; *and*
- Has been designated by the State as a CAH; *and*
- Is currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989 to November 29, 1999; or is a health clinic or health center that was downsized from a hospital; *and*
- Is located in a rural area or is treated as rural; *and*
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles); *and*
- Maintains no more than 25 inpatient beds; *and*
- Maintains an annual average length of stay of 96 hours per patient for acute inpatient care; *and*
- Complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services 7 days per week.[12]

Medicare Critical Access Hospital Conditions of Participation:

Medical critical access hospital (CAH) CoPs have a similar structure to that of acute care hospitals in that the governing body is responsible for appointing practitioners to the medical staff, must approve of the medical staff bylaws that establish the criteria for medical staff appointment, and must review the periodic evaluations of medical staff. However, since CAHs are very small and rural, a responsible individual can serve in the role of the hospital governing body. In addition, CAHs may have a single physician on staff, but does not need to be on site at all times. A mid-level practitioner may also be the medical staff of a CAH.

The medical staff membership of a CAH has similar responsibilities to screen candidates for appointment to the medical staff. An interesting difference in the CAH interpretive guidelines when compared to the acute care hospital guidelines is that there is no mention of the medical

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[12] Centers for Medicare and Medicaid Services, *Certification and Compliance: Critical Access Hospitals,* http://www.cms.hhs.gov/CertificationandComplianc/04_CAHs.asp

staff criteria to be applied equally. It is not known if this is an intentional oversight or is an indication of CMS willing to grant more flexibility for CAHs. Consultation with CMS would be required to determine the significance of this difference.

Critical Access Hospital Accreditation and Deemed Status:

ACCREDITATION TYPE/STATUS	NUMBER OF CALIFORNIA CRITICAL ACCESS HOSPITALS
The Joint Commission	12
American Osteopathic Association	1
Det Norske Veritas Healthcare	0
Non-accredited	15
Total	**28**

Information from the California Department of Public Health, Licensing and Certification, Office of Statewide Health Planning and Development, and accreditation organization websites. (3/10)

Fifty-three percent (53%) of all critical access hospitals in California are not accredited.

The Joint Commission
TJC was granted deemed status approval for its critical access hospital accreditation program effective July 2009, through November 21, 2011.[13] TJC has stated that, "... all Medicare CoPs for CAHs are encompassed by Joint Commission standards..." [14]

American Osteopathic Association/Health Facilities Accreditation Program
The AOA/HFAP has been deemed to meet or exceed Medicare CoPs. The AOA/HFAP also incorporates the Medicare CoPs in its standards.

Consequences of Non-compliance for Accredited and Non-accredited Hospitals: The consequences and enforcement of CAH non-compliance is the same as for acute care hospitals. Hospitals are provided an opportunity to correct the non-compliance. The timeframe within which the CAH is required to complete correction depends on the severity of the violation and how it affects the health and safety of patients. CAHs with deemed status may have their deemed status revoked by CMS until the hospital is confirmed to be back in compliance with CoPs.

California State Licensing Requirements for Critical Access Hospitals:

CAH designation is a federal designation. CAHs are licensed as general acute care hospitals (GACHs) in California, and must comply with the same state requirements for medical staff credentialing for GACHs. There are also special state regulatory requirements for "small and

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[13] The Joint Commission press release, *CMS Recognizes The Joint Commission's Critical Access Hospital Accreditation*, July 8, 2009.

[14] The Joint Commission website: *Facts about Critical Access Hospital Accreditation*, http://www.jointcommission.org/AccreditationPrograms/CriticalAccessHospitals/cah_facts.htm

rural hospitals" that provides some flexibility from CAH requirements[15]. However, the requirements for medical staff are the same for CAHs as for "small and rural" hospitals.

[15] Title 22, Sections 70901 through 70923.

C. Clinics

The potential for conflict between credentialing requirements for Medicare participation and AO does not exist at this point in time for any category of clinic. No AO has applied, nor has CMS approved any accreditation program for "deemed status" designation for rural health clinics (RHCs), federally-qualified health centers (FQHCs), FQHC look-alikes, Indian health clinics, or other categories of primary care clinics.

Rural Health Clinics (RHCs):

Rural Health Clinics (RHCs) can be owned and operated by a physician, non-profit or for-profit organization, hospital, skilled nursing facility, or home health agency and the clinic must be located in a an area that is designated as a shortage area. Hospital-based RHCs must meet hospital medical staff credentialing requirements. Otherwise, the RHC must confirm that physician's who own, are employed by or under contract to provide services in the clinic are licensed in the state where the center is located. The RHC must also ensure that there are arrangements or agreements with providers for inpatient and other services.[16] Credentialing or privileging by proxy would not be prohibited under Medicare CoPs in an RHC unless the RHC is hospital provider-based.

Oversight of compliance with federal Medicare CoPs rests with the SSA. CMS would consider as high priority (Tier 1 workload), a complaint that presents the potential for immediate jeopardy to patients. In addition, CMS has set a SSA goal of conducting at least 5% of RHCs of providers more at risk of quality problems (Tier 2 workload) Otherwise, CMS has assigned to the SSA a survey interval of 7.0 years (Tier 3 workload), or 6.0 years (Tier 4 workload), if higher priority workload for other provider categories has first been completed.

Federally-Qualified Health Centers (FQHCs) and FQHC look-alikes:

FQHCs must meet the same conditions of participation as RHCs. FQHC primary care providers must be licensed to practice in the State where the center is located. The FQHC's physicians, "... should obtain admitting privileges at their referral hospital(s) so health center patients can be followed as inpatients by health center clinicians in order to ensure continuity of care. When this is not possible, the applicant must have firmly established arrangements for patient hospitalization, discharge planning and patient tracking".[17] These are the only requirements related to credentialing or privileging, therefore privileging by proxy arrangements would not be prohibited by CMS for FQHCs.

However, unlike RHCs, oversight for FQHC compliance does not rest with the SSA. An FQHC that wishes to become a Medicare-certified supplier is subject to a filing procedure instead of certification through the SSA. The FQHC must attest that it is in compliance with Medicare

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[16] 42 CFR 491.9(d).

[17] United States Health Resources and Service Administration (HRSA), *Policy Information Notice 2003-21:Federally Qualified Look-Alike Guidelines and Application,* http://bphc.hrsa.gov/policy/pin0321.htm

regulations. The SSA does not conduct a survey to confirm compliance with Medicare requirements.

Any complaints about the FQHC are the jurisdiction of the CMS Regional Office. The RO reviews the complaint and refers the complaint to the United States Health Resources and Services administration (HRSA) or to the Indian Health Service (HIS), as applicable. If the complaint alleges non-compliance with the federal Medicare Conditions of Participation, the RO will request that the SSA conduct the complaint investigation. The RO will conduct the complaint investigation if the FQHC is located on reservation property.

The CMS RO may terminate the Medicare agreement with an FQHC if it finds that the FQHC no longer meets the Medicare eligibility standards and/or is not in substantial compliance with other Medicare requirements for FQHCs. [18]

FQHC's seeking enrollment as a Medi-Cal provider do go through the SSA application process.

Indian Health Service Clinics:
Medicare certification for any facility owned or operated by the IHS is the jurisdiction of the CMS Regional Office because it involves intergovernmental jurisdiction. The state is responsible for determining whether the facility meets state Medicaid certification requirements. The state may accept Medicare certification as evidence of meeting Medicaid requirements, or the state may conduct a survey. Indian health tribal facilities may or may not be under Federal jurisdiction, therefore the CMS RO determines whether the RO or the state has jurisdiction.[19]

V. Medi-Cal requirements

California requires Medicare certification as a condition for provider enrollment in the Medi-Cal program.

> Title 22, § 51200(d) states that, "All applicants applying for enrollment, or providers applying for continued enrollment, in the Medi-Cal program shall be certified for participation in the Medicare program of the Federal Social Security Act (Title XVIII), if they provide services that are included in the Medicare scope of benefits and if they provide those services to persons who are eligible beneficiaries of the Medicare program".

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[18] Centers for Medicare and Medicaid Services, *CMS Manual System: Publication 100-07 State Operations Provider Certification*

[19] Centers for Medicare and Medicaid Services, *State Operations Manual: Chapter 1Program Background and Responsibilities, Section 1018, http://www.cms.hhs.gov/manuals/downloads/som107c01.pdf*

In addition, the California State Plan[20] establishes the relationship between the state Medicaid agency (Department of Health Care Services) and the SSA (California Department of Public Health or CDPH), for purposes of establishing standards for public or private institutions that provide services to Medicaid beneficiaries. CDPH determines if institutions and agencies meet the requirements for participation in the Medicaid program. This arrangement complies with 42 CFR 610.610 which requires this relationship be established. CDPH uses Medicare CoPs for provider categories that are included in the Medicare scope of benefits. For primary care clinics that provide services that are not included in the Medicare scope of benefits, the SSA uses state licensing requirements as the standard for enrollment in the Medi-Cal program.

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[20] California State Plan, Section 4.11, http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

VI. Impact of Credentialing Standards on Private Pay Patients:

Medicare Conditions of participation are requirements for each hospital that wishes to bill Medicare and/or Medi-Cal. Medicare requires a single medical staff with the criteria for medical staff credentialing and privileging to be applied equally to all practitioners, thereby not permitting a different medical staff credentialing process for private pay patients than is required for Medicare or Medi-Cal beneficiaries. Indeed, even if a different process were permitted, hospitals may find a dual-credentialing and privileging process to be extraordinarily cumbersome, and expose the hospital to unnecessary liability.

VII. Summary and Conclusions

At this time, CMS will not permit credentialing or privileging by proxy for telehealth practitioners. The federal Medicare hospital CoPs clearly require each hospital's governing body to have the authority and responsibility to appoint each practitioner to the hospital's medical staff or to grant hospital privileges. The appointment or granting of privileges is to be approved only after the hospital medical staffs have satisfied themselves that the candidate meets or exceeds the criteria established by the medical staff and approved by the governing body. CMS requires that this criterion be applied equally to all hospital practitioners.

It is important that all stakeholders involved in promoting the use of telehealth services engage CMS to determine the extent to which hospital credentialing and privileging processes can continue to protect the health and safety of hospital patients and not present such a significant barrier to using telehealth services. CMS would most likely insist that hospitals have the same credentialing/privileging requirements whether they are accredited, accredited with deemed status or non-accredited. CMS would also most likely insist that all AOs have largely the same types of requirements.

Achieving a sensible, nation-wide credentialing/privileging standard for telehealth practitioners cannot be done by the AOs alone. Necessary change requires a fundamental regulatory solution that is embraced by CMS, recognizes the importance of telehealth in today's health care delivery system, and develops uniform standards that do not overly-burden hospitals providers.

Appendix A: 42 CFR 482

(Medicare Hospital Conditions of Participation)

Governing Body
Regulations: 42 CFR 482.12(a)(5) **Standard: "Ensure that the medical Staff is accountable to the governing body for the quality of care provided to patients."**
Interpretive Guidelines: "...All hospital patients must be under the care of a practitioner ... who has been granted medical staff privileges, or under the care of a practitioner who is directly under the supervision of a member of the medical staff. All patient care is provided by or in accordance with the orders of a practitioner who has been granted privileges in accordance with the criteria established by the governing body, and who is working within the scope of those granted privileges."
Survey Procedure: "Verify that any individual providing patient care services is a member of the medical staff or is accountable to a member of the medical staff qualified to evaluate the quality of services provided, and in turn, is responsible to the governing body for the quality of services provided"[21]

Governing Body
Regulations 42 CFR 482.12(a)(6) Standard: **"Ensure the criteria for selection are individual character, competence, training, experience, and judgment."**
Interpretive Guidelines: "The governing body must ensure that the hospital's bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners [emphasis added] in each professional category of practitioners."
Survey Procedures: No guidance on the specific interpretation related to "privileges applying equally".

[21] State Operations Manual, *Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.*

Medical Staff
Regulations 42 CFR 482.22 Condition: **"The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to its patients by the hospital."**
Interpretive Guidelines: "The hospital may have only one medical staff for the entire hospital (including all campuses, provider-based locations, satellites, remote locations, etc.). The medical staff must be organized and integrated as one body that operates under one set of bylaws approved by the governing body. These medical staff bylaws must apply equally to all practitioners [emphasis added] within each category of practitioners at all locations of the hospital and to the care provided at all locations of the hospital. The single medical staff is responsible for the quality of medical care provided to patients by the hospital."
Survey procedures: There are no survey procedures for this condition-level requirement.

Medical Staff
Regulations 42 CFR 482.22(a)(2) Standard: the medical staff must examine credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates.
Interpretive Guidelines: There must be a mechanism established to examine credentials of individual prospective members (new appointments or reappointments) by the medical staff. … The medical staff makes recommendations to the governing body for each candidate for medical staff membership/privileges that are specific to type of appointment and extent of the individual practitioner's specific clinical privilege, and then the governing body takes final appointment action. A separate credentials file must be maintained for each individual medical staff member of applicant. The hospitals must ensure that the practitioner and appropriate hospital patient care areas/departments are informed of the privileges granted to the practitioner.
Survey Procedures: Determine whether the medical staff bylaws identify the process and criteria to be used for the evaluation of candidates for medical staff membership/privilege. Determine whether the criteria used for evaluation comply with the requirements of this section, State law, and hospital bylaws, rules and regulations. Determine whether the medical staff has a system to ensure that practitioners seek approval to expand their privileges for tasks/activities/procedures that go beyond the specified list of privileges for their category of practitioner.

Medical Staff
Regulations 42 CFR 482.22(a)(2) Standard: the medical staff must examine credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates.
Interpretive Guidelines: There must be a mechanism established to examine credentials of individual prospective members (new appointments or reappointments) by the medical staff. ... The medical staff makes recommendations to the governing body for each candidate for medical staff membership/privileges that are specific to type of appointment and extent of the individual practitioner's specific clinical privilege, and then the governing body takes final appointment action. A separate credentials file must be maintained for each individual medical staff member of applicant. The hospitals must ensure that the practitioner and appropriate hospital patient care areas/departments are informed of the privileges granted to the practitioner.
Survey Procedures: Determine whether the medical staff bylaws identify the process and criteria to be used for the evaluation of candidates for medical staff membership/privilege. Determine whether the criteria used for evaluation comply with the requirements of this section, State law, and hospital bylaws, rules and regulations. Determine whether the medical staff has a system to ensure that practitioners seek approval to expand their privileges for tasks/activities/procedures that go beyond the specified list of privileges for their category of practitioner.

Medical Staff
Regulations 42 CFR 482.22(c)(4) Standard: "Describe the qualification to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body."
Interpretive Guidelines: "...The bylaws must apply equally [emphasis added] to all practitioners in each professional category of practitioner. The medical staff then recommends individual candidates that meet those requirements to the governing body for appointment to the medical staff."
Survey Procedures: "Verify that there are written criteria for appointments to the medical staff and granting of medical staff privileges. Verify that granting of medical staff membership or privileges, is based upon an individual practitioner's meeting the medical staff's membership/privileging criteria. Verify that at minimum, criteria for appointment to the medical staff/granting of medical staff privileges are individual character, competence, training, experience, and judgment. ..."

Medical Staff
Regulations 42 CFR 482.22(c)(6 Standard): "Include criteria for determining the privileges to be granted to individual practitioners and a procedure for apply the criteria to individuals requesting privileges."
Interpretive Guidelines: "All patient care is provided by or in accordance with the orders of a practitioner show meets the medical staff criteria and procedures for the privileges granted, who has been granted privileges in accordance with those criteria by the governing body, and who is working within the scope of those granted privileges. Privileges are granted by the hospital's governing body to individual practitioner's qualifications and the medical staff's recommendations for that individual practitioner to the governing body."
Survey Procedures: "Verify that the medical staff bylaws contain criteria for granting, withdrawing, and modifying clinical privileges to individual practitioners of the medical staff and that a procedure exists for applying those criteria. Verify that practitioners who provide care to patients are working with in the scope of the privileges granted by the governing body."

Appendix B: 42 CFR 485

(Medicare Critical Access Hospital Conditions of Participation)

Governing Body
Regulation 42 CFR 485.627(a) Standard: "The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment."
Interpretive Guidelines: "...It is the responsibility of the governing body (or responsible individual) to appoint, with the advice of the medical staff, the individual practitioners to the medical staff. After considering medical staff recommendations and in accordance with established CAH medical staff criteria ... the governing body (or responsible individual) decide whether or not to appoint new medical staff members or continue current members of the medical staff. ... All CAH patients must be under the care of a member of the medical staff or under the care of a practitioner who is under the supervision of a member of the medical staff. ... Criteria for selection of both new medical staff members and selection of current medical staff members for continued membership must be based on: Individual character; Individual competence; Individual training; Individual experience; and Individual judgment."
Survey Procedures: "... Evaluate records of medical staff appointments to substantiate the governing body's (or responsible individual's) involvement in appointments of medical staff members. Confirm that the governing body (or responsible individual) appoints all members to the medical staff in accordance with established policies based on the individual practitioner's scope of clinical expertise and in accordance with Federal and State law. Verify that the medical staff operates under current bylaws that are in accordance with Federal or State laws and regulations. ... Verify that any individual providing patient care services is a member of the medical staff or is accountable to a member of the medical staff qualified to evaluate the quality of services provided, and in turn, is responsible to the governing body (or responsible individual) for the quality of services provided. Verify that there are written criteria for staff appointments to the medical staff. Verify that selection of medical staff for membership, both new and renewal is based upon an individual practitioner's compliance with the medical staff's membership criteria. Verify that at minimum, criteria for selection to the medical staff are individual character, competence, training, experience and judgment.

AGENDA ITEM 16

ENFORCEMENT DATA AND REPORTS.

Attached are the following:

- Citations issued date for the period 7/1 – 9/30/2011.
- Enforcement Statistical reports for the period 7/1 – 9/30/2011.
- Listing of current probationers.

CITATIONS ISSUED
7/1/11 - 9/30/11

#	LICENSURE CLASS			VIOLATION						CIT. #	FINE (OT)	OT Fine Modified	GRAND TOTAL FINE DUE (OT)	FINE (OTA)	OTA Fine Modified	GRAND TOTAL FINE DUE (OTA)	DATE ISSUED	DUE DATES		Appeal Rcvd		PAYMENT			
	OT	OTA	No Lic	FDC	UPC	CC	ULP	PDU	AD									Req For Conf.	Fine	ICR	ADMIN	Pymnt Date	Pymnt Amnt	Bal (OT)	Bal (OTA)
1	1								1	OT 2010-587	$50		$50				07/01/11	07/31/11	07/31/11			07/11/11	$50	$0	
1	1								1	OT 2010-611	$50		$50				07/01/11	07/31/11	07/31/11					$50	
1	1								1	OT 2010-581	$50		$50				07/01/11	07/31/11	07/31/11					$50	
1	1								1	OT 2010-619	$50		$50				07/01/11	07/31/11	07/31/11			07/20/11	$50	$0	
1	1								1	OT 2010-588	$50		$50				07/05/11	08/04/11	08/04/11			07/15/11	$50	$0	
1		1							1	OA 2010-585				$50		$50	07/01/11	07/31/11	07/31/11			07/11/11	$50		$0
1		1							1	OA 2010-589				$50		$50	07/01/11	07/31/11	07/31/11						$50
1	1							1		OT 2010-537	$250		$250				07/06/11	08/05/11	08/05/11			07/18/11	$250	$0	
1		1						1		OA 2010-597				$250		$250	07/07/11	08/06/11	08/06/11						$250
1	1							1		OT 2010-596	$250		$250				07/08/11	08/07/11	08/07/11			07/25/11	$250	$0	
1	1						1			OT 2010-496	$275		$275				07/08/11	08/07/11	08/07/11			07/21/11	$275	$0	
1	1								1	OT 2010-668	$50		$50				07/08/11	08/07/11	08/07/11					$50	
1	1								1	OT 2010-654	$50		$50				07/08/11	08/07/11	08/07/11			08/19/11	$50	$0	
1	1								1	OT 2010-650	$50	$50	$0				07/08/11	08/07/11	08/07/11	1		WITHDRAWN		$0	
1	1								1	OT 2010-669	$50		$50				07/08/11	08/07/11	08/07/11					$50	
1		1							1	OA 2010-582				$50		$50	07/19/11	08/18/11	08/18/11			08/18/11	$50		$0
1	1								1	OT 2010-550	$50		$50				07/19/11	08/18/11	08/18/11			10/07/11	$50	$0	
1	1								1	OT 2010-580	$50		$50				07/19/11	08/18/11	08/18/11			07/28/11	$50	$0	
1	1								1	OT 2010-554	$50		$50				07/19/11	08/18/11	08/18/11			09/01/11	$50	$0	
1	1								1	OT 2010-543	$50		$50				07/19/11	08/18/11	08/18/11			07/27/11	$50	$0	
1	1								1	OT 2010-573	$50		$50				07/19/11	08/18/11	08/18/11					$50	
1	1								1	OT 2010-584	$50		$50				07/19/11	08/18/11	08/18/11			07/25/11	$50	$0	
1	1						1			OT 2010-482	$2,500		$2,500				07/19/11	08/18/11	08/18/11			09/26/11	$300	$2,200	
1	1								1	OT 2010-656	$50		$50				07/28/11	08/27/11	08/27/11			08/15/11	$50	$0	
1	1								1	OT 2010-649	$50		$50				07/28/11	08/27/11	08/27/11					$50	
1	1								1	OT 2010-655	$50		$50				07/28/11	08/27/11	08/27/11					$50	
1	1								1	OT 2010-646	$50		$50				07/28/11	08/27/11	08/27/11			10/07/11	$50	$0	
1	1								1	OT 2010-630	$50		$50				07/29/11	08/28/11	08/28/11				$50	$0	
1	1						1			OT 2010-642	$375		$375				07/29/11	08/28/11	08/28/11			08/02/11	$375	$0	
1	1						1			OT 2010-642	$275		$275				07/29/11	08/28/11	08/28/11			08/22/11	$275	$0	
1	1			1		1				AL 2010-626	$400		$400				08/11/11	09/10/11	09/10/11			09/06/11	$400	$0	
1	1								1	OT 2010-679	$50		$50				08/22/11	09/21/11	09/21/11					$50	
1	1								1	OT 2011-32	$50		$50				08/22/11	09/21/11	09/21/11					$50	
1	1								1	OT 2010-539	$50	$50	$0				08/23/11	09/22/11	09/22/11	1		DISMISSED		$0	
1	1						1			OT 2010-552	$900		$900				08/25/11	09/24/11	09/24/11			09/19/11	$900	$0	

CITATIONS ISSUED
7/1/11 - 9/30/11

1	1								1	OT 2010-508	$50	$50	$0				08/30/11	09/29/11	09/29/01	1		DISMISSED		$0	
1	1							1		OT 2010-667	$250		$250				09/01/11	10/01/11	10/01/11			09/29/11	$250	$0	
1		1						1		OA 2010-681				$250	$250	$0	09/02/11	10/02/11	10/02/11	1	1	WITHDRAWN			$0
1		1							1	OA 2011-17				$50		$50	09/02/11	10/02/11	10/02/11						$50
1		1							1	OA 2011-22				$50		$50	09/02/11	10/02/11	10/02/11			09/23/11	$50		$0
1	1								1	OT 2011-9	$50		$50				09/02/11	10/02/11	10/02/11					$50	
1	1								1	OT 2011-26	$50		$50				09/02/11	10/02/11	10/02/11					$50	
1	1									OT 2011-11	$50		$50				09/06/11	10/06/11	10/06/11					$50	
1	1								1	OT 2011-23	$50		$50				10/04/11	11/03/11	11/03/11					$50	
1		1							1	OA 2011-7				$50		$50	10/04/11	11/03/11	11/03/11						$50
1	1								1	OT 2011-24	$50		$50				10/04/11	11/03/11	11/03/11					$50	
1		1			1					OA 2008-83				$1,000		$1,000	10/05/11	11/04/11	11/04/11						$1,000
1	1								1	OT 2011-6	$50		$50				10/07/11	11/06/11	11/06/11			10/12/11	$50	$0	
1	1								1	OT 2011-16	$50		$50				10/07/11	11/06/11	11/06/11					$50	
1	1								1	OT 2011-12	$50		$50				10/07/11	11/06/11	11/06/11					$50	
1		1			2					AR 2010-614				$500		$500	10/11/11	11/10/11	11/10/11						$500
1	1		1							AL 2011-20	$250		$250				10/11/11	11/10/11	11/10/11					$250	
1		1							1	OA 2011-33				$50		$50	10/13/11	11/12/11	11/12/11						$50
1	1								1	OT 2011-52	$50		$50				10/13/11	11/12/11	11/12/11					$50	
1	1								1	OT 2011-18	$50		$50				10/13/11	11/12/11	11/12/11					$50	
55	44	11	1	1	3	1	5	5	40		$7,425	$150	$7,275	$2,350	$250	$2,100				4	1		$4,075	$3,350	$1,950

Violation Key:

Applicant
FDC - Failure to Disclose Criminal Convictions
UPC - Unprofessional Conduct-Misrepresent credentials

Assigned to FTB Intercept program = 19 cases

Licensee
UPC - Unprofessional Conduct
CC - Criminal Convictions
ULP - Unlicensed Practice
PDU - Continuing Education
AD - Failure to Notify of Address Change

Non-Licensed
UL P- Unlicensed Practice

**Citation payments received in this quarter for citations issued in a previous quarter are not reflected in this table.

***Appeals requested in this quarter. Conferences and hearings may have been/will be held within a different quarter

BOT ENFORCEMENT STATISTICAL REPORT
July 1, 2011 – September 30, 2011

Total Complaints-Received: 132

Complaints-Closed: 145

Total Complaints-Pending: 131 (Oldest: 9/19/08)

Record of Arrests and Prosecutions [RAP] Received: 11

DOI Investigations Initiated: 16

DOI Investigation Reports Received: 12

Formal DOI Investigations Pending: 16 (Oldest: 2/8/11)

Subsequent Arrest Reports Received: 11

Applications Denied pursuant to Business and Professions Code 480/485: 1

Cases Pending with the Attorney General (AG): 22

Transmitted	Complaint No	Type	Current Status
09/22/09	OT 2008-374	Accusation	Stipulated Settlement adopted, 3 year probation effective 11/11/11
01/20/10	OT 2008-87	Accusation	Proposed Decision adopted, case dismissed effective 10/13/11
07/21/10	D1 2008-77	Pet to Rev Prob	Stipulated Settlement adopted, prob ext to 10/23/15 eff 11/11/11
08/03/10	OA 2009-134	Accusation	Stipulated Settlement adopted, 3 yrs probation effective 11/11/11
08/31/10	OT 2009-278	Accusation	Stipulated Settlement adopted, 3 yrs probation effective 11/11/11
09/02/10	OA 2009-266	Accusation	Stipulated Settlement adopted, 2 yrs probation effective 10/25/11
09/16/10	OT 2009-43	Accusation	Hearing held 10/26/11, Proposed Decision TB voted on 12/1/11
11/03/10	OT 2009-195	Accusation	Accusation filed 3/24/11; NOD recd 4/12/11; Hearing scheduled 2/16/12
11/12/10	OT 2009-139	Accusation	Accusation filed 2/2/11; NOD recd 2/22/11; Hearing scheduled 1/12/12
01/05/ 11	AR 2010-153	SOI	Hearing held, ALJ Proposed Decision pending
01/18/11	D1 2008-27	Pet to Rev Prob	PTR filed 6/27/11; Hearing scheduled 2/9/12
03/10/11	D1 2007-90	Pet to Rev Prob	PTR filed 10/11/11; NOD recd, DAG to schedule hearing
03/21/11	AL 2010-176	SOI	Board Decision to grant license w probation; 3 yrs prob eff 11/7/11
03/23/11	OA 2010-177	Accusation	Accusation filed 6/28/11; NOD recd; Hearing scheduled 3/19/12
04/07/11	D1 2008-455	Pet to Rev Prob	PTR filed 6/3/11; NOD recd; Hearing scheduled 1/30/12
04/14/11	D1 2009-15	Pet to Rev Prob	PTR filed 8/30/11; NOD recd; Hearing request to OAH 10/11/11
04/26/11	OA 2010-315	Accusation	Accusation filed 7/11/11; NOD recd; Hearing scheduled 3/19/12
04/27/11	AL 2010-327	SOI	Board Decision to grant lic w prob; 1 yr prob TB eff upon rcpt of ILF
05/10/11	OT 2010-182	Accusation	Accusation filed 6/28/11; NOD recd; Hearing scheduled 2/22/12
07/13/11	AL 2010-527	SOI	Statement of Issues filed 9/21/11; Hearing request to OAH 10/14/11
07/14/11	OT 2010-205	Accusation	Closed 10/31/11 – Resp. stips to psych eval; eval TBS
08/22/11	OT 2007-220	Accusation	Accusation filed 11/3/11

Statement of Issues filed: 2
Petition to Revoke Probation filed: 2

Accusations filed: 1
Accusation & Petition to Revoke Probation filed: 0

Report prepared 11/15/2011

Final Decisions: **3**

July 6, 2011	Scott Kemp	Default Revocation
July 21, 2011	Shana Novegrod	3 Years Probation
July 26, 2011	Shawna Kemp	18 Months Probation

Cease Practice Orders Issued: **2**

September 19, 2011	Anne Hickey
September 28, 2011	Solena Clements

Practitioners Currently on Probation

NAME	LICENSE #			LENGTH OF PROBATION	EFFECTIVE DATE
Adams, Monica	OT 10760	Charging Document	Probation Order	3 Years	08/11/09
Belasco, Jonathan	OTA 1063	Charging Document	Probation Order	3 Years	06/16/10
Champlin, Susan	OT 10842	Charging Document	Probation Order	3 Years	09/15/09
Clements, Solena	OTA 1504	Charging Document	Probation Order	3 Years	09/01/10
Crane, Jody	OT 10136	Charging Document	Probation Order	4 Years	07/23/08
Dunham, Cynthia	OT 9217	Charging Document	Probation Order	5 Years	01/30/07
Fujikawa, Kris	OT 5673	Charging Document	Probation Order	5 Years	05/13/07
Galaviz, Jaime H.	OTA 1799	Charging Document	Probation Order	3 Years	12/09/10
Harris, Donald	OTA 1772	Charging Document	Probation Order	4 Years	04/23/10
Hickey, Anne	OT 7080	Charging Document	Probation Order	3 Years	08/19/10
Jayne, Benjamin	OT 10605	Charging Document	Probation Order	3 Years	04/10/09
Kemp, Shawna M.	OT 2364	Charging Document	Probation Order	18 mos	07/26/11
Lucia, Rinea	OT 6433	Charging Document	Probation Order	3 Years	08/20/09
McGowin, Terry D.	OTA 757	Charging Document	Probation Order	2 Years	10/25/11
Ngo, Lisa B.	OT 11572	Charging Document	Probation Order	3 Years	11/19/10
Novegrod, Shana E.	OT 4624	Charging Document	Probation Order	3 years	07/21/11
Pitts, Andre	OTA 1829	Charging Document	Probation Order	5 Years	09/23/08
Rogers, Amy	OT 10926	Charging Document	Probation Order	3 Years	10/29/09
Schmidt, Rebecca	OT 8291	Charging Document	Probation Order	3 Years	11/27/09
Searcy, Mary	OT 6209	Charging Document	Probation Order	2 Years	09/01/10
Severin, Sandra	OTA 1975	Charging Document	Probation Order	3 Years	12/22/09
Smith, Lindsey	OT 11072	Charging Document	Probation Order	30 mos	01/07/10
Yoshino, Kevin	OT 9052	Charging Document	Probation Order	3 Years	11/11/10

If you are unable to access or print the linked documents on this page, these items can be sent to you via email, fax or regular postal mail. If you are requesting it be faxed to you, please be sure to provide your fax number. Otherwise please call us at 916/263-2294 and press '2' or send an email to: EnfPrg@dca.ca.gov.

This web site contains PDF documents that require the most current version of Adobe Reader to view. To download click on the icon below.

REGULATIONS UPDATE REPORT

The Regulations Update report is attached for review.

REGULATION UPDATE REPORT

Rulemaking File Subject	Sec.	Status	Close of public comment period	Date Pkg Sent to DCA	Date Pkg Rtn'd from DCA (1-yr deadline)	Final Pkg Due to OAL	Actual Submit Date To OAL	Date language goes into effect
Definitions and Delegation of Certain of Functions, Other	4100, 4101, 4146, 4148 4149, 4149.1	Language adopted by the Board at September 2011 meeting. (CPEI regulations)	09/05/2011	10/20/2011	07/21/2012			
Registration for Sponsored Health Care Events	4116, 4117, 4118, 4119	Language adopted by the Board at September 2011 meeting. (This language implements AB 2699)	09/05/2011	11/2/2011	07/21/2012			
Advanced Practice Application (PAMS only)	4155	Language adopted by the Board at September 2011 meeting. (Error in rulemaking file – technical amendment)	09/05/2011	11/2/2011	07/21/2012			
Definitions and Supervision Plan for an Occupational Therapist	4180, 4184, 4187	Language to amend sections 4180 and 4187 approved at July 2010 Board meeting and section 4184 approved at March 2011 Board meeting; to be published.	11/14/2011		10/13/2012			
Retired Status	4123	Language approved at July 2010 Board meeting; ~~to be published~~. Practice Committee reviewed; revised language to be brought back to Board at December 2011 Board meeting. (existing 4123 to be re-numbered 4126)						
Ethical Standards of Practice	4170	Language approved at July 2010 Board meeting; to be published.						
Notification to Consumers	4171	Language approved at September 2011 meeting; to be published						

REGULATION UPDATE REPORT

Rulemaking File Subject	Sec.	Status	Close of public comment period	Date Pkg Sent to DCA	Date Pkg Rtn'd from DCA	Final Pkg Due to OAL	Actual Submit Date To OAL	Date language goes into effect
Provide mechanism for OT to request to supervise more than 2 OTAs	tbd	Implement BPC 2570.3(j)(2). Draft language to be presented to the Board for approval.						
Citations and Disciplinary Guidelines	4144 4147	Enforcement Committee to review; draft language to be presented to the Board for approval.						

AGENDA ITEM 18

SELECTION OF 2012 MEETING DATES.

A 2012 calendar is attached for review.

STATE OF CALIFORNIA
APPOINTMENT CALENDAR
STD. 101 (REV. 9/2010)

State Pay Period Calendar for 2012

JANUARY 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY 2012
21 Days 168 Hours

SU	M	TU	W	TH	F	SA
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29			

MARCH 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

APRIL 2012
21 Days 168 Hours

SU	M	TU	W	TH	F	SA
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

MAY 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

JUNE 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
				31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

JULY 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

AUGUST 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

SEPTEMBER 2012
21 Days 168 Hours

SU	M	TU	W	TH	F	SA
					31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

OCTOBER 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

NOVEMBER 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			31	1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

DECEMBER 2012
22 Days 176 Hours

SU	M	TU	W	TH	F	SA
					30	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOTE: Holidays and pay periods after July 1, 2010 are subject to any collective bargaining agreements negotiated in Fiscal Year 2010–2011 or thereafter.