

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

Occupational Therapist– Occupational Therapy Assistant Partnerships: Achieving High Ethical Standards in a Challenging Health Care Environment

Health care reform, regardless of its design or policies, will likely influence the practice of occupational therapy in both traditional settings and emerging practice areas. Expected budget cuts in federal and state programs may affect occupational therapy in school systems, hospitals, community agencies, and skilled nursing facilities (SNFs) nationwide. Greater demand could be placed on occupational therapy assistants to fill positions for more delivery of occupational therapy services, which would free occupational therapists to focus on conducting evaluations and performing supervisory tasks. Managers with fiscal accountability may place higher productivity expectations on practitioners. In a field in which staffing shortages exist, practitioners need to stay focused on delivering high-quality care that meets ethical standards.

The American Occupational Therapy Association (AOTA) provides guidance to occupational therapy personnel regarding the ethical standards of the profession. Principle 1G of the *Occupational Therapy Code of Ethics* (2015; referred to as the “Code”; AOTA, 2015) states that it is the duty of occupational therapy practitioners to “maintain competency by ongoing participation in education relevant to one’s practice area” (p. 3). Principle 4E, Justice, guides occupational therapy personnel to “maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy” (p. 5). Occupational therapy assistants need to be supervised appropriately according to state practice acts, regulations, and organizational policies. Successful occupational therapy practitioners in an evolving health care delivery system must be familiar with and consider professional ethical standards as they confront potential new challenges of health care reform. This Advisory Opinion addresses trends in the workforce, as well as strategies for ensuring appropriate supervision of occupational therapy assistants, teamwork, and effective collaboration to provide high-quality occupational therapy services despite budgetary constraints. Case examples are included to illustrate ethical dilemmas and practical solutions in an occupational therapist–occupational therapy assistant partnership.

WORKFORCE TRENDS

As an occupational therapist working for a rehabilitation company that contracts with SNFs, Pat splits her day between two buildings. She is responsible for evaluating new patients and supervising the occupational therapy assistants in those facilities. The recruiter just hired a new occupational therapy assistant graduate who is working under a temporary license. The plan is that she will replace the occupational therapy assistant in one of Pat's facilities. The staffing coordinator says that Pat's working situation will remain the same. However, because of the restrictions placed on someone working with a temporary license, Pat knows that she, as the supervising occupational therapist, needs to be on site while the new occupational therapy assistant is working with clients. Pat's strategy to address the ethical concern is to obtain a copy of the state licensure regulations and present them to the recruiter and staffing coordinator. She explains the restrictions for those working under a temporary license as well as the need for occupational therapy supervision and mentoring for new graduates and then discusses the importance of ensuring consistent service competency.

Jim works in a comprehensive outpatient rehabilitation facility (CORF) as an occupational therapy assistant. The rehab manager has asked Jim to do all the treatments so that the occupational therapist can spend more time on evaluations. Medicare guidelines state that in CORFs, the occupational therapy assistant cannot provide the final discharge treatment, because that visit is considered a reassessment. Jim's strategy is to explain to the rehab manager that even though the guideline on final discharge treatment is not specified in his state's practice act, Jim must comply with the more stringent Medicare policy.

Although the health care environment has been challenging in recent years, there is good news for the profession of occupational therapy. In part because of increasing numbers of aging Baby Boomers, the employment outlook for occupational therapy practitioners is bright. With increasing demand in the job market, it is critical that all parties adhere to rules and regulations related to supervision. As depicted in the case examples, there are times when department managers in other disciplines are not knowledgeable about regulations for delivering occupational therapy services. Principles 4E and 4F of the Code state that occupational therapy professionals must be familiar with rules and regulations that guide our practice and must inform those we work for and with of any changes to those laws and AOTA policies. With appropriate supervision to meet legal and ethical requirements, occupational therapy assistants can effectively deliver high-quality

occupational therapy services in both traditional and emerging practice areas.

SUPERVISING OCCUPATIONAL THERAPY ASSISTANTS AND SHARING RESPONSIBILITIES

Kim is an occupational therapy assistant working on an inpatient rehabilitation unit. Her supervising occupational therapist has written a plan of care that includes the use of electrical stimulation with a patient who has had a stroke. Kim completed the required training and has documentation to support her competency in the use of physical agent modalities (PAMs).

According to the state licensure law, Kim must be supervised by an occupational therapist who has also had the necessary training in PAMs. However, the supervising occupational therapist is not competent or qualified in the use of PAMs.

Kim's strategy is to show her supervisor a copy of the state licensure law's language regarding the use of PAMs and explain that she must be supervised by an occupational therapist who also has "verifiable competence" in the use of PAMs (AOTA, 2012). (If Kim's state did not specify requirements for the use of PAMs, then she should refer to the AOTA Position Paper on PAMs, which states, "Only occupational therapists with service competency in this area may supervise the use of PAMs by occupational therapy assistants"; AOTA, 2012, p. S79.) Kim can request that another occupational therapist in the hospital who has competency in this area ascertain whether electrical stimulation is an appropriate intervention for this patient; if so, that occupational therapist should supervise its administration. In addition, Kim can suggest that the initial occupational therapy supervisor pursue training in PAMs if patients in this unit often require this intervention.

Under Principle 1E of the Code, it is the duty of practitioners to ensure that they provide services "that are within each practitioner's level of competence and scope of practice" (AOTA, 2015, p. 3) to benefit patients and avoid harm. As stated in Principle 2A, "occupational therapy personnel shall avoid inflicting harm or injury to recipients of occupational therapy services, students, research participants, or employees" (p. 3).

SUPERVISION AND THE COLLABORATIVE PROCESS

Scope of Practice

The manager of the rehabilitation department in a SNF, who is not an occupational therapist or occupational therapy assistant, asks Ari, the occupational therapy assistant, to evaluate a patient.

The rehab manager says that the client's activities of daily living status needs to be established to determine whether the patient's insurance will pay for her stay at the SNF. Ari is the only occupational therapy practitioner on site.

Ari's strategy is to provide the rehab manager with a copy of the state practice act and explain that, as per Medicare guidelines, AOTA documents, and state regulations, evaluation is not within the scope of practice of an occupational therapy assistant. Although the occupational therapy assistant may contribute to the evaluation process if he or she has been trained, competency has been documented, and tasks are delegated by the occupational therapist, the occupational therapist must first direct "all aspects of the initial contact during the occupational therapy evaluation" (AOTA, 2005, p. 3).

Only the occupational therapist is qualified to evaluate a patient's occupational performance deficits through standardized tests and other methods, identify deficits or barriers to performance that may be addressed by intervention, interpret data, determine goals, and develop the plan of care.

The delivery of occupational therapy services should be a collaborative process between the occupational therapist and the occupational therapy assistant. Occupational therapy practitioners must familiarize themselves with their state practice act, licensure board regulations, and organizational policies. State regulatory language may include occupational therapy assistants' scope of practice and specific supervision requirements. In addition, Medicare guidelines for rehabilitative services state that occupational therapy practitioners must provide services in accordance with state regulations. This practitioner role delineation is supported by Principle 4E of the Code, which states that it is the duty of occupational therapy personnel to "Maintain awareness of current laws and AOTA policies and Official Documents that apply to the profession of occupational therapy" (AOTA, 2015, p. 5). On the Association website, AOTA has provided a list of each state or U.S. territory with occupational therapy regulations (AOTA, n.d.).

Supervision

The "Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services" (AOTA, 2014) provide guidance to those supervising occupational therapy assistants and occupational therapy aides. It is an excellent overview of occupational therapy assistant supervision and addresses the necessity for a "cooperative

process” (p. S16). Occupational therapists are responsible and accountable for overseeing occupational therapy service delivery for clients. Occupational therapy assistants work “under the supervision and in partnership with” (pp. S16–S17)) occupational therapists. For the benefit of client, the supervisory process promotes professional growth toward achieving competence. The guidelines for supervision place responsibility on both occupational therapists and occupational therapy assistants for devising a collaborative plan for the process.

According to Medicare guidelines, occupational therapy assistants must work under the supervision of a qualified occupational therapist. The occupational therapist must conduct the evaluation and establish the plan of care. The qualified occupational therapy assistant can then carry out delegated intervention (Centers for Medicare and Medicaid Services, 2014). Medicare guidelines do not define different levels of supervision that are necessary for less experienced assistants. However, state practice acts may contain more specific language about frequency and type of supervision as well as a definition of supervision levels.

Amount and type of supervision are dependent on several variables. State practice acts, Medicare, other payers, and institutional policies may differ in what is specified or required. Occupational therapy practitioners should adopt whichever regulation or policy is most stringent. However, occupational therapists need to use their judgment as to how much supervision is necessary beyond what is mandated by law. Variables such as the experience and competency skill level of the occupational therapy assistant, complexity and condition of clients, number of clients, and type of setting can determine the frequency and type of supervision. When working with clients who have more acute conditions that may require frequent care plan modifications, the occupational therapist should provide closer supervision of the occupational therapy assistant (AOTA, 2014; Ryan & Sladyk, 2005).

Ryan and Sladyk (2005) defined each level of occupational therapy assistant practice and the recommended amount of supervision that practitioners should receive on the basis of AOTA guidelines. Close supervision, which should be provided to entry-level practitioners, is defined as providing “direct, on-site, daily contact” (p. 512) to practitioners who have less than 1 year of experience. Beyond the entry level and as the occupational therapy assistant develops greater competence, the amount and type of supervision change. At that time, general supervision may be appropriate, which could consist of face-to-face meetings that occur at specific intervals; alternatively, a variety of supervision methods can be used, such as observation of treatment,

documentation review, and written or electronic communication. However, because some state practice acts specify how frequently meetings should be held or what types of supervision are allowable, these regulations always take precedence.

Additionally, Ryan and Sladyk (2005) recommended that, when feasible and appropriate for the situation, facilities adhere to minimum supervision times of 3 to 5 direct contact hours per week for full-time occupational therapy assistants and fewer hours for part-time occupational therapy assistants (e.g., 1.5–2.5 hours per week for half-time occupational therapy assistants). Occupational therapists who are supervisors need to use their discretion and consider their working partnerships with their supervisees when determining how much time should be devoted to supervision.

Getting to Know the Strengths and Weaknesses

Lee is an occupational therapy assistant who is a new employee in an acute care hospital. He is experienced in working with orthopedic patients; however, in this setting, he is being assigned to treat patients with neurological diagnoses. Lee realizes it is his duty to let his supervisor know that although he is licensed and therefore technically qualified, he does not feel adequately competent to provide occupational therapy intervention to patients with complex neurological diagnoses. As stated in Principles 1E and 1G and of the Code, Lee needs to have the experience, knowledge, and competence to meet the patient's occupational therapy needs. This could include continuing education courses to expand his knowledge of patients with neurological diagnoses and a mentor who can provide guidance to him.

The supervisory process is an interactive and dynamic relationship between the occupational therapist and the occupational therapy assistant. Both parties must make an effort to understand and communicate with each other so that their strengths and weaknesses can be identified. Above all, occupational therapy practitioners have a responsibility to the clients they serve, and, by making the most of the supervisory relationship, they ensure that occupational therapy is delivered in a safe and competent manner. Service competency means that regardless of whether the occupational therapist or the occupational therapy assistant performs a task or test, the skill level is equivalent and the outcomes are the same. Competency should be documented and tested at appropriate intervals. As stated in the Code, Principle 5A, "occupational therapy personnel shall represent credentials, qualifications, education, experience, training, roles, duties, [and]

competence . . . accurately in all forms of communication” (AOTA, 2015, p. 6). In addition, as previously stated, Principle 1G mandates maintaining high standards and continuing competence.

As Ryan and Sladyk (2005) noted, the occupational therapist is responsible for facilitating an atmosphere in which supervisees can increase their talents, knowledge, and skills to support professional development. Having the occupational therapy assistant complete a skills checklist is an excellent way to discover areas of competence and the need for additional training and supervision. In addition, a critical component of supervision is to assess the supervisee’s learning style to facilitate assimilation of new information. Does he or she learn best by observing? Does he or she need hands-on practice to grasp a concept and integrate technique?

Establishing clear guidelines and expectations about job performance from the beginning can go a long way toward avoiding miscommunication and misunderstanding later. A job description should be provided, and the supervisor should make sure that the occupational therapy assistant is informed of other expectations, such as productivity and performance. The supervisee also should be made aware of any system of rewards for outstanding performance as well as consequences for unsatisfactory performance.

An effective supervisor is supportive, truthful, and fair when giving feedback; respects differences; gives credit where credit is due; is open to new ideas; and is a role model for high standards of occupational therapy practice. Principle 5G of the Code states, “Occupational therapy personnel shall be honest, fair, accurate, respectful, and timely in gathering and reporting fact-based information regarding employee job performance and student performance” (AOTA, 2015, p. 6). The supervisee has a responsibility to readily accept feedback and modify behavior accordingly, be an active participant in the learning process, and seek additional support or clarification when needed. The supervisor also should be receptive to feedback to facilitate the process.

Ensuring Adequate Supervision: Communicate, Collaborate, Document

It is necessary for occupational therapist– occupational therapy assistant teams to determine the system they will use for the supervision process. State regulations may guide practitioners as to the minimum required supervision, frequency, and modes of acceptable communication.

However, within any regulatory or guideline parameters, the team can determine what will work best for their supervisory process. Developing a supervisory plan that works for both parties is

important for the process. Early in the relationship, the supervisor and supervisee should decide when, where, and how often supervision should occur.

Sufficient documentation of the supervisory process is the responsibility of both supervisor and supervisee and is good practice even if not required by state law. Developing a system for including evidence that discussions have taken place also is important. Co-signatures are not enough to prove that conversations have taken place. Although face-to-face supervision during client treatment may need to occur at certain intervals and may be dependent on variables, there are times throughout the duration of client treatment when supervision can be handled through other modes of communication as long as patient privacy is protected. When practitioners use voice mail or telephone systems, it is more difficult to protect patient confidentiality. Practitioners may benefit from certain technology that would allow more flexibility during collaborative delivery of occupational therapy, such as password-protected electronic medical records. In all cases, the occupational therapist and occupational therapy assistant must communicate prior to initiating intervention or discontinuing services. During the course of intervention, it is important for both parties to collaborate and exchange ideas as issues come up or changes in the plan of care or goals are indicated.

CONCLUSION

Occupational therapists and occupational therapy assistants must practice due diligence in providing services to clients to deliver ethical, high-quality care. Both parties need to know the legal and ethical requirements for supervision. State practice acts, regulatory bodies, Medicare, and other sources of guidelines regarding supervision of occupational therapy assistants must be followed to ensure the delivery of occupational therapy services that meet the ethical standards of the profession.

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