Vermont Physical Therapy Advisory Board

Office of Professional Regulation, Vermont Secretary of State

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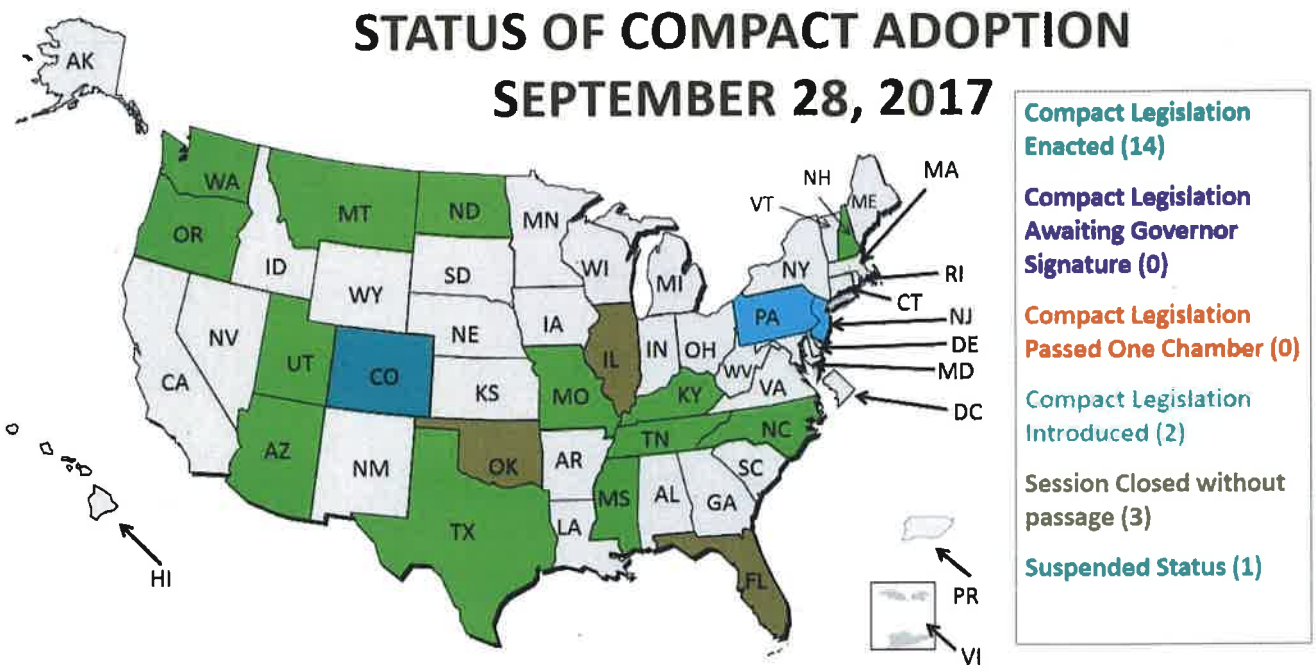
Meeting
Friday January 12, 2018 at 10:00am

1. **Topics for Discussion:**
   a. PT Compact adoption
   b. Draft Disciplinary Guidelines Matrix for review
   c. Telehealth issues and concerns
2. **Administrative Updates:**
   a. Online License training and review

Click here to join the meeting remotely

For VT OPR meeting Jan 2018

PT Compact:



- 14 states have passed legislation so far
- First meeting of the initial Compact states met after the FSBPT annual meeting in Nov 2017 to begin forming by-laws and procedures.
- PTs using the compact will have "privileges" to practice, not a "license" to practice
- Will increase portability to work in other states; helpful for military spouses, for example
- Should Vermont join?
    - At annual meeting, several states discussed process they used. NH is willing to lend advice.
    - Would require legislation to change Rules (see Model Practice Act for suggested wording)
        - Chapter should be one to present to legislators
        - Show legislators there are other compacts that VT is involved in (Nursing, ?MD)
        - Military liaison from Dept of Defense can be on outside helping to lobby in support.
    - Would require:
        - our full participation in the FSBPT's Exam, Licensure and Discipline Data Base (we still only have 1 star)
        - Change to application process for licensure to require criminal background check (Compact language says we need, but does not say that we have to share the info... how will info be shared? We don't have answer yet.... ? check nursing literature?)

Telehealth:

- Several states have introduced and/or passed new legislation relative to telehealth for PT (KY, WA, OR, AK, MO)
- Check practice act to see if initial eval must be face to face; any statute that would prohibit? If so, this could be seen as anti-competitive.
- Most see telehealth as just a change to method of delivery.
- Documentation would include when tx via face to face or telehealth
- Electronic communications must be secure
- Alaska: has used telehealth since 2008; so far, can't bill for those tx.
- Are we interested in including this in our Rules?

Minimum Data Set:

Consistent set of data elements collected on all licensees to understand work force needs. A couple of states have re-written practice acts to require this information as part of license renewal. See form designed by FSBPT and APTA. See free resources on FSBPT website.

Model Practice Act: 6th edition on FSBPT website.

- Adds 3 duties: background checks, report to the Exam, Licensing and Disciplinary Data Base, and participates fully in such.
- Office has authority to collect biometric info for background checks
- Office has authority to collect data for MDS
- And as a qualification for licensure, applicant gets background check
- Evaluation of US Military-trained PTA (don't have a license to practice in military, not from a CAPTE-approved program). New section of Model Practice Act allows evaluation for substantial equivalency (using the PTA Tool) Vermont already has this: AN ACT RELATING TO THE PROFESSIONAL REGULATION FOR VETERANS, MILITARY SERVICE MEMBERS, AND MILITARY SPOUSES http://www.leg.state.vt.us/docs/2014/Acts/ACT177.pdf . Includes this wording: The licensing authority must deem the training or experience equivalent to that which is required for licensure. What tools does OPR use? Course Work Tool for PT and Course Work Tool for PTA?
- Telehealth section
- Examination section connects to changes in FSBPT regulations (see below re NPTE updates)

NPTE Updates:

- 6 attempts lifetime limit
- Limit of 2 very low scores (≤ 400)
- TOEFL completion proof (as of 2018):

- Proof of education equivalency: any agency tool can be used, and candidate can provide their copy to FSBPT. Course Work Tool 6 can be used as of 2020.
- As of 2020: minimum scores: read 22, write 22, listen 21, speak 24

- 2018 test changes: separate out the lymphatic system from cardiovascular & pulmonary, so there can be some specific questions. 3 extra questions needed to pass with 600 score.
- Alternate Eligibility Process for NPTE (new process being piloted now... do we want to help pivot this? Contact Jeff Rosa if interested)
  - Student registers for NPTE via FSBPT (FSBPT responsible for test accommodations)
  - After test, FSBPT sends scores to state
  - State determines if all requirements for licensure met → issues license

Professional Licensure Coalition:

- 2016: FSBPT one of the founding members after NC Dental Board case. Purpose: decrease frivolous law suits against boards.
- Libertarians proposed Restore Board Immunity Act legislation to decrease regulation. FSBPT and 15 other agencies wrote letter against this bill and are working to educate Congress re frivolous law suits that could result.

Clinical Education: Task Force worked on data collection and recommendations for changes needed/wanted to DPT clinical education (including process of graduation → clinical internship → residency)

- FSBPT does not support: ? feasibility, cost implications not explored, where is analysis on healthcare system and workforce?

Dry Needling: some states have passed legislation:

- Maryland: collaborated with acupuncturists to get support: 40 hours instruction (face to face or real time) and 40 hours on hands on under supervision of someone also able to assess competence.
- Washington: endorsement on license with 1 year education and 54 hours of training (no supervised clinical practice)
- Discussion of "do we need to regulate"? Evidence shows low risk. If PT feels they are trained and competent, can they go ahead in VT?
- Discussion of how it is being billed. Some say they bill as manual therapy, but that is not correct.
- APTA for advice?
- White papers on FSBPT website
- Something we should do?

Not from annual meeting, but from FSBPT newsletter:

Home Health PT Review of Medications

States Disagree on PTs' Authority to Review Medications. State auditors have informed APTA that their interpretation of the state practice act for PTs and OTs is that they cannot do what the federal government requires. When statutes are silent, it is interpreted by surveyors as not authorized.

The APTA document on medications by the physical therapist gives some examples of where the profession sees this disconnect with best practice, patient safety, home care requirements and regulations, and data set completion. APTA believes the difficulty and the misunderstanding are in the definitions. PTs are not doing medication management, they are doing drug regimen review. In this situation, discussions between CMS and the state PT board determined that the comprehensive assessment may be completed by a physical therapist only if the agency has implemented a policy and procedure that requires collaboration between the PT and other agency staff. That works because the guidance manual states that collaboration does not break the rule of one person completing it. That's a best practice and that's what agencies do.

General Suggestions from FSBPT on wording in documents issued from OPR:

- Change of address policy: 30 business or calendar days?

- Active Supervision over Boards: consider this to demonstrate:
    - List functions that need overview
    - Identify timeframe by which veto can be done (e.g. 7,14,21 days)
    - If no veto in timeframe, then "it's a go"

- Consider using FSBPT's Model Board Action Guidelines (see other attachment)
    - Good idea to have some guidelines so board actions are fairly standardized across time and cases
    - Takes into consideration remediation vs punitive

Guidelines Matrix

An offense of failing to act

An offense of action - potential for harm is expected to be primarily financial or ethical

An offense of action - potential for harm is expected to be related to clinical issue

An offense of action – implications or consequences of licensee action potentially extend beyond limits of the practice setting

*Cost of investigation and administration of violations may be assessed in any/all cases

Type I		Type II		Type III	
Isolated	**Multiple**	**Isolated**	**Multiple**	**Isolated**	**Multiple**
A	**B**	1 & A	**2 & A**	2 & A	**2 & B**
1 & A	**2 & A**	2 & B	**3 & B**	3 & B	**3 & C**
1 & B	**2 & B**	2 & C	**3 & C**	3 & C	**4 & C**
2 & C	**2 & C**	3 & B	**3 & C**	3 & C	**4 & C**

Isolated- means one incident occurring one time
Multiple- means more than one incident of the same violation (either same patient or different patients)

Classes of Punitive & Remedial Actions

Punitive Action		Remedial Actions	
Class 1	Civil Penalty + Censure	**Class A**	Advisory letter → Continuing Competence Activity
Class 2	Civil Penalty + Censure → Denial of License	**Class B**	Periodic Monitoring → Supervised Clinical Practice
Class 3	Civil Penalty + Restricted License → Revocation	**Class C**	Continuing Competence Activity → Treatment Program
Class 4	Civil Penalty + Denial of License → Revocation		

Punitive & Remedial Actions Ranked in Severity (low to high)	
Punitive	**Remedial**
Censure	Advisory letter
Civil Penalty (monetary)	Periodic monitoring
Community Service	Continuing competence activity
Restrict a license	Examinations/assessments
Suspension	Supervised clinical practice
Denial of a license	Examination of fitness to practice
Voluntary surrender	Treatment program
Summary suspension	

Revocation		

Infraction Types

Use the factors below to determine where the licensee's action fit best.

Type I

Factors to Consider- all may not apply

- No expected direct harm to the patient from this offense
- Unintentional error
- Licensee believes acting in patient's best interest; no self-serving intent
- Honest mistake
- Safety not compromised
- Little to no intended risk

Type II

Factors to Consider- all may not apply

- Potential for direct harm to the patient exists
- Poor judgement demonstrated
- Acting in licensee's own best interest
- Conscious awareness act is improper
- Faulty decision-making is evident
- Potentially unsafe choice
- Risk believed to be insignificant or justified

Type III

Factors to Consider- all may not apply

- Harmful intent with or without direct harm to the patient including but not limited to: financial, emotional, physical
- Acted with recklessness
- Disregard for interest of patient or others
- Dangerous or unsafe choice
- Decision with conscious disregard of substantial and unjustifiable risk to the patient, others, or licensee

Definitions

Advisory Letter- a non-disciplinary, private, written notification to the licensee [or certificate holder] that, while there is no evidence to merit disciplinary action, the board believes that the licensee [or certificate holder] should become educated about the requirements of the [act] and board rules

Censure- a disciplinary, written expression of formal disapproval to the licensee [or certificate holder] that does not impose any further conditions and is a matter of public record

Civil Penalty (monetary) - impose a sanction of a monetary nature. Civil penalty does not include, but is in addition to, administrative costs, including, but not limited to: investigative costs, attorney costs, and staff time, assigned to the licensee [or certificate holder]

Community Service- mandated performance of a number of hours of unpaid work by the licensee [or certificate holder] for the benefit of the public

Continuing Competence Activity-

1. require licensee [or certificate holder] to attend a continuing competence activity on a specific topic related to practice/work, and/or
2. require licensee [or certificate holder] to demonstrate or complete continued competence requirements required during a period of suspended or revoked licensure

Denial of License- refuse to issue or renew a license [or certificate]

Examination of fitness to practice- licensee [or certificate holder] must be examined in order to determine his or her mental or physical ability to practice as a physical therapist or work as a physical therapist assistant

Examinations/Assessments- licensee [or certificate holder] is required to complete examinations or assessment tools approved by the board

Isolated- means one incident occurring one time

Multiple- more than one incident of the same violation (either same case or different cases)

Periodic Monitoring- method of holding a licensee [or certificate holder] accountable by observing practice/work at regular intervals for a specified period of time

Restriction[1]

1. Any condition placed upon the licensee [or certificate holder] as to scope of practice, place of practice, supervision of practice, periodic monitoring, duration of licensed status, or type or condition of individual to whom the licensee [or certificate holder] may provide services. May include a restriction of a licensee's [or certificate holder's] employment pending proceedings by the board.
2. The licensee [or certificate holder] may enter into a written agreement with the board for a restricted license [or certificate] when entering into a substance abuse program.

Revocation- formal action to terminate a license, which cannot thereafter be renewed or restored, but only replaced upon application for a new license

Summary Suspension- immediately suspends a license [or certificate] **without** a hearing or the opportunity for the licensee [or certificate holder] to defend his or her license. The licensee [or certificate holder] is immediately precluded from practicing as a physical therapist or working as a physical therapist assistant

Supervised clinical practice- formal process of professional support to enable a licensee [or certificate holder] to develop knowledge and competence, assume responsibility for their own practice, and enhance public protection in a clinical situation[2]

Suspension- suspend a license [or certificate] for a period prescribed by the board which temporarily precludes a licensee's [or certificate holder's] ability to practice as a physical therapist or work as a physical therapist assistant

Treatment program- as part of the agreement established between the licensee [or certificate holder] and the board, the licensee [or certificate holder] signs a waiver allowing the substance abuse program to release information to the board if the licensee [or certificate holder], does not comply with the requirements of the Board laws or rules, or is unable to practice or work with reasonable skill or safety.

Voluntary Surrender-action initiated by the licensee [or certificate holder] based on an order of consent from the board to terminate a license, which can only be replaced upon application for a new license

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[1] Probation is not one of the options for discipline in the model practice act as it is considered simply one form of a restricted license. Probation is the specified period of time to assure compliance by the licensee [or certificate holder] with the restrictions established in the Board's order to continue to practice.

[2] "Clinical supervision." A Dictionary of Nursing. *Encyclopedia.com.* 27 Feb. 2017 <http://www.encyclopedia.com>

Mitigating and Aggravating Factors

*Aggravating and mitigating circumstances are specific to the individual case, but factors that may influence Board decisions can include such things as (not all-inclusive list):

Mitigating:
Licensee implemented remedial measures on their own- from knowledge of infraction up to prior to Board action
Personal circumstances
Remorse
Self-reporting- prior to a complaint
Voluntary admission of misconduct-post complaint

Aggravating:
Age and vulnerability of the patient
Obstruction
Personal circumstances
Total number of offenses
Time span over which offenses occurred

*Note that multiple events, recidivism, and harm to the patient are somewhat accounted for in the matrix

Mitigating and Aggravating Factors should be considered and influence the assessment of the remediation or disciplinary sanction. The Board may consider the mitigating and aggravating factors and determine whether or not these should influence the severity of the remediation or disciplinary sanction.

Application of mitigating/aggravating factors: Influences the severity of the sanction (within Class 1-4 and Class A-C) or number of sanctions applied; the class does not change.

DRAFT

Grounds for Action Categorization

Grounds for Action Categorization Coding	Basis for Action Code
An offense of failing to act	
Failing to complete continuing competence requirements as established by rule.	A2
Failing to maintain adequate patient records. For the purposes of this paragraph, adequate patient recordsll means legible records that contain at minimum sufficient information to identify the patient, an evaluation of objective findings, a diagnosis, a plan of care, a treatment record and a discharge plan.	50, 45
Failing to maintain patient confidentiality without documented authorization of the patient or unless otherwise required by law. All records used or resulting from a consultation by telehealth, as defined in [*Definitions,* Article 1.02], are part of a patient's records and are subject to applicable confidentiality requirements.	C3
Failing to supervise physical therapist assistants or physical therapy aides in accordance with this [act] and board rules.	G1, G2
Failing to report to the board, where there is direct knowledge, any unprofessional, incompetent, or illegal acts that appear to be in violation of this [act] or any rules established by the board.	A3, 23, E4
Failing to adhere to the recognized standards of ethics of the physical therapy profession as established by rule.	D3,D7, E4,81,E5,5, FA
An offense of action - potential for harm is expected to be primarily financial or ethical	
Promoting any unnecessary device, treatment intervention, or service resulting in the financial gain of the practitioner or of a third party.	D3, E5, E6
Violating any provision of this [act], board rules or a written order of the board.	A5
Providing treatment intervention unwarranted by the condition of the patient or continuing treatment beyond the point of reasonable benefit.	E2
Participating in underutilization or overutilization of physical therapy services for personal or institutional financial gain.	E2, E5, E6, D3
Charging fraudulent fees for services performed or not performed.	55, 56, E1,E3
Making misleading, deceptive, untrue or fraudulent representations in violation of this [act] or in the practice of the profession.	55, 56, E3, E4, 81, E5, E6
Having had a license [or certificate] revoked or suspended, other disciplinary action taken, or an application for licensure [or certification] refused, revoked or suspended by the proper authorities of another jurisdiction, territory, or country.	39
Attempting to engage in conduct that subverts or undermines the integrity of the examination or the examination	E4

process including, but not limited to, a violation of security and copyright provisions related to the national licensure exam, utilizing in any manner recalled or memorized examination questions from or with any person or entity, failing to comply with all test center security procedures, communicating or attempting to communicate with other examinees during the test, or copying or sharing examination questions or portions of questions.	
Interfering with an investigation or disciplinary proceeding by failure to cooperate, by willful misrepresentation of facts, or by the use of threats or harassment against any patient or witness to prevent that patient or witness from providing evidence in a disciplinary proceeding or any legal action.	23
Obtaining or attempting to obtain a license [or certificate] by fraud or misrepresentation.	E4, E3, 81
Directly or indirectly requesting, receiving or participating in the dividing, transferring, assigning, rebating or refunding of an unearned fee, or profiting by means of a credit or other valuable consideration such as an unearned commission, discount or gratuity in connection with the furnishing of physical therapy services. This does not prohibit the members of any regularly and properly organized business entity recognized by law and comprising physical therapists from dividing fees received for professional services among themselves as they determine necessary.	71, E6
An offense of action - potential for harm is expected to be related to clinical issue	
Practicing or offering to practice beyond the scope of the practice of physical therapy.	29
Aiding and abetting the unlicensed practice of physical therapy.	G2
Acting in a manner inconsistent with generally accepted standards of physical therapy practice, regardless of whether actual injury to the patient is established.	F6
An offense of action - implications or consequences of licensee action potentially extend beyond limits of the clinic	
Having been convicted of or pled guilty to a felony in the courts of this jurisdiction or any other jurisdiction, territory or country. Conviction, as used in this paragraph, shall include a deferred conviction, deferred prosecution, deferred sentence, finding or verdict of guilt, an admission of guilt, an Alfred plea, or a plea of *nolo contendere*.	19
Engaging in sexual misconduct.	D1
Practicing physical therapy with a mental or physical condition that impairs the ability of the licensee to practice with skill and safety.	F3, F4
Practicing as a physical therapist or working as a physical therapist assistant when physical or mental abilities are impaired by the use of controlled substances or other habit-forming drugs, chemicals or alcohol, or by other causes.	F2
Practicing after having been adjudged mentally incompetent by a court of competent jurisdiction.	F1, F3

Steps to Use Disciplinary Guidelines

Step 1: Determine Grounds for Disciplinary Action

- Determine the "Color" Category

Step 2: Determine if isolated event or multiple events

- Can be multiple events of same grounds in one investigation
- Can be prior disciplinary actions for same grounds

Step 3: Determine if type I, type II, or type III infraction

Step 4: Use matrix to determine the applicable classes of punitive and remedial actions

Step 5: Assign remedial action and/or punitive sanction

Step 6: Identify any mitigating/aggravating factors

Step 7: Modify remedial action and/or punitive sanction within the class (if applicable)

Step 8: Repeat with any additional ground for disciplinary action

Step 9: Determine final discipline/remediation to be taken. Report to NPDB/ELDD

- Use Basis for Action codes suggested

federation forum
Winter 2017

This article is based on a presentation by Leslie Adrian, PT, DPT, MPA, Director of Professional Standards, Federation of State Boards of Physical Therapy; Linda Grief, Executive Officer, Montana Board of Physical Therapy Examiners; James D. Heider, Executive Director, Oregon Physical Therapist Licensing Board; Scott Majors, Executive Director, Kentucky Board of Physical Therapy; Chrisandra Osborne, PT, PDT, Board Member, Washington Board of Physical Therapy; and Connie Petz, Licensing Examiner, Alaska Board of Physical Therapy and Occupational Therapy at the 2017 FSBPT Annual Meeting.

Tackling Telehealth

States and jurisdictions considering telehealth should strive to keep the rules or legislation simple. Telehealth is a means to deliver physical therapy services; it is not a change to the scope of practice of physical therapists. Yes, regulatory boards need to do due diligence by researching their specific situation and collaborating with their specific stakeholders, but when it comes to the language, keep it simple and flexible.

There are common policy challenges shared by all jurisdictions when considering telehealth. Jurisdictions need to regulate without stifling technology, balance public protection versus public access, and write flexible enough regulations to keep up with the advances of technology advances. Additionally, the jurisdiction must determine answers to questions like "where does practice occur?" and "where does the PT need to be licensed?".

Those are the lessons from some of the states that have moved forward with specific authorization of delivering physical therapy services via telehealth. From Alaska to Washington, Oregon, Montana, and Kentucky, the message is the same.

These jurisdictions do not view telehealth as a change to their scope of practice nor should physical therapists (PTs) be held to a different standard of care. The rules still maintain the same standard of care, whether the PT provides that visit in person or via telehealth. PTs providing physical therapy services through telehealth are still held to the same state and federal laws, which protect patient confidentiality, including HIPAA and HITECH compliance. Those rules pertain just as they would in any setting.

Still, regulatory agencies need to decide how to regulate the unique form of delivery without stifling the technology. There is a real need to balance public protection with public access. They need to determine how to keep up with technology advances when it often takes longer to get a rule published than it takes the technology to advance. The regulatory board should clarify for practitioners where the practice occurs and where the PT needs to be licensed.

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Why Should You Consider Telehealth in Your Jurisdiction?
There are various reasons why jurisdictions decide to jump into telehealth. The Kentucky Board of Physical Therapy promulgated its telehealth regulation in response to legislation. In 2000, an Omnibus Bill was filed in the Kentucky legislature requiring all regulatory boards in the state to create telehealth regulations. Technology was in its infancy but the legislature saw where the future was going.

The Washington Board of Physical Therapy was approached by therapists inquiring if telehealth could be done. The board reviewed its practice act and determined telehealth is simply a tool that physical therapists can employ. The board saw telehealth as a method to improve access to physical therapy services and facilitate more integrated care, especially in situations where patients are separated geographically from specific specialists — a common problem in Washington, Alaska, and Montana.

The Oregon Physical Therapist Licensing Board reviewed the issue of telehealth for several reasons. The board's mission is tied to the safe and effective delivery of physical therapy services. Safe and effective delivery of services includes appropriate access to care, making telehealth high on the list of items the board wanted to review. Additionally, like Washington, Oregon had PTs inquiring about using telehealth as a method to treat patients. The Oregon board also was considering the Physical Therapy Licensure Compact and what that meant relative to having a Compact Privilege in the state. A Compact Privilege facilitates telehealth services as it allows physical therapists located outside of Oregon to more easily obtain the authorization to practice in the state. Oregon decided that to get ready for the Compact, the area of telehealth really needed to be addressed. The Affordable Care Act and its challenge to look for more innovative ways in breaking down barriers and providing healthcare in cheaper and more innovative ways also was a factor.

The Alaska Board of Physical Therapy and Occupational Therapy began researching telehealth in 2005 in response to a licensee inquiry; a physical therapist asked the board if they had to be on site and physically present when supervising an aid via telecommunication. The board confirmed that aids were required to have continuous onsite supervision, so that was not acceptable. However, that sparked the board's curiosity on video conferencing scenarios.

The main driver for the Montana Board of Physical Therapy Examiners to act on telehealth has been the Physical Therapy Licensure Compact. Montana had introduced the PT Compact and decided to consider telemedicine as well. The Board of Medical Examiners was tackling telehealth through legislation and the Board of Nursing was in the process of expanding its Compact, so the timing was right.

KISS Your Regulations
Telehealth relies on technology. Technology is notorious for changing monthly, weekly, or even daily. If jurisdictions become too prescriptive, they will have to rewrite the rules every quarter. That's the rationale behind keeping it simple.

Kentucky is among the states that struggled with that concept initially. Initially, the committee in Kentucky working on the regulations found itself caught up in the weeds and overthinking the concept of telehealth and wanting to make contingencies for every

possible situation. They were making the rules more complicated than necessary. Finally, they boiled it down to three simple areas. They needed to 1) verify the identity of the patient; 2) ensure the confidentiality of the information; and 3) obtain informed consent. To reiterate, telehealth is not a new service; it's simply a new method of delivering service. In the end, Kentucky's telehealth regulation is a half-page long; a very small part of the 30-page document that has all of Kentucky's statutes and administrative regulations for physical therapy.

Washington's rule also has three parts. The first part is that a licensed therapist can provide PT via telehealth, following all requirements for standard of care, including those defined in the previously promulgated rules. The second rule is a documentation standard that the board must identify that the therapy happened via telehealth. The third part of the rule defines telehealth, because it's the first time it shows up in Washington's rules. Washington defines telehealth to mean providing physical therapy via electronic communication, where the therapist and the patient are not in the same physical location.

However, Washington defines electronic communication a bit more restrictively. It states it's the use of interactive, secure, multimedia equipment that includes, at a minimum, audio and visual. The therapist still needs to have eyes on the patient. It's not a phone call, it's being able to see the patient through secure and compliant technology. It's further described as real-time, interactive communication using synchronous technology.

Oregon's committee also found itself traveling into the weeds and details. Committee members wanted to write rules about how you do it, where you do it, who you do it to, and what technology you use. Reviewing the literature, however, persuaded them to look at the big picture.

Tele-rehabilitation, the term adopted in Alaska, is discussed at every board meeting. Alaska's board prides itself on not overregulating. The process was simpler there and Alaska simply added six points in existing law.

Montana added only two sections in its practice act. But that came after much homework. Prior to moving forward with the legislation to specifically add and define telehealth to the practice act, not only did they identify their stakeholders, but also potential adversaries who could be against their bill. The Montana final statutory language follows:

> (7) "Physical therapy" means the evaluation, treatment, and instruction of human beings, in person or through telehealth, to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction and pain, injury, and any bodily or mental conditions by the use of therapeutic exercise, prescribed topical medications, and rehabilitative procedures for the purpose of preventing, correcting, or alleviating a physical or mental disability.
>
> (11) "Telehealth" means the practice of physical therapy using interactive electronic communications, information technology, or other means between a physical therapist in one location and a patient in another location with or without an intervening health care provider.

Homework is More Productive when Done with Likeminded People

Jurisdictions have found that collaboration is very important to success.

When the Kentucky board attempted to draft a regulation on telehealth, board members realized it was bigger than them, it was something in which they needed to involve their stakeholders. The board directed staff to contact the state professional association and the PT programs at the University of Kentucky and the Bellarmine University to recruit volunteers for a task force to look at the issue. Among those appointed to the task force were a representative from the Veterans Administration, appointed for the military perspective, and a student. The task force met for two occasions in the latter part of 2013. The second meeting was part of a regular board meeting, where the board convened, approved its minutes from the last meeting, and recessed the meeting. The telehealth committee then conducted its meeting for three hours while the board members sat in the public gallery and listened and watched. When that meeting was over, the board reconvened and discussed it as a board.

Oregon formed a volunteer Rules Advisory Committee, which included the initially interested parties who approached the board. The board also targeted known subject matter experts who had been using telehealth in Washington.

Montana had a surprise collaborator in the Montana Hospital Association (MHA). The board had discussed the issue with the MHA but had no idea they would become such huge advocates. The Montana Board also collaborated with key legislators who were highly motivated to get telemedicine legislation passed.

What You Need to Research and Cover

All the jurisdictions began with a review of current statutes and their jurisdiction rules and regulations. Montana discovered it needed to go the legislative route to incorporate PT telemedicine in its jurisdiction. Washington, Oregon, Kentucky, and Alaska, however, found they already had the authority under state law and only needed to add language to their rules.

Kentucky benefitted greatly by the telehealth regulations that had already been promulgated by Alaska and Washington. They were the trailblazers, and Kentucky relied on their legislation and statutes and their rules and regulations to serve as a model. Kentucky then made individual adjustments to fit the particulars of its state. Kentucky also reviewed the American Telemedicine Association (ATA) blueprint for tele-rehabilitation, something the Federation of State Boards of Physical Therapy's Ethics and Legislation Committee had studied carefully when authoring the resource paper discussed at the end of this article. The definitions of telehealth, consultation, and electronic communications in the Model Practice Act also were consulted.

Likewise, Oregon included the publications from National Telehealth Resource Network and Telehealth Alliance of Oregon in its research. They collected rule language from other Oregon health boards that had already implemented telehealth. Oregon also benefitted from the trailblazing states, which by then included Kentucky. They also researched Federation of State Boards of Physical Therapists (FSBPT) and American Physical Therapy Association (APTA) publications.

Next, jurisdictions need to decide what needs to be covered in the regulation in order to ensure the safety of the patient. Current statutory and regulatory language in law or rule must be reviewed to determine if the language is adequate or if language needs to be added to authorize practice via telehealth. Some of the areas to consider are the competence of the

PT to deliver services via telehealth technology, the security of the data and transmission, patient location, and patient safety.

Kentucky's regulation is among those that specifically states PTs who participate in telehealth must document that it is within their area of competence. They are subject to the same documentation requirements as any other physical therapy service they perform and must make sure the information is protected electronically. Technological security is not an issue in in-person practice. Face-timing or Skyping with a patient is not secure and it doesn't meet the federal guidelines for HITECH and HIPPA compliance.

In Alaska, follow-up treatments are conducted at Native Health Centers via video conference in a secure room at the clinic. A health aide or a nurse is present in the room when the patient is at that distant site. This is to ensure patient safety. Some jurisdictions require someone be in the room with a patient so if something happens, there is an immediate response.

Oregon wrote into its rules standards relative to following the federal guidelines for electronic communications. The board holds therapists providing telehealth responsible to know where their patients are and if there's an emergency on the other end, what steps they will take to ensure the patient receives care. It includes knowing the emergency contacts in the area and having someone with the patient.

Resources to Begin the Process

In addition to following the lead of jurisdictions that have already tackled telehealth, in April of 2015, the FSBPT board approved publication of *Telehealth and Physical Therapy: Policy Recommendations for Appropriate Regulation*. The resource paper has three major sections. The first is Guidelines for Use of Telehealth in Physical Therapy Practice. The next major section is Guidelines for Privacy and Security in Physical Therapy Practice Using Telehealth Technologies. This section includes administrative and technical guidelines for boards to consider. The third section contains Emergencies and Client Safety Procedures. It's available for download in the public section of the FSBPT website.

Leslie Adrian, PT, DPT, MPA, is the Director of Professional Standards for the Federation of State Boards of Physical Therapy. Her education includes a DPT from Shenandoah University, Master of Science in Physical Therapy from Ithaca College and a Master of Public Administration from Virginia Tech. Leslie's responsibilities include responding to the needs and requests of member state boards, authoring resource papers, and tracking legislative and regulatory activities relevant to physical therapy.

Linda Grief is the Executive Officer for the Montana Board of Physical Therapy Examiners, a position she has held since 2003.

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James D. Heider is the Executive Director of the Oregon Physical Therapist Licensing Board. In his 15 years with the Board, Jim has been instrumental in the recruitment, orientation, and development of several Public Members to the Oregon Board.

Scott Majors has served as Executive Director for the Kentucky Board of Physical Therapy since 2012. In July of 2017, Scott was appointed as Deputy Commissioner for the Department of Professional Licensing with Kentucky's Public Protection Cabinet, which has contracted with Kentucky's Physical Therapy Board to permit Scott to continue as its Executive Director on an interim basis. Scott has more than 30 years of experience working in state government with administrative boards, agencies, and commissions, with a focus on licensing and regulation, disciplinary procedures, administrative adjudication, and professional ethics.

Chrisandra Osborne, PT, PDT, is a physical therapist appointed to the Washington State Board of Physical Therapy in 2015. She received her DPT from Eastern Washington University in 2005. For the past 12 years, her focus of practice has been pediatric school-based therapy. She has taught CE courses on evidence-based practice in school-based therapy and has been a guest lecturer at PT programs in Washington. Telehealth has become of interest to her as she is passionate about improving access to physical therapy and recognizes the benefit of innovative technology as a platform to achieve that. Through her role on the board, she has furthered her study of telehealth through CE and collaboration, as Washington has recognized the use of telehealth in the practice of physical therapy since 2011.

Connie Petz is a Licensing Examiner for the Alaska Board of Physical Therapy and Occupational Therapy. Prior to beginning her career with the board, she was a licensed insurance agent for 12 years, a claims administrative assistant for seven years, with property management and banking prior to those. Alaska enacted its Telerehabilitation law on September 27, 2008, to increase access to clients in an area that spans 663,300 square miles with complex transportation issues. She works with the Alaska Board and they are revising regulations for telehealth service to increase access to clients.

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