

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

**OT/OTA Partnerships: Achieving High Ethical Standards in a Challenging Health Care Environment**

**Introduction**

Health care reform, regardless of its design or policies, will likely impact 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. There could be greater demand placed on occupational therapy assistants (OTAs) to fill positions for more direct delivery of occupational therapy services, freeing occupational therapists (OTs) 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 5F of the *Occupational Therapy Code of Ethics and Ethics Standards (2010)* (Code and Ethics Standards) states that it is the duty of occupational therapy practitioners to “take responsibility for maintaining high standards and continuing competence in practice, education, and research by participating in professional development and educational activities to improve and update knowledge and skills” (AOTA, 2010). Principle 5 also reflects procedural justice and guides occupational therapy personnel to “comply with institutional rules and local, state, federal, international, and AOTA documents applicable to the profession of occupational therapy” (AOTA, 2010). OTAs 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 article addresses trends in the workforce, strategies for ensuring appropriate supervision of OTAs, teamwork, and effective collaboration to provide high-quality occupational therapy services despite budgetary constraints. Scenarios are included to examine ethical dilemmas and practical solutions in an OT/OTA partnership.

**Workforce Trends**

***Case Example:** As an OT 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 OTAs in those facilities. The recruiter just hired a new OTA graduate who is working under a temporary license. The plan is that she will replace the OTA in one of Pat’s facilities. The staffing coordinator said that Pat’s working situation will remain the same. However, due to the restrictions placed on someone working with a temporary license, Pat*

*knows that she, as the supervising OT, needs to be on site while the new OTA is working with clients.*

**Strategy:** *Pat should obtain a copy of the state licensure regulations and present them to the recruiter and staffing coordinator. She needs to explain 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 discuss the importance of ensuring consistent service competency.*

**Case Example:** *Jim works in a comprehensive outpatient rehabilitation facility (CORF) as an OTA. The rehab manager has asked Jim to do all the treatments so that the OT can spend more time on evaluations. Medicare guidelines state that in CORFs the OTA cannot provide the final discharge treatment, because that visit is considered a reassessment.*

**Strategy:** Even though not specified in his state's practice act, Jim needs to explain to the rehab manager that one 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 rules and regulations related to supervision are adhered to by all parties. As depicted in the above case examples, there are times when department managers in other disciplines are not knowledgeable about regulations for delivering occupational therapy services. Principles 5 and 5C of the Code and Ethics Standards state that occupational therapy professionals must be familiar with rules and regulations that guide our practice and inform those we work for and with, of any changes to those laws and AOTA policies (AOTA, 2010). With appropriate supervision to meet legal and ethical requirements, OTAs can effectively deliver high-quality occupational therapy services in both traditional and emerging practice areas.

### **Supervising OTAs and Sharing Responsibilities**

**Case Example:** *Kim is an OTA working on an inpatient rehabilitation unit. Her supervising OT 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 OT who has also had the necessary training in PAMs. However, the supervising OT is not competent or qualified in the use of PAMs.*

**Strategy:** Kim should 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 OT who also has "verifiable competence" in the use of PAMs (AOTA, 2008). [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, 2008).] Kim can request that another OT in the hospital who has competency in this area ascertain whether electrical stimulation is an appropriate intervention for this patient, and if so, that OT should supervise its administration. In

addition, Kim can suggest that the initial OT supervisor pursue training in PAMs if this is an intervention often required by patients in this facility.

Under Principle 1E of the Code and Ethics Standards, 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 (qualifications, experience, and the law)” to benefit patients and avoid harm (AOTA, 2010). As stated in Principle 2A, “occupational personnel shall avoid inflicting harm or injury to recipients of occupational therapy services, students, research participants, or employees” (AOTA, 2010).

## **Supervision and the Collaborative Process**

### **Scope of Practice**

***Case Example:** The manager of the rehabilitation department in a SNF, who is not an OT or OTA, asked Ari, the OTA, to evaluate a patient. The rehab manager said that the client’s activities of daily living status needs to be established to determine if the patient’s insurance will pay for her stay at the SNF. Ari is the only occupational therapy practitioner on site.*

***Strategy:** Ari should 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 OTA. Although the OTA may contribute to the evaluation process if trained, competency has been documented, and tasks were delegated by the OT, the OT must first direct “all aspects of the initial contact during the occupational therapy evaluation...” (AOTA, 2005). Only the OT 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 OTs and the OTAs. Occupational therapy practitioners must familiarize themselves with their state practice act, licensure board regulations, and organizational policies. State regulatory language may include OTA scope of practice and specific supervision requirements. In addition, Medicare guidelines for rehabilitative services state that OT practitioners must provide services in accordance with state regulations. This practitioner role delineation is supported by the Code and Ethics Standards, Principle 5, as it is the duty of occupational therapy personnel to “comply with ... Association documents applicable to the profession of occupational therapy” (AOTA, 2010). The AOTA Web site also has a link that lists 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, 2009) provides guidance to those supervising OTAs and occupational therapy aides. It is an excellent overview of OTA supervision and addresses the necessity for a

“cooperative process” (p. 797). OTs are responsible and accountable for overseeing occupational therapy service delivery for consumers. OTAs work “under the supervision and in partnership with” OTs (p. 797). For the benefit of consumers, the supervisory process promotes professional growth toward achieving competence. The guidelines for supervision place responsibility on both OTs and OTAs for devising a collaborative plan for the process.

As per Medicare guidelines, OTAs must work under the supervision of a qualified OT. The OT must conduct the evaluation and establish the plan of care. The qualified OTA can then carry out delegated intervention (Centers for Medicare and Medicaid Services, 2009). 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 is 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, OTs 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 OTA, 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 OT should provide closer supervision of the OTA (AOTA, 2009; Ryan & Sladyk, 2005).

Ryan and Sladyk (2005) define each level of OTA practice and the recommended amount of supervision that practitioner should receive based on AOTA guidelines. *Close supervision* should be provided to entry-level practitioners, which is defined as providing “direct, on-site, daily contact” to the practitioner who has less than 1 year of experience (p. 512). Beyond the entry level and as the OTA develops greater competence, the amount and type of supervision changes. At that time, *general supervision* may be appropriate, which could consist of face-to-face meetings that occur at specific intervals, or 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, when feasible and appropriate for the situation, Ryan and Sladyk (2005) recommend time devoted to supervision should be a minimum of 3–5 direct contact hours per week for full-time OTAs and fewer hours for part-time OTAs (e.g., 1.5–2.5 hours per week for half-time OTAs). OTs who are supervisors need to use their discretion and consider their working partnerships with their supervisees when it comes to how much time should be devoted to supervision.

### **Getting to Know the Strengths and Weaknesses**

*Case Example:* Lee is an OTA 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.

**Strategy:** Lee realizes it is his duty to let his supervisor know that although he is licensed, and so technically qualified, he does not feel adequately competent to provide occupational therapy intervention to patients with complex neurological diagnoses. As stated in Principles 5F and G of the Code and Ethics Standards (AOTA, 2010), 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 OT and the OTA. 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 OT or OTA 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 and Ethics Standards, Principle 6A, occupational therapy personnel "shall represent the credentials, qualifications, education, experience, training, roles, duties, competence ...accurately in all forms of communication about recipients of service, students, employees, research participants, and colleagues" (AOTA, 2010). In addition, as previously stated, Principle 5F mandates maintaining high standards and continuing competence (AOTA, 2010).

According to Ryan and Sladyk (2005), the OT is responsible for facilitating an atmosphere in which supervisees can increase their talents, knowledge, and skills to support professional development. Having the OTA complete a skills checklist is an excellent way to discover areas of competence and also 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 to perform the job 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 OTA 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 6H of the Code and Ethics Standards states that "occupational therapy personnel shall be honest, fair, accurate, respectful, and timely in gathering and reporting fact-based information regarding employee job performance" (AOTA, 2010). 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 OT/OTA 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. While 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 that supervision can be handled through other modes of communication as long as patient privacy is protected. When using 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, communication must take place between the OT and OTA 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**

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

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