Ethical Telehealth Practice

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ABSTRACT
The American Occupational Therapy Association (AOTA) and occupational therapy providers have been advocating for telehealth as an occupational therapy service delivery option since the beginning of the 21st century. In recent years, demand for telehealth services has increased, and telehealth has emerged as an innovative method of health care delivery.

Because telehealth is a relatively new mode of service delivery, occupational therapy practitioners offering these services must learn about the associated practice, history, and ethical considerations. Ethical issues specific to telehealth are analyzed using the standards of conduct from the Occupational Therapy Code of Ethics (AOTA, 2020a) to guide clinicians in effectively managing these scenarios when providing telehealth services.

Ethical issues examined in this article include a client’s benefit or loss, the right to choose the therapy and react to dissatisfactory services, privacy and confidentiality, informed consent, the client–provider relationship, competence, continuity of care, appropriateness, access, capacity for equitable treatment, state licensure and interstate practice, reimbursement, and cultural competence.

Occupational therapy practitioners are encouraged to engage in intentional planning and preparation for providing ethical, evidence-based telehealth services.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Describe and document telehealth practice using appropriate language
2. Describe the history of telehealth
3. Discuss ethical considerations for providing telehealth occupational therapy services
4. Identify the benefits and limitations of telehealth
5. Identify and discuss emergent ethical dilemmas

INTRODUCTION
In response to the relaxation of federal regulation of telehealth, telemedicine, and other means of distancing to meet health care needs during the COVID-19 pandemic, the American Occupational Therapy Association (AOTA) published OT and Telehealth in the Age of COVID-19 (AOTA, n.d.) in March 2020. By June, general interest publications such as The New Yorker were widely extolling the virtues of virtual health care (Seabrook, 2020).

AOTA and occupational therapy providers have been advocating for telehealth as an occupational therapy service delivery option since the beginning of the 21st century, and the number of occupational therapists and occupational therapy assistants (OTAs) who engage in telehealth is increasing (AOTA, n.d.). As demand grows, there is much to learn from telehealth’s young history, particularly how to manage the ethical considerations related to its practice.

CONCEPTUAL DEFINITIONS OF TELEHEALTH AND OTHER TERMS
AOTA defines telehealth as “the application of evaluative, consultative, preventative, and therapeutic services delivered through information and communication technology (ICT)” (AOTA, 2018, p. 1). Telehealth is the term currently favored by AOTA because it most widely embraces the variety of populations and delivery systems occupational therapy practitioners engage in, including health and wellness, education, and emerging practice (Cason, 2020).
Other terms may be used to describe occupational therapy tele-services, such as telemedicine (used in medical settings), telehabilitation (used primarily in occupational therapy in the past or currently in other countries), tele-occupational therapy (in Canada), telecare (in the United Kingdom), and telepractice (used primarily by the American Speech-Language-Hearing Association) (Cason, 2020). Teletherapy (Turgoose et al., 2018) and telemental health (Hilty et al., 2013) are terms that may be used in the practice of psychosocial occupational therapy services.

For reimbursement, the Centers for Medicare & Medicaid Services (CMS) defines telemedicine (which includes other health care providers besides physicians) as “two-way, real-time interactive communication between the patient and provider [with the provider located] at a distant site” (Chaet et al., 2017, p. 1136).

Most important in defining telehealth is to note that it is not an intervention per se but rather a mode of service delivery for providing evaluation and interventions that are within the scope of occupational therapy practice; it is not a separate practice area (Cason, 2014).

A TELEHEALTH GLOSSARY
Terms related to how telehealth practice is implemented include the following:

- **ICT** is the overarching term used by AOTA (2018), the World Federation of Occupational Therapists (2014), and the World Health Organization (2010) to describe the technologies involved in providing telemedicine and occupational therapy telehealth. They are distinguished as synchronous, asynchronous, or both.
- **Synchronous technologies** describe videoconferencing software used for live audio and video interaction (AOTA, 2018).
- **Asynchronous or store and forward** refers to the transmission of stored digital information such as radiological films or photographs, which are shared with practitioners, consultants, and specialists in other locations (AOTA, 2018; Institute of Medicine [IOM], 2012).
- **Hybrid service delivery model** is a combination of in-person and remote services (Cason, 2020).
- **Distant site** is used by CMS to describe locations where specialists may be consulted. Other terms meaning distant site include hub, specialty, provider, referral, and consulting site (IOM, 2012).
- **Originating site** is how CMS describes where the client is located (IOM, 2012).
- **Mobile health (mHealth), remote monitoring, telemonitoring, and sensor technologies** refer to the use of devices such as wearables and virtual assistant home equipment that allow the telehealth provider to receive data about the client for assessment purposes. Examples include Echo Dot, gaming systems, Apple Watch, and smart phone apps (AOTA, 2018). The term mHealth may also include vans or trucks (IOM, 2012) that carry portable MRIs and other diagnostic or treatment-based equipment found in more urban settings to rural sites.


These terms are important in clarifying how information is shared and are relevant not only for reimbursement purposes, but also in applying ethical scrutiny over how telehealth services are provided. A variety of terms are found in state statutes that regulate telehealth practice, so proper usage also has legal ramifications.

A BRIEF HISTORY OF TELEHEALTH

Bashshur and Shannon (2009) argued that as early as ancient Greece, there was evidence of human communication over long distances in the use of healing arts, but the origin of modern telemedicine is attributed to the National Aeronautics and Space Administration (NASA), which studied the physiological effects of manned space flights on astronauts and used such monitoring to develop support systems and emergency treatments during extended flight times (Zundel, 1996).

There are other modern precursors to this initial NASA implementation of telemedicine. During the late 1950s and early 1960s, the University of Nebraska worked with the Nebraska Psychiatric Institute and Norfolk State Hospital to provide consultation, training, and research for patients between the two institutions using two-way closed-circuit television (Bashshur & Shannon, 2009; Doarn, 2018; Zundel, 1996). In 1967, Massachusetts General Hospital used a telecommunications system for linking professionals with paraprofessionals to provide services to patients at the Logan Airport medical station (Bashshur & Shannon, 2009; Zundel, 1996).

In the early 1970s, NASA; the Papago Tribe (now known as the Tohono O’odham Indian Nation); the Lockheed Missile and Space Company; the Indian Health Service; and the Department of Health, Education, and Welfare partnered in what is known as the Space Technology Applied to Rural Papago Advanced Health Care project. Telecommunication technology was used to improve health care for this population in a remote area of Arizona (Bashshur & Shannon, 2009; Doarn, 2015; Freiburger et al., 2007).

The first documented incidence of telemedicine in rehabilitation was in 1998 (Hung & Fong, 2019), and AOTA published the first position paper on the use of what was then known as telerehabilitation in 2005 (Cason, 2020). Since then, a body of research has emerged, and two systematic reviews of telerehabilitation were conducted (Hung & Fong, 2019; Kairy et al., 2009). The second review used only articles that included occupational therapy (Hung & Fong, 2019).

Conclusions from the research have consistently found telehealth rates to be favorable in measures of client satisfaction and outcomes comparable to, or better than, traditional modes of service delivery (Cason, 2014; Hung & Fong, 2019; Kairy et al., 2009; Shigekawa et al., 2018).

In addition, it has been argued that telehealth is well-suited for homebound, rural, and underserved populations, and those
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with conditions requiring specialty providers (Bashshur & Shannon, 2009; Chaet et al., 2017; Demiris, 2016).

ETHICAL CONSIDERATIONS IN PROVIDING TELEHEALTH SERVICES

Although research supports using telehealth, it also raises questions about how telehealth is used and the ethical aspects of providing telehealth services. As Moghbeli and colleagues (2017) stated, “‘Ethical issues’ in telemedicine implies a consideration of patient’s benefit or loss in receiving telemedicine services and his/her right to choose the therapy and react to dissatisfactory services” (p. 351). Other ethical issues in using remote technologies include:

• Privacy and confidentiality (Chaet et al., 2017; Demiris et al., 2009; Mehta, 2014; Moghbeli et al., 2017)
• Informed consent (Chaet et al., 2017; Demiris et al., 2009; Moghbeli et al., 2017)
• The client–provider relationship (Demiris et al., 2009; Mehta, 2014; Moghbeli et al., 2017)
• Competence (Chaet et al., 2017)
• Continuity of care (Chaet et al., 2017; Demiris et al., 2009)
• Appropriateness (Cason, 2020; Chaet et al., 2017; Mehta, 2014)
• Access (Demiris et al., 2009; Fleming et al., 2009)
• Capacity for equitable treatment (Demiris et al., 2009; Fleming et al., 2009)

Specific to occupational therapy are ethical issues related to licensure (Cason, 2014, 2020) and reimbursement (AOTA, 2020c; Cason, 2014; Cohn & Cason, 2019).

ETHICAL PRINCIPLES AND STANDARDS RELATED TO TELEHEALTH PRACTICE

In the recently revised Occupational Therapy Code of Ethics (AOTA, 2020a), the principles of Beneficence, Nonmaleficence, Autonomy, Justice, Veracity, and Fidelity remain the same, but the new code reflects changes relevant to the practice of telehealth. The preamble explicitly names technology as a focus of potential ethical concern. In addition, standards of conduct are now classified within seven sections as follows and address current and emerging practice:

• Section 1: Professional Integrity, Responsibility, and Accountability
• Section 2: Therapeutic Relationships
• Section 3: Documentation, Reimbursement, and Financial Matters
• Section 4: Service Delivery
• Section 5: Professional Competence, Education, Supervision, and Training
• Section 6: Communication
• Section 7: Professional Civility

Each section contains 4 to 15 standards of conduct that are attached to the principle involved and key words for reference. One standard of conduct (i.e., 6 [Communication] B [Maintain privacy and truthfulness in delivery of occupational therapy services, whether in person or virtually]), lists telehealth as one of its key words and veracity as the encompassing ethical principle guiding its conduct (AOTA, 2020a). Another standard, 5C, describes steps to ensure best practice when standards of practice do not exist for emerging technology.

Many other standards of conduct are applicable to the practice of telehealth occupational therapy. They can be classified according to the issues that have been raised in this article and are stated in the following sections according to each issue. These standards can all be found in the Occupational Therapy Code of Ethics (AOTA, 2020a).

Consideration of Client’s Benefit or Loss

• 2B. Principle: Nonmaleficence. “Do not inflict harm or injury to recipients of occupational therapy services” (p. 5).

Right to Choose the Therapy and React to Dissatisfactory Services

• 2A. Principle: Autonomy. “Respect and honor the expressed wishes of recipients of services” (p. 5).
• 4G. Principle: Autonomy. “Respect the client’s right to refuse occupational therapy services” (p. 7).

Privacy and Confidentiality

• 6A. Principle: Autonomy. “Maintain the confidentiality of all verbal, written, electronic, augmentative, and nonverbal communications in compliance with applicable laws” (p. 8).
• 6B. Principle: Veracity. “Maintain privacy and truthfulness in delivery of occupational therapy services, whether in person or virtually” (p. 8).

Informed Consent

• 1L. Principle: Fidelity. “Do not engage in conflicts of interest” (p. 5).
• 1O. Principle: Beneficence. “Conduct and disseminate research in accordance with … guidelines and standards … including informed consent and disclosure of potential risks and benefits” (p. 5).
• 4D. Principle: Autonomy. “Obtain informed consent (written, verbal, electronic, or implied) after disclosing appropriate information and answering any questions … to ensure voluntary participation” (p. 7).
• 4E. Principle: Autonomy. “Fully disclose the benefits, risks and potential outcomes of any intervention … and any reasonable alternatives” (p. 7).
• 6H. Principle: Veracity. “Ensure that all marketing and advertising are truthful, accurate, and carefully presented” (p. 9).

The Client–Provider Relationship

• 1G. Principle: Fidelity. “Do not engage in actions that reduce the public’s trust in occupational therapy” (p. 5).
• 2F. Principle: Autonomy. “Establish a collaborative relationship with recipients of services … to promote shared decision making” (p. 6).
• 7B. Principle: Fidelity. “Demonstrate courtesy, civility, value, and respect to persons … when engaging in … electronic communication” (p. 9).

Competence

• 5C. Principle: Beneficence. “Take steps … to ensure proficiency, use careful judgment, and weigh potential for
harm when generalized standards do not exist in emerging technology or areas of practice” (p. 8).
• 5D. Principle: Beneficence. “Maintain competence by ongoing participation in professional development” (p. 8).
• 5E. Principle: Beneficence. “Ensure that all duties delegated to other occupational therapy personnel are congruent with their … qualifications” (p. 8).

Continuity of Care
• 4I. Principle: Beneficence. “Reevaluate and reassess recipients of service in a timely manner” (p. 7).
• 4K. Principle: Beneficence. “Refer to other providers when indicated” (p. 7).

Appropriateness
• 2G. Principle: Fidelity. “Do not abandon the service recipient, and attempt to facilitate appropriate transitions when unable to provide services for any reason” (p. 6).
• 2K. Principle: Nonmaleficence. “Do not engage in any undue influences that may impair practice or compromise the ability to safely and competently provide … services” (p. 6).
• 2M. Principle: Fidelity. “Do not engage in actions or inactions that jeopardize the safety or well-being of others or team-effectiveness” (p. 6).
• 4B. Principle: Beneficence. “Provide appropriate evaluation and a plan of intervention for recipients of occupational therapy services specific to their needs” (p. 7).
• 4I. Principle: Beneficence. “Terminate occupational therapy services in collaboration with the … recipient … when services are no longer beneficial” (p. 7).
• 6L. Principle: Fidelity. “Engage in … interprofessional teams to facilitate quality care and safety for clients” (p. 9).

Access
• 4L. Principle: Justice. “Address barriers to access for persons in need of … services” (p. 7).

Capacity for Equitable Treatment
• 4C. Principle: Beneficence. “Use, to the extent possible … intervention … assessments … and equipment that are evidence based, current, and within the recognized scope of occupational therapy practice” (p. 7).
• 4M. Principle: Justice. “Report systems and policies that are discriminatory or unfairly limit or prevent access to occupational therapy services” (p. 7).
• 7A. Principle: Justice. “Treat all stakeholders professionally and equitably” (p. 9).

Licensure
• 1A. Principle: Justice. “Comply with current federal and state laws, state scope of practice guidelines, and AOTA policies and Official Documents that apply to the profession of occupational therapy” (p. 5).
• 5G. Principle: Justice. “Provide appropriate supervision” (p. 8).

Reimbursement
• 3B. Principle: Justice. “Ensure that documentation for reimbursement purposes is done in accordance with applicable laws, guidelines, and regulations” (p. 6).
• 4N. Principle: Beneficence. “Provide professional services within the scope of occupational therapy practice during community-wide public health emergencies as directed by federal, state, and local agencies” (p. 7).

Solving Ethical Dilemmas in Telehealth
Based on the ethical issues described in the literature, experts have documented means for mitigating these issues. In addition, AOTA’s Ethics Commission created an advisory opinion to assist providers in assuring ethical care when using telehealth practice (AOTA, 2017), and the American Speech-Language-Hearing Association provided a resource to assist their members and other rehabilitation providers with managing specific scenarios related to ethics and telehealth (Cohn & Cason, 2019). AOTA has also posted an algorithm on its website for making decisions in telehealth, which includes ethical considerations (AOTA, 2020c).

The following section discusses strategies for managing each ethical issue cited in the literature.

Consideration of Client’s Benefit or Loss
Nonmaleficence and quality care are at the heart of this issue, and several authors stress the need to follow standards of care when practicing telehealth as one would with any other practice method (AOTA, 2017; Cohn & Cason, 2019; Moghbeli et al., 2017). This is underscored by state practice acts regulating telehealth nationwide (AOTA, 2021).

But there is more to ensuring no harm and optimal benefit than simply adhering to standards of practice. Before deciding on telehealth as a means for therapy, weigh the pros and cons of such a decision using AOTA’s decision guide (AOTA, 2020c). Use clinical and ethical reasoning to determine whether telehealth is appropriate for the client, and if so, whether the greatest benefit would be with a hybrid model (Cason & Criss, 2020) or a synchronous vs. asynchronous platform (AOTA, 2020c).

In addition to positive therapeutic outcomes, specific benefits or pros may include reducing exposure to illness—as with the COVID-19 pandemic—or eliminating the need for transportation, therefore improving access to services (AOTA, 2018; Demiris, 2016). Specific losses or cons may be the inability to control unforeseen safety concerns; communication barriers; and lack of equipment and supplies, which would be used in the traditional setting (Brennan et al., 2010). Safety concerns may include fall risk from environmental factors, such as tripping over pets (Cason & Criss, 2020). Communication barriers may include technical incompatibility because of hearing loss (AOTA, 2017; Demiris et al., 2009).

Mediating risks beforehand by thorough assessment, preparation, and modification will help improve telehealth outcomes (Demiris, 2016; Richmond et al., 2017).

Right to Choose the Therapy and React to Dissatisfactory Services
The ethical principle of autonomy guides practitioners in making sure clients collaborate when making the choice whether to engage in telehealth (AOTA, 2017). Providers of
occupational therapy have a “duty to treat the client or service recipient according to their own desires” (AOTA, 2020a, p. 3). They must also allow clients to refuse services, even when such a choice negatively affects outcomes (AOTA, 2017, 2020a). Client choice is also related to informed consent; ethically, one must provide full disclosure such that clients can make the best choice for themselves and later change their mind if moved to do so (Moghbeli et al., 2017).

Such a scenario is described in an incident whereby an adolescent girl with cerebral palsy agreed to a telehealth session with a specialist from another state, but when she was asked by the distant site therapist to partially disrobe on camera so that the specialist could better assess the girl’s musculoskeletal status, the girl objected. The attending therapist immediately discontinued the session, which was the ethically appropriate action to take; it was suggested that a more complete description of what to expect during the session should have been done before beginning (AOTA, 2017).

Privacy and Confidentiality
Personnel using telehealth platforms to conduct occupational therapy services are held to the same standards, laws, and ethical codes related to privacy and confidentiality as those practicing face-to-face services. These include the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act, and the Family Educational Rights and Privacy Act (Cason, 2014; Richmond et al., 2017). In addition, service providers must also ensure that the technology platforms they use during each session are secure (AOTA, 2017; Chaet et al., 2017; Demiris et al., 2009; Mehta, 2014; Moghbeli et al., 2017).

Transmission, maintenance, and storage of video and audio recordings, images, and other data must be addressed before any telehealth session, for both the originating and distant sites. Be sure that memos of understanding or other contracts with technology providers contain information about such concerns and include their privacy policies (Chaet et al., 2017; Demiris et al., 2009). Beware of free services and false marketing claims by providers (Cohn & Cason, 2019) and make sure technology services include encryption (Demiris, 2016).

Similarly, therapy providers should develop privacy protocols and provide clients with their privacy policies. While conducting the session, ensure that spaces are safeguarded such that others do not accidently enter the room, and use headsets or other devices to make sure the client cannot be overheard in an adjoining room or hallway. If a technical assistant is used, be sure to obtain written permission from the client beforehand (AOTA, 2017). Privacy and confidentiality may also be an issue when providing asynchronous telehealth services (Mehta, 2014), necessitating reassurance that responders may differ, but that all are bound by the same policies and standards.

Informed Consent
Informed consent is important not only for the care provided, but also for the use of specific technologies; this includes the ability of the client to participate in said technologies (Chaet et al., 2017; Demiris et al., 2009; Moghbeli et al., 2017). Consent to treat should be in writing and contain (AOTA, 2017):

- risks and benefits (disclose not only potential outcomes, but also limitations of technology) (Chaet et al., 2017),
- right to refuse, and
- policies regarding privacy and the storage and use of recorded video, audio, and electronic communication.

Make certain such policies include notification of how data will be managed as well as who may access it. Offer options for modifying aspects the client may object to (Demiris et al., 2009). Determine whether the client and/or caregiver has the skills necessary to use the technology needed, and disclose what equipment and training may be required to exploit it successfully (Chaet et al., 2017).

Consent may also be required of family members or caregivers who reside with the client at the originating site, especially if equipment must be installed or if they need to assist with the session, for they, too, may have privacy or other concerns related to telehealth (Demiris et al., 2009).

Be complete in describing procedures and offer alternative options (AOTA, 2020a; Moghbeli et al., 2017); explain concepts and terms for those who may not be familiar with technology (Demiris et al., 2009); and most importantly, be transparent (Chaet et al., 2017).

Disclosures for consent should include any conflicts of interest (AOTA, 2020a) and unusual financial arrangements (e.g., if the technology provider charges additional fees) (Cohn & Cason, 2019). Marketing brochures or other promotional media for telehealth practices should disclose the limitations of technology as well as its benefits, and avoid misleading information (AOTA, 2020a). If telehealth episodes of care are part of a research study, separate consent disclosures may be required (AOTA, 2020a).

When reviewing consent with the client and/or caregiver, include an opportunity to ask questions (AOTA, 2020a) and to reject aspects of the service they do not wish to take part in.

The Client–Provider Relationship
Occupational therapy providers are well versed in therapeutic use of self; we know the beneficial effect of the relationship between client and practitioner and the difficulty in establishing and maintaining it. This is especially true when the relationship is from a distance (Demiris et al., 2009; Mehta, 2014), and human touch is absent (Demiris et al., 2009). Clients may feel that care is “less personal,” and potentially negative feelings about telehealth need to be included in a risk-benefit analysis (AOTA, 2017). Because of the therapeutic importance of the client–provider relationship, Mehta (2014) recommended that telehealth only be implemented if it is supplemental to face-to-face visits or if a relationship has already been established.

Despite difficulties establishing trust and respect in distance relationships, nonverbal communication can be elicited during videoconferencing, which fosters rapport and empathy (Demiris et al., 2009). Vocal tone during audio encounters may do the
same. One measure of the client–provider relationship is client satisfaction (Moghbeli et al., 2017). Respect, collaboration, civility, and courtesy are markers of an ethical relationship with one’s client (AOTA, 2020a), and may be measured as well.

Competence
Practitioners must be trained and demonstrate competence in the technologies they use as well as skill in adapting procedures from the traditional setting to the telehealth format (Chaet et al., 2017). One suggestion is using a competency checklist (AOTA, 2020c) to determine training needs. Practitioners should also incorporate technological competence into their professional development plan.

Clients must also be able to use the technology required (AOTA, 2017), and if unable, caregivers or other care extenders may need to assist (Cason & Criss, 2020). Extenders, defined as family members or support staff (AOTA, 2017), and also known as E-helpers, may provide technical support and physical assistance (Cason & Criss, 2020). They must also be familiar with the technology used and demonstrate the ability to use it (AOTA, 2017).

E-helpers must provide effective communication and adhere to privacy and confidentiality policies (Cason & Criss, 2020). In addition, they may need to be available before and after the session (Richmond et al., 2017) to assist with set up and restoring the environment or other functions as necessary.

Any additional persons accompanying the client or participating in the session must be approved beforehand by both the occupational therapy practitioner and the client (Richmond, 2017). The decision to approve depends on the competence of the extender, and ethically, the occupational therapy practitioner is responsible for making sure the extender is qualified to perform the functions delegated to them (AOTA, 2020a).

For clients and extenders, a backup plan should be in place in the event of technology failure (AOTA, 2017). The telehealth practitioner should also provide technical support phone numbers or other means for access to immediate assistance and alternative communication (Cohn & Cason, 2019; Richmond et al., 2017). Policies should include emergency protocols (Richmond et al., 2017).

Cohn and Cason (2019) described a scenario in which the client at the originating site was alone and sustained a seizure during the telehealth visit. The therapist did not know the address to call 911 nor did they have emergency contact information to notify family or a neighbor. The case illustrates not only the need for technical competence, but also the need to anticipate the limitations of technology.

Continuity of Care
Because telehealth sessions are often one-time consultations or provided by specialists unfamiliar with local resources, it is especially important that mechanisms are developed for referral and follow-up (AOTA, 2020a; Chaet et al., 2017; Cohn & Cason, 2019; Demiris et al., 2009) and for timely reassessment (AOTA, 2020a).

Telehealth interventions may be asynchronous and provide immediate response to data reported by smart-sensor and remote monitoring or send automated reminders and other notifications between visits (Mehta, 2014). Such interventions are especially useful in providing care to those who have chronic conditions (Chaet et al., 2017). Choosing whether to use synchronous or asynchronous may depend on timing (AOTA, 2020c) and the ability to respond immediately or more frequently to client needs.

Appropriateness
Telehealth is not necessarily appropriate for every client and condition (Chaet et al., 2017; Mehta, 2014). Reduced sensory, cognitive, and motor function may be contraindicative of telehealth as a suitable mode of service delivery (AOTA, 2017; Demiris, 2016). Conversely, certain forms of telehealth technology may work well with such losses (e.g., asynchronous monitoring devices).

Specific conditions and circumstances dictate whether telehealth is appropriate (Mehta, 2014). For example, those with posttraumatic stress disorder may feel less anxious in teletherapy than during an office visit (Turgoose et al., 2018), whereas those receiving hospice care may need more intimate face-to-face services to discuss end-of-life concerns (Mehta, 2014).

Appropriateness may also be based on the intervention plan. Here are some dos and don’ts:

- Do not use telehealth when manual therapy is indicated (Chaet et al., 2017).
- Do not use telehealth if it does not meet standards of practice (AOTA, 2020a; Chaet et al., 2017).
- Do not use telehealth if it compromises therapy or team effectiveness (AOTA, 2020a).
- Do use telehealth when in-person care is not feasible or if local access is limited for the care that is needed (Chaet et al., 2017; Demiris et al., 2009), but it must be specific to client needs (AOTA, 2020a).

Safety concerns and evidence are important factors in determining whether telehealth is appropriate (AOTA, 2020a). Take care to educate the client and/or E-helper regarding safety awareness and strategies to make the environment safe in the originating site. Knowledge of evidence related to telehealth and clinical reasoning to determine what client factors indicate a good fit for telehealth (Cason, 2020; Chaet et al., 2017; Mehta, 2014), and limitations of the technology must be weighed (Chaet et al., 2017).

If therapy does not seem to be working in a telehealth format, address the barriers, and either adopt a hybrid model of part in-person/part telehealth, or provide modifications to improve the outcome (Cason, 2020). If attempts at adaptation fail, discharge the client and refer to another provider if available (AOTA, 2020a).

Ultimately, the decision whether to use telehealth must be made on a case-by-case basis, using professional reasoning, and
not for the sake of the therapy provider’s needs (AOTA, 2017; Cohn & Cason, 2019).

Access
Access may be interpreted in three ways:

- Client access to care
- Provider access to evidence
- For both client and provider, access to technology

Client access to telehealth describes issues related to location, specialty care (Demiris et al., 2009), and, during the COVID-19 pandemic, restrictions and availability (AOTA, n.d.). Rural areas and certain urban populations are historically medically underserved (Gorawara-Bhat et al., 2019; Jaegers et al., 2020). Rural clients may need to travel great distances to receive specialty services, and in the case of northern states such as Alaska, they may not be able to travel to them in the winter months (Demiris et al., 2009). Other services such as support groups may not have the numbers needed in rural areas to be effective (Demiris et al., 2009).

Provider access to evidence refers to resources such as journals, webinars, and other evidence-based information. AOTA offers members free access to the American Journal of Occupational Therapy, British Journal of Occupational Therapy, Australian Occupational Therapy Journal, and Canadian Journal of Occupational Therapy (Cason & Criss, 2020). In addition, the International Journal of Telehabilitation has free access (Cason & Criss, 2020), and the website Telehealthshare.com provides training, resources, and a marketplace for providers to share information (AOTA, 2020c).

Access to technology includes the need for adequate internet bandwidth (AOTA, 2020c), especially in rural areas (Demiris et al., 2009; Fleming et al., 2009). Both clients and providers need software and hardware, including webcams, and technical support. The Occupational Therapy Telehealth Decision Guide provides links to technical support resources (AOTA, 2020c).

Telehealth may make the difference between getting needed care or not (AOTA, 2017; Demiris et al., 2009). Work with clients to make sure they have the technology required for telehealth, and offer as many options and resources as are available for them to manage barriers and make informed and viable choices (AOTA, 2020a; Moghbeli et al., 2017).

Capacity for Equitable Treatment
Telehealth presents multiple challenges with providing consistent experiences among clients. Originating site environments vary among clients, with space limitations, distractions, and poor lighting affecting response to intervention and occupational performance. In addition, problems such as assessment reliability when implemented remotely (AOTA, 2017), copyright limitations for digital presentation of handouts and other materials (Cason & Criss, 2020), and lack of equipment used in the traditional workplace must be considered. With research and preparation, these challenges can be mitigated.

Cason and Criss (2020) suggest strategies for managing standardized assessments in telehealth:

- Review protocols and psychometric properties to determine usability.
- Use online evaluation systems such as those used by the vendors, Pearson, and WPS, which are secure, encrypted, and HIPAA compliant.
- Mail non-digitalized evaluations such as the Beery VMI to the client before the session.

More broadly, equitable services that use technology are associated with factors related to health disparities. Factors that have found to be associated with health disparities include financial status, residence (including those who are homeless), race, ethnicity, and gender (Chaet et al., 2017; Chang et al., 2004).

The greatest barrier to telehealth equity is that many clients cannot afford the cost of devices such as computers, smartphones, and sensor interfaces required for certain telehealth processes (Demiris et al., 2009).

Cohn and Cason (2019) described a scenario where employees of a home health agency convinced management that they could use telehealth with clients who lived in impoverished neighborhoods they deemed unsafe. Ethically, clients must receive services appropriate to their needs and preferences, not the providers’, and such discriminatory policies must be reported (AOTA, 2020a).

Licensure
It is not enough to be licensed; one must be familiar with the statutes one is licensed under for both the distant site and originating site (AOTA, 2017; Cason, 2020). In addition, providers must be familiar and comply with laws governing telehealth (Richmond et al., 2017), or if using telehealth internationally, follow laws and regulations in the country of the originating site (Cason & Criss, 2019). AOTA maintains a state-by-state chart of telehealth laws and state actions affecting occupational therapy (AOTA, 2020c). There is great variety among states regarding adoption of telehealth laws and language describing telehealth (AOTA, 2018). It is the responsibility of the practitioner to monitor laws and regulations on an ongoing basis (AOTA, 2017, 2018).

In addition to statutes in one’s own distant site state, one must also be aware of laws in the state of the originating site, and hold a license to practice there (Cason, 2014). AOTA has embarked on a campaign to establish license portability among states by 2024, which would allow practitioners to practice across state lines (AOTA, n.d.).

If ICT is used for supervising OTAs, factors that may affect such a choice include number of clients, client complexity and diversity, skill sets of both the OTA and therapist, and the type of setting (AOTA, 2018). Time related to travel for supervision sessions may make ICT a good solution, but be sure to check

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with your licensing board and review other regulations (AOTA, 2017).

Reimbursement

Each payer approaches reimbursement differently (AOTA, 2020c). Medicaid, the Department of Defense, and the Veterans Administration allow telehealth, but this varies state to state (AOTA, 2020c; Cason, 2014). Medicare allows telehealth with restriction to outpatient services in certain settings (AOTA, 2020b). Follow billing and coding processes (Richmond et al., 2017), and use modifiers as appropriate (AOTA, 2018). Document that the service delivery model was telehealth (Brennan et al., 2010). Be aware of and avoid fraudulent practices such as waiving co-pays (Cohn & Cason, 2019). Links to resources such as a chart of telehealth guidelines for commercial payers and Medicare waiver updates can be found in the Occupational Therapy Telehealth Decision Guide (AOTA, 2020c).

CONCLUSION

Ethics in telehealth should be considered as one would consider any other delivery system (Mehta, 2014). “Technology is inherently neither ethical nor unethical. Rather, it is the intent and means by which” it is implemented (Fleming et al., 2009, p. 797). As with other aspects of practice, one must approach telehealth intentionally and be guided by evidence; it may be wise to engage a mentor (Cohn & Cason, 2019) or consultant. Successful telehealth programs require extensive pre-planning and may take as long as 23 months to fully implement (Hoel et al., 2021). Negotiate the time necessary to research resources needed and the means for procuring them before attempting to work with clients.

REFERENCES


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**How to Apply for Continuing Education Credit**

A. To get pricing information and to register to take the exam online for the article *Ethical Telehealth Practice*, go to http://store.aota.org, or call toll-free 800-729-2682.

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**Ethical Telehealth Practice**

**To receive CE credit, exam must be completed by July 31, 2024**

**Learning Level:** Intermediate

**Target Audience:** Occupational therapists and occupational therapy assistants

**Content Focus:** Professional Issues; Contemporary Issues and Trends

1. The favored term by AOTA to describe occupational therapy services provided via information and communication technologies is:
   - A. Telehealth
   - B. Teletherapy
   - C. Telepractice
   - D. Telemedicine

2. A recommended solution for ethically considering a client’s benefit or loss associated with the use of telehealth services is:
   - A. Have the client make their own determination for using telehealth versus in-person therapy sessions.
   - B. Complete a risk–benefit analysis for the client on the use of this service delivery model.
   - C. Submit each scenario to the client’s payer source to determine reimbursement before proceeding.
   - D. Follow standards of practice and there should be no ethical dilemma.

3. A client is asked to engage in activities that some might consider “private” to address their self-care goals during a telehealth occupational therapy session. The client declines to participate in this activity and requests to discontinue the session at this time. This scenario reflects which ethical issue?
   - A. Privacy and Confidentiality
   - B. Informed Consent
   - C. Competence
   - D. Right to Choose Therapy and React to Dissatisfactory Services
4. Which of the following is necessary to ensure privacy and confidentiality when providing telehealth services?

- A. Remind technical support staff at the beginning of the session to uphold HIPAA laws.
- B. Use a technology platform that is documented to be HIPAA-compliant, secure, and encrypted.
- C. Use a technology platform that advertises itself to uphold HIPAA laws.
- D. Provide a flyer in the informed consent packet that explains HIPAA laws.

5. Which of the following items is not required in a written informed consent document for telehealth services?

- A. Risks and benefits of participation in a telehealth session
- B. Potential limitations of technology used
- C. Client’s right to refuse participation in a telehealth session
- D. The amount of reimbursement the provider will receive for this service

6. Which of the following ethical principles are most applicable to developing an effective client–provider relationship when providing telehealth services?

- A. Fidelity & Autonomy
- B. Fidelity & Beneficence
- C. Veracity & Justice
- D. Nonmaleficence & Beneficence

7. Competency training for providers offering telehealth services should include:

- A. Tips for writing policies and procedures
- B. Information regarding standards of practice
- C. Safety guidelines
- D. Technology functions and troubleshooting

8. The ethical principle beneficence guides telehealth providers to:

- A. Refer to other providers when indicated
- B. Reevaluate recipients of services in a timely manner
- C. Attempt to facilitate appropriate transitions when unable to provide services
- D. Engage as a member of interprofessional teams to facilitate safety

9. Telehealth is not an appropriate service delivery model for everyone. In which of the following scenarios would use of telehealth not be advisable?

- A. Client indicates a preference for telehealth because of convenience.
- B. Client requests telehealth services from a specialized clinician they would not otherwise have access to in their local area.
- C. Client’s plan of care includes facilitating functional movement using manual therapy techniques.
- D. Client reports feeling more comfortable participating in therapy from the privacy of their own home versus the clinic.

10. Ethical dilemmas related to access can be interpreted to address multiple distinct scenarios. Which of the following is not a specific area of ethical concern related to access?

- A. Client access to care
- B. Provider access to evidence
- C. Access to technology for both the provider and client
- D. Client access to evidence of provider competency

11. Efforts to address health disparities are an attempt to address which of the following ethical issues?

- A. Informed consent
- B. Capacity for equitable treatment
- C. Privacy & Confidentiality
- D. Competence

12. A client in a neighboring state is requesting telehealth services from a practitioner who offers a specialty service unavailable in their local area. Which of the following statements is true regarding delivery of telehealth services across state lines?

- A. The practitioner must be licensed to practice in the state in which the client resides.
- B. The practitioner can provide telehealth services to the client as long as they are licensed in their own home state.
- C. The practitioner must request approval to provide these services from the client’s payer source.
- D. There are no specific regulations governing delivery of telehealth services across state lines.

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