Report of Recommendations and Findings

By the Occupational Therapy

Technical Review Committee

To the Nebraska State Board of Health, the Director of the Division of Public Health, Department of Health and Human Services, and the Members of the Health and Human Services Committee of the Legislature

January 29, 2025

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Part One: Preliminary Information

Introduction

The Credentialing Review Program is a review process advisory to the Legislature that is designed to assess the need for state regulation of health professionals. The credentialing review statute requires that review bodies assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on the public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division, along with any other materials requested by these review bodies. These two review bodies formulate their own independent reports on credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

LIST OF MEMBERS OF THE OCCUPATIONAL THERAPY TECHNICAL REVIEW COMMITTEE

Connie Petersen, PhD (Chair)

David Deemer, Nursing Home Administrator

Jennifer Dreibelbis

Su Eells

Ryan Flugge, RP, PharmD, BCPS

Jeffrey Howorth

Marcy Wyrens, LRCP, RRT

Part Two: Summary of Committee Recommendations

The committee members recommended approval of the applicant's proposal by a vote of six in favor with one abstention.

Part Three: Summary of the Applicant's Proposal

The applicant's proposal would, if approved, incorporate the following wording into the existing statute that regulates the practice of Occupational Therapy, Occupational Therapists, Occupational Therapy Assistants (OTAs), and Occupational Therapy aides:

Occupational Therapy:

- "The Practice of Occupational Therapy" means the therapeutic use of everyday life occupations with persons, groups, or populations (clients) to support occupational performance and participation. Occupational therapy practice includes clinical reasoning and professional judgement to evaluate, analyze, and diagnose occupational challenges (e.g., issues with client factors, performance patterns, and performance skills) and provide occupation-based interventions to address them. A license does not authorize a license holder to independently diagnose a medical condition or disease. Occupational therapy services include habilitation, rehabilitation, and the promotion of physical and mental health and wellness for clients with all levels of ability-related needs. These services are provided for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Through the provision of skilled services and engagement in everyday activities, occupational therapy promotes physical and mental health and well-being by supporting occupational performance in people with, or at risk of experiencing, a range of developmental, physical, and mental health disorders.
- The practice of occupational therapy includes the following components:
    1. Evaluation of factors affecting activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play leisure, and social participation, including:
        a. Context (environmental and personal factors) and occupational and activity demands that affect performance.
        b. Performance patterns including habits, routines, roles, and rituals.
        c. Performance skills, including motor skills (e.g., moving oneself or moving and interacting with objects), process skills (e.g., actions related to selecting, interacting with, and using tangible task objects), and social interaction skills (e.g., using verbal and nonverbal skills to communicate).
        d. Client factors, including body functions (e.g., neuromuscular, sensory, visual, mental, psychosocial, cognitive, pain factors), body structures (e.g., cardiovascular, digestive, nervous, integumentary, and genitourinary systems; structures related to movement), values, and spirituality.
    2. Methods or approaches to identify and select interventions, such as
        a. Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline.
        b. Compensation, modification, or adaptation of occupations, activities, and contexts to improve or enhance performance.

c. Maintenance of capabilities to prevent decline in performance in everyday life occupations.
d. Health promotion and wellness to enable or enhance performance in everyday life activities and quality of life.
e. Prevention of occurrence or emergence of barriers to performance and participation, including injury and disability prevention.

3. Interventions and procedures to promote or enhance safety and performance in ADLs, IADLs, health management, rest and sleep, education, work, play, leisure, and social participation, for example:
   a. Therapeutic use of occupations and activities.
   b. Training in self-care, self-management, health management (e.g., medication management, health routines), home management, community/work integration, school activities, and work performance.
   c. Identification, development, remediation, or compensation of physical neuromusculoskeletal, sensory-perceptual, emotional regulation, visual, mental, and cognitive functions; pain tolerance and management; praxis; developmental skills; and behavioral skills.
   d. Education and training of persons, including family members, caregivers, groups, populations, and others.
   e. Care coordination, case management, and transition services.
   f. Consultative services to persons, groups, populations, programs, organizations, and communities.
   g. Virtual interventions (e.g., simulated, real-time, and near-time technologies, including telehealth and mobile technology).
   h. Modification of contexts (environmental and personal factors in settings such as home, work, school, and community) and adaptation of processes, including the application of ergonomic principles.
   i. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices.
   j. Assessment, recommendation, and training in techniques to enhance functional mobility, including fitting and management of wheelchairs and other mobility devices.
   k. Exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation.
   l. Remediation of and compensation for visual deficits, including low vision rehabilitation.
   m. Driver rehabilitation and community mobility.
   n. Management of feeding, eating, and swallowing to enable eating and feeding performance.
   o. Application of physical agent, instrument-assisted, and mechanical modalities (and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, motor, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills.
   p. Facilitating the occupational participation of persons, groups, or populations through modification of contexts (environmental and personal) and adaptation of processes.

q. Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their everyday life occupations.
r. Group interventions (e.g., use of dynamics of group and social interaction to facilitate learning and skill acquisition across the life course).

Occupational Therapist and Occupational Therapy Assistant; services authorized.

- An Occupational Therapy professional may perform any services as identified above which they are competent to perform based on their entry level training or continued professional development. Occupational Therapy professionals may pursue specialization, training, or professional development in specific modalities, procedures, and techniques. It is the responsibility of the practitioner to be proficient and document proficiency in the specific modality he/she is practicing.

Occupational therapy assistant, defined.

- "Occupational Therapy Assistant" means a person licensed to assist in the practice of Occupational Therapy under this Act and who shall work under the appropriate supervision of and in partnership with an Occupational Therapist.

Supervision

- "Supervision" means a collaborative process for responsible, periodic review and inspection of all aspects of occupational therapy services. The Occupational Therapist is accountable for occupational therapy services provided by the Occupational Therapy Assistant and the Aide. In addition, the Occupational Therapy Assistant is accountable for occupational therapy services they provide. Within the scope of occupational therapy practice, supervision is aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and development.

Occupational therapy aide, defined.

- "Aide" means a person who is not licensed by the Board and who provides supportive services to Occupational Therapists and Occupational Therapy Assistants. An Aide shall function only under the guidance, responsibility, and supervision of the licensed Occupational Therapist or an Occupational Therapy Assistant who is appropriately supervised by an Occupational Therapist. An aide does not provide occupational therapy services. An Aide must first demonstrate competence before performing assigned, delegated client related and non-client related tasks.
- Positions that provide supportive services for therapy may also be title rehabilitation aide, rehabilitation technician or other designation as a non-licensed, supportive professional.

Physical agent and instrument assisted modalities, defined.

- Physical agent and instrument-assisted modalities means modalities that produce a biophysiological response through the use of water, temperature, sound, electricity, or mechanical devices.

Electrotherapeutic agent modalities, defined.

- Modalities that use electrotherapeutic currents and waveforms to facilitate physiologic changes in tissues to increase circulation, facilitate tissue healing, and modulate pain. Examples include, but are not limited to, high-voltage galvanic stimulation for tissue and wound repair (ESTR) and high voltage pulsed current (HVPC). They also facilitate neuromuscular or sensory activity to improve muscle strength, reeducate muscle function, or modulate pain response. Examples include, but are not limited to, neuromuscular electrical stimulation (NMES), functional electrical stimulation (FES), transcutaneous electrical nerve stimulation (TENS), and interferential current.

Mechanical devices, defined.

- The therapeutic use of mechanical devices to apply force, such as compression, distraction, vibration, or controlled mobilization, to modify biomechanical properties and functions of tissues. Mechanical devices do not include devices to perform spinal traction. The scope of practice of occupational therapists does not include the use of joint manipulation, grade V mobilization/manipulation, thrust joint manipulation, high-velocity/low-amplitude thrust, nor any other procedure intended to result in joint cavitation. Joint manipulation commences where grades one through four mobilization ends.

Superficial thermal agent modalities, defined.

- Modalities such as hydrotherapy, whirlpool, cryotherapy (cold packs, ice), fluidotherapy, hot packs, paraffin, water, infrared, and other commercially available superficial heating and cooling technologies.

Deep thermal agents, defined.

- Modalities such as therapeutic ultrasound, phonophoresis, and other commercially available technologies.

Instrument-assisted modalities, defined.

- Instrument-assisted modalities refer to the therapeutic use of an instrument or tool that is manually applied by a trained practitioner to target specific tissues like skin, fascia, and other connective tissues or muscle. These modalities include but are not limited to dry needling and cupping.

Electromagnetic modalities, defined.

- Electromagnetic modalities use electromagnetic waves such as radio waves, microwaves, and light waves to transport electrical and magnetic energy through space to effect changes in body structures. Low-level laser (light) therapy (LLLT): Low intensity, nonthermal (cold) lasers use light energy to cause a photochemical reaction in body tissues that can influence tissue repair, inflammation, and pain.

Physical agent and instrument-assisted modalities; certification required.

- If the licensee's Occupational Therapy educational program included education on superficial thermal, deep thermal, electrotherapeutic, and mechanical devices or the

therapist is certified by the Hand Therapy Certification commission or other equivalent entity recognized by the board, nothing further is needed to utilize these techniques in Nebraska practice. If these techniques were not part of the licensee's educational program, the licensee must request approval to utilize them in Nebraska practice. An occupational therapist may perform dry needling only in accordance with the level of education and training successfully completed. Education and training must have been approved by the State Board of Occupational Therapy and includes clinical instruction and application on the performance of dry needling. Diathermy: Diathermy uses short-wave frequencies to affect healing tissue or higher frequencies that cause tissue heating. An occupational therapist may not use diathermy.

Oxygen management.

- Occupational therapy professionals are allowed to complete insertion and removal of cannulas for oxygen and adjustment of the rate of flow per physician order.

Occupational therapy assistant; physical agent and instrument-assisted modalities.

- In order to apply physical agent modalities, an Occupational Therapy Assistant may administer a physical agent modality if the Occupational Therapy Assistant (a) Has successfully completed a training course approved by the board and passed an examination approved by the board on the physical agent modality; (b) is appropriately supervised by an Occupational Therapist who is approved to utilize physical agent modalities in NE and (c) shall not complete evaluation, re-evaluation, treatment planning, or treatment goals related to physical agent modality use. An Occupational Therapy Assistant may not utilize the instrument-assisted modality of dry needling or diathermy.

Occupational therapist; therapy assistant; temporary license; applicability of section.

Addition of:

- (C) A temporary permit expires the earlier of:

1. The date the person holding the permit is issued a permanent license under this article.
2. The date the Board disapproves the person's license application; or
3. One hundred eighty (180) days after the date the permit is issued.
4. The date the applicant is notified of a failure of the licensure examination.

Examination; requirements.

- (1) Each applicant for licensure pursuant to the Occupational Therapy Practice Act shall be examined by an examination which tests his or her knowledge of the basic and clinical sciences relating to Occupational Therapy and Occupational Therapy theory and practice including, but not limited to, professional skills and judgment in the utilization of Occupational Therapy techniques and methods and such other subjects as identified by the entity administering the national licensure examination.
- (2) Applicants shall follow the rules as outlined by the entity administering the national licensure examination and meet the minimum requirements for the examination. Results of the examination should be sent to the Board for verification of entry-level competency.

The full text of the applicant's proposal can be found under the Occupational Therapy tab of the Credentialing Review program link at:

https://dhhs.ne.gov/licensure/Pages/Credentialing-Review.aspx

Part Four: Discussion on issues by the Committee Members

Applicant Comments

Melissa Kimmerling Ed. D, MOT, OTR/L presented the applicant's proposal. She began by explaining the current scope of practice for Occupational Therapists (OTR) and Occupational Therapy Assistants (OTA). Dr. Kimmerling continued that, Occupational Therapists use the Occupational Therapy Practice Framework- 4th Edition and statutory language for Occupational Therapy that Nebraska has been using from over 20 years ago. This has led to many issues related to billing Medicaid and creating undue barriers for providers and patients. Additionally, under current language, the use of physical agent modalities is only allowed with supplemental licensure, despite it being taught in entry-level education, because the language has not been updated in statute. Further, the proposal is seeking the use of instrument assisted modalities by Occupational Therapists with supplemental education. Another goal of the applicant group is to maximize Occupational Therapy Assistants (OTAs) by allowing them to utilize physical agent modalities with additional education to increase access to care for Nebraskans in rural areas where an Occupational Therapist may not be readily available. The secondary goals of the proposal are to include clarifying language to statute and modify temporary licensure to reduce the gap between temporary and permanent licensure.

Put simply, the proposal is seeking to align current entry-level education with statute, increase the scope of practice for OTs to include instrument-assisted modalities, increase the scope of practice for OTAs to include physical-agent modalities, and adjust provisions to reduce the gap between temporary and permanent licensure. These aim to address burden faced by practitioners such as billing and duplicative trainings of certain skills taught in entry-level education while also reducing barriers to receive care by clients served in less populated areas.

Questions for the Applicant Group from the Committee

Jeffrey Howorth asked the applicants what percentage of patients were on Medicaid. Dr. Kimmerling answered, saying she estimates around 70% of their patients are billed through Medicaid or Medicare.

Dr. Ryan Flugge asked for clarification on the temporary licensure issues. Dr. Kimmerling responded saying that individuals complete their board process and receive a temporary license until the day that their board score is published. From there, their license goes away regardless of passing or failing the board exam. She continued that the people who pass now must wait 8 to 10 weeks because these requests must be processed by the State Patrol. She added, the applicant group is hoping to expand that temporary license until they can receive the full license for those who passed the board exam. Dr. Connie Petersen asked about the length of time that

a temporary license is functional for. Dr. Kimmerling responded, saying the temporary license is functional for 90 days and they can take their board exam anywhere within those 90 days. Dr. Flugge asked how their licensing process compares to other similar professions in terms of timelines, saying there should be a consistent expectation. Dr. Kimmerling was not sure about the timelines for other professions but stated that OT students can get an extension of their temporary license. David Deemer said that for Nursing Home Administrators, you can get your provisional license before you take your board test with a potential extension. Dr. Connie Petersen spoke about her license as a psychologist, that students get provisional licenses, and they can get a renewal of a provisional license when they are taking their exam. Marcy Wyrens stated that for Respiratory Care, they eliminated the temporary license because of similar issues.

Marcy Wyrens asked what training in medications OTs have. Dr. Kimmerling responded saying that they do not have the determination of dosing and that they work more closely with medication management. Su Eells asked if OTs titrate oxygen. Dr. Kimmerling said yes, but they do not determine the dosing themselves.

Su Eells asked how many modalities, especially out of state, are different from what they are trained on or what is accepted practice, and for those modalities, what is the oversight for the OTA. A member of the applicant group stated that neighboring states such as Colorado, Iowa, Kansas, and Wisconsin use the Model Practice Act definition with no additional training even at the assistant level. South Dakota, Missouri, and twelve other states have no regulation beyond the general scope of practice. Dr. Kimmerling added on, explaining the use of the different modalities and that OTRs, with their entry-level education, can perform said modalities. They are asking that OTAs be able to take a certification course to qualify them to use these modalities. Dr. Ryan Flugge asked if those certification courses exist, to which Dr. Kimmerling said yes, for OTRs, but not OTAs.

Su Eells asked how out of state OTAs were being supervised. Dr. Kimmerling said yes, they are being supervised however with there being fewer OTRs in more rural areas it creates an access to care issue. Jeff Howorth asked if new OTRs or OTAs need the 4 or 8 hours of direct supervision for the first year and who would go out and do that? Dr. Kimmerling said that there are OTRs in those counties, they just have a wider radius and must split their time accordingly.

David Deemer asked what the other states are doing for the pathway for OTAs. Dr. Kimmerling said that the Physical Agent Modalities Credentialing Association (PAMCA) offers courses. A member of the applicant group stated that there are fourteen states right now that do not require any additional licensure for physical-agent modalities besides the entry-level education and 6 more states have moved towards language for not requiring additional licensure for physical-agent modalities. A member of the applicant group stated, regarding “advanced pathways” and what other states are doing, other states are accepting the entry-level education and training they received to perform those physical-agent modalities accurately and safely.

Dr. Flugge asked the difference between an Occupational Therapy Assistant (OTA) and an Occupational Therapy Aide. Dr. Kimmerling explained that an OTA is someone who went to school and received either an associate or bachelor’s degree. An OT Aide is like a nurse’s aide. The aides help with minor tasks, they did not go to school to become an Aide, nor did they have to pass an exam.

Marcy Wyrens asked what an OT does as far as wound care. A member of the applicant group said that OTs could be treating unhealed diabetic ulcers, lymphedema, or weeping skin. Ms. Wyrens continued, asking what type of training is necessary for an OT to be able to perform the wound care services. A member of the applicant group said they would need additional education, certification, or documentation of their ability to perform those practices and that it is not an entry-level form of care.

Dr. Flugge acknowledged that the education requirement has changed over years and asked if there is any additional training that people who have received their education at a different time would need to compensate for the new level of education. Dr. Kimmerling answered that in South Dakota, their law says that if you received physical-agent modalities as a part of your entry-level education then nothing further needs to be done. If not, a form is provided, that they must fill out and explain what you must do to be licensed to do so.

Su Eells asked how long the OTA program is. The applicant group responded, saying their programs are five semesters, or typically two years. Su Eells asked, as new modalities come up, how OTs and OTAs stay up to date. Dr. Kimmerling answered saying that that is part of the language that the applicant group is seeking to update to ensure continued competency and what that looks like.

Jeffrey Howorth asked if there is an agreement between the OTR and the OTA. Dr. Kimmerling said that there is no agreement between the two of them, it is just the employer. A member of the applicant group explained that if there was an OTA that did not follow instructions, then both practitioners' licenses could be disciplined since the OTA acts by the plan of care set by the OTR.

Dr. Petersen asked if there is any registration with the licensure as to who supervises. Dr. Kimmerling said no, that the OTR is signing the notes of the OTA which is the verification necessary from a supervisor.

Jennifer Dreibelbis asked how supervision works for OTAs utilizing physical-agent modalities in rural areas that do not have many OTRs. Dr. Kimmerling said the OTAs would still need the supervision, and they are not recommending any supervision limitations. They still believe the OTA should have the supervision requirements.

Dr. Flugge asked about continuing education, that some professions break that down into parts such as safety or jurisprudence etc. Dr. Kimmerling said she is familiar with that in other states, but Nebraska does not have that. Dr. Flugge asked if that type of continuing education would be beneficial when adding these physical-agent modalities. Dr. Kimmerling said it may be duplicative.

Marcy Wyrens asked about how commercial insurance reimbursement works for OTs. Dr. Kimmerling said they almost exclusively follow Medicare guidelines. Ms. Wyrens asked if they have outpatient offices where they see the bills. Dr. Kimmerling said in an outpatient clinic they would bill like a CPT code for time. She continued that a study found that Occupational Therapy was the only thing that minimized hospital readmissions. She added that it is PDPM in home health and skilled nursing facilities.

Dr. Flugge asked if there is state budget available through CMS to accommodate these changes. Dr. Kimmerling said she does not think it will increase the number of CPT codes billed,

rather, it would be adding or choosing a different code. Dr. Flugge asked how they are paying them currently. Dr. Kimmerling responded saying that the therapist is practicing, they just do not get to choose the intervention, so they are doing a different one and billing in 15-minute increments with lower reimbursement rates. She continued saying, by being able to perform the proposed changes, they would be able to minimize the cost of care by getting to the answers quicker. A NOTA member added that they will have to get more codes added to their scope for Medicaid.

Dr. Petersen asked, having to do with credentialing, and moving from a temporary to a permanent license, if they must wait that period for Medicaid credentialing. Dr. Kimmerling said yes and added that the liability and credentialing are for the OT supervising those under temporary licenses. Dr. Petersen clarified that waiting for a licensing score takes about two weeks, then getting the full licensure, and waiting for the credentialing. Member of NOTA, Candice Mullendore said that it can take up to 180 days to receive credentialing because there are multiple steps and platforms that must go through to be approved.

Dr. Flugge asked what the bottleneck is to getting permanent licensure. Dr. Kimmerling said that the background check and the fingerprint only being allowed through the State Patrol. Dr. Flugge asked at what time the process could be initiated. Dr. Kimmerling said the student is supposed to have applied for, registered for, and have a date for their exam. Dr. Flugge asked when talking about changing language would they consider creating language so they could start the process earlier or is this an opportunity.

Jennifer Dreibelbis asked if there is an option besides the State Patrol to move along the process of licensure. Marcy Wyrens added, saying that she thinks the compact license is what directs the State Patrol requirement. Dr. Kimmerling said that the compact that includes multiple states, all had to adopt the same language and that other states have outsourced their background checks and fingerprints to make the process smoother.

Marcy Wyrens asked how the PT and PTA's processes differ. Dr. Kimmerling responded saying that they take their exam on the same day as each other which takes away some of the processing time.

Comments from other Interested Parties

Amy Reynoldson from the Nebraska Medical Association (NMA) said that the NMA has appreciated their work with the Occupational Therapy Association on their original concerns and add that they no longer have any concerns in not taking a position. She continued that the applicant group's ability and willingness to listen and not get defensive was positive.

Additional Information

The applicant group reached out to most if not all professional medical associations to receive and incorporate feedback into their proposal. They have modified language to address concerns from the Technical Review Committee members, Chiropractors, Athletic Trainers, Physical Therapists, Nebraska Medical Association among other groups.

Feedback that was incorporated from the technical review committee into the final language included the following:

- Replacing “wound care management; techniques to enhance sensory, motor, perceptual, and cognitive process; manual therapy techniques” with “physical agent and mechanical modalities”
  - Change made to create consistent language.
- Added “medication management such as oxygen under physician order.”
  - Addition made because State Board of Occupational Therapy in 2010 made a statement about Occupational Therapists being allowed to titrate oxygen under physician’s order.
  - Clarifying the discussion of medication management such as oxygen to make it clear that they are not prescribing medications.
- Added entirely new section titled “Oxygen management” so that it would not be misinterpreted of what is allowed in their scope of practice.
- Removed “Should a complaint or lawsuit arise involving an OT’s application of a specific modality, procedure, or technique, the OT would be responsible for proving his/her proficiency and appropriateness of application of the modality,” from original proposed language.
  - Technical Review Committee members suggested taking this portion out considering if someone is facing a complaint or lawsuit, they would be asked to do so anyway.
- Added clearer language to section titled, “Occupational therapy assistant, defined,” to indicate a more definitive collaborative partnership.
- Upon TRC member suggestion, the applicant group kept “Mechanical devices does not include devices to perform spinal traction.”
- Added language specifying the time limit and justifications for an OT or OTA to hold their temporary permit.
  - TRC members added that they think the time limit is important so that people could not avoid taking their exam and still practicing.
  - Also included by suggestion, the applicant group retained language pertaining to failure of the licensure examination.

Original Draft language and Final Draft Language will be posted on the Credentialing Review Webpage under the Occupational Therapy tab

All sources used to create Part Four of this report can be found on the Credentialing Review program link at:

https://dhhs.ne.gov/licensure/Pages/Credentialing-Review.aspx

Part Five: Formulation of Recommendations on the Applicant's Proposal

Committee action on the Six Statutory Criteria as they pertain to this proposal.

Criterion one: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

Connie Petersen, PhD	ABSTAINED
David Deemer, NHA voted	YES
Jennifer Dreibelbis voted	YES
Su Eells	YES
Ryan Flugge, RP, PharmD, BCPS voted	YES
Jeffrey Howorth voted	YES
Marcy Wyrens, LRCP, RRT voted	YES

Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

Connie Petersen, PhD	ABSTAINED
David Deemer, NHA voted	YES
Jennifer Dreibelbis voted	YES
Su Eells	YES
Ryan Flugge, RP, PharmD, BCPS voted	YES
Jeffrey Howorth voted	YES
Marcy Wyrens, LRCP, RRT voted	YES

Criterion three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

Connie Petersen, PhD	ABSTAINED
David Deemer, NHA voted	YES
Jennifer Dreibelbis voted	YES
Su Eells	YES
Ryan Flugge, RP, PharmD, BCPS voted	YES
Jeffrey Howorth voted	YES
Marcy Wyrens, LRCP, RRT voted	YES

<u>Criterion four:</u> The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

Connie Petersen, PhD	ABSTAINED
David Deemer, NHA voted	YES
Jennifer Dreibelbis voted	YES
Su Eells	YES
Ryan Flugge, RP, PharmD, BCPS voted	YES
Jeffrey Howorth voted	YES
Marcy Wyrens, LRCP, RRT voted	YES

<u>Criterion five:</u> There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill or service in a safe manner.

Connie Petersen, PhD	ABSTAINED
David Deemer, NHA voted	YES
Jennifer Dreibelbis voted	YES
Su Eells	YES
Ryan Flugge, RP, PharmD, BCPS voted	YES
Jeffrey Howorth voted	YES
Marcy Wyrens, LRCP, RRT voted	YES

<u>Criterion six:</u> There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

Connie Petersen, PhD	ABSTAINED
David Deemer, NHA voted	YES
Jennifer Dreibelbis voted	YES
Su Eells	YES
Ryan Flugge, RP, PharmD, BCPS voted	YES
Jeffrey Howorth voted	YES
Marcy Wyrens, LRCP, RRT voted	YES

Action taken on the proposal as a whole.

The Committee members acted the proposal via an up/down roll call vote as follows:

Connie Petersen, PhD: Abstained

David Deemer, NHA voted: Yes.

Jennifer Dreibelbis voted: Yes.

Su Eells voted: Yes.

Ryan Flugge, RP, PharmD, BCPS voted: Yes.

Jeffrey Howorth voted: Yes.

Marcy Wyrens voted: Yes.

The result of this roll call votes was six committee members voting to support the proposal. This means that the members of the Occupational Therapy Technical Review Committee recommended approval of the Occupational Therapy proposal.