

Board of Occupational Therapy Meeting Minutes

September 1, 2026

1. Roll call

Marcus Doughty, Chair, called the meeting of the Board of Occupational Therapy to order at 9:02 a.m. on September 1, 2026, in the lower-level Goldenrod Conference Room at the Nebraska State Office Building located at 301 Centennial Mall South, Lincoln, Nebraska. Pursuant to Neb. Rev. Stat. § 84-1411 of the Nebraska Open Meetings Act, copies of the agenda were e-mailed to the Board members and other interested parties, posted on the DHHS website at <https://dhhs.ne.gov/licensure/Pages/Agendas-and-Minutes.aspx>, and posted in the Nebraska State Office Building East Vestibule on August 20, 2026.

Doughty announced that this is an open meeting and the Open Meetings Act is posted.

Members Present:

The following members answered roll call:

Marcus Doughty, OTD, OTR/L, CHT Chairperson
Alfred Bracciano, EdD, OTR/L, FAOTA Vice-Chairperson
Mary Walsh-Sterup, OTR/L, CHT Secretary
Elizabeth Bailey, Member

Staff Present:

Amy Blinston, Program Manager
Kim Hitzel, Health Licensing Coordinator
Abby Hoy-Nissen, Assistant Attorney General
Kat Amyot, DHHS Legal Attorney
Tyler Walvoord, DHHS Staff Attorney
Jeanette Peterson, DHHS Compliance Monitor

Members of the Public Present:

Melissa Kimmerling, Nebraska Occupational Therapy Association (NOTA):
mskimmerling@gmail.com (via Webex)
Candice Mullendore, Vice-President of Policy and Advocacy NOTA
policyandadvocacy.nota@gmail.com (via Webex)
Kristen Neville, kneville@aota.org (via Webex)
Fracielle Pineda, Assistant Director, NOCOT fpineda@nbcot.org (via Webex)
Erin Westover, President NOTA, president.nota@gmail.com (via Webex)

2. Adoption of Agenda

Motion: Walsh-Sterup moved, seconded by Bracciano, to adopt the agenda. Voting aye: Bracciano, Bailey, Doughty, and Walsh-Sterup. Voting nay: none. Motion carried.

3. Approval of Meeting Minutes

Bracciano moved and Walsh-Sterup seconded to approve the meeting minutes for the August 11, 2026, meeting. Voting aye: Bracciano, Doughty, Walsh Sterup, and Bailey. Voting nay: None. Motion carried.

4. Reaffirmation of Mail Ballot

A mail ballot was sent to Board members on August 19, 2026, to review the request for coursework for Jamie Schneider. Voting to recommend: Doughty. Voting to Defer: Bailey. Not voting: Bracciano and Walsh-Sterup.

5. Closed Session

Bracciano moved, seconded by Walsh-Sterup, to move into closed session at 9:06 am to hear discussions regarding confidential information and to protect the reputation of individuals named or referenced in such discussions. Voting aye: Bracciano, Doughty, Bailey and Walsh-Sterup. Voting nay: none. Motion carried.

6. Board Recommendations

The Board returned to Open Session at 9:25 am

Walsh-Sterup moved, seconded by Bracciano to approve the coursework for Jamie Schneider, OTA license # 324. Voting aye: Bracciano, Doughty, Walsh-Sterup, and Bailey. Voting nay: none. Motion carried.

7. Regulation Review

Regulation Review discussion was held during the meeting. Topics discussed were supervision of two Occupational Therapy Assistants at one time, the requirement for on-site supervision of Occupational Therapist Assistants, use of the word client vs patient, dry needling prerequisites, clinical experience standards, and continuing education requirements. Once the minor revisions have been made to the regulations the Board will vote on those changes. After the Board votes to approve the Regulation Revisions the next step will be for the DHHS Legal Department to review them.

8. Schedule Meeting Dates for 2027

The meeting dates for 2027 will be February 2, 2027, and August 17, 2027.

9. Topics for Next Meeting

The next meeting is scheduled for February 2, 2027, at 9:00 am. Topics identified for the next meeting include: The OT Compact, Voting for Officers, Legislation Update, Per Diem Discussion, Notice of Publication, and Public Comment.

10. Public Comment

Kimmerling, Neville, Pineda, and Mullendore each had questions for the Board regarding the draft regulations. (Addendum attached.)

11. Adjournment

The meeting adjourned at 10:41 a.m.

Respectfully submitted,

(signature on file)

Mary Walsh-Sterup, Secretary



NOTA Comments for Proposed Occupational Therapy Practice Act Regulations

Comments for the September 1 OT License Board Meeting

NOTA appreciates the Board's continued work to implement the changes to the Occupational Therapy Practice Act. After reviewing the August 11, 2026 draft regulations, we have identified a limited number of areas where we believe additional clarification or consideration would be helpful before the regulations are finalized.

1. Occupational Therapy Assistant Supervision

The proposed regulations require an occupational therapist supervising an occupational therapy assistant to provide four or more hours per month of on-site supervision, with the amount of supervision determined by the occupational therapist based on patient needs, standards of practice, and standard of care.

We request reconsideration or clarification of the requirement that these hours specifically be provided on-site.

LB 257 defines supervision as a collaborative process involving responsible, periodic review and inspection to ensure safe and effective occupational therapy services. The statute does not establish a minimum number of hours of physical, on-site supervision.

We believe supervision should allow the occupational therapist to determine the appropriate method and frequency of supervision based on the OTA's competency and experience, patient needs, practice setting, and standard of care. This may include in-person supervision when clinically appropriate as well as real-time virtual supervision when appropriate. Other factors that might impact the frequency, type, and content of supervision — and are listed in AOTA's official document [Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services](#) — are number of clients, service delivery approach, and payer requirements.

Federal policy also reflects a movement toward greater flexibility in supervision. CMS now permits general supervision of OTAs in Medicare private practice for applicable occupational therapy services.

We respectfully request that the Board consider whether requiring a minimum of four hours of physical on-site supervision each month is necessary, or whether the regulation could instead allow the supervising OT to determine the appropriate method of supervision.

2. Use of "Client" and "Patient"

NBCOT advised that terminology such as "person," "client," or "patient" may be selected by an individual licensing board based on the terminology most appropriate for its regulations and practice settings.

NBCOT's primary recommendation was that whichever terminology is selected be used consistently throughout the regulations.

We request that the Board review the proposed definitions and use of "client" and "patient" throughout the chapter to ensure that the definitions accurately reflect occupational therapy practice and that the terminology is used consistently.

NOTA recommends that the Board adopt "client" as the term used consistently throughout the chapter, for the following reasons:

The Occupational Therapy Practice Framework: Domain and Process (OTPF-4) explicitly defines the recipient of OT services as a "client." The OTPF defines clients broadly as persons, groups, and populations. Restricting language in state regulations to "patient" conflicts with the national scope of practice and fails to reflect the full breadth of OT training.

Occupational therapy is delivered in non-medical environments such as public schools (under IDEA), community mental health programs, workplace ergonomics settings, early intervention homes, and adult day centers.

Labeling a student on an Individualized Education Program (IEP) or an adult in a community wellness program as a "patient" mischaracterizes the nature of the service. It imposes a clinical narrative on settings designed around educational access, social participation, or vocational performance.

Potential payer misinterpretation: Commercial insurers, Medicaid managed care organizations (MCOs), or grant-funding bodies for non-traditional services could interpret the term "patient" strictly. Payers might argue that services delivered outside a clinical/medical setting to a non-patient do not meet regulatory definitions, leading to claim denials or coverage disputes for community-based OT.

Medicaid and IDEA alignment: School-based Medicaid billing and early intervention (IDEA Part C) rely on educational or developmental eligibility rather than standard medical necessity. Over-medicalizing regulatory terminology creates administrative hurdles when establishing coverage under non-medical state plans.

3. Physical Agent and Instrument-Assisted Modalities

Examination Requirement

Section 004.01(D) identifies passage of the Nebraska Physical Agent Testing Service Examination as a pathway related to certification.

We recommend that the regulation not limit practitioners to one specifically named proprietary examination. We request consideration of language such as:

"Passage of ~~the Nebraska Physical Agent Testing Service Examination or an alternate examination~~
a Physical Agent Examination approved by the Board."

This would maintain the Board's authority to determine whether an examination adequately demonstrates competency while allowing the regulation to accommodate equivalent examinations that may become available in the future.

It would also avoid unnecessarily tying Nebraska's regulatory requirements to a single examination provider.

OTA Supervision When Administering PAMs

Section 006.03 requires an occupational therapist to provide on-site supervision whenever an occupational therapy assistant administers a physical agent modality.

We request reconsideration of this requirement.

Under the revised certification process, both occupational therapists and occupational therapy assistants must independently meet the applicable education, competency, examination, and certification requirements before being authorized to administer physical agent modalities.

During the credentialing review associated with LB 257, the standard considered was not whether PAMs were without risk, but whether allowing appropriately trained occupational therapy practitioners to provide these interventions presented an increased risk to the public.

If an OTA has demonstrated the same required competency and obtained the required state certification, we question the clinical or public-safety rationale for requiring an OT to be physically on-site every time the OTA administers a modality.

We request that supervision instead be based on the OTA's demonstrated competency, patient needs, standard of care, and the supervising OT's professional judgment unless there is evidence supporting an additional physical-presence requirement for PAM administration.

4. Dry Needling Certification Requirements

The proposed regulations require an occupational therapist seeking dry needling certification to meet one of the following experience requirements:

- 4,000 hours of direct clinical practice in physical rehabilitation;
- ~~AOTA Board Certification in Physical Rehabilitation; or~~

- ~~certification as a hand therapist through the Hand Therapy Certification Commission.~~

The applicant must additionally complete a minimum of 22 hours of Board-approved, in-person, hands-on dry needling training.

We request additional consideration of the experience requirement and removal of the items crossed out. Please see below for the rationale..

4,000-Hour Requirement

LB 257 requires successful completion of Board-approved dry needling education and training that includes clinical instruction and application but does not establish a 4,000-hour prerequisite.

We recommend considering a requirement expressed as a period of clinical practice, such as two years of practice in physical rehabilitation, rather than 4,000 individual hours. A time-based standard would be significantly easier for both practitioners and the Department to document and administer while accomplishing the same goal of requiring meaningful clinical experience before dry needling certification.

Other states offer useful reference points: Florida requires two years of licensed practice, Maryland requires at least two years of practice, and Mississippi requires three years of clinical experience before dry needling certification. AOTA agrees dry needling is not an entry-level intervention but does not prescribe a specific number of required years of licensure.

A time-based standard would also ease the administrative burden associated with monitoring individual practice hours. Unlike a running hour count, a period of licensed practice is already monitored by the state and would not require the Department to build new systems for tracking practitioner hours.

AOTA Board Certification and CHT Certification

We recommend that AOTA Board Certification in Physical Rehabilitation and Certified Hand Therapist (CHT) certification not be accepted as independent pathways for satisfying the clinical experience prerequisite for dry needling certification. As has been stated before, AOTA's Board Certification in Physical Rehabilitation should not be construed as ensuring competence to perform dry needling. Additionally, none of AOTA's advanced certifications were developed for the purpose of serving as a gateway for someone to be allowed to perform a certain intervention. They are simply an option for an experienced practitioner to demonstrate that they have met a higher standard of competence in a certain practice area, as opposed to a license, which is the entry-level standard of competence. Similarly, the Hand Therapy Certification exam does not cover dry needling and does not currently ensure competence to provide dry needling.

Removing these pathways would also help ensure that all applicants meet a consistent amount of clinical experience in alignment with protecting client safety, a standard that the CHT and AOTA Board Certification pathways do not, on their own, guarantee.

These credentials recognize advanced practice but are not themselves dry needling certifications.

There is also concern about incorporating a specific external certification into regulation when the requirements or structure of that certification may change in the future.

We recommend that the prerequisite focus on a consistent amount of relevant clinical experience rather than relying on unrelated specialty credentials that do not include dry needling in their advanced certification requirements as alternative pathways.

5. Continuing Education Credit for Student Supervision

The proposed continuing education language allows three continuing education hours for serving as the primary direct clinical supervisor for a student's entire Level II or greater fieldwork experience, with a maximum of six hours per renewal period. The proposed language specifically excludes Level I fieldwork.

We request clarification regarding the rationale for excluding Level I fieldwork supervision.

Although Level I fieldwork differs from Level II fieldwork, supervising these students still involves professional education, clinical reasoning, mentoring, feedback, and coordination with occupational therapy educational programs. If the concern is that Level I experiences vary substantially in duration and intensity, we would encourage consideration of a reduced or prorated amount of continuing education credit rather than excluding Level I supervision entirely.

We also request that the Board address **doctoral capstone mentorship** separately.

A doctoral capstone experience is distinct from Level I and Level II fieldwork. We previously discussed recognition of capstone mentorship, but we do not see language in the current draft that clearly allows continuing education credit for practitioners who serve as capstone site mentors.

Because ACOTE has changed capstone-related terminology in the past and may do so again, we recommend the Board use language that will not require future amendment, for example, recognizing continuing education credit for supervision of a student completing the requirements of an ACOTE-accredited academic program, with an appropriate amount and maximum number of hours established by the Board.

Summary of Requested Considerations

NOTA respectfully asks the Board to consider:

1. Allowing flexibility in the method of OTA supervision rather than requiring a minimum of four hours of physical on-site supervision each month.
2. Adopting "client" as the term used consistently throughout the chapter, consistent with the OTPF's broad definition of the individuals and populations OT practitioners serve.

3. Adopting examination language that does not name a single proprietary examination, requiring instead passage of a Board-approved physical agent examination.
4. Reconsidering mandatory on-site OT supervision every time a certified OTA administers PAMs.
5. Adopting a time-based clinical experience standard (e.g., two years of practice) in place of the 4,000-hour dry needling prerequisite, and removing AOTA Physical Rehabilitation Board Certification and CHT certification as alternative pathways.
6. Allowing continuing education recognition for appropriate Level I fieldwork supervision, and specifically addressing supervision of students completing post-fieldwork doctoral requirements using terminology that will remain accurate regardless of future ACOTE naming changes.

We appreciate the Board's consideration of these comments and its continued work to develop regulations that protect the public while allowing occupational therapy practitioners to practice to the level of their education, training, demonstrated competency, and professional judgment.

We truly appreciate the collaborative effort of all parties involved including the DHHS staff, the OT Licensing Board Members, NOTA Board Members, AOTA and NBCOT.

Candice Mullendore, MS, OTR/L

Vice President of Policy and Advocacy, on behalf of Nebraska Occupational Therapy Association.