Ramsey, Nonnie S

From: Ramsey, Nonnie S
Sent: Friday, August 28, 2020 2:17 PM
To: Laura Donahoe
Subject: RE: Comment period for proposed amendments to PT and PTA General Provisions and Fees

Laura,

After reviewing your comment regarding Section 13.5.2, the Board has now changed the wording as follows:

13.5.2. may only be performed once an in-person examination has been performed and/or after a patient provider relationship has been established. The patient/provider relationship may be established via an in-person exam, personally knowing the patient and his/her health status, or through an on call or cross coverage arrangement with the patient's regular treating physical therapist.

Thank you for taking the time to comment on the proposed rules.

Sincerely,

Nonnie S. Ramsey
Executive Director

WV Board of Physical Therapy
2 Players Club Drive Suite 102
Charleston, WV 25311
Ph# (304) 558-0367
Fax# (304) 558-0369
www.wvbopt.com

From: Laura Donahoe <lauradonahoe@gmail.com>
Sent: Tuesday, August 4, 2020 12:24 PM
To: Ramsey, Nonnie S <Nonnie.S.Ramsey@wv.gov>
Subject: Re: Comment period for proposed amendments to PT and PTA General Provisions and Fees

Dear WVBOPT,

I am writing regarding the proposed changes to the General Provisions for PTs and PTAs. I agree with the proposed changes with one exception. Section 13.5.2 states that telehealth services "may only be performed once an in-person evaluation has been performed and a relationship with the patient has been established." I would like to propose to remove this statement.

Telehealth provides PTs an opportunity to bring our skills to patients who are limited in ability to access clinics due to transportation issues, rural access issues or avoidance of face-to-face appointments due to concerns of COVID-19. I am not advocating that every patient or every condition is appropriate for telehealth care, however I believe there are plenty of clinical scenarios in the outpatient setting that are appropriate for telehealth throughout the entire plan of care, including evaluation. Again, there are clinical situations that require at least an initial in-person evaluation and may be appropriate for telehealth follow up but I believe that this is not every case. I believe that clinicians are well-equipped to make informed decisions on who is and is not appropriate for a telehealth evaluation.

I thank you for seeking feedback from the PT community on this topic.

Best regards,
Laura Donahoe, PT, DPT

On Wed, Jul 29, 2020 at 3:51 PM Ramsey, Nonnie S <Nonnie.S.Ramsey@wv.gov> wrote:

The WV Board of Physical Therapy is accepting written comments on proposed amendments to ***Series 1 General Provisions for Physical Therapists and Physical Therapist Assistants and Series 4 Fees***.

You are encouraged to review the proposed rules on our website at www.wvbopt.com under the current info tab. Please submit any comments via mail, fax or email Nonnie.S.Ramsey@wv.gov or WVBOPT@wv.gov.

Thank you,

Nonnie S. Ramsey

Executive Director

WV Board of Physical Therapy

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Fax# (304) 558-0569

Ramsey, Nonnie S

From: Ramsey, Nonnie S
Sent: Friday, August 28, 2020 2:22 PM
To: Swisher, Anne
Subject: RE: [External] Comments on Proposed Board of PT rule changes

Anne,

After reviewing your comment regarding Section 13.5.2, the Board has now changed the wording as follows:

13.5.2. may only be performed once an in-person examination has been performed and/or after a patient provider relationship has been established. The patient/provider relationship may be established via an in-person exam, personally knowing the patient and his/her health status, or through an on call or cross coverage arrangement with the patient's regular treating physical therapist.

After review of your comment regarding the decrease of fees in W. Va. Code R. §16-4, the Board stands by the current fees as presented for public comment and will continue with the decrease in fees.

Thank you for taking the time to comment on the proposed rules.

Sincerely,

Nonnie S. Ramsey
Executive Director

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From: Swisher, Anne <aswisher@hsc.wvu.edu>
Sent: Tuesday, August 11, 2020 10:50 AM
To: WVBOPT <wvbopt@wv.gov>; Ramsey, Nonnie S <Nonnie.S.Ramsey@wv.gov>
Subject: [External] Comments on Proposed Board of PT rule changes

Dear Ms. Ramsey and WVBoPT,

I have reviewed the proposed changes to the rules and have the following comments:

On 16.01 regarding telehealth practice:

13.5.2--'*may only be done once an in-person evaluation has been performed*'

does that mean establishing a plan of care, or could a brief screen be performed in person then the full plan developed via telehealth?

The term 'evaluation' refers to the judgement part of the PT assessment (e.g. the 'A' of a SOAP note) I think it should be 'assessment'???

What constitutes a '*relationship*' with the patient? Does it need any descriptors?

I think Telehealth is going to the be the HUGE driver in PT from now on (equivalent to direct access laws). It is important to get the wording right now.

On 16.04

As for the CEU review fees, I'm curious about why the need to decrease fees? As more education is provided through APTA, its components and PT/PTA schools, it seems the 'outside' providers will be fewer. It also seems like the WVBoPT can still benefit from the current fee income, especially if there are fewer providers.

Thank you for your consideration,

Anne K. Swisher PT, PhD, CCS, FAPTA
Professor
Director, Scholarship Development
Division of Physical Therapy
Member, Mary Babb Randolph Cancer Center
West Virginia University
PO Box 9226
Room 8314
Morgantown, WV 26506-9226
phone 304.293.1319
fax 304.293.7105
email aswisher@hsc.wvu.edu

WVBOPT

From: WVBOPT
Sent: Friday, August 28, 2020 2:36 PM
To: Davis, Scott
Subject: RE: [External] WVBOPT Rule Change - Comment Period

Scott,

After reviewing your comments regarding 2.19 and 13.1, the Board has now changed the wording in both sections to read as follows to avoid confusion:

13.1. Telehealth services means the use of synchronous or asynchronous telecommunications technology by a physical therapist or physical therapist assistant, within the scope of W. Va. Code R. §16-1-2.15, to provide physical therapy services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services and health administration. This term does not include audio-only telephone calls, email messages, or facsimile transmissions.

After lengthy discussion and taking into consideration of all comments received the Board has changed the wording for 13.5.2 as follows:

13.5.2. may only be performed once an in-person examination has been performed and/or after a patient provider relationship has been established. The patient/provider relationship may be established via an in-person exam, personally knowing the patient and his/her health status, or through an on call or cross coverage arrangement with the patient's regular treating physical therapist.

Thank you for taking the time to comment on the proposed rules.

Sincerely,

Nonnie S. Ramsey
Executive Director

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From: Davis, Scott <davis1090@marshall.edu>
Sent: Thursday, August 13, 2020 3:49 PM
To: WVBOPT <wvbopt@wv.gov>
Subject: [External] WVBOPT Rule Change - Comment Period

Dear WVBOPT,

I am writing to comment on the proposed rule change related to telehealth. Please know that I am writing as an individual licensee, and I am NOT writing in my capacity as the WVPTA, President. All comments reflect my personal opinion as a physical therapist that has been licensed in West Virginia for 32 years. I stand in general support of the rule change but want to express a few concerns.

1. 2.19 and 13.1 The language should be edited to avoid any confusion about physical therapist assistants (PTA) performing assessment or diagnosis.
2. 13.5.2 I am in favor of this provision for two reasons: a) Conditions that are caused or created by trauma (e.g., motor vehicle accident, sports injury) require a hands-on evaluation to ensure joint stability (subluxation/dislocation), rule out neurovascular injury, and to help rule out a possible fracture. While I agree that many non-traumatic or overuse conditions (e.g., tendinopathy, bursitis) could be safely screened through history and observation, the standard of care requires hands-on tests and measures in order to perform a complete examination. There is always the possibility of underlying sinister conditions. b) Requiring an in-person evaluation will reduce the risk of unregulated or unauthorized predatory out-of-state providers from performing substandard care and taking business and tax dollars out of the state of West Virginia. While this may extend beyond the scope of WVBOPT (i.e., patient protection), it is a concern that should be of importance to both the Governor and the West Virginia legislature. Additionally, an out-of-state provider will be unavailable to provide an in-person assessment if the condition were to change or worsen. The later issue does pose a risk of patient safety. While this rule may be seen by some to reduce patient access to physical therapy services, the risk of harm to the patient/client associated with an incomplete "hands-on" examination outweighs the potential risk of limited access to care under normal circumstances. The restriction on access to services is particularly compelling during a government-mandated lock-down, where in-person evaluation is not possible. It is my understanding that the WVBOPT has the ability to suspend this rule temporarily if a government lock-down were to occur.

Lastly, I want to thank the WVBOPT for their work on the proposed rule changes. While it is impossible to foresee all future circumstances, I believe that the rule errs on the side of patient safety and patient protection. While the WVBOPT should consider access to physical therapy services and the impact of rules and regulations on West Virginia businesses, the primary function of the WVBOPT is patient protection.

Scott

D. Scott Davis PT, MS, EdD
Chairperson/Program Director/Professor
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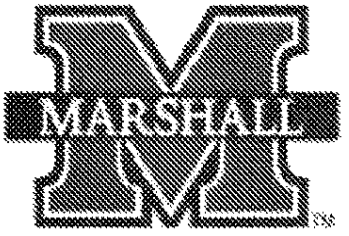
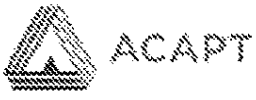
304-696-5614





American Council of Academic Physical Therapy (ACAPT)

Ramsey, Nonnie S

From: Ramsey, Nonnie S
Sent: Friday, August 28, 2020 2:39 PM
To: ERIC SHAW
Subject: RE: [External] Comments of Proposed Amendments to 16 CSR 1

Eric,

After reviewing your comments regarding 2.19 and 13.1, the Board has accepted your recommendations and changed the wording in both sections to read as follows to avoid confusion:

13.1. Telehealth services means the use of synchronous or asynchronous telecommunications technology by a physical therapist or physical therapist assistant, within the scope of W. Va. Code R. §16-1-2.15, to provide physical therapy services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services and health administration. This term does not include audio-only telephone calls, email messages, or facsimile transmissions.

After lengthy discussion and taking into consideration of all comments received the Board has changed the wording for 13.5.2 as follows:

13.5.2. may only be performed once an in-person examination has been performed and/or after a patient provider relationship has been established. The patient/provider relationship may be established via an in-person exam, personally knowing the patient and his/her health status, or through an on call or cross coverage arrangement with the patient's regular treating physical therapist.

Thank you for taking the time to comment on the proposed rules.

Sincerely,

Nonnie S Ramsey

Executive Director

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Fax# (304) 558-0369
www.wvbopt.com

From: ERIC SHAW <eshaw52@comcast.net>
Sent: Tuesday, August 25, 2020 12:26 AM
To: Ramsey, Nonnie S <Nonnie.S.Ramsey@wv.gov>
Subject: [External] Comments of Proposed Amendments to 16 CSR 1

Nonnie,
Please find attached a document with my comments on the proposed amendments to 16 CSR 1 for the WV Board of Physical Therapy.
Thank you for your work on this matter and the Boards efforts to communicate the changes to licensees.
Sincerely
J. Eric Shaw PT 1157

Nonnie S. Ramsey, Executive Director
WV Board of Physical Therapy
2 Players Club Drive, Suite 102
Charleston, WV 25311

Re: Comments on Proposed Amendments to 16 CSR 1

I appreciate all the work the members of the West Virginia Board of Physical Therapy have done recently on the proposed amendments to 16 CSR series 1 and 4-6. I would like to take this opportunity to comment on the proposed changes.

The first comment is a change to 16-1-2.19 Telehealth Services, and 16-1-13.1. The phrase "within the scope of W. Va Code R. 16-1-2.15" limiting physical therapist assistants' scope of practice should go after "physical therapist assistant" in the first sentence.

2.19. "Telehealth services" means the use of synchronous or asynchronous telecommunications technology by a physical therapist or physical therapist assistant, within the scope of W. Va. Code R. §16-1-2.15, to provide physical therapy services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services and health administration. This term does not include audio-only telephone calls, email messages, or facsimile transmissions.

13.1. Telehealth services means the use of synchronous or asynchronous telecommunications technology by a physical therapist or physical therapist assistant, within the scope of W. Va. Code R. §16-1-2.15, to provide physical therapy services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services and health administration.. This term does not include audio-only telephone calls, email messages, or facsimile transmissions.

The second comment I would like to make is regarding 16-1-13.5.2 which requires an "in-person evaluation" prior to the use of telehealth services. I would recommend that rule be deleted. It essentially makes the use of telehealth services impossible in the case of patients in remote areas of our state or in the case of the recent Covid-19 pandemic. During the recent months physical therapists throughout West Virginia and across the country have petitioned insurance companies, Medicaid, and Medicare to recognize that Physical Therapists are capable of safely providing services through telehealth. These efforts were rewarded with wide recognition and reimbursement for PT service through telehealth. While it is quite early, I think we will find these services were provided safely. HB 4003 gives the WVBOPT the opportunity to use their clinical judgement to determine when an in-person examination is necessary, but not required.

Physical Therapists are educated at the Doctoral level and can determine when a patient cannot be successfully managed through telehealth services, or when referral is needed to a more appropriate provider. 16-1-13.5.1 holds the physical therapist to the same standard of care for an in-person examination which would include 16-1-8.6.1 thru10 that defines the minimal standard of practice. This should be sufficient to accomplish the WVBOPT mission of protecting the public. Other licensure Boards whose licensees are educated at the doctoral level are finding ways to safely regulate telehealth services without an in-person examination to establish the PT/client relationship. This precedent is already in WV Code for Medicine at 30-3-13a, for Speech language Pathologists at 30-32-16 and rules 29-1-15, and the recent agency approved Occupational Therapist rules 13-9-4, and 13-9-5.

I would like to point out that the Federation of State Boards of Physical Therapy's Telehealth in Physical Therapy document section on patient-provider relationships acknowledges that telehealth inherently may not have a face to face examination.

Physical therapist/client relationship

Developing a physical therapist/client relationship is relevant regardless of the delivery method of the physical therapy services. As alternative delivery methods such as telehealth emerge, it bears stating that the PT/client relationship can be established in the absence of actual physical contact between the PT and client. Just as in a traditional (in-person) encounter, once the relationship is established, the therapist has an obligation to adhere to the reasonable standards of care for the patient (duty of care).

I should also mention the ability to fulfill the American Physical Therapy Association Position on Telehealth would be hampered by a requirement for face to face examination to establish the PT/client relationship. This is especially true of addressing the growing cost of health care, the disparity in accessibility, and the impact of workforce shortages.

TELEHEALTH HOD P06-19-15-09 [Initial: HOD P06-14-07-07] [Position] Telehealth is a well-defined and established method of health services delivery. Physical therapists provide services using telehealth as part of their scope of practice, incorporating elements of patient and client management as needed, to enhance patient and client interactions. The American Physical Therapy Association (APTA) supports:
- Inclusion of physical therapist services in telehealth policy and regulation on the national and state levels to help society address the growing cost of health services, the disparity in accessibility of health services, and the potential impact of health workforce shortages.
- Advancement of physical therapy telehealth practice, education, and research to enhance the quality and accessibility of physical therapist services; and
- Expansion of broadband access to provide all members of society the opportunity to receive services delivered via electronic means.

If the members of the WVBOPT feel some statement is necessary to emphasize that a face to face examination may be needed, then I would suggest alternative language.

13.5.2 Telehealth may be used to establish a new patient relationship only if the physical therapist is physically available to perform an in-person hands-on examination and/or re-examination throughout the course of the patient's care. The physical therapist must determine if an in-person examination is required based on the physical therapist's clinical judgment and the standard of care.

Or like the recently adopted Board of Occupational Therapy Language:

13.5.2 A Physical Therapist shall determine whether in-person examination and interventions are necessary and make every attempt to ensure an on-site physical therapist shall provide the appropriate interventions.

While these comments are long, I wanted to provide the WVBOPT supporting evidence for my comments that may be used in your discussions. In summary there is precedent in WV Code and administrative law to establish patient/provider relationships safely without an in-person examination. Physical therapists are well trained to make decisions regarding this matter on an individual basis. The current rules adequately cover the standard of care necessary for the WVBOPT to fulfill its mission of protection of the public. Greater access to telehealth services will decrease disparities in health care access.

Thank you for your consideration of these comments and suggestions.

Sincerely,

J. Eric Shaw PT

License # 1157

Ramsey, Nonnie S

From: ERIC SHAW <eshaw52@comcast.net>
Sent: Friday, August 28, 2020 8:23 AM
To: Ramsey, Nonnie S
Subject: [External] Addendum to Public comment sent earlier this week
Attachments: 1-s2.0-S1836955317300929-main.pdf

Good Morning Nonnie,
I wanted to forward this article as an attachment or addendum to the comments that I had submitted earlier this week on the proposed amendments to the PT rules. If it is not too late please attach this as a reference for the WVBOPT when considering my comments.
Thank You for your assistance.
J. Eric Shaw PT #1157

Journal of
PHYSIOTHERAPY
journal homepage: www.elsevier.com/locate/jphys

Editorial

Telephysiotherapy: time to get online

Anne E Holland[a,b,c]

[a] College of Science, Health and Engineering, School of Allied Health, La Trobe University; [b] Alfred Health; [c] Institute for Breathing and Sleep, Melbourne, Australia

The science and practice of telehealth have undergone rapid growth in recent years. A search of the Web of Science for the term 'telehealth' would have returned only two papers in 1995, compared with 104 papers in 2000, and 5060 papers in June 2017. This exponential growth is also evident in the number of randomised, controlled trials and systematic reviews indexed in the Physiotherapy Evidence Database with 'telehealth' in the title, rising from 10 records in 2008 to 70 records in 2017. These papers span the breadth of physiotherapy practice, with particularly strong representation from musculoskeletal and cardiorespiratory physiotherapy (Figure 1). High-quality randomised, controlled trials that support the benefits of telehealth interventions in many physiotherapy subdisciplines have been published over recent years. These have included telephysiotherapy interventions for chronic knee pain,[1] non-specific low back pain,[2] chronic obstructive pulmonary disease (COPD),[3] heart disease,[4] breast cancer,[5] joint arthroplasty,[6] and urinary incontinence.[7] Many of these studies have demonstrated significantly better clinical outcomes than usual care that did not include physiotherapy, including improved exercise capacity, better physical function, reduced symptoms and enhanced health-related quality of life.

Telephysiotherapy can take many different forms, with the components driven by the goals of treatment. Videoconferencing provides direct contact between patients and physiotherapists, either 'one-to-one' or in a 'virtual group setting'.[3] For some telephysiotherapy programs (eg, pulmonary rehabilitation, stroke rehabilitation) it may be necessary to perform a limited number of home visits, in order to perform assessments or provide instruction in the use of equipment.[3,4] However, some telephysiotherapy programs are delivered entirely from a distance, without ever meeting the patient in person, including notable examples of successful treatment of stress urinary incontinence using email support[7] and a mobile app.[8] Telephysiotherapy programs may include remote monitoring of physiological signals, such as pulse rate, oxygen saturation, electrocardiograms (ECG), and joint range of movement, in specific populations such as cardiorespiratory or orthopaedic disease.[4,10,11] Whilst some telephysiotherapy models require specially designed equipment,[9,11] others have achieved similarly successful outcomes with off-the-shelf consumer devices and software.[3,6] The ubiquitous nature of the smartphone provides new opportunities for telephysiotherapy, including: physical activity monitoring; sound and light cues to set exercise intensity and duration; real-time feedback on exercise performance; and text messaging to provide exercise advice or progression.[10,12] Simple web-based diaries can be used to record exercise and provide feedback.[12] Didactic or interactive education programs can also be provided.[3] In some populations it may be possible to automate aspects of a telephysiotherapy program to provide efficient and effective care to large patient populations; for instance using internet platforms that provide automated goal setting and feedback in conjunction with a pedometer for patients with non-specific low back pain.[2]

The increase in our capacity to deliver physiotherapy at a distance using telehealth has occurred at the same time that 'hands-on' physiotherapy techniques have become less important for some health conditions. For example, electrotherapy is no longer recommended for routine treatment of low back pain,[13] whereas exercise therapy is an important component of care.[14] Interventions designed to increase physical activity and physical fitness now have an important role in physiotherapy management for numerous clinical groups and across the lifespan, recognising the critical impact of these factors on long-term health outcomes.[15] Many of these interventions, which typically involve goal setting, exercise prescription and self-management training, do not require hands-on therapy and are highly amenable to telephysiotherapy.

Despite the potential for telehealth to increase the capacity of the health system and deliver better health outcomes, there has been relatively slow uptake in practice. Enthusiasm has been tempered by the lack of clinically relevant benefits seen in some large-scale randomised trials involving people with chronic diseases such as heart failure and COPD;[16–18] however, these trials relied heavily on telemonitoring of physiology and symptoms, rather than on delivery of therapy. Remote monitoring has not delivered consistent benefits over usual care, perhaps because it is difficult to maintain long-term adherence with monitoring, or the difficulty in identifying meaningful changes in monitored variables. Trials in telephysiotherapy, which typically involve delivering a treatment from a remote location, have generally been more successful, producing similar results to interventions that are delivered face to face. For instance, in 205 patients who had undergone knee arthroplasty, in-home rehabilitation delivered by videoconference demonstrated equivalent outcomes for pain, stiffness and function when compared with face-to-face rehabilitation.[6] Similarly, in 152 people with heart failure, cardiac rehabilitation with exercise prompts and ECG monitoring transmitted via a mobile phone produced similar benefits to a traditional outpatient cardiac rehabilitation program.[10] A key feature of these successful telephysiotherapy interventions is that they delivered treatments of known effectiveness in a different way, using technology to reach patients who are located away from healthcare facilities.

As for all physiotherapy interventions, effective telephysiotherapy requires clinicians to understand the essential components of their treatments and ensure that these are included in the care package. For instance, some treatments may require real-time interactions between physiotherapist and patient, in which case videoconferencing will be a better choice than a web portal with automated messaging. The group environment is a key component

http://dx.doi.org/10.1016/j.jphys.2017.08.001

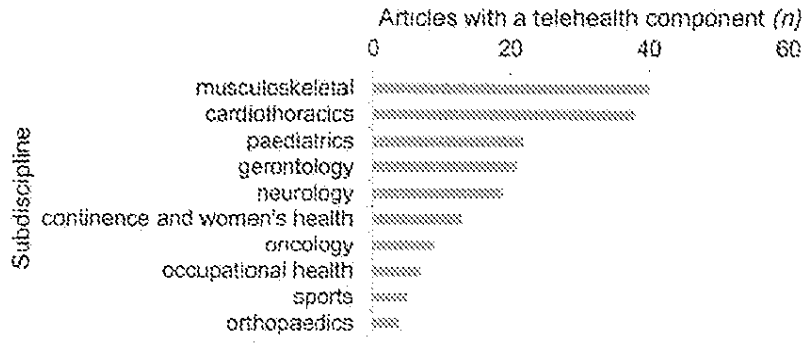

Figure 1. Number of randomised trials and systematic reviews indexed on the Physiotherapy Evidence Database (PEDro) that have a telehealth element, categorised by subdiscipline. Articles were identified using the search terms *tele* or *internet* with screening by title and abstract to confirm a telehealth element. Subdiscipline categorisations are those on the PEDro website, with some articles categorised under more than one subdiscipline.

of many modern physiotherapy-led rehabilitation interventions and provides peer support; telephysiotherapy can deliver this using multi-participant videoconferencing[3,16] or an online patient community.[2] In some cases, to ensure safety, physiotherapists may wish to specify that a carer be present during telephysiotherapy sessions.[16,17] Successful skills development has been demonstrated using internet-based packages, such as a recent trial that delivered pain coping skills to those with chronic knee pain.[3] Self-management training is a key component of many rehabilitation interventions in chronic disease; this can be delivered using online diaries to prompt symptom monitoring and self-treatment of disease exacerbations.[12] Goal setting, motivational messages and feedback are often core components of face-to-face physiotherapy sessions and may be particularly amenable to delivery via electronic methods using web platforms and text messaging.[2,13] Although the nature of telephysiotherapy interventions often means that there is a substantial physical distance between the clinician and the patient, and direct contact may be limited, the physiotherapist's expertise will remain critical to ensure that the components of the telephysiotherapy package are well aligned with the aims and expected outcomes of treatment.

The growing evidence base for telephysiotherapy provides new impetus to address the 'valley of death' that prevents many new treatments being used in clinical practice. A critical link in this area will be reimbursement mechanisms, including public and private providers and insurers. For instance, government funding of telehealth services in Australia seldom extends to allied health practitioners, although it is available to medical practitioners, nurse practitioners and Aboriginal health workers. A notable exception is the New South Wales Workers' Compensation Scheme, where video consultations may be reimbursed if pre-approved by the worker, physiotherapist and insurer. Some private health insurers offer telephone coaching services for people with chronic disease, but generally do not subsidise more advanced digital delivery of physiotherapy services. Telephysiotherapy has many potential advantages for health funders, including: broader access to evidence-based care and downstream reduction in healthcare utilisation (eg, pulmonary and cardiac rehabilitation); provision of more cost-effective care, particularly for patients who live further away from major centres;[21,22] more timely delivery of interventions due to removal of barriers (transport, travel, parking, waiting lists) and flexible scheduling; and increased patient choice, resulting in a more patient-centred approach to care. Whilst longer term data on the cost effectiveness of telephysiotherapy are currently available in only a few areas (eg, joint replacement, management of urinary incontinence),[21,23] clinical efficacy data are available across a wide range of clinical areas, and development of a funding model is essential to drive further research into long-term health, financial and societal benefits.

Those who lead the way in funding and provision of telephysiotherapy services are likely to have a competitive advantage. They will attract the 'digital native', younger generation of health consumers who are accustomed to accessing health and medical resources online.[24] There is increasing evidence that older people are also connected. In Australia in 2014/2015, 51% of adults aged >65 years accessed the internet in a typical week, which was increased from 46% in 2012/2013.[24] Older people with chronic health conditions are reported to be more likely than their healthy peers to use the internet for health-related tasks.[25] A recent study in this journal showed that of 254 older people (mean age 73 years) undertaking pulmonary rehabilitation or maintenance programs, 85% regularly used a mobile phone, 70% regularly used a computer or tablet, and 60% were willing to use telerehabilitation.[26] Leaders in telephysiotherapy will also offer broader and more attractive treatment options for: people in regional and rural areas; people in full-time employment who are currently excluded from chronic disease rehabilitation programs that are run during working hours; and the wide range of individuals with limited mobility, distressing symptoms, and inability to access centre-based programs.[27]

The science underpinning telephysiotherapy is advancing rapidly. This provides physiotherapists with new ways to deliver treatments of known effectiveness, as well as innovative treatment strategies underpinned by modern technologies. Patients are digitally connected and ready to adopt telephysiotherapy. The increasing number of older people in developed societies, many of whom are living with one or more chronic diseases, means there will be growth in demand for physiotherapy services, along with the expectation that it is delivered in a flexible and patient-centred manner. Telephysiotherapy provides opportunities to improve access to effective care, reduce disability and enhance wellness. We now need modern funding models that can realise this potential.

Ethics approval: N/A.

Competing interests: The author declares no competing interests.

Source of support: Nil.

Acknowledgements: Nil.

Provenance: Invited, Peer reviewed.

Correspondence: Anne Holland, College of Science, Health and Engineering, School of Allied Health, Latrobe University, Australia. Email: A.Holland@alfred.org.au

References

1. Beomoli KL, et al. *Ann Intern Med.* 2017;166:453–462.
2. Piette SL, et al. *J Med Internet Res.* 2013;15:e181.
3. Tsai LL, et al. *Respirology.* 2017;22:699–707.
4. Vanfield M, et al. *Heart.* 2014;100:1770–1775.
5. Galiano-Castillo N, et al. *Cancer.* 2016;122:3165–3174.
6. Moffet H, et al. *J Bone Joint Surg Am.* 2015;97:1129–1141.
7. Sjostrom SB, et al. *BMJ Int.* 2015;116:853–864.
8. Chumble NK, et al. *J Telemed Telecare.* 2015;21:159–165.
9. Askland I, et al. *Neurourol Urodyn.* 2017;36:1269–1276.
10. Piotrowicz E, et al. *Eur J Heart Fail.* 2016;18:164–171.
11. Pepera G, et al. *J Rehabil Med.* 2018;48:382–396.
12. Tabak M, et al. *Clin Rehabil.* 2013;28:583–593.
13. Saco J, et al. *Spine J.* 2011;11:668–672.
14. Kent SW, et al. *Eur Spine J.* 2018;18:2075–2084.

15. Lee IM, et al. Lancet. 2012;380(9838):219–229.
16. Chaudhry SI, et al. N Engl J Med. 2010;363:2301–2309.
17. Cartwright M, et al. BMJ. 2013;346:f653.
18. Ong MK, et al. JAMA Intern Med. 2016;176:310–318.
19. Hwang R, et al. J Physiother. 2017;63:101–107.
20. Piotrowicz E, et al. Eur J Prev Cardiol. 2015;22:1368–1377.
21. Sjostrom M, et al. J Med Internet Res. 2017;19:e154.
22. Torrington M, et al. J Med Internet Res. 2016;18:e83.
23. Kyrgios I, et al. Int J Med Inform. 2017;103:65–84.
24. Household Use of Information Technology, Australia, 2014–15. Australian Bureau of Statistics; 2016. http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/productsby8146.0Main%20Features12014-15?opendocument&tabname=Summary&prodno=8146.0&issue=2014-15&num=&view=. Accessed 7th July 2017.
25. Choi NG, DiNitto DM. J Med Internet Res. 2013;15:e93.
26. Ozkaynak M, et al. J Physiother. 2017;63:175–181.
27. Cox NS, et al. J Physiother. 2017;63:84–93.

WVBOPT

From:	WVBOPT
Sent:	Friday, August 28, 2020 2:57 PM
To:	Melanie Pagliaro
Cc:	Mancinelli, Corrie; Scott Davis <davis1090@marshall.edu>
Subject:	RE: [External] WVPTA's Public Comment on Proposed Amendment to Legislative Rule 16-01

Good afternoon,

After reviewing all comments received the Board has changed the wording for 13.5.2 as follows::

13.5.2. may only be performed once an in-person examination has been performed and/or after a patient provider relationship has been established. The patient/provider relationship may be established via an in-person exam, personally knowing the patient and his/her health status, or through an on call or cross coverage arrangement with the patient's regular treating physical therapist.

After lengthy discussion and taking into consideration the WVPTA 's position, the Board has accepted the recommendation of 8.1.2 to now read as follows:

8.1.2. Alleviate impairments, functional limitations and disabilities by designing, implementing and modifying treatment intervention that may include, but are not limited to: therapeutic exercise, functional training in self-care in relation to motor control function; mobility; and in home, community or work integration or re-integration; manual therapy techniques including but not limited to mobilization of the joints and dry needling; therapeutic massage; fabrication of assistive, adaptive, orthotic, prosthetic, protective and supportive devices and equipment; airway clearance techniques; integumentary protection and repair techniques; patient-related instruction, mechanical and electrotherapeutic modalities, and physical agent or modalities including, but not limited to, heat, cold, light, air, water, and sound;

However, after discussion the Board agrees that is important to keep the educational requirements as outlined due to lengthy discussions with PERD and the Joint Committee on Government Operations, and the Joint Committee on Government Organization. The Board feels it is important to keep the educational requirements within the rules and regulations.

Thank you for taking the time to comment on the proposed rules.

Sincerely,

Nonnie S. Ramsey
Executive Director

WV Board of Physical Therapy
2 Players Club Drive Suite 102
Charleston, WV 25311
Ph# (304) 558-0367
Fax# (304) 558-0369
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Disclaimer:
Please note that all responses the West Virginia Board of Physical Therapy (hereinafter "Board") gives to individual questions are based solely upon WV Code § 30-20-1 et seq. and the Code of State rules 16-1-1 et seq. These Statutory and Regulatory provisions govern the jurisdiction of the Board, and its sole purpose of regulating the practice of Physical Therapy and the protection of the public. Moreover, a provider should consult with his/her legal counsel and insurance payers for questions pertaining to billing for Physical Therapy services.

From: Melanie Pagliaro <melanie@h2cstrategies.com>
Sent: Tuesday, August 25, 2020 8:44 AM
To: WVBOPT <wvbopt@wv.gov>
Cc: Mancinelli, Corrie <cmancinelli@hsc.wvu.edu>; Scott Davis <davis1090@marshall.edu> <davis1090@marshall.edu>
Subject: [External] WVPTA's Public Comment on Proposed Amendment to Legislative Rule 16-01

CAUTION: External email. Do not click links or open attachments unless you verify sender.

Dear Ms. Ramsey:

The West Virginia Physical Therapy Association is submitting the attached letter as our public comment on WVBOPT purposed amendment to existing Legislative Rule Title Series 16-01, General Provisions for Physical Therapist and Physical Therapist Assistants. If you have any questions, please do not hesitate to contact us.

Sincerely,

WVPTA Executive Director
Melanie A. Pagliaro
Hartman Harman Cosco | H2C Public Policy Strategists, LLC

Connect with H2C:
www.h2cstrategies.com | @H2Cstrategies

Call Melanie: 304-612-1815
Call H2C: 800-346-5127
Visit H2C: 1412 Kanawha Blvd., East, Charleston, WV 25301

West Virginia
Physical Therapy
Association

P.O. Box 11115
Charleston, WV 25339

Toll Free: 1-800-346-5127
voice: 304-612-1815

August 24, 2020

West Virginia Board of Physical Therapy
2 Players Club Drive
Suite 102
Charleston, WV 25311

RE: Comment on Legislative Rule

Dear WVBOPT Board Members,

The West Virginia Physical Therapy Association has reviewed the proposed changes to the Title 16, Legislative Rule document. After careful deliberation, the WVPTA has formed a position on both the telehealth and the dry needling proposed rule changes.

Position #1: Telehealth
The WVPTA is firmly in support of promoting patient access and the use of telehealth in the delivery of physical therapy services; however, we seek to ensure that patient safety is preserved when telehealth is used to establish a new patient relationship. The Patient-Client Management Model (PCMM) outlined in the APTA Guide to Physical Therapist Practice 3.0 outlines the components of a physical therapist examination. The examination may include tests and measures that require a "hands-on" examination. While a hands-on examination is not always required, there are situations where an in-person "hands-on" examination is required by the standard of care. We think that the physical therapist should use their clinical judgment to determine when an in-person examination is required based on their education, training, best evidence, and the standard of care. As such, the physical therapist must be physically available to perform a hands-on examination and/or re-examination when these tests and measures are required. Therefore, we are proposing the following edit to 13.5.2.

13.5.2 telehealth may be used to establish a new patient relationship only if the physical therapist is physically available to perform an in-person hands-on examination and/or re-examination throughout the course of the patient's care. The physical therapist must determine if an in-person examination is required based on the physical therapist's clinical judgment and the standard of care. The in-person examination requirement may be temporarily waived when state regulations prevent face-to-face contact.

Position #2: 16-1-12 Dry Needling
The WVPTA recognizes the role of the WVBOPT under 30-20-6(4 and 11) to set educational, experience, and continuing education requirements; however, the WVPTA strongly recommends striking the language that outlines in detail the education and training for a physical therapist to

perform dry needling. While we fully support the that physical therapists must be adequately educated and trained to perform all physical therapy examination and intervention procedures, we think that singling out dry needling as the only therapeutic procedure with detailed educational requirements is a dangerous precedent to set. No other therapeutic procedure has its own set of requirements for education and training. We believe that 16-1-8 Scope of Practice for Physical Therapists – 8.6.3 *"Performing or attempting to perform techniques, procedures, or both in which the licensee is untrained by education or experience"* is sufficient to address any concerns about untrained physical therapists performing dry needling without proper training. As such, we recommend that the WVBOPT edit 8.1.2 as follows and striking 12.1 thru 12.6 under 16.1.12.

8.1.2. Alleviate impairments, functional limitations, and disabilities by designing, implementing and modifying treatment intervention that may include, but are not limited to: therapeutic exercise, functional training in self-care in relation to motor control function; mobility; and in home, community or work integration or re-integration; manual therapy techniques including <u>but not limited to</u> mobilization of the joints <u>and dry needling</u>, therapeutic massage; fabrication of assistive; adaptive, orthotic, prosthetic, protective and supportive devices and equipment; airway clearance techniques; integumentary protection and repair techniques; patient-related instruction, mechanical and electrotherapeutic modalities, and physical agent or modalities including, but not limited to, heat, cold, light, air, water, and sound;

Respectfully,

WVPTA Board of Directors

D. Scott Davis, President
Corrie Mancinelli, Vice President
Rhonda Haley, Secretary
Matt Madrid, Treasurer
Kristin Philips, Chief Delegate, APTA HOD
Bryanna Ordiway PTA Caucus Representative

Ramsey, Nonnie S

From: Kerry Carter <webcarters4@yahoo.com>
Sent: Wednesday, July 29, 2020 9:46 PM
To: Ramsey, Nonnie S
Subject: Question re: DN for LAT's

In looking over the info on DN for LAT's I'd like clarification on the courses and who approves them. As NATABOC certified athletic trainers, they have approved of at least three different providers for DN courses that meet the guidelines stated. The guidelines mention courses taken out of state will need to go through a different process. Am I reading this correctly? The providers, like most CEU providers put classes and seminars on in bigger cities, and don't come to WV cities. I've actually looked into Dr. Ma's IDN as well as the course from AAMT and both are offered in Nashville. So will I need to submit additional information to WVBOPT to have these classes approved since the education will happen out of the state of WV, even though they are already approved courses through the NATABOC for CEUs?

I fully agree with WVBOPT adding guidelines about DN to the LAT and PT acts. I think this is a positive step. I'm just needing guidance as I literally was going to sign up for the courses today but now I'm concerned they might not be approved??

Thank you for your time,

Kerry Carter

Sent from Yahoo Mail for iPhone

Ramsey, Nonnie S

From: Ramsey, Nonnie S
Sent: Thursday, July 30, 2020 3:32 PM
To: Kerry Carter
Subject: RE: Question re: DN for LAT's

Kerry,

That is correct! As long as the course taken meets these requirements it doesn't matter if the course is taken in state or out of state. Typically NATABOC courses will meet these requirements. You must provide to the Board proof of your certification once obtained.

Thank you,

Nonnie S. Ramsey
Executive Director

WV Board of Physical Therapy
2 Players Club Drive Suite 102
Charleston, WV 25311
Ph# (304) 558-0367
Fax# (304) 558-0369
www.wvbopt.com

From: Kerry Carter <webcarters4@yahoo.com>
Sent: Thursday, July 30, 2020 3:22 PM
To: Ramsey, Nonnie S <Nonnie.S.Ramsey@wv.gov>
Subject: Re: Question re: DN for LAT's

Thank you for responding. Section 12.3 states:

12.3. Any athletic trainer who obtained the requisite twenty-four (24) hours of instruction as described in paragraph 12.2.2. in another state or country must provide the same documentation to the Board, as described in paragraph 12.2.2. that is required of a course provider. The Board or its consultant must approve the practitioner's dry needling coursework before the athletic trainer can practice dry needling in this state.

I believe it states the same for the PT act as well.

So as long as the NATABOC approves the course (for athletic trainers), all that is necessary is to submit proof that the course was taken and passed, correct?

Thank you for your time!

Kerry Carter

On Thursday, July 30, 2020, 8:07:04 AM EDT, Ramsey, Nonnie S <nonnie.s.ramsey@wv.gov> wrote:

Kerry,

Thank you for your concern, can you please reply back with the exact section your reading that implies courses need to be taken in state just in case it does need clarified in the rules. The Board doesn't require any continuing education or certifications to be done in state. You would be perfectly fine to register for the courses in TN. If the proposed rule does say that somewhere then that will definitely need to be fixed.

Once you complete the course, please provide the Board with a copy of your certification. Thank you and have a great day!

Sincerely,

Nonnie S. Ramsey

Executive Director

WV Board of Physical Therapy

2 Players Club Drive Suite 102

Charleston, WV 25311

Ph# (304) 558-0387

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www.wvbopt.com

Ramsey, Nonnie S

From: allinda4@frontier.com
Sent: Thursday, July 30, 2020 8:25 AM
To: Ramsey, Nonnie S
Subject: [External] Proposals

I believe both proposals are good.

Ramsey, Nonnie S

From: joe.blauser@mountainriverpt.com
Sent: Thursday, July 30, 2020 12:51 PM
To: Ramsey, Nonnie S
Subject: [External] General Provisions for Athletic Trainers Series 5 and 6

I am fully in agreement with the proposals in Series 5 and Series 6 regarding athletic trainers in the state of West Virginia.

Joseph S. Blauser MS ATC

Ramsey, Nonnie S

From: Amber Phillips <AJPhillipsPTA@outlook.com>
Sent: Monday, August 3, 2020 4:49 PM
To: Ramsey, Nonnie S
Subject: [External] Proposed Amendments

18 CSR 1 Agree with amendment(s) proposed

18 CSR 4 Agree with amendment(s) proposed

18 CSR 8 Agree with amendment(s) proposed

18 CSR 8 Agree with amendment(s) proposed

Amber J Phillips, PTA
WV PTA 1339

Sent from Mail for Windows 10