

H B

205

STATE OF ALASKA
THE LEGISLATURE

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May, 1988

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Mary Van Nimwegen

House Hess

April 16, 1987

HOUSE COMMITTEE REPORT

(7)

Date referred: 3/25/87

FURTHER REFERRALS: HESS
Finance

DATE: 4/16/87
HB 205

The Labor & Commerce Committee has considered

"An Act relating to regulation of the practice of occupational therapy and physical therapy; and providing for an effective date."

RECOMMENDS:

- replace with _____ the same title
- attached amendment(s) a new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):

- fiscal impact same as previous fiscal note published _____
- zero fiscal note same as previous zero fiscal note published _____
- zero with analysis

SIGNING DO PASS:

David Douley
[Signature]
Cliff Davidson
[Signature]
[Signature]

SIGNING OTHER RECOMMENDATIONS:

None

David Douley
 Chairman's signature

HB 205

OVERVIEW

The purpose of this measure is to provide some measure of protection to the health care consumer by establishing licensing requirements for the occupational therapy discipline. It also creates a combined 7 member board of occupational and physical therapists. Since approximately 100 new licenses will be added to the chapter, the expected fiscal impact of creating the new board is zero.

Currently, there is no licensing standard for occupational therapists, and no definition of the practice of occupational therapy. This bill will define occupational therapy, set minimum educational and experience standards, and will require the board to supervise and conduct examinations for new licensees. The text accomplishing the last two items is virtually identical in substance to the current statutes concerning physical therapists.

The bill outlines disciplinary powers of the board, and provides for a transitional phase from the current 5 member board to the new 7 member board.

The bill changes the composition of the State Physical Therapy board by adding two new members to represent the Occupational Therapy profession and amending the name of the board.

Aside from combining the two professions within one board, licensing of the occupational therapy profession is expected to cost \$13,000.00.

Basically, the \$13,000.00 consists of:

- | | |
|---|-----------------|
| 1) PERSONAL SERVICES: | \$8,700 |
| - .40% of administrative support costs
(.40% is based on the number of occupational therapists (100)
divided by the total number of division licensees (27,049) which
includes physical therapists); | |
| - 10% of a Licensing Examiner; and | |
| - 5% of an Investigator. | |
| 2) TRAVEL: | \$1,100 |
| Costs for two members to attend one board meeting. | |
| 3) CONTRACTUAL: | \$3,100 |
| - Professional Services (exam) costs; | |
| - Communication costs; | |
| - Advertising and Printing costs, etc. | |
| 4) SUPPLIES: | \$ 100 |
| TOTAL: | <u>\$13,000</u> |

The occupational therapy profession has expressed its willingness to pay licensing fees necessary to cover costs associated with regulating the profession, and costs are expected to be covered by program receipts. Therefore, licensing fees will be established to offset the costs of regulating the profession.

**STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE**

Bill Version: HB 205
Publish Date: 3/25/87

REQUEST: _____

Revision Date: _____

Agency Affected: Commerce & Economic Dev.

Title: An Act relating to regulation of the practice of occupational therapy and physical therapy...
BRU: Occupational Licensing

Sponsor: Rep. Navarre

Components: All

Requestor: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES	0	8.7	8.7	8.7	8.7	8.7
TRAVEL	0	1.1	1.1	1.1	1.1	1.1
CONTRACTUAL	0	3.1	3.1	3.1	3.1	3.1
SUPPLIES	0	.1	.1	.1	.1	.1
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	13.0	13.0	13.0	13.0	13.0

CAPITAL						
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REVENUE	0	13.0	13.0	13.0	13.0	13.0
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FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	13.0	13.0	13.0	13.0	13.0
TOTAL	0	13.0	13.0	13.0	13.0	13.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS : (Attach a separate page if necessary)

(See attached)

Prepared by: Jennifer Strickler, Management Analyst

Phone: 465-2144

Division: Occupational Licensing

Date: 4/9/87

Approved by Commissioner: J. Anthony Smith

Date: _____

Agency: Commerce and Economic Development

Distribution (by preparer):

- Legislative Finance
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- Senate Secretary

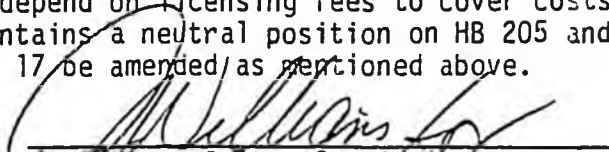
HB 205: An Act relating to regulation of the practice of occupational therapy and physical therapy; and providing an effective date.

HB 205 proposes to amend the composition of the State Physical Therapy Board by adding the occupational therapy profession to the board and its licensing jurisdiction.

The bill basically conforms to guidelines of licensing legislation with the exception of Section 17, AS 08.84.50(b)(4). This provision exempts a practitioner from licensure if the individual practices occupational therapy in the state for 120 days or less in a calendar year. There is no way to track or ensure that an individual who claims exemption under this section is legitimately entitled to the exemption. This section would also defeat the purpose of licensing occupational therapists or assistants. The department suggests three possible alternatives to make this section enforceable:

1. establish a locum tenens permit provision for both the physical therapy and occupational therapy professions, similar to other licensed occupations (i.e., medical doctors). The permit would be valid for 120 days and requires applicants to possess a current license from another state, submit proof of national certification, hold a personal interview with a board member, and pay the required fees; or
2. specify the conditions under which a practitioner can practice in Alaska without obtaining licensure, such as to provide consulting services to licensed practitioners, or for educational purposes in conducting seminars, or for emergency purposes only; or
3. delete the entire exemption and require all practitioners to obtain an Alaska license.

The department was advised that there are approximately 100 occupational therapy practitioners in Alaska. The department was also advised of the profession's willingness to pay licensing fees necessary to cover costs associated with regulating the profession. Therefore, the department finds no reason why the profession should not be licensed. However, because of the uncertainty of the actual number of individuals that will seek licensure, and the need to depend on licensing fees to cover costs of the function, the department maintains a neutral position on HB 205 and strongly recommends that Section 17 be amended as mentioned above.


J. Anthony Smith, Commissioner
Department of Commerce & Economic
Development

DATE: 4/2/87

SECTIONAL ANALYSIS

HB 205

"An Act relating to regulation of the practice of occupational and physical therapy, and providing for an effective date."

- * Section 1: Adds "and Occupational Therapy" to title of State Physical Therapy Board (AS 08.01.010(15))
- * Section 2: adds occupational therapists to those persons required to use professional titles, and/or letters after their name indicating their professional status when offering their services to the public (AS 08.02.010(a))
- * Section 3: amends title of board in that statute relating to expiration date of the board (AS 08.03.010 (c) (8))
- * Section 4: amends title of board in AS 08.84.010, changes membership from five to seven persons, calls for the 2 new members to be occupational therapists or 1 occupational therapist and 1 occupational therapy assistant, amends other language to put occupational therapists under regulatory power of board
- * Section 5: adds new subsection to AS 08.84.030, listing specific requirements for licensing of occupational therapists and occupational therapy assistants who are educated within the United States
- * Section 6: adds new subsection to AS 08.84.032, listing specific requirements for licensing of occupational therapists and occupational therapy assistants who are educated outside the United States
- * Section 7: adds the practice of occupational therapy to AS 08.84.040, relating to application for license, performs minor "housekeeping" measures within this chapter

SECTIONAL ANALYSIS (cont'd)

HB 205

- * Section 8: adds occupational therapists and occupational therapy assistants to AS 08.84.060, allowing licensing by acceptance of credentials
- * Section 9: adds language to AS 08.84.065(c), specific to temporary licensing as a physical therapist or physical therapy assistant pending results of examination (original language did not need to be specific, as chapter only applied to PT's)
- * Section 10: adds occupational therapy to AS 08.84.065(d), dealing with temporary permits for foreign educated therapists during internship
- * Section 11: adds new subsection AS 08.84.065(e), allowing for temporary permit for occupational therapists or OT assistants pending result of examination
- * Section 12: amends language in AS 08.84.080, broadening the board's power to conduct examinations to both professions licensed under this chapter
- * Section 13: adds occupational therapists and OT assistants to AS 08.84.090, licensing duties of the board
- * Section 14: broadens description of persons subject to license renewal under this section (to include occupational therapists and OT assistants), changes renewal period from four to two years, allows the board to require proof of continued competency in cases where a license has remained lapsed for three or more years
- * Section 15: adds occupational therapy to AS 08.84.120(a), which allows the board to revoke, suspend or refuse to renew a license for cause

SECTIONAL ANALYSIS (continued)

HB 205

- * Section 16: adds new subsections, AS 08.84.130(c)&(d), classifying the offense of practicing occupational therapy without proper license as a class B misdemeanor
- * Section 17: adds new subsection, AS 08.84.150 (b), prohibiting practice of occupational therapy without a license except under certain conditions
- * Section 13: adds occupational therapists to AS 08.84.160 (limiting licensed persons to their professional discipline)
- * Section 19: repeals and reenacts 08.84.185, defining the disciplinary powers of the board
- * Section 20: amends AS 08.84.190(1), redefining "board" for purposes of this chapter
- * Section 21: amends AS 08.84.190 by adding new paragraphs that define occupational therapists, occupational therapy, OT aides and OT assistants
- * Section 22: amends 08.24.200, the short title of this statute, to include occupational therapists
- * Section 23: adds occupational therapists to the definition of "health care provider" under AS 09.55.560(1) - Medical Liability laws
- * Section 24: adds occupational therapists to the definition of "health care provider" under AS 18.23.070(3) - Health Care Services Information laws
- * Section 25: adds occupational therapists to the definition of "health care provider" under AS 21.88.900(9) - Health Care Providers Insurance (MICA)
- * Section 26: adds definition of occupational therapist under AS 21.88.900 - Health Care Providers Insurance (MICA)

SECTIONAL ANALYSIS (continued)

HB 205

- * Section 27: adds occupational therapist to definition of "practitioners of the healing arts" for purposes of AS 47.17.070(9) - Child Protection statutes (requires reporting of abuse)
- * Section 28: adds language allowing for transitional period for licensing, so that the department and new board can "catch up"
- * Section 29: adds language allowing for licensing by credential, so that current practitioners who meet certain criteria can be licensed immediately
- * Section 30: Experience-Based licensure. This allows OT assistants with 4 years of experience accumulated before July 1, 1988, to substitute this experience for formal education, and become licensed as occupational therapists by examination.
- * Section 31: provides that this act does not affect existing valid licenses when act takes effect
- * Section 32: requires the Governor to appoint 2 new members to new 7 member board by March 1, 1988, sets out length of term for new members
- * Section 33: calls for immediate effective date for Section 28 of this bill
- * Section 34: calls for effective date on balance of this measure as January 1, 1988



Alaska Occupational Therapy Association

TESTIMONY

Presented before the

ALASKA HOUSE OF REPRESENTATIVES, LABOR AND COMMERCE COMMITTEE
On

LICENSURE FOR OCCUPATIONAL THERAPISTS

Presented by

Beverly Ingram

ALASKA OCCUPATIONAL THERAPY ASSOCIATION

April 16, 1957

Mr. Chairman and members of the committee, I appreciate the opportunity to speak with you regarding the Occupational Therapy Practice Act being considered today. I am Beverly Ingram from the Alaska Occupational Therapy Association. The Alaska Occupational Therapy Association represents over 110 Registered Occupational Therapists and Certified Occupational Therapy Assistants. Our membership has voted to make a united effort to obtain licensure for occupational therapists in this State. This effort is fully supported by our national organization, the American Occupational Therapy Association.

Our presentation will provide you with an overview of what occupational therapy is, the training required to practice occupational therapy, and, most importantly, the reasons for our pursuit of a licensure law.

We would like to give you an overview of the practice of occupational therapy and the various types of people who benefit from it, through a brief slide presentation.

As you have seen from this slide presentation, occupational therapists treat a wide variety of disabled people which requires an extensive educational and experiential background. In order to become qualified to work in the field of occupational therapy, an occupational therapist must complete at least a 4 year bachelor's degree program from an accredited university, and an occupational therapy assistant must complete a 2 year college degree program. Our

academic coursework includes anatomy, neurophysiology, human development, psychology, physical medicine, and intensive training in occupational therapy evaluation and treatment techniques. Occupational therapists must complete a full-time supervised fieldwork experience following their studies. A final requirement is that entry level therapists must pass a national certification examination approved by the American Occupational Therapy Association. This is a voluntary credentialing program and there is a problem with individuals who choose not to participate. The national association has no effective means of enforcing these requirements in order to prevent unqualified people from being employed as occupational therapists. The profession has often relied on facilities such as hospitals, nursing homes, school districts and rules set up by third party payors to maintain qualified providers. It is not the major responsibility of these bodies and programs such as Medicaid and Medicare to enforce personnel qualification standards. Since no legal definition exists in our State, these regulations are, in fact, unenforceable.

This leads to our reasons for pursuing licensure. By allowing the practice of occupational therapy to go unregulated, the health and welfare of the public is endangered. The abuse and potential harm generated by unregulated practice occurs on two fronts. First, in many instances the public is misled when unqualified people represent themselves as occupational therapists. The patient is often unaware of what is expected in treatment or what qualifications are necessary for an occupational therapist to practice. Therefore, patients believe they are receiving legitimate services, when in fact they may not be. These consumers are then deprived of the services they need to make a full recovery. Also facilities claim to provide occupational therapy when actually no qualified therapist is employed. There have been instances in Alaska health care institutions where this has occurred. Without licensure, consumers are misled to believing they are receiving these needed services and sometimes falsely charged with no legal recourse.

Secondly, and more importantly, cases of serious harm and abuse due to improper treatment by untrained people representing themselves as occupational therapists have been documented. As you have seen presented in the slides, occupational therapists work with many critically ill or severely injured patients. In the majority of instances, patients such as a burn patient do not have the luxury of shopping around to determine if a therapist is qualified. Moving a burned limb or joint too soon or improperly splinting an extremity can cause tendon rupture, irreparable damage, or loss of function. In other patients, such as one suffering with a cardiac condition, they could suffer life threatening damage if they are not assessed properly. If a cardiac patient's activities are not graded to his tolerance level and closely monitored, he can re-arrest. Many other examples of potential harm are evident in the rehabilitation of injuries. A qualified occupational therapist has the knowledge and training in treatment techniques and of the precautions and contra-indications that greatly reduce risk to the consumer. Without a legal definition of occupational therapy and a mechanism to monitor

the provision of these services in our State, the consumer does not have adequate protection. Enactment of a licensure law is a substantial deterrent to the unqualified practice of occupational therapy and decreases the potential for fraud. The power of the State to enforce the law and the action against those who violate the law also discourages fraud and abuse.

This licensure bill (HB 205) proposes that a joint board be created, combining the regulation of occupational therapy with the existing physical therapy board. We realize this is important due to the current State economic status and trend towards combining boards. We recommend a combined board which allows equal representation of the professions being licensed under it. We have worked with the Division of Occupational Licensing to insure minimal (if any) additional costs to the State in regulating this profession.

Occupational and physical therapists have similar yet different educational and fieldwork requirements. Treatment goals are often shared by the occupational and physical therapist in the rehabilitation setting. Although treatment goals may be shared, the modalities used by each profession often differ. For example, in the rehabilitation of a stroke patient to be able to return to his home and function as independently as possible; the physical therapist may be working on muscle strengthening through exercises and gait training or use of assistive devices to aid in walking while the occupational therapist may also use exercises or functional activities to improve the patient's ability to dress himself, prepare a meal, and take care of himself within the home or with the assistance of adapted devices.

In summary, occupational therapy focuses on productive and independent function. Inappropriate treatment is a very expensive and a risky proposition for the consumer. Thirty-two other states have enacted licensure laws covering occupational therapy with three other states combining occupational and physical therapy boards. The Alaska Occupational Therapy Association believes that licensure of occupational therapists is in the best interest of this State's citizens. There is no alternative to licensure. The purpose is to regulate the practice of occupational therapy, not to infringe on the rights of other professionals to practice what they are qualified to practice.

Mr. Chairman and members of the committee, an occupational therapy licensure law is needed now. I urge you to approve this bill. I appreciate this opportunity to express our concerns. Thank you for your time.

WHO CAN BE HARMED BY AN UNQUALIFIED OCCUPATIONAL THERAPIST?

The majority of functions performed by Occupational Therapists do not, in themselves, put the patient in harm. Rather it is the patient's response to these functions and/or the patient's mental, emotional or physical instability which may cause the functions to be dangerous. A well-trained therapist has both theoretical and practical knowledge of the neuromuscular and cardiovascular systems of the body as well as of physical, emotional and psychological development of the individual. He/she is trained in treatment of rehabilitation of injuries to these systems and of precautions and contra-indications that greatly reduce risk to the consumer.

The following chart provides a few examples of possible complications.

<u>DIAGNOSIS OR DISABILITY</u>	<u>METHOD OF TREATMENT WHICH COULD BE DANGEROUS</u>	<u>POSSIBLE COMPLICATIONS</u>
1. Neonatal evaluations and treatment	1. Evaluations and treatment	1. Overstraining neurological and logical and physical systems Medical instability/death
2. Cardiac Conditions	2. Prescribing progressive activities for patients	2. Medical instability/death
3. Neurological diseases and impairments a. Cerebral vascular accidents b. Head stroke trauma c. Cerebral Palsy	3. Neurological treatment ADL activities	3. Choking Seizures Delay or impede neurological return
4. Traumatic injuries a. Amputation of upper extremity b. Burns	4a Evaluation and prescription of prosthesis in conjunction with prosthetist and physician 4b Reducing hypertrophic scarring by applying pressure to patient through conforming splints and/or pressure garments	4a Vascular problems Weight fluctuations that affect fit of prosthesis Skin breakdown 4b Infection Skin breakdown Contractures/deformity
5. Sensory Integrative Dysfunction	5. Sensory stimulation	5. Sensory overload Seizures Respiratory Arrest
6. Muscular Diseases a. Muscular dystrophies b. Multiple sclerosis	6. Exercise programs for range of motion and muscle strengthening	6. Joint damage Inadequate or improperly performed motion exercises can result in permanent contractures of muscles, tendons, and ligaments.
7. Geriatric	7. Designing and monitoring treatment, environment. Transfers to tub, toilet, bed or chair.	7. Further cognitive, physical, psychological or social impairment. Falling resulting in physical and psychological harm.
8. Diseases of Bones and Joints a. Arthritis	8. Positioning of patient. Exercise programs for range of motion and muscle strengthening. Splinting	8. Joint damage Loss of function due to improper splinting.
9. Developmentally Delayed + Retardation	9. Improper treatment or lack of treatment	9. Prevent individual from obtaining highest level of function possible
10. Psychiatric Disorders a. Psychosis	10. Design and monitor treatment environment	10. Further cognitive psychological or social impairment.
11. Respiratory Diseases	11. Prescribing progressive activity. Use of substances with toxic fumes.	11. Overstressing respiratory and cardiovascular systems Exacerbation of disease process

DEVICES OR TREATMENT TECHNIQUESPOSSIBLE HARM

- | | |
|--|---|
| 1. Splint or brace | 1. Possible nerve, muscle, skin, or orthopedic or functional loss and debilitation. |
| 2. Slings | 2. Possible axillary nerve damage or impaired brachial artery circulation due to improper fit. Improper positioning - loss of extremity function. |
| 3. Neuromuscular facilitation devices of vibration and ice | 3. Adverse effects on central nervous system or vascular system. |

The financial burden to the consumer is also reduced when a skilled practitioner performs these tasks, as appropriate treatment is planned and implemented in the most expedient way. Consumers of health care services in the latter part of the 20th century are caught in a "CATCH 22" situation. Technology has outstripped our social values and government policies. The capabilities are in place for keeping persons alive in more disabled states, while at the same time services delivery is being moved to less restrictive arenas and government policies regulating qualifications of delivery personnel are being lessened.

Consider the following ways an individual, family or 3rd party payor can be harmed:

Potential for independence is enhanced by early intensive intervention of occupational therapy personnel. If these personnel are not qualified, the potential for return to independent functioning is lost and the family incurs long term financial burdens.

Because some insurance policies use licensing as the criteria for determining qualified reimbursable services, the consumer may be denied the financial coverage they thought they had. They are left with the choice of paying additionally for something they assumed was taken care of or not getting the needed service.

Consumers experience long term emotions of guilt and anger at being duped. Guilt occurs when they realize too late that selection of services and service personnel depended on their personal knowledge of qualifications of a cadre of health care deliverers. Anger and feelings of being duped occur when they realize that protections were not in place to help them make the necessary decisions. Because SOME HEALTH PERSONNEL ARE LICENSED (REGULATED) WHILE OTHERS ARE NOT THE CONSUMER IS LULLED INTO BELIEVING THE GOVERNMENT IS MONITORING THE QUALIFICATIONS OF ALL DELIVERERS.

Consider the following government guidelines in place to protect the public from unqualified O.T. personnel.

Federal Medicare guidelines have removed a previous requirement that Occupational Therapy personnel meet AOTA's certification requirements and provide instead that they meet qualifications specified by the medical staff, consistent with state law.

Federal regulations for nursing homes require an O.T. to complete the education and field work experience but does not require passing the AOTA certification exam.

Public law 94-142 requires schools to provide special education and related services for children with handicaps. O.T. is a related service and must be provided by qualified personnel but the definition of "qualified" is left up to the state education agencies.

Other accrediting agencies such as JCAH, CARF and ACRMDD require O.T. services to be provided by qualified personnel. They do not, however, define "qualified." This is left to the state or private facility.

Do these guidelines seem adequate to assure safety and quality OT services to ALL consumers? We don't think so. Please share this information with your legislator when talking about why OT's need to be licensed. Ideally we would like to elicit actual cases of these situations occurring or having occurred. If you as an individual can recall such instances please contact Jeanne Carbon at the AOTA Office. A specific case example when talking with a legislator is worth more than 20 "what ifs".

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AMANDA IRENE ANDRADE
7030 Crawford
Anchorage, AK 99502
(907) 243-7931/257-2740

April 13, 1987

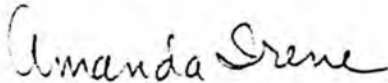
Representative Johnny Ellis
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, AK 99811

RE: HB 205

Dear Representative Ellis:

Attached is a copy of a letter I have sent to various newspapers. As co-chair of the Senate Health, Education and Social Services Committee, I hope you will find the time to respond and to help support the change in language on this bill. Thank you very much.

Sincerely,


Amanda Irene Andrade

Attachment a/s

AMANDA IRENE ANDRADE
7030 Crawford
Anchorage, AK 99502
(907) 243-7931/257-2740

April 8, 1987

TO WHOM IT MAY CONCERN:

One of the items before our legislature this session is House Bill 205 introduced by Representative Mike Navarre (D) of Kenai. This bill is "An Act relating to regulation of the practice of occupational therapy and physical therapy; and providing for an effective date." The bill's purpose appears to be the licensing, and control through licensing requirements, of those professionals engaged in health care; specifically, it adds the realm of Occupational Therapy to the already existing State Physical Therapy Board. The bill's intent appears to be to protect the public from unqualified or incompetent individuals who charge the consumer a fee for services they are not suitably prepared to deliver--a matter of ethics. At least that is the way I have read this document and I concur; consumer protection is most reasonable. Most of us agree that many professions (doctor, lawyer, health care professions, etc.) need certain guidelines provided by their schools, professional associations, their peers, and the states in which they practice.

All too often, however, the authors of a piece of legislation forget that loopholes in language can provide a means for prosecution (persecution) by those who would misuse a law whose intent is protection.

According to HB 205, this board has the power to

- set qualifications and eligibility guidelines and to pass judgment on such;
- conduct examinations;
- issue permits and licenses and refuse, suspend, or revoke those licenses;
- limit or condition the authority to practice; and
- adopt regulations as necessary to carry out their purpose.

As HB 205 presently reads, the proposed State Physical Therapy and Occupational Therapy Board would have the power to say one may not practice "occupational therapy," as defined in the bill, unless one meets the board's specifications. That body may also levy a civil fine of up to \$5,000. The bill proposes the following definition for occupational therapy.

(6) "occupational therapy" means the use of purposeful activity, evaluation, treatment, and consultation with human beings whose ability to cope with the tasks of daily living are threatened with, or impaired by developmental deficits, learning disabilities, aging, poverty, cultural differences, physical injury or illness, or psychological and social disabilities to maximize independence, prevent disability, and maintain health;

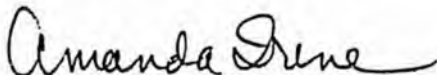
The bill goes on to say "'occupational therapy' includes (A) developing daily living, play, leisure, social, and development skills . . . (C) enhancing functional performance, prevocational skills, and work capabilities using specifically designed exercises, therapeutic media, and manual intervention . . . [and] (G) adapting environments for the disabled." The first, (A), accurately describes every mother that every lived; (C) might describe the husband, wife, or coworker who rubs your neck when you're tense or overstressed; the son who builds a ramp so that his aging father can enter his home in a wheelchair would be in violation of (G).

As presently written, the scope of occupational therapy could be misconstrued to cover just about anyone doing just about anything from raising children and caring for other human beings to common kindnesses. The language of HB 205 in defining "occupational therapy" is too all-encompassing, thus opening doors for the possibility of misuse of the power it grants. A simple change in wording would bring the definition of occupational therapy into appropriate focus without taking anything from the bill's objectives. I propose the following language be added.

(6) "occupational therapy" is defined as, but is not limited to occupational therapists, [means] the use of purposeful activity, evaluation, treatment, and consultation with human beings . . . ; "occupational therapy" includes, but is not limited to occupational therapists, (A) developing daily living, play, leisure, social, and development skills . . .

This language would seem to grant the proper authority to the licensing body and prevent possible misuse of its power.

Sincerely,



Amanda Irene Andrade



COLLINS & ASSOCIATES

2600 Denali, Suite 501
Anchorage, Alaska 99503
(907) 276-7943

April 11, 1987

Representative Red Boucher
P.O. Box V
Juneau, AK 99811

Dear Representative Boucher:

I am in support of the regulation of the practice of occupational therapy in Alaska. In my professional experience with injured workers, I have come to recognize the positive impact of the unique services offered by occupational therapists upon the quality of life and functional performance of the disabled. Therefore, the potential for harm is also great without some guarantee of appropriate education and training of occupational therapists working in both private and non-profit sectors.

I, therefore, support HB 205 and urge you to pass this bill. This will help assure quality occupational therapy services to those Alaskans who are in need of this type of assistance.

Thank you for your consideration.

Sincerely,

Mike Head, M.Ed., CIRS, CRC
Certified Rehabilitation Counselor

MH:lg/17-68

ROBERT W. LIPKE, M.D.

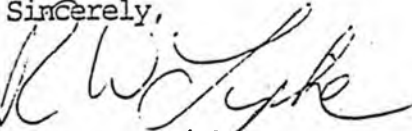
— Orthopedic Surgery —
Practice Limited to Surgery
of the Hand and Upper Extremity

Rep. Red Boucher
P.O. Box V
Juneau, Alaska 99811

Dear Mr. Boucher,

I would like to express my support for the passage of HB 205. I feel it is important to license Occupational Therapists in the State of Alaska. This bill, if passed would help protect the general public from unauthorized, and perhaps ill-prepared practitioners. It is important to insure and maintain professional standards in this area as it is in other health occupations.

Sincerely,



Robert W. Lipke, M.D.

Michael D. Manuel, M.D.
Plastic and Reconstructive Surgery

April 8, 1987

Steve Rieger
P.O. Box V
Juneau, AK 99811

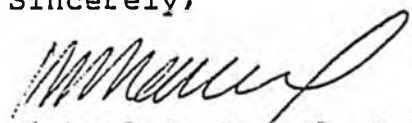
RE: House Bill #205, Licensing of Occupational Therapist

Dear Mr. Rieger,

I write in support of House Bill #205 pertaining to the licensing of Occupational Therapist. I believe that the licensing of Occupational Therapist will not only help them gain recognition as a separate and important identity in the care of rehabilitation of patients but will more importantly allow the public to have the assurance that their therapists are indeed subject to licensure and have satisfactorily completed a course leading to the licensing.

I believe that passing House Bill #205 is in the best interest of the public and I appreciate your support in seeing it passed.

Sincerely,



Michael D. Manuel, M.D.

MDMbwc

Representative Alyce Hanley
Alaska House of Representatives
State Capital
Pouch V
Juneau, Alaska, 99811

4/11/87

Dear Ms. Hanley:

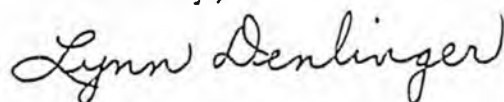
I am writing to you as a concerned voter in your district in Anchorage. I would like to bring to your attention something I feel is very important. Sometime in the near future the Alaska State House will be voting on House Bill 205 concerning the regulation of the practice of occupational therapy. As a current patient of an occupational therapist I can understand the importance of strict licensing and governance of occupational therapists. I must admit that I was rather amazed to find out that occupational therapists are currently not under any kind of scrutiny or licensing in the State of Alaska. I feel that this is a serious oversight on the part of the State of Alaska and should be remedied by the upcoming bill.

If a person recovering from a traumatic injury was to go unaware to an unskilled, untrained, unlicensed person acting as a therapist it could result in major physical and psychological problems. Unskilled treatment of an injury could and most likely would result in further loss of work, permanent disability and irreparable psychological damage.

My personal dealings with my present occupational therapist have been very positive. Her knowledge and skills have helped me in a speedier, safer recovery. I shudder to think that I could have had any further setbacks in trying to regain a normal lifestyle.

I would appreciate your serious consideration of this bill and your support on this matter.

Sincerely,



Lynn Denlinger
8607 Jade St.
Anchorage, Alaska 99502

April 12, 1987

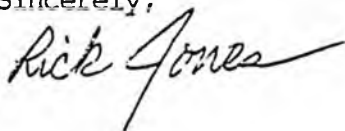
Representative Niilo Koponen
P.O. Box V
Juneau, Ak. 99811

Dear Representative Koponen:

I am writing to express my support of HB 205 for regulation of occupational therapy services. Since my injury I have been under the care of an occupational therapist. The injury has made a negative impact on nearly every aspect of my life. Things that I once took for granted are now time-consuming, difficult or impossible. I can see that occupational therapy is essential in helping me to achieve greater mobility and to return me to my previous level of function at home and at work.

I believe that HB 205 is important to regulate quality of care for others who may be injured or disabled in the future.

Sincerely,

A handwritten signature in cursive script that reads "Rick Jones". The signature is written in dark ink and is positioned below the typed word "Sincerely,".

Tamara Thomas
Box 874311
Wasilla, Ak

Representative Alyce Hanley
P.O. Box V
Juneau, Ak. 99811

Dear Representative Alyce Hanley:

I ' am writing this letter in regards to HB 205. I'd like to urge you to pass this bill to protect the public from unqualified therapist. Secondary to a hand injury, I've recieved various therapy and find there is varying quality in services available. I'd appreciate it if you would see to it that there is regulation in this area.

Thank you ;

Tamara Thomas

Tamara Thomas

The Honorable Curt Mendenhall
P.O. Box V
Juneau, Alaska 99811

Dear Curt:

I am writing in support of H.B. 205, which asks for licensure of occupational therapists in the state of Alaska.

As a physical therapist, I have worked closely with occupational therapists in Alaska since 1967. My experience has been varied, with it including work in the Mat. Su. Borough and Anchorage school districts, Hope Cottages, The Alaska Psychiatric Institute, The Alaska

Treatment Center, and Michigan
and Human Hospital.

If well qualified, occupational
therapists bring a high level
of expertise to their patients
to improve their functioning
in day to day life. If not
qualified, as I have seen in
two instances, one in the
M.I. - In School District,
they can cause harm to
their patients. An example
would be a therapist working
with a cerebral pained child
who has muscle tightness
due to spasticity. In stretching
to prevent muscle contracture,
a poorly trained therapist
could cause a muscle to be
torn or even break a bone.

As a professional yourself,
I am sure you can appreciate
the need for persons who
practice in our state to be
of the highest caliber. Please
consider supporting H.B. 205.

D. [unclear]
Garry
Bulter



NORTHERN REHABILITATION SERVICES, INC.

4325 Laurel, Suite 103
Anchorage, Alaska 99508
(907) 561-3162

April 10, 1987

Representative Red Boucher
Anchorage District 10
P.O. Box V
Juneau, Alaska 99811

RE: House Bill 205

Dear Mr. Boucher:

NRS would like to express its support for regulation of the practice of occupational therapy. The professionals at NRS work directly with occupational therapy in the treatment of injured workers. We recognize the importance of providing quality services, therefore, support standardization of the licensing practices. This will ensure the continuation of appropriate medical care throughout the state, in both the private and non-profit sectors.

If you should have any concerns or questions regarding this letter, please do not hesitate to contact me. Thank you for your consideration of this issue.

Respectfully submitted,

Carol Jacobsen, R.N., C.R.R.N.
Certified Rehabilitation Registered Nurse

CJ:lw



**ALASKA
TREATMENT
CENTER**

Medical Rehabilitation Services

April 9, 1987

Dave Donley
Alaska State Legislature
PO Box V, Room 106
Juneau, AK 99811

RE: HB 205

Dear Representative Donley:

The Alaska Treatment Center, an out-patient medical rehabilitation facility and employer of occupational and physical therapists, supports HB 205 for the following reasons:

1. Provides concise definition of occupational therapy services (assists Medicaid and other insurance claims).
2. Provides consumer protection in cases where occupational therapy services are wrongfully delivered.
3. Enables consumers to know what is expected from occupational therapy services.

Employers of physical and occupational therapist rely on the state licensing board to perform its functions in an expedient and thorough manner. Factors in HB 205 which affect this expediency and which should be considered, include:

1. Additional board members/additional expense (proposed: 2 occupational therapists; Sec. 08.84.010).
2. Additional business to conduct/necessitates more meeting time.

Thank you for your thoughtful consideration in this matter. Please contact me if I can be of any additional assistance.

Sincerely,

Avis C. Hayden
Executive Director

ACH/bel

cc: Dale Shirk, Health Association of Alaska
~~Melissa Robinson~~, President, Alaska Occupational Therapy
Association
Patricia McAdoo, President, Alaska Physical Therapy
Association

Education

All occupational therapists have classroom and clinical educational experiences. In entry-level positions the occupational therapist may be an occupational therapist, registered (OTR) or certified occupational therapy assistant (COTA).

The registered occupational therapist (OTR) has completed a four-year baccalaureate degree program and six to nine months of field work experience. The OTR may have spent the full four years in an occupational therapy program, or may have transferred to occupational therapy after two years in a liberal arts program. Course work includes the physical, biological and behavioral sciences, and is followed by supervised field work experience dealing with conditions that are commonly met in practice.

For the person who already has a baccalaureate degree in an area other than occupational therapy, entry-level master's programs are available. Some schools may require post-baccalaureate students to have credits in human growth and development, psychology, sociology or anthropology. The master's programs require about 45 semester credits plus six to nine months of fieldwork experience.

There are currently about 65 professional entry-level programs accredited jointly by the American Medical Association and The American Occupational Therapy Association, Inc.

The certified occupational therapy assistant (COTA) is a high school graduate or the equivalent, who has completed an approved program in occupational therapy. Course work focuses on human development, the tasks and skills used in daily life, and includes at least two months of supervised fieldwork. At present, there are 50 such programs available in academic settings.

Following completion of course and clinical work, the entry-level OTR or COTA candidate must pass a national certification examination to become credentialed for practice. Master's and doctoral programs for OTR's are also available. These prepare the therapists for specialized practice, the teaching of occupational therapy, and research activities.

Of all therapists providing direct patient services, most occupational therapists work with physically and developmentally disabled persons, while others work with emotionally handicapped clients. Therapists providing indirect patient services include educators, administrators, consultants and researchers.

Progress

Occupational therapy had its beginning during World War I when tens of thousands of servicemen suffered serious injuries.

A rehabilitation program was imperative if these lives were to be reclaimed.

Once the profession got its start, the recognition of occupational therapy's value gained momentum. By the mid-1930's more than 200 hospitals employed occupational therapists. With World War II came emphasis on psychological as well as physical rehabilitation. In the decade and a half after the war, the occupational therapy education programs were expanded, the specialization began. By the 1960's, occupational therapy programs included many specializations such as: children's learning disabilities, hand rehabilitation, barrier-free design of homes and public buildings, and infant and child development.

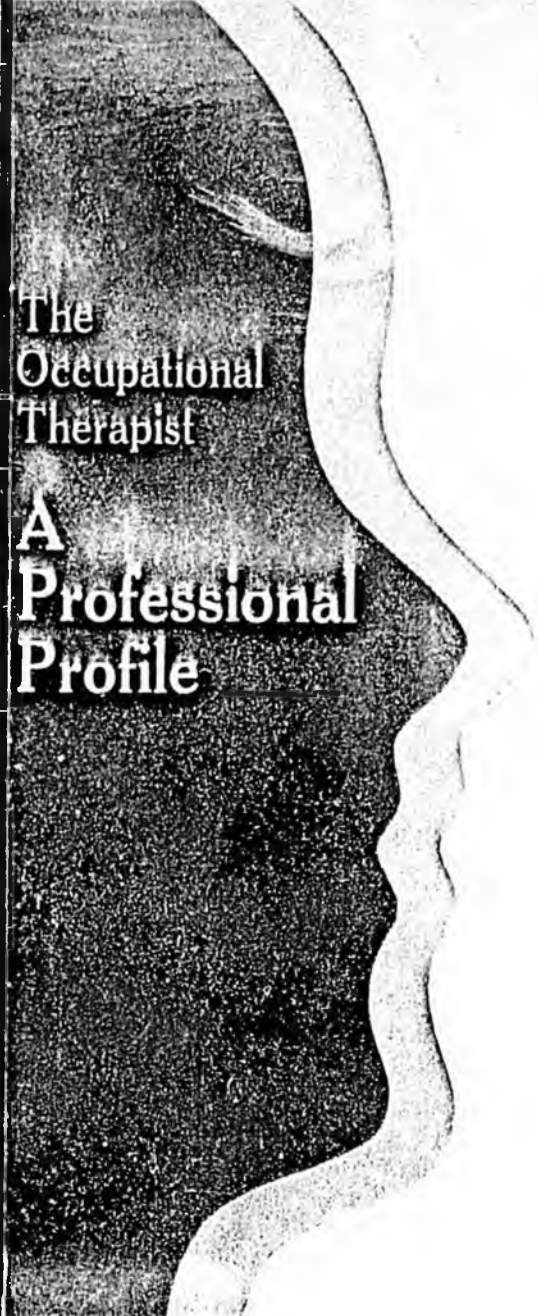
During the 1970's, occupational therapists were instrumental in establishing large numbers of innovative community based programs, especially in the public schools.

In the '80's they will be expanding on these accomplishments and will join with other health providers in bringing needed services to previously underserved populations including the elderly, the profoundly retarded and the severely handicapped.

aoia

American Occupational Therapy Association
1383 Piccard Drive
Rockville, Maryland 20850
(301) 948-9626

(R-7-83)



The Occupational Therapist A Professional Profile

CERTIFICATION COMMITTEE

The Certification Committee is a standing committee of the Standards and Ethics Commission of the American Occupational Therapy Association (AOTA). Its major charge is to develop, maintain, and review certification examinations for entry-level occupational therapists and occupational therapy assistants. The Committee is empowered to act autonomously in the development and administration of certification examinations, and enforces eligibility requirements as determined by AOTA policy. Responsibilities of this Committee may be modified or supplemented by action of the Representative Assembly which sets all policies of the Association.

COMMITTEE MEMBERSHIP

The Chairperson of the Certification Committee is appointed by the Chairperson of the Standards and Ethics Commission and approved by the Representative Assembly. Nominations for committee members are solicited through announcements in the Occupational Therapy Newspaper. Appointments are made by the Chairperson with the approval of the committee members. Membership is representative of various areas of practice, clinical and academic education and geographic distribution. Membership also includes two representatives of the public sector who are not Occupational Therapists - a consumer and a practice based administrator. Members serve a three-year term and may be appointed for one successive term.

For further information please contact:

Division of Credentialing
American Occupational Therapy
Association, Inc.
1383 Piccard Drive
Rockville, Maryland 20850
301/948-9626

4/84

CERTIFICATION EXAMINATIONS

for
OCCUPATIONAL THERAPISTS
and
OCCUPATIONAL THERAPY
ASSISTANTS

an information brochure

provided by
the Certification Committee
American Occupational Therapy Association
1383 Piccard Drive
Rockville, Maryland 20850
301/948-9626

PURPOSE OF THE EXAMINATIONS

The examinations are designed to test application of occupational therapy theory and practice. The purpose of the Certification Examinations for Occupational Therapist, Registered, and Occupational Therapy Assistant is to provide objective evidence of the candidate's qualifications to practice occupational therapy. The three eligibility criteria for certification as either Occupational Therapist, Registered, or Occupational Therapy Assistant are:

1. Graduating from an accredited/approved educational program
2. Successfully completing all fieldwork requirements
3. Successfully sitting the certification examination

FORMAT OF THE EXAMINATIONS

The Certification Examinations are criterion-referenced tests in which domains are identified and items are formulated in relation to specified performance criteria.

Each examination consists of 250 objective multiple choice questions. Answers are marked on separate answer sheets, which are computer scored. The expert judgement of occupational therapy personnel currently engaged in occupational therapy practice and/or education is used to determine the probability that a minimally qualified entry-level occupational therapist/occupational therapy assistant will choose the correct answer of each exam item. Based on an analysis of all examination items a minimal score is set to determine the level of performance required to become certified.

EXAMINATION ADMINISTRATION

A private testing agency is contracted to administer the examinations twice a year for both therapist and assistant levels. The same examination is never repeated in subsequent administrations. Upon receipt of documentation, the Certification Committee may grant variance in standard administration procedures for handicapped candidates or individuals whose religion prohibits sitting an examination on the scheduled day.

REPORTING EXAMINATION FINDINGS

After each examination, candidates are notified of their total and subsection scores. A candidate may review his own examination results in accordance with procedures established by the Certification Committee in conjunction with the testing agency. Occupational therapy educational

programs receive similar data on each of their graduates with names removed to preserve confidentiality. Individuals' scores will be sent to one or more state licensure boards upon request by the candidate and payment of a small processing fee.

DEVELOPMENT AND REVIEW OF THE EXAMINATIONS

The Certification Committee determines the content allocations (categories and number of questions in each category) of the examinations by using information from a variety of studies that identify the competencies expected of entry-level therapists and assistants. The allocations are periodically reviewed and adjusted to reflect current practice.

Items (questions) for the examinations are generated:

- through item development workshops which are held with the assistance of occupational therapy practitioners and specialists in test construction.
- by invited professionals. Confidentiality is maintained throughout the process of item construction.

Items are edited by a professional testing agency for psychometric soundness and reviewed by occupational therapy practitioners for relevance, correctness, and appropriateness for entry-level therapists and assistants.

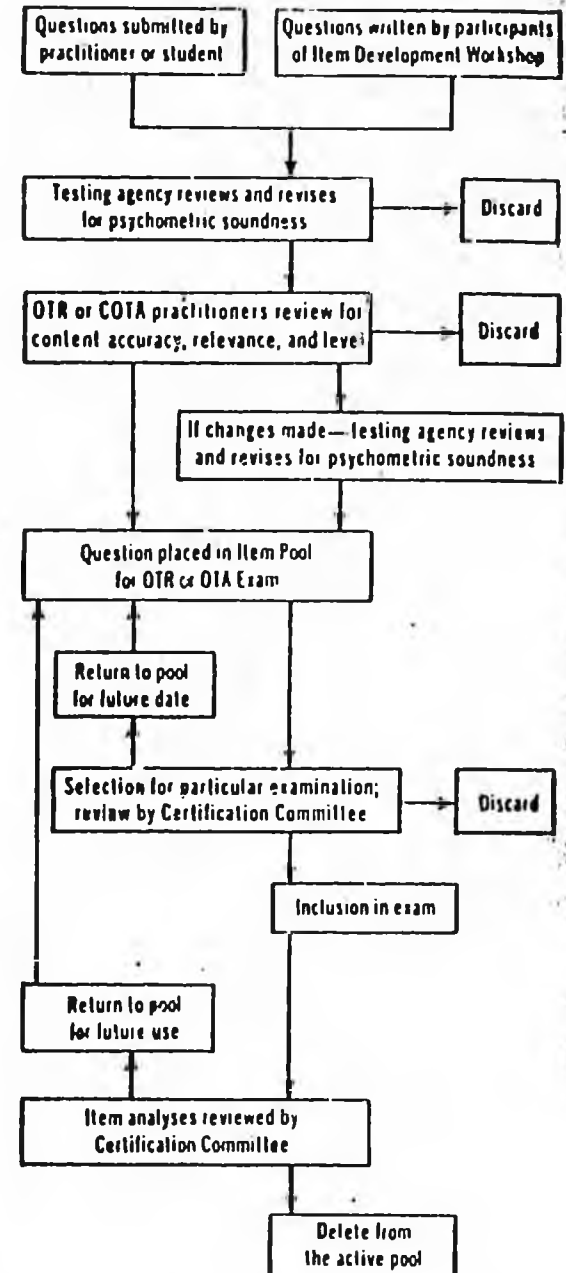
Approved test questions are placed in separate item pools for each level. Each year, two examinations for each level are constructed from items in the respective pools. A draft of each examination is reviewed and approved by the Certification Committee.

After each administration, examination statistics and item analyses are reviewed by the Committee and the testing agency. Items not proving to be statistically sound are deleted from the active pool.

EXAMINATION AND LICENSURE

States with licensure laws have used AOTA Certification Examinations as part of their licensure requirements. Authorized representatives of state licensure boards may inspect the item pools and/or representative forms of the examinations through a procedure established by the AOTA and the testing agency. The procedure provides boards with needed information while maintaining security of the examinations and item pools. Such a request may be initiated by contacting the AOTA Division of Credentialing.

SCHEMATIC REPRESENTATION OF TEST CONSTRUCTION



Kathy Huxley Registered Occupational
Therapist

~~of~~ Alaska Occupational Therapy
Association

Testimony 4/30/87: HB 205

1. Request that the Physical Therapists clarify the specific issues that they have with HB 205.
2. Communication is going on between the Occupational and Physical Therapists to resolve differences about the bill.
3. Since the joint board situation has been proposed ^{in order for} ~~for~~ the Occupational Therapists to obtain licensure, I ^{believe} ~~feel~~ the legislature needs to mediate an arrangement that is agreeable to both professions.

K.H.

Entry-Level Role Delineation

For OTRs And COTAs

**The American Occupational
Therapy Association Inc.**

**1383 Piccard Drive
Rockville, MD 20850**

**Approved by
Representative Assembly**

March 1981

Introduction

This role delineation is intended for internal use by the American Occupational Therapy Association, Inc. as a guide to assist members in the practice of their profession. The role delineation may be used to assist in the development of entry-level educational Essentials and certification criteria, but may not be used (except with the written permission of the AOTA) to draft legal documents of any kind such as licensure bills or private contracts.

The contents of this document are not to be construed as entirely original, but represent a compilation of resource materials and professional judgment. Resource documents used were:

1. AOTA Entry Level Functions of the Registered Occupational Therapist, Certified Occupational Therapy Assistant and Occupational Therapy Aide; AOTA; 1972.
2. Task Inventory for Entry Level Occupational Therapy Personnel in Direct Service Roles; N.H. Contract No. 72-4172; AOTA; June 1973.
3. Phase I-Delineation of the Role of Entry Level Occupational Therapy Personnel; Contract #231-76-0052; AOTA; July 1, 1976 - February 1, 1978.
4. AOTA Standards of Practice for Occupational Therapy Services for the Developmentally Disabled Client; Clients with Physical Disabilities; in a Mental Health Program; and in a Home Health Program; AOTA; January 1979.
5. Essentials of an Accredited Educational Program for the Occupational Therapist; June 1972; and Essentials of an Approved Educational Program for the Occupational Therapy Assistant; April 1975.
6. AOTA Resolutions #533-79 (Funding for 518-77), #535-79 (Role Delineation Concept and Use), #552-79 (Strategy to Educate Independent Health Professionals), #551-79 (Position on Proficiency Testing for Individuals Outside the Field of Occupational Therapy), and proposed Resolution "J"-1980 (Strategy for Determining the Place of the COTA in the Profession of Occupational Therapy).
7. Entry Level Study Committee Memo; AOTA; April 7, 1980.
8. Essentials Review Committee Report: Recommendation #1; AOTA; 1980.
9. Components and Interrelationships of a Competency Assurance System, Chart #1 and Management of the AOTA Competency Assurance System, Chart #2; AOTA; 1979.
10. AOTA Uniform Terminology for Reporting Occupational Therapy Services; AOTA; 1979.

The following principles/concepts were used in the development of the role delineation document:

1. OTRs must be able to do all COTA roles and functions.
2. The role delineation reflects present and future practice of occupational therapy.
3. The role delineation reflects entry-level practice only and may be used only for that level when used to develop educational Essentials or certification requirements.
4. Entry-level is defined as the first year of practice.
5. Entry-level COTAs must receive direct supervision by an OTR during the first year of occupational therapy practice. COTAs are encouraged to participate in continuing education programs provided by agencies and professional associations and to pursue other continuing education opportunities.
6. Entry-level OTRs are certified for general practice and are able to independently provide services. Entry-level OTRs are encouraged to pursue continuing education, consultation and other collaborative activities in their professional role.
7. Employers should provide appropriate personnel for the supervision of new graduates.
8. The role delineation addresses tasks and not "professional" behaviors that reflect ethical or value judgments.

Refer to the Role Delineation Glossary and AOTA Uniform Terminology System for Reporting Occupational Therapy Services for definitions of terms used in this document.

Entry Level/Role Delineation Committee:

Jay Bullock, OTR
Sr. Miriam Joseph Cummings, OTR
Jeanne Madigan, OTR

Gladys Masagatani, OTR
Linda McGourty, OTR
Nancy Moulin, OTR

Nancy Prendergast, OTR
Sally Ryan, COTA
Javan Walker, Jr., OTR

AOTA Staff

Madelaine Gray, OTR
Carole Hays, OTR
Stephanie Presseller, OTR

Entry-Level OTR And COTA Role Delineation

The Entry-Level OTR

The Entry-Level COTA

I. Referral: the initiation or acknowledgment of a referral may be before initial screening or after. A referral for occupational therapy service must be based upon the provisions as outlined in the AOTA Statement of Referral.

- A. Responds to request for service, whatsoever its source
- B. Initiates referrals when appropriate
- C. Supervises documentation and filing of referrals according to department standards
- D. Delegates case to COTA, as appropriate, according to standards of department and profession

- A. Responds to a request for service by relaying information or formal referral to supervising OTR
- B. Initiates referrals for independent living/ daily living skills intervention
- C. Enters case as appropriate to standards of department and profession when authorized by supervising OTR

II. Occupational Therapy Assessment: Occupational therapy assessment refers to the process of determining the need for, nature of, and estimated time of treatment, determining the needed coordination with other persons involved, and documenting these activities.

A. Screening: determine client's need for occupational therapy services; may occur before or after referral

- 1. Collect data:
 - a. identify type and sources of information that are needed
 - b. obtain and review information and identify pertinent details about client; or plan and supervise data collection
 - c. explain overall occupational therapy services to client, family, and significant others
 - d. observe and interview client, family, and significant others to obtain general history and information
- 2. Analyze data:
 - a. organize data
 - b. summarize data
 - c. interpret data
- 3. Formulate recommendations
- 4. Document and report occupational therapy screening data, interpretation, and recommendations

B. Evaluation: obtain and interpret data necessary for treatment. This includes planning for and documenting the evaluation process and results. The OTR is responsible for the evaluation process.

- 1. Select appropriate area(s) to evaluate
 - a. independent living/daily living skills
 - (1) Physical Daily Living Skills
 - (a) Grooming and Hygiene
 - (b) Feeding/Eating
 - (c) Dressing
 - (d) Functional Mobility
 - (e) Functional Communication
 - (f) Object Manipulation
 - (2) Psychological/Emotional Daily Living Skills
 - (a) Self-concept/Self-identity
 - (b) Situation Coping
 - (c) Community Involvement
 - (3) Work
 - (a) Homemaking
 - (b) Child Care/Parenting
 - (c) Employment Preparation
 - (4) Play/Leisure

A. Screening: determine client's need for occupational therapy services in collaboration with OTR; may occur before or after referral

- 1. Collect data:
 - a. obtain and review information as determined by OTR and identify pertinent details about client
 - b. explain overall occupational therapy services to client, family and significant others
 - c. observe and interview client, family, and significant others using a structured guide to obtain general history and information
- 2. Organize data:
 - a. summarize own data
 - b. record and report own data to OTR

B. Evaluation: The COTA contributes to the evaluation process under the supervision of the OTR.

- b. sensorimotor components
 - (1) Neuromuscular
 - (a) Reflex Integration
 - (b) Range of Motion
 - (c) Gross and Fine Coordination
 - (d) Strength and Endurance
 - (2) Sensory Integration
 - (a) Sensory Awareness
 - (b) Visual-Spatial Awareness
 - (c) Body Integration
- c. cognitive components
 - (1) Orientation
 - (2) Conceptualization/Comprehension
 - (a) Concentration
 - (b) Attention Span
 - (c) Memory
 - (3) Cognitive Integration
 - (a) Generalization
 - (b) Problem Solving
- d. psychosocial components
 - (1) Self-management
 - (a) Self-expression
 - (b) Self-control
 - (2) Dyadic Interaction
 - (3) Group Interaction

2. Plan evaluation methodology

3. Explain evaluation plan to client, family, significant others, and other health professionals

4. Interview client, family, and significant others for information about:

- a. medical history and current health status
- b. developmental milestones
- c. social and family history
- d. self-care abilities
- e. academic history
- f. vocational history
- g. play history
- h. leisure interests and experiences
- i. future plans and goals
- j. accessibility of home environment
- k. accessibility of work or school system
- l. accessibility of community support system

5. Observe client while engaged in individual and/or group activity to collect data and report on: (refer to areas in Section II.B.1 for specifics in each area)

- a. independent living/daily living skills
- b. sensorimotor skills
- c. cognitive skills
- d. psychosocial skills

6. Administer standardized and non-standardized assessments in the following areas: (refer to areas in Section II.B.1 for specifics in each area)

- a. independent living/daily skills and performance
- b. sensorimotor skills and performance
- c. cognitive skills and performance

1. Assist OTR by interviewing client, family, and significant others using a structured format as determined by OTR for information about:

- a. family history
- b. self-care abilities
- c. academic history
- d. vocational history
- e. play history
- f. leisure interests and experiences

2. Assist OTR by observing client while engaged in individual and/or group activity to collect general data and report on: (refer to areas in Section II.B.1 for specifics in each area)

- a. independent living/daily living skills
- b. selected sensorimotor skills:
 - (1) Gross and fine coordination
 - (2) Strength and endurance
 - (3) Tactile awareness
- c. cognitive skills
- d. psychosocial skills

3. Administer structured tests as directed by the OTR to collect data on:

- a. independent living/daily living skills and performance
- b. sensorimotor skills and performance in the following areas of:
 - (1) Gross and Fine Coordination
 - (2) Tactile Awareness
- c. cognitive skill and performance in the area of orientation

- d. psychosocial skills and performance
 - c. therapeutic adaptations
 - (1) Orthotics
 - (2) Prosthetics
 - (3) Assistive/Adaptive Equipment
 - 7. Analyze and synthesize evaluation data:
 - a. state evaluation findings
 - b. analyze, interpret, and synthesize scores or results of tests and assessments
 - c. state client's assets and deficits
 - 8. Document evaluation data and interpretation
 - 9. Report evaluation data
 - 10. Develop recommendations as to the continuation or discontinuation of occupational therapy services and/or referral to other type of service
- 4. Summarize record and report own evaluation data to OTR supervisor
 - 5. Report evaluation data as determined by OTR
 - 6. Make recommendations to the OTR supervisor as to the continuation or discontinuation of occupational therapy services and/or referral to other type of service

III. Program Planning: Planning refers to the identification of achievable program goals and the methods to those goals.

- A. Develop long- and short-term goals (in collaboration with client, family, and significant others) to develop, improve, and/or restore the performance of necessary functions; compensate for dysfunction; and/or minimize debilitation, in the areas of: (refer to areas in Section II.B.1 for specifics in each area)
 - 1. Independent living/daily living skills and performance
 - 2. Sensorimotor skills and performance
 - 3. Cognitive skills and performance
 - 4. Psychosocial skills and performance
 - B. Refer client to experienced OTR for specialized evaluation and services
Examples of specialized evaluations are employment preparation, evaluation (prevocational testing), sensory integration evaluation, prosthetic evaluation, driver's training evaluation.
 - C. Select occupational therapy techniques, media, and determine sequence of activities to attain goals in all areas
 - D. Analyze components which make up tasks and activities
 - E. Adapt techniques/media to meet needs, capacities and roles of the client
 - F. Discuss occupational therapy goals and methods with client, family, significant others and other staff
 - G. Document and report program plan
 - H. Coordinate the program with staff and other services
 - I. Determine point of termination
- A. Assist OTR with the development of long- and short-term goals (in collaboration with client, family, and significant others) to develop, improve, and/or restore the performance of necessary functions; compensate for dysfunction; and/or minimize debilitation, in the areas of:
 - 1. Independent living/daily living skills and performance
 - 2. Sensorimotor skills and performance in the following areas:
 - a. gross and fine coordination
 - b. strength and endurance
 - c. range of motion
 - d. tactile awareness
 - 3. Cognitive skills and performance
 - 4. Psychosocial skills and performance
 - B. Assist OTR in selecting occupational therapy techniques, media, and in determining sequence of activities to attain goals in areas designated above
 - C. Analyze activities in the following areas:
 - 1. Relevance to client's interests and abilities
 - 2. Major motor processes
 - 3. Complexity
 - 4. Steps involved
 - 5. Extent to which it can be modified or adapted
 - D. Adapt techniques/media, under the supervision of the OTR, to meet client needs
 - E. Discuss occupational therapy program goals and methods with client, family, significant others, and staff
 - F. Document and report program plan as directed by the OTR

IV. Occupational Therapy Treatment: Occupational therapy treatment refers to the use of specific activities or methods to develop, improve, and/or restore the performance of necessary functions; compensate for dysfunction; and/or minimize debilitation.

- In situations where patient conditions or treatment settings are complex (involving multiple systems) and where conditions change rapidly, requiring frequent or ongoing reassessment and modification of treatment plan, the COTA is required to have close supervision by the OTR.
- In situations where patient conditions or treatment settings are more singular or stable so that decisions regarding program revision are required less frequently, the COTA may function independently as directed by the OTR.

A. Engage client in purposeful activity, in conjunction with therapeutic methods, to achieve goals identified in the program in the following areas:

1. Independent living/daily living skills
 - a. physical daily living skills
 - (1) Grooming and Hygiene
 - (2) Feeding/Eating
 - (3) Dressing
 - (4) Functional Mobility
 - (5) Functional Communication
 - (6) Object Manipulation
 - b. psychological/emotional daily living skills
 - (1) Self-Concept/Self-Identity
 - (2) Situational Coping
 - (3) Community Involvement
 - c. work
 - (1) Homemaking
 - (2) Child Care/Parenting
 - (3) Employment Preparation
 - (a) Work Process Skills and Performance
 - (b) Work Product Quality
 - d. play/leisure
2. Sensorimotor components
 - a. neuromuscular
 - (1) Reflex Integration
 - (2) Range of Motion
 - (3) Gross and Fine Coordination
 - (4) Strength and Endurance
 - b. Sensory integration
 - (1) Sensory Awareness
 - (2) Visual-Spatial Awareness
 - (3) Body Integration
3. Cognitive components
 - a. orientation
 - b. conceptualization/comprehension
 - (1) Concentration
 - (2) Attention Span
 - (3) Memory
 - c. cognitive integration
 - (1) Generalization
 - (2) Problem Solving
4. Psychosocial components
 - a. self-management
 - (1) Self-Expression
 - (2) Self-Control
 - b. dyadic interaction
 - c. group interaction

A. Under the direction of the OTR, engage client in purposeful activity, in conjunction with therapeutic methods, to achieve goals identified in the program plan in the following areas:

1. Independent living/daily living skills
 - a. physical daily living skills
 - (1) Grooming and Hygiene
 - (2) Feeding/Eating
 - (3) Dressing
 - (4) Functional Mobility:
 - (a) Bed Mobility
 - (b) Wheelchair Mobility
 - (c) Transfers
 - (d) Functional Ambulation
 - (e) Public Transportation
 - (5) Functional Communication
 - (6) Object Manipulation
 - b. psychological/emotional daily living skills
 - (1) Self-Concept/Self-Identity
 - (2) Situational Coping
 - (3) Community Involvement
 - c. work
 - (1) Homemaking
 - (2) Child Care/Parenting
 - (3) Work Process Skills and Performance
 - d. play/leisure
2. Sensorimotor components
 - a. neuromuscular
 - (1) Range of Motion
 - (2) Gross and Fine Coordination
 - (3) Strength and Endurance
 - b. Tactile Awareness
 - c. Postural Balance
3. Cognitive components
 - a. orientation
 - b. conceptualization/comprehension
 - (1) Concentration
 - (2) Attention Span
 - (3) Memory

- | | |
|--|---|
| <p>5. Therapeutic adaptation</p> <ol style="list-style-type: none"> a. orthotics <ol style="list-style-type: none"> (1) Static Splints (2) Slings b. assistive/adaptive equipment <p>6. Prevention</p> <ol style="list-style-type: none"> a. energy conservation b. joint protection/body mechanics c. positioning d. coordination of daily living activities <p>B. Orient and instruct family, significant others and non-OT staff in activities which support the therapeutic program</p> <p>C. Observe medical and safety precautions</p> <p>D. Prepare and instruct a program with client, family and significant others to implement at home</p> <p>E. Monitor client's program</p> <ol style="list-style-type: none"> 1. Observe client's response to program 2. Summarize and analyze client performance 3. Document response to program 4. Discuss client performance with client, family, significant others, and staff 5. Reassess client's performance 6. Modify goals 7. Modify program 8. Coordinate program modifications with other services | <p>4. Therapeutic adaptation</p> <ol style="list-style-type: none"> a. orthotics <ol style="list-style-type: none"> (1) Static Splints (2) Slings b. assistive/adaptive equipment <p>5. Prevention</p> <ol style="list-style-type: none"> a. energy conservation b. joint protection/body mechanics c. positioning d. coordination of daily living skills <p>B. Orient and instruct family and significant others in activities which support the therapeutic program</p> <p>C. Observe medical and safety precautions</p> <p>D. Assist in instruction of client, family and significant others in implementation of home program developed by OTR</p> <p>E. Monitor client's program</p> <ol style="list-style-type: none"> 1. Observe client's performance as directed by OTR 2. Summarize client's performance as directed by OTR 3. Document client's performance as directed by OTR 4. Discuss client performance with client, family, significant others, and staff as directed by OTR 5. Discuss need for reassessment with OTR 6. Assist OTR in identifying program changes 7. Coordinate program modifications with other services |
|--|---|

V. Program Discontinuation: Program discontinuation refers to the termination of occupational therapy services when the client has achieved the program goals and/or has achieved maximum benefit from the services.

- | | |
|--|--|
| <p>A. Formulate, in collaboration with client, family, significant others and staff, discharge and follow-up plan</p> <p>B. Recommend termination of occupational therapy services</p> <p>C. Prepare program for implementation at home</p> <p>D. Recommend adaptations in client's everyday environment</p> <p>E. Refer client and/or family to another occupational therapist or other service provider</p> <p>F. Recommend community resources</p> <p>G. Summarize and document outcome of the OT program</p> <p>H. Terminate program</p> | <p>A. Discuss need for program discontinuation with OTR</p> <p>B. Assist OTR in preparing program for implementation at home</p> <p>C. Assist OTR in recommending adaptations in client's everyday environment</p> <p>D. Assist OTR in identifying community resources</p> <p>E. Assist in summarizing and documenting outcome of the OT program</p> |
|--|--|

VI. Service Management: Service management refers to planning, leading, organizing, and controlling the occupational therapy facility and service

- | | |
|---|--|
| <p>A. Maintain service</p> <ol style="list-style-type: none"> 1. Plan daily schedule according to assigned workload 2. Prepare and maintain work setting, equipment, and supplies 3. Order supplies and equipment according to established procedures 4. Determine space, equipment and supply needs 5. Prepare and maintain records and budget 6. Ensure safety and maintenance of program areas and equipment 7. Compile and analyze data of OT service 8. Follow reimbursement procedures 9. Conduct and participate in employee meetings | <p>A. Maintain service</p> <ol style="list-style-type: none"> 1. Plan daily schedule according to assigned workload 2. Prepare and maintain work setting, equipment, and supplies 3. Order supplies and equipment according to established procedures 4. Maintain records according to department procedure 5. Ensure safety and maintenance of program areas and equipment 6. Assist with compiling and analyzing data of total OT service 7. Follow reimbursement procedures 8. Participate in employee meetings |
|---|--|

The Entry-Level OTR

The Entry-Level COTA

- 10. Participate in program-related conferences
 - 11. Receive supervision from immediate supervisor in order to enhance self-performance
 - 12. Comply with established standards and/or evaluate adherence to institutional policies
 - 13. Seek and use consultation
8. Recruit, select, orient, train, supervise, and evaluate:
- 1. COTAs
 - 2. Support staff such as secretary, aide, transport personnel
 - 3. Volunteers
- C. Plan, direct, coordinate and evaluate service programs
- D. Determine service and personnel needs
- E. Assure collaboration, coordination, and communication
- F. Develop and implement quality review program including:
- 1. Standards of quality treatment/services
 - 2. Chart audit program
 - 3. Occupational therapy care review
 - 4. Inservice education programs
- G. Participate in accrediting reviews
- H. Supervise Level I fieldwork students, and non-OT students
- I. Develop, through the use of statistics, the justification for having or increasing OT services

- 9. Participate in program-related conferences
 - 10. Receive supervision from immediate supervisor in order to enhance self-performance
 - 11. Comply with departmental standards and/or evaluate adherence to institutional policies
- B. Assist with other personnel:
- 1. Orient, supervise aides and assist in their training
 - 2. Recruit, select, orient, train, supervise and evaluate volunteers under direction of OTR
- C. Assist OTR with evaluation of service program
- D. Participate in quality review program
- E. Participate in accrediting reviews
- F. Supervise Level I OTA fieldwork students as assigned by OTR

VII. Continued Education: Continued education refers to ongoing educational experiences beyond basic education.

- A. Participate in continuing education programs
- B. Participate in inservice programs
- C. Plan and provide inservice education

- A. Participate in continuing education programs
- B. Participate in inservice programs
- C. Assist OTR in planning and providing inservice education

VIII. Public Relations: Public relations refers to promoting awareness and understanding of the profession of occupational therapy.

- A. Identify the need for and explain occupational therapy services and profession to public and professional groups
- B. Serve as a representative of the profession and the association

- A. Explain occupational therapy services and profession to public groups
- B. Serve as a representative of the profession and the association

Definitions

Independent living/daily living skills refer to the skill and performance of physical and psychological/emotional self-care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability. Life-space refers to an individual's cultural background, value orientation, and physical and social environment.

Physical daily living skills refer to the skill and performance of daily personal care, with or without adaptive equipment. It includes but is not limited to:

Grooming and hygiene refer to the skill and performance of personal health needs, such as bathing, toileting, hair care, shaving, applying make-up.

Feeding/eating refers to the skill and performance of sequentially feeding oneself, including sucking, chewing, swallowing, and using appropriate utensils.

Dressing refers to the skill and performance of choosing appropriate clothing, dressing oneself in a sequential fashion, including fastening and adjusting clothing.

Functional mobility refers to the skill and performance in moving oneself from one position or place to another. It includes skills necessary for activities such as bed mobility, wheelchair mobility, transfers (bed, car, tub, toilet, chair), and functional ambulation, with or without adaptive aids. It also includes use of public and private travel systems, such as driving own automobile and using public transportation.

Functional communication refers to the skill and performance in using equipment or systems to enhance or provide communication, such as writing equipment, typewriters, letterboards, telephones, braille writers, artificial vocalization systems and computers.

Object manipulation refers to the skill and performance in handling large and small common objects, such as calculators, keys, money, light switches, doorknobs, and packages.

Psychological/emotional daily living skills refer to the skill and performance in developing one's self-concept/self-identity, coping with life situations, and participating in one's organizational and community environments. It includes but is not limited to:

- Self-concept/self-identity refers to the cognitive image of one's functional self. This includes but is not limited to:*
- clearing perceiving others' needs, feelings, conflicts, values, beliefs, expectations, sexuality, and power
 - realistically perceiving others' needs, feelings, conflicts, values, beliefs, expectations, sexuality, and power
 - knowing one's performance strengths and limitations
 - sensing one's competence, achievement, self-esteem, and self-respect
 - integrating new experiences with established self-concept/self-identity
 - having a sense of psychological safety and security
 - perceiving one's goals and directions.

Situational coping refers to skill and performance in handling stress and dealing with problems and changes in a manner that is functional for self and others. This includes but is not limited to:

- setting goals, selecting, harmonizing, and managing activities of daily living to promote optimal performance
- testing goals and perceptions against reality
- perceiving changes and need for changes in self and environment
- directing and redirecting energy to overcome problems
- initiating, implementing, and following through on decisions
- assuming responsibility for self and consequences of actions
- interacting with others, dyadic and group.

Community involvement refers to skill and performance in interacting within one's social system. This includes but is not limited to:

- understanding social norms and their impact on society
- planning, organizing, and executing daily life activities in relationship to society, including such activities as budgeting, time management, social role management and using community resources
- recognizing and responding to needs of families and groups
- understanding and responding to organizational/community role expectations as both recipient and contributor.

Work refers to skill and performance in participating in socially purposeful and productive activities. These activities may take place in the home, employment setting, school, or community. They include but are not limited to:

Homemaking refers to skill and performance in home-making and home management tasks, such as meal planning, meal preparation and clean-up, laundry, cleaning, minor household repairs, shopping, and use of household safety principles.

Child care/parenting refers to skill and performance in child care activities and management. This includes but is not limited to physical care of children, and use of age-appropriate activities, communication, and behavior to facilitate child development.

Employment preparation refers to skill and performance in precursory job activities including prevocational activities. This includes but is not limited to:

- job acquisition skills and performance
- organizational and team participatory skills and performance
- work process skills and performance
- work product quality.

Play/leisure refers to skill and performance in choosing, performing, and engaging in activities for amusement, relaxation, spontaneous enjoyment, and/or self-expression. This includes but is not limited to:

- Recognizing one's specific needs, interests, and adaptations necessary for performance
- Identifying characteristics of activities and social situations that make them play for the individual
- Identifying activities that contain those characteristics
- Choosing play activities for participation, such as sports, games, hobbies, music, drama, and other activities
- Testing out and adapting activities to enable participation
- Identifying and using community resources.

Sensorimotor components refer to the skill and performance of patterns of sensory and motor behavior that are prerequisites to self-care, work, and play/leisure performance. The components in this section include neuromuscular and sensory integrative skills, including perceptual motor skills.

Neuromuscular refers to the skill and performance of motor aspects of behavior. This includes but is not limited to:

Reflex integration refers to skill and performance in enhancing and supporting functional neuromuscular development through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses coordinated at subcortical and cortical levels.

Range of motion refers to skill and performance in using maximum span of joint movement in activities with and without assistance to enhance functional performance. The standard levels of performance include:

- **active range of motion:** movement by patient, unassisted through a complete range of motion
- **passive range of motion:** movements performed by someone other than patient or by a mechanical device, requiring no muscle contraction on the part of the patient
- **active-assistive range of motion:** movement performed by the patient to the limit of his/her ability, and then completed with assistance.

Gross and fine coordination refers to skill and performance in muscle control, coordination, and dexterity while participating in activities

- **muscle control**
muscle control refers to skill and performance in directing muscle movements
- **coordination**
coordination refers to skill and performance in gross motor activities using several muscle groups
- **dexterity**
dexterity refers to skill and performance in tasks using small muscle groups.

Strength and endurance refers to skill and performance in using muscular force within time periods necessary for purposeful task performance. This involves but is not limited to progressively building strength and cardiac and pulmonary reserve, increasing the length of work periods, and decreasing fatigue and strain.

Sensory integration refers to skill and performance in development and coordination of sensory input, motor output, and sensory feedback. This includes but is not limited to:

Sensory awareness refers to skill and performance in perceiving and differentiating external and internal stimuli, such as:

- **tactile awareness:** the perception and interpretation of stimuli through skin contact
- **stereognosis:** the identification of forms and nature of objects through the sense of touch
- **kinesthesia:** the conscious perception of muscular motion, weight, and position
- **proprioceptive awareness:** the identification of the positions of body parts in space
- **ocular control:** the localization and visual tracking of stimuli
- **vestibular awareness:** the detection of motion and gravitational pull as related to one's performance in functional activities, ambulation, and balance
- **auditory awareness:** the differentiation and identification of sounds
- **gustatory awareness:** the differentiation and identification of tastes
- **olfactory awareness:** the differentiation and identification of smells

Visual-spatial awareness refers to skill and performance in perceiving distances between and relationships among objects, including self. This includes but is not limited to:

- **figure-ground:** recognition of forms and objects when presented in a configuration with competing stimuli
- **form constancy:** recognition of forms and objects as the same when presented in different contexts
- **position in space:** knowledge of one's position in space relative to other objects

Body integration refers to skill and performance in perceiving and regulating the position of various muscles and body parts in relationship to each other during static and movement states. This includes but is not limited to:

- **body schema**
body schema refers to the perception of one's physical self through proprioceptive and interoceptive sensations
- **postural balance**
postural balance refers to skill and performance in developing and maintaining body posture while sitting, standing, or engaging in activity
- **bilateral motor coordination**
bilateral motor coordination refers to skill and performance in purposeful movement that requires interaction between both sides of the body in a smooth, refined manner
- **right-left discrimination**
right-left discrimination refers to skill and performance in differentiating right from left and vice versa
- **visual-motor integration**
visual-motor integration refers to skill and performance in combining visual input with purposeful voluntary movements of the hand and other body parts involved in an activity. Visual-motor integration includes eye-hand coordination
- **crossing the midline**
crossing the midline refers to skill and performance in crossing the vertical midline of the body
- **praxis**
praxis refers to skill and performance of purposeful movements that involves motor planning.

Cognitive components refer to skill and performance of the mental processes necessary to know or apprehend by understanding. This includes but is not limited to:

Orientation refers to skill and performance in comprehending, defining, and adjusting oneself in an environment with regard to time, place, and person.

Conceptualization/comprehension refers to skill and performance in conceiving and understanding concepts or tasks such as color identification, word recognition, sign concepts, sequencing, matching, association, classification, and abstracting. This includes but is not limited to:

Concentration refers to skill and performance in focusing on a designated task or concept.

Attention span refers to skill and performance in focusing on a task or concept for a particular length of time.

Memory refers to skill and performance in retaining and recalling tasks or concepts from the past.

Cognitive integration refers to skill and performance in applying diverse knowledge to environmental situations. This involves but is not limited to:

Generalization refers to skill and performance in applying specific concepts to a variety of related situations.

Problem solving refers to skill and performance in identifying and organizing solutions to difficulties. It includes but is not limited to:

- *defining or evaluating the problem*
- *organizing a plan*
- *making decisions/judgments*
- *implementing plan, including following through in logical sequence*
- *evaluating decision/judgment and plan.*

Psychosocial components refer to skill and performances in self-management, dyadic and group interaction.

Self-management refers to skill and performance in expressing and controlling oneself in functional and creative activities.

Self-expression refers to skill and performance in perceiving one's feelings and interpreting and using a variety of communication signs and symbols. This includes but is not limited to:

- *experiencing and recognizing a range of emotions*
- *having an adequate vocabulary*
- *having writing and speaking skills*
- *interpreting and using correctly an adequate range of nonverbal signs and symbols.*

Self-control refers to skill and performance in modulating and modifying present behaviors, and in initiating new behaviors in accordance with situational demands. It includes but is not limited to:

- *observing own and others' behavior*
- *conceptualizing problems in terms of needed behavioral changes or action*
- *imitating new behaviors*
- *directing and redirecting energies into stress-reducing activities and behaviors.*

Dyadic interaction refers to skill and performance in relating to another person. This includes but is not limited to:

- *Understanding social/culture norms of communication and interaction in various activity and social situations*
- *Setting limits on self and others*
- *Compromising and negotiating*
- *Handling competition, frustration, anxiety, success, and failure*
- *Cooperating and competing with others*
- *Responsibly relying on self and others.*

Group interaction refers to skill and performance in relating to groups of three to six persons, or larger. This includes but is not limited to:

- *Knowing and performing a variety of task and social/emotional role behaviors*
- *Understanding common stages of group process*
- *Participating in a group in a manner that is mutually beneficial to self and others.*

Therapeutic adaptations refer to the design and/or restructuring of the physical environment to assist self-care, work, and play/leisure performance. This includes selecting, obtaining, fitting, and fabricating equipment, and instructing the client, family, and/or staff in proper use and care of equipment. It also includes minor repair and modification for correct fit, position or use. Categories of therapeutic adaptations consist of:

Orthotics refer to the provision of dynamic and static splints, braces, and slings, for the purpose of relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.

Prosthetics refer to the training in use of artificial substitutes of missing body parts, which augment performance of function.

Assistive/adaptive equipment refers to the provision of special devices that assist in performance, and/or structural or positional changes such as the installation of ramps, bars, changes in furniture heights, adjustments of traffic patterns, and modifications of wheelchairs.

Prevention refers to skill and performance in minimizing debilitation. It may include programs for persons where predisposition to disability exists, as well as for those who have already incurred a disability. This includes but is not limited to:

Energy conservation refers to skill and performance in applying energy-saving procedures, activity restriction, work simplification, time management, and/or organization of the environment to minimize energy output.

Joint protection/body mechanics refers to skill and performance in applying principles or procedures to minimize stress on joints. Procedures may include the use of proper body mechanics, avoidance of static or deforming postures, and/or avoidance of excessive weight bearing.

Positioning refers to skill and performance in the placement of a body part in alignment to promote optimal functioning.

Coordination of daily living activities refers to skill and performance in selecting and coordinating activities of self-care, work, play/leisure, and rest to promote optimal performance of daily life tasks.

Reassessment refers to the process of obtaining and interpreting data necessary for updating treatment plans and goals. This frequently involves administering only portions of the initial evaluation, documenting results, and/or revising treatment.

Development of standards of quality treatment service refers to the development, implementation, evaluation, and documentation of departmental policy and procedures for the purpose of assuring standardized and quality treatment. This policy includes but is not limited to those procedures governing standards of occupational therapy practice, health and safety, infection control, and ethical behavior.

Chart audit refers to the evaluation of documentation based on criteria developed within the facility, the profession, Health Systems Agency (Health Planning Act.), and/or Professional Standards Review Organizations for a specified geographical area.

Occupational therapy care review refers to the ongoing evaluation and documentation of the quality of care given. Three review programs may be included in the care review process: preadmission screening, concurrent review, and retrospective studies.

Inservice education refers to the participation of regularly employed occupational therapy personnel (e.g., OTR, COTA, OT Aide, or OT orderly) in regularly scheduled classes, in-house seminars, and special training sessions, either in or outside the facility.

Accrediting reviews refer to those activities that are necessary to routinely document the meeting of the standards of a recognized accrediting body such as State Department of Health, Joint Commission on the Accreditation of Hospitals, Commission on Accreditation of Rehabilitation Facilities; or other accreditation procedures, voluntary or mandated by state or local law, and/or by the administration of a particular institution.

ROLE DELINEATION GLOSSARY

1. *structured assessment*: an assessment instrument or form that is constructed and organized to provide guidelines for the content and process of the assessment; e.g., Interest Inventory.
2. *standardized assessment*: an assessment that provides for measurement against a criterion or norm. The assessment must be done according to the testing protocol; e.g., ROM assessment; Southern California Sensory Integration Tests.
3. *non-standardized assessment*: an assessment that provides information but with no precise comparison to a norm; e.g., Social History.
4. *therapeutic activities in occupational therapy*: self-care, work, home management, child care, educational, play/leisure, and cultural activities that have been selected and adapted to meet specific occupational therapy goals.
5. *significant others*: refers to persons, excluding the individual's family and health professionals, who have an important relationship to the individual.
6. *OT Program*: refers to the delivery of occupational therapy services to a client.
7. *OT service*: refers to the organizational structure and system within which occupational therapy programs are provided.
8. *Level I Fieldwork*: is that which occurs as an integral part of didactic course work.

APR 8 1987

April 3, 1987

Representative Lawrence Donley
P.O. Box V
Juneau, AK 99811

Dear Representative Donley:

I am writing you at this time to urge you to vote for state occupational therapy licensure Bill # HB205. Licensure will protect the public from harm and fraudulent services rendered by unqualified personnel. It is our duty as professionals to provide quality care as dictated by specific diagnosis and individual situation. This is unfortunately not guaranteed nor is consistent top quality service unless state licensure is instated.

Again, please vote for Bill # HB205 and help us to help the general public. Thank you for your time and attention.

Sincerely

Jim Mampplin OTR

1161 Bettis Bay Loop
09/15

7-6-87

APR 9 1987

The Honorable Dan Dooley
P.O. Box 1
Juneau, AK 99811

JAMES E. ATWELL
352 Pioneer Dr.
#1005
99804

Dear Representative Dooley:

I am writing this letter to show my support for House Bill #205, which pertains to Occupational Therapy licensure. I am a Medical Technologist, and I have practiced my profession for the past seven years in the state of Alaska. I believe that House Bill #205, which is before your committee at this time, should be considered in favor of licensure.

I have worked in the Health Care field for over 10 years and I strongly believe that licensing of health care workers is an important step toward providing quality health care.

Without licensing it is very difficult to evaluate the qualifications of a therapist.

I'm sure that if you or a loved one
required the services of an occupational therapist,
you would want someone who is qualified and
has the credentials to show their competence
in their chosen field. By requiring state
licensure of Occupational Therapists, standards
can be assured of receiving quality care.

Once again I would like to urge
your support of House Bill #265. Thank you
for your time & concern regarding health
care issues.

Sincerely
James E. Atwell MIT (CHS)

APR 10 1987

April 5, 1987
Homer, Alaska

Representative Dave Donley
Pouch V
Juneau, AK 99811

Dear Rep. Donley,

I am writing in support of House Bill 205, the Occupational Therapy (O.T.) Practice Act. This bill will be presented in the state legislature within the next few weeks.

As an occupational therapist working with children with various handicapping conditions, I am concerned about the integrity and standards of occupational therapy within the state. Licensure will be a provision to allow only qualified professionals to be delivering O.T. services to the health care consumer. This act will then indeed protect the health care consumer and assist in providing high standards of occupational therapy statewide.

I encourage you to support House Bill 205 when it comes to the floor. Thank you.

Sincerely,

Susie Cunningham

Susie Cunningham, MS, OTR
P.O. Box 1837
Homer, AK 99603

Annette Leick

POB 221421

99523-1421

April 4, 1987

Honorable Dave Donley
PO Box V
Juneau, Alaska 99811

APR 9 1987

Dear Mr. Donley

I'm writing to you in regards to
Bill # HB 205.

I am an occupational therapist,
presently practicing in pediatrics.
I have a Bachelor of Science degree
with a major in Occupational Therapy.
I have taken numerous continuing
education classes beyond my degree
to keep current of practices of
occupational therapy.

I am writing about an issue of
importance, that concerns you
your constituents and consumers, as
to the regulation of occupational
therapy.

Please become knowledgeable
about the benefits of occupational
therapy and how unqualified
persons may harm the consumer
by inappropriate (or by tearing

muscles, ligaments, or breaking bones) treatment.

Since, I am presently working in early intervention with the pediatric population, I have concerns of: lack of occupational therapy services to this population, unqualified peoples providing so called, occupational therapy services which may delay or impede neurological return.

I invite you to join me during an occupational therapy treatment session when you are in Anchorage. Below is my home and work telephone number.

I am asking for your support of Bill # HB205 and your concern regarding health issues as it relates to consumers.

Best Regards,
Annette Leier, OT

561-8060 work
248-7418 Home



THAD L. WOODARD M.D. & ASSOCIATES
BIRTH THROUGH ADOLESCENT CARE

APR 10 1987
APR 8 1987

March 31, 1987

House Committee on Labor and Commerce
P.O. Box V
Juneau, AK 99811

ATTN: Representative Dave Donley

Thad L. Woodard, MD
PEDIATRIC AND
ADOLESCENT CARE
CHILDHOOD ASTHMA

To Whom It May Concern:

This is to express my support of H.B. 205. I feel it is extremely important that occupational therapists be licensed in the State of Alaska to protect the quality of services provided to clients and ensure that occupational therapists are adequately prepared to practice.

Rosebeth R. Marcou, MD
LEARNING
AND
BEHAVIOR DISORDERS

Sincerely,

Mary Lou Hanson, C.S.N.P.

Mary Lou Hanson
Certified School Nurse Practitioner

Bonnie Anderson, C/NP
PEDIATRIC
AND
ADOLESCENT CARE

cc House Committee Member
Representative Walt Furnace

House Health, Education & Social Services Committee
Atten: Alice Hanley

House Finance Committee
Atten: Al Adams, Chairperson

Mary Lou Hanson, CSNP
COUNSELING ON LEARNING
AND
BEHAVIOR DISORDERS

WLL

Mar. 30, 1987

SINGER

APR 3 1987

Dear Sir,

I Support House Bill 205.

Regarding licensure of occupational!
Therapists to assure safe and quality
health care ~~to~~ ^{to} the consumer.

Thanks for your help.

Dorrell Young.



Elizabeth Dowler, OTR, CRC, CVE
Executive Director

GINGER
constituent?
Work Therapy Enterprises, Inc.

3700 Woodland Dr. #400
Anchorage, Alaska 99503
243-6116

March 30, 1987

Representative Dave Donley
P.O. Box 1
Juneau, Ak 99811

Dear Rep Donley,

I am writing to request your support of HB 205, the licensure of Occupational Therapists in the State of Alaska. I understand it will be introduced to the Labor & Commerce Committee very soon.

I am an Occupational Therapist who has practiced in this state for 14 years. It is very important to our professional practice that only qualified persons be allowed to practice. Harm can come to individuals who receive treatment from persons who have not received proper training in the neuromuscular, cardio-vascular & psychological systems in which our bodies operate. We work with a great variety of disability groups including injured workers, back injuries, muscular diseases, diseases of bones & joints with adults, children & infants.

I am a company that evaluates the physical capabilities of injured workers the state

Workers Compensation Board relies on accurate information from my testing. It is crucial that only skilled persons be allowed to do this or any other judgement & treatment of disabilities.

It'd be good to have you visit our facility when you are in Anchorage.

Thank you for your consideration of this matter.

Sincerely
Dir Fowler

GLMBER

Lulu Williams
7617 E. 4th Ave Apt. B
Anchorage, Ak 99504

Mar. 31, 1987

Mr. Dave Donley
P.O. Box V
Juneau, Ak 99811

Dear Sir:

I am writing to let you know I am in favor of House Bill 205 in my support of the licensing of Occupational Therapists in Alaska. I currently work in a program that utilizes a counselor and an O.T. We work with the injured worker population and I personally realize the degree of knowledge and experience that is needed in O.T. work. This profession is being used more frequently by the workers compensation system in physical capacities testing and in assistance in returning the injured worker to the workplace. Therefore, I think it imperative that they become licensed as their expertise is used more and more outside the hospital setting by a non-medical consumer.

An testing physical capacities the O.T. determines exactly how much physical demand can be placed on a worker without the worker further injuring himself. The O.T. is instrumental in preparing the injured worker or handicapped individual for the workplace and developing any modifications that are necessary. The O.T.

greatly influences the degree of the worker's
success. So you can understand how important
it is that the D.T. be a competent professional.

Sincerely,
Lulu Williams

GLIMBER

Beth Daugherty
8570 Spandlove Dr.
Anchorage, AK
99516

Dave Donley

House Committee on Labor & Commerce

PO Box V

Juneau, AK 99811

March 30, 1987

APR 2 1987

Dear Representative Donley:

I am writing in support of House Bill #205, regarding Occupational Therapy. As a special education teacher in a pre-school program where many of the children need & receive O.T., I am aware of the importance of licensure for Occupational Therapists. Licensure will assure quality service to these many deserving little consumers. Since medical science is developing more & more ways of assuring the survival of more & more premature infants, we are receiving ever increasing numbers of children needing this service. This means that the number of therapists employed in the state of Alaska will increase and we need to be ready to insure the quality of their work..... for two reasons

- 1) Of course, primarily, we are concerned that the children receive the best care.
- 2) Secondly we'd like to avoid law suits.

Thank you for your support of House Bill #205.

Sincerely,

Beth Daugherty
teacher

GLUSKER

March 31, 1987

APR 3 1987

Representative Dave Donley
P.O. Box V
Juneau AK 99811

Dear Representative Donley,

I am writing to express my support of HB # 205, which would license Occupational Therapists.

As a health care consumer and occupational therapist I urge you to support this bill.

Licensure of O.T.'s is necessary in order to insure that only properly trained and qualified personnel offer O.T. services in this state. Federal guidelines for medicare, nursing homes and PL 94-142 leave it to the state to regulate qualified personnel. Unqualified personnel can inflict very real harm to clients in

terms of neurological, neuro-muscular, orthopedic and psychological functioning.

Should you be interested in seeing the work of registered occupational therapists I would be happy to arrange a tour of Alaska Treatment Center for you or your committee members.

Thank you for your consideration of HB# 205. Your support of this bill is important to health care consumers and families throughout our State.

Sincerely,

Ellen B. Pujon OTR

7535 E. 20th

Anchorage AK 99504

333-7088 hm.

272-0586 wk.

"Occupational therapy is an integral component of today's comprehensive health care arena—we need their expertise."

E.W. Johnson, M.D.
The Ohio State University Hospitals

"It appears to me that in view of the alarming increase in health care costs in recent years, we should support proper coverage for occupational therapy, which has proven to be cost effective and medically beneficial."

Congresswoman Lindy (Mrs. Hale) Boygs

"Occupational therapy is a professional health care service, which when properly used can be instrumental in decreasing hospital confinement, disability, and the ultimate cost of health care."

Health Insurance Association of America

"The best medical intervention in the world to save a life is incomplete if it does not include a program to help ensure that the life which has been saved will be meaningful and productive."

Jerry A. Johnson
Past President,
The American Occupational Therapy
Association, Inc.

For further information contact:

aota

The American Occupational Therapy Association, Inc.
1383 Piccard Drive, Rockville, Md. 20850
(301) 948-9626

QABA

Occupational Therapy Makes Good Sense



Robin

Occupational therapy makes good sense for children like **Robin** who has cerebral palsy. An occupational therapist helped Robin learn the balance and muscle control she needed for learning and walking. With help from parents, teachers, and occupational therapy personnel, children like Robin enjoy school, games, and friendship, and grow up to be useful, productive citizens.

An occupational therapist helped **Lori** regain full use of her hand after an injury. As a trained sign language interpreter, Lori had just landed the job of a lifetime as a business communicator for a firm with hearing impaired executives and employees. An occupational therapy program of activity and exercise brought her back to full hand function, and she again uses her special skill. It makes good sense to keep people performing at jobs they enjoy and do well.



Lori



Peter

It also makes good sense to provide occupational therapy to people like **Peter** who is recovering from a stroke. With the help of a nurse's aide and with regular visits from an occupational therapist, Peter can live at home while he regains function on his affected side. Now he maneuvers his wheelchair around his adapted apartment, shaves, dresses himself, and prepares simple meals. Home care provides greater incentive for recovery and costs much less than hospital or institutional care.

Returning a child to school and play as soon as possible makes good sense for healthy growth and development. Surgery for a brain tumor left Alisa with a right-sided weakness and vision problems that interfered with reading. With regular occupational therapy, Alisa overcame her problems. Today, one year later, she rides the bus to school, keeps up academically with her schoolmates, and enjoys her piano lessons.



It makes good sense to treat the visual and perceptual problems that may remain after recovery from a brain injury. Bill found his return to work hampered by problems such as using and verbalizing numbers. Occupational therapy treatment helped Bill relearn these important functions.



Because of her own special determination and the skill of her occupational therapist, Connie shows few signs of the stroke she suffered less than one year ago. Occupational therapy treatment helped Connie overcome the weakness that affected her right side and helped her regain the skills she needed to return to her secretarial job and to her active social life.

It made good sense to provide occupational therapy to Laura who is battling multiple sclerosis. She overcame the weakness and depression that characterizes her disease. She learned to take care of herself and her apartment. An occupational therapist taught Laura to pace her activities in order to conserve energy and prevent setbacks or hospitalization.



PAUL It makes good sense to treat emotional problems that interfere with job performance and family life. Occupational therapy at a mental health center helped Paul learn to confront and solve problems such as poor concentration and emotional outbursts. (not pictured)

Occupational therapy makes good sense for individuals.

Every year millions of people are temporarily or permanently disabled by birth defects, illness, or injury. Timely, skilled help provided by occupational therapists and occupational therapy assistants means the majority can live independent, productive, and satisfying lives.

Occupational therapy makes good sense for society.

Providing disabled individuals with the services they need means fewer days in hospitals and less dependence upon costly institutional care. It means more people learning job skills and securing employment. It means more people taking an active role in caring for their own health and depending less on the health care system.

PRINCIPLES OF OCCUPATIONAL THERAPY ETHICS



Principles of Occupational Therapy Ethics

Adopted April, 1977, Revised April, 1980

PREAMBLE:

The American Occupational Therapy Association (AOTA) and its component members are committed to furthering man's ability to function fully within his total environment. To this end the occupational therapist renders service to clients in all stages of health and illness, to institutions, other professionals, colleagues, students and to the general public.

In furthering this commitment the American Occupational Therapy Association has established the Principles of Occupational Therapy Ethics. The Principles are intended for use by all occupational therapy personnel, including practitioners in all settings, administrators, educators, and students. Licensure laws and regulations should reflect and support these Principles which are intended to be action oriented, guiding and preventive rather than negative or merely disciplinary. The Principles, likewise, should influence the consulting, planning, and teaching of occupational therapists.

It should be noted that these Principles are intended only for internal use by the American Occupational Therapy Association as a guide to appropriate conduct of its members. The Principles are not intended to define a standard of care for patients or clients of a particular community.

Professional maturity will be demonstrated in applying these basic Principles while exercising the large measure of freedom which they provide and which is essential to responsible and creative occupational therapy service.

For the purpose of continuity the following definitions will support information in this document: Occupational therapist includes registered occupational therapists, certified occupational therapy assistants, occupational therapy students; Clients include patients, students, and those to whom occupational therapy services are delivered.

I. Related to the Recipient of Service

The occupational therapist demonstrates a beneficent concern for the recipient of services and maintains a goal-directed relationship with the recipient which furthers the objectives for which it is established. Services are evaluated against objectives and accountability is maintained therefor. Respect shall be shown for the recipients' rights and the occupational therapist will preserve the confidence of the client relationship.

Guidelines: Recipients of occupational therapy services refer to clients, patients, students and the employers of occupational therapists, i.e., agencies, facilities, institutions, etc.

It is the professional responsibility of occupational therapists to provide services for clients without regard to race, creed, national origin, sex, handicap or religious affiliation. Occupational therapists recognize each client's individuality and worth as a unique person.

Services provided should be planned in concert with clients' involvement in goal-directed activities, in accordance with the overall habilitation or rehabilitation plan. Treatment objectives and the therapeutic process must be measurable to insure professional accountability.

Clients' and students' rights are to be protected as stipulated in the Federal Privacy Act of 1974, in addition to any specified rules, regulations or procedures as may be required by the employer.

The financial gain of occupational therapists should never be paramount to the delivery of services. Those occupational therapists who are compensated by virtue of being a direct service provider or vendor have the right to assess reasonable fees for profit.

Occupational therapists are obligated to provide the highest quality of service to the recipient. If further services would be beneficial to the client, the referring practitioner should be informed. It is also incumbent upon occupational therapists to recommend termination of services when established goals have been met, or when further services would not produce improved recipient performance.

Occupational therapy educators are obligated to provide the highest quality educational services supporting the AOTA "Essentials" and the current theory that supports service delivery.

II. Related to Competence

The occupational therapist shall actively maintain and improve one's professional competence, represent it accurately, and function within its parameters.

Guidelines: Occupational therapists recognize the need for continuing education and where relevant, they obtain training, experience, self-study or counsel to assure competent occupational

profession and the services that can be provided. Occupational therapists should remain informed about changes in the profession and represent the profession accurately to the consumer.

Occupational therapists may provide information to the public about available services through procedures established by the employing facility or contracting agency. When an occupational therapist provides an independent service, it is appropriate to advertise those services in accordance with AOTA established policy.

Occupational therapists should conduct themselves in a manner befitting professionals. The profession is judged in part by the conduct of its members as they carry out their functions.

Occupational therapists should show support and loyalty to the Association by cooperating with the Representatives in collecting information regarding proposed Association policy, replying to official requests for information and supporting the policies of the Association. It is the member's duty if he disagrees with an Association policy to work through existing channels to effect change.

Occupational therapists who engage in work or volunteer activities in addition to professional occupational therapy responsibilities, shall not violate the ethical principles of the Association in such activities.

X. Related to Advertising

Advertising by therapists under their professional title shall be in accordance with propriety and precedent in health professions.

Guidelines: Occupational therapists may provide information to the public about available services through procedures established by the employing facility or contracting agency. If an occupational therapist provides an independent service, it is appropriate to advertise those services.

The occupational therapist shall not use, or participate in the use of, any form of communication containing a false, fraudulent, misleading, deceptive, self-laudatory or unfair statement or claim. Testimonials or statements which promise a favorable result shall be avoided.

XI. Related to Law and Regulations

The occupational therapist shall seek to acquire information about applicable local, state, federal and institutional rules and shall function accordingly thereto.

Guidelines: Occupational therapists are obligated

to function professionally as a practitioner within the limits of all laws related to the delivery of health services, and applicable to the practice of occupational therapy. Occupational therapists will not engage in any cruel, inhumane or degrading practices in the treatment of clients or in the education of students, or in supervision of others or in peer relationships.

It is the responsibility of occupational therapists to make known to their employers, employers and colleagues, those laws applicable to the practice of occupational therapy and education of occupational therapists.

XII. Related to Misconduct

The occupational therapist shall not appear to act with impropriety nor engage in illegal conduct involving moral turpitude and will not circumvent the principles of occupational therapy ethics through actions of another.

Guidelines: As employees, occupational therapists refuse to participate in practices inconsistent with legal, moral and ethical standards regarding the treatment of employees or the public. For example, occupational therapists will not condone practices that are inhumane, or that result in illegal or otherwise unjustifiable discrimination on the basis of race, age, sex, religion, handicap or national origin in hiring, promotion or training.

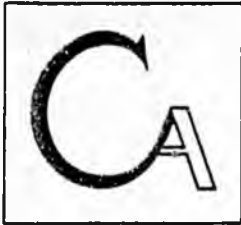
In providing occupational therapy services, occupational therapists avoid any action that will violate or diminish the legal and civil rights of clients or of others who may be affected.

As practitioners and educators, occupational therapists keep abreast of relevant federal, state, local and agency regulations and American Occupational Therapy Association Standards of Practice and education essentials concerning the conduct of their practice. They are concerned with developing such legal and quasi-legal regulations that support the interests of the public, students and the profession.

XIII. Related to Bioethical Issues and Problems of Society

The occupational therapist seeks information about the major health problems and issues to learn their implications for occupational therapy and for one's own services.

Guidelines: The principle is a philosophical statement that encourages occupational therapists to be global in their views of health in relationship to society.



48-005

COLLINS & ASSOCIATES

2600 Denali, Suite 501
Anchorage, Alaska 99503
(907) 276-7943

April 11, 1987

Representative Niilo Koponen
P.O. Box V
Juneau, AK 99811

Dear Representative Koponen:

I am in support of the regulation of the practice of occupational therapy in Alaska. In my professional experience with injured workers, I have come to recognize the positive impact of the unique services offered by occupational therapists upon the quality of life and functional performance of the disabled. Therefore, the potential for harm is also great without some guarantee of appropriate education and training of occupational therapists working in both private and non-profit sectors.

I, therefore, support HB 205 and urge you to pass this bill. This will help assure quality occupational therapy services to those Alaskans who are in need of this type of assistance.

Thank you for your consideration.

Sincerely,

Mike Head, M.Ed., CIRS, CRC
Certified Rehabilitation Counselor

MH:lg/17-68



**ALASKA
TREATMENT
CENTER**

Medical Rehabilitation Services

April 9, 1987

Niilo Koponen
Alaska State Legislature
PO Box V, Room 106
Juneau, Alaska 99811

RE: HB 205

Dear Representative Koponen:

The Alaska Treatment Center, an out-patient medical rehabilitation facility and employer of occupational and physical therapists, supports HB 205 for the following reasons:

1. Provides concise definition of occupational therapy services (assists Medicaid and other insurance claims).
2. Provides consumer protection in cases where occupational therapy services are wrongfully delivered.
3. Enables consumers to know what is expected from occupational therapy services.

Employers of physical and occupational therapist rely on the state licensing board to perform its functions in an expedient and thorough manner. Factors in HB 205 which affect this expediency and which should be considered, include:

1. Additional board members/additional expense (proposed: 2 occupational therapists; Sec. 08.84.010).
2. Additional business to conduct/necessitates more meeting time.

Thank you for your thoughtful consideration in this matter. Please contact me if I can be of any additional assistance.

Sincerely,

Avis C. Hayden
Executive Director

ACH/bel

cc: Dale Shirk, Health Association of Alaska
Melissa Robinson, President, Alaska Occupational Therapy Association
Patricia McAdoo, President, Alaska Physical Therapy Association



Official Business

COMMITTEE:

HOUSE LABOR & COMMERCE

DATE: April 16, 1987 1:30

SIGN-IN

Subject of meeting:

HB 205 Occupational Therapists

HB 230 Premium Tax on Insurers

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
✓ Beverly Ingram	Box 610 Homer, AK 97603	235-6998	Alaska Occupational Therapy Association.	yes 205 ✓
✓ Ann Mattson	1125 Slim Williams Wy, Juneau, AK 99801	789-5224	Alaska Occupational Therapy Association	yes 205 ✓
✓ Jim Shine	P.O. Box 1211 Juneau, AK	6-3340	Metropolitan Life, Prudential, Vanowen Life, etc.	YES HB 230 ✓
✓ Kathy Marshall		465-2534	Occupational Licensing	if question 205 ✓
Rep. Collins	Leg.			205 ✓
Haylen Bressik	P.O. Box 34324 Juneau, AK 99802	586-5245	Alaska State Fire Fighters Association	230 ✓
✓ Bill Hagiver	Box 423 Douglas, AK	364-2154	Postness Chapter A.S.F.A.	230 ✓
✓ JP Tangen	105 Municipal Way #303, Juneau	586-2286	Am. Council on Life Ins Alliance of Am. Insurers	HB 230 ✓
✓ Gordon Brunton			Public Safety	HB 230 ✓

ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672

4536 HES HB 205 - HB 224

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QUESTIONS AND ANSWERS ABOUT OCCUPATIONAL THERAPY AND ADULT DAY CARE

Q. What is the purpose of adult day care programs?

A. Adult day care provides a structured program of services for adults experiencing physical, cognitive, or emotional difficulties. Many of the services focus on the development of functional independence to prevent unnecessary or premature institutionalization. These programs also provide respite, emotional support, and problem-solving assistance to care givers and family members.

Q. What types of day care programs are offered?

A. Health maintenance programs focus on preventing social isolation and on maintaining physical health and independence in daily living skills.

Rehabilitation programs focus on treatment for specific physical, social or emotional problems that interfere with independent living.

Some programs serve individuals with a variety of needs while other more specialized programs are dedicated to individuals with problems associated with a specific illness such as Alzheimer's Disease and related dementias.

Both day care centers and day hospitals may offer programs with social components, leisure time activities, self-care training, and other rehabilitation services.

Q. What is the role of occupational therapy personnel in adult day care programs?

A. The goal of occupational therapy is to increase or maintain an individual's ability to function as independently as possible. Treatment includes a variety of therapeutic activities to enhance the individual's quality of life.

The occupational therapy practitioner assesses physical and cognitive capacities, designs adaptive equipment to maintain or improve function, teaches skills which promote independence in self-care activities, and recommends changes in an individual's living environment to promote safety and self-sufficiency. Treatment is provided to meet the important social, physical, and sensory needs of the adult who has significant health problems, or who is at risk for developing such problems.

Q. What skills do occupational therapy personnel bring to the care of adult day care clients?

A. Education of occupational therapy personnel includes emphasis on the process of human growth and development, the psychological and physiological aspects of illness, and the importance of occupation, self-care, and independence in maintaining a healthy existence.

Q. Who pays for adult day care services?

A. Many adult day care programs are funded through agencies of federal, state, and municipal governments with additional support provided through charitable contributions and private bequests. Often the daily charges to individuals are based upon the person's ability to pay.

Q. Where are adult day care programs offered?

A. Programs may be offered by hospitals, long-term care institutions, senior centers, and other community agencies. To find locations in your community, contact your public health department or the state Office of Aging.

OCCUPATIONAL THERAPY: A VITAL LINK TO PRODUCTIVE LIVING

AOTA • 1383 Piccard Drive • PO Box 1725 • Rockville, MD 20850-4375 • (301) 948-9626

OCCUPATIONAL THERAPY SERVICES FOR THE ELDERLY

Occupational therapy uses goal-directed activity in the evaluation or treatment of persons whose ability to function is impaired by normal aging, illness, injury or developmental disability. Treatment goals in occupational therapy include the promotion of functional independence, prevention of disability and maintenance of wellness.

Therapeutic activities are designed to assist individuals in adapting to their social and physical environment, given their functional capacity, through mastery of essential living tasks. Examples of important services in gerontic occupational therapy are:

- education and retraining in daily living skills such as bathing, dressing, and eating,
- therapeutic adaptations, such as assistive equipment and physical environmental design to promote in-home and community mobility,
- sensorimotor treatment for strengthening, endurance, range of motion, coordination and balance,
- daily living adaptation to sensory loss such as impaired vision or hearing,
- therapeutic activities for memory, orientation, cognitive integration, and the life review process,
- prevention and health promotion through pre-retirement planning for leisure time, self-management skills, socialization, energy conservation, body mechanics and joint protection,
- care of the terminally ill through maintenance of independent living skills and meaningful activity.

Occupational therapy personnel provide services to the elderly in many settings such as:

- hospitals
- home health programs
- community-based health care centers
- hospices
- congregate living facilities
- outpatient rehabilitation facilities
- senior centers
- long term care facilities
- adult day care programs
- community service agencies
- retirement housing

Currently, approximately 30% of the 40,000 certified occupational therapy personnel in the United States work primarily with persons over age 65.

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Occupational Therapy is important...

when you are living with

ARTHRITIS

More than one out of seven Americans has some form of arthritis. You may be one of these people. But...before you decide that your aches, pains and joint problems are a result of arthritis...you should have a complete examination by a qualified physician.

IMPORTANT WARNING SIGNS OF ARTHRITIS ARE:

- pain, tenderness or swelling in one or more joints
- pain or stiffness in the morning
- recurring or persistent pain and stiffness in the neck, lower back, knees or other joints

When a diagnosis of arthritis is made, you will want to seek the services of an occupational therapist for help in:

- controlling pain and swelling in joints
- protecting joints from damage
- managing stress and fatigue
- obtaining special assistive devices

When arthritis is causing problems such as pain, stiffness and difficulty in performing daily tasks, an occupational therapist can:

- make custom splints to rest or support your limbs
- design special adaptive equipment to help you function
- recommend assistive devices to aid you in your tasks at home and work
- evaluate your home and workplace and suggest modifications so you can work independently and avoid stress to your joints
- teach you methods of carrying out daily tasks without causing pain or joint damage

If arthritis is causing difficulty in using your hands...an occupational therapist can:

- advise you on what exercises are best and what activities to avoid
- teach you to carry out daily tasks more easily
- provide equipment to ease your work and conserve energy

If you have arthritis in your hips and knees...an occupational therapist can:

- help you to rearrange and adapt your home to reduce pain and stress on your joints

When arthritis causes tiredness...an occupational therapist can:

- teach you methods of relaxation
- advise you on how to save energy while doing daily tasks
- help you to increase your endurance for home and work tasks

Occupational therapists are important members of the health care team working with people who have arthritis. By teaching people how to reduce stress in painful joints, everyday activities such as driving, housekeeping or simply getting dressed, can be performed with greater ease and less discomfort.

Occupational therapists can help by developing customized splints for joints in order to reduce pain and prevent damage. Treatment includes teaching individuals about activities which may be harmful and those which are beneficial.

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Occupational Therapy is important...

when you are in need of

HOME HEALTH SERVICE

It's not surprising to learn that people recovering from illness and injuries get better faster in their own homes. More people are proving this every day thanks to the rapidly growing availability of home health services.

WHAT ARE HOME HEALTH SERVICES?

These are specialized programs, which bring the services of professionals like occupational therapists, nurses, physical therapists, and speech and language pathologists to your home. Here, in familiar surroundings, you can complete your recovery and learn to deal with any remaining health problems that could interfere with your ability to carry out daily tasks.

WHO CAN BENEFIT FROM HOME HEALTH SERVICES?

Home health services can be important in the treatment of people with limitations due to health problems such as those resulting from:

- arthritis
- heart attack
- stroke
- head injury
- respiratory disease
- hip fracture
- cancer
- Parkinson's disease
- diabetes
- spinal cord injury
- muscular dystrophy or multiple sclerosis
- amyotrophic lateral sclerosis
- developmental disability

OCCUPATIONAL THERAPY CAN HELP YOU AT HOME BY:

- working with you to help you be as **independent** as possible while you are recovering
- providing you with training and recommending equipment to help you care for your personal needs such as **bathing, dressing and grooming**
- helping you find ways in which you can **prepare and serve meals** for yourself and your family
- teaching you ways to make your home safer and **more accessible** when you must use a wheelchair, walker or other aids
- arranging supplies and equipment so you can continue your **daily household tasks**
- designing a program of activities and exercise that will help you **regain as much function as possible**
- advising you on how to **conserve energy** as you go about daily tasks
- **constructing splints** and adaptive equipment that will allow you to be as independent as possible
- aiding you in finding ways in which you can **return to favorite leisure and recreational activities**
- guiding you in planning for return to **work and community life**

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WHO PROVIDES OCCUPATIONAL THERAPY SERVICES

Occupational therapy personnel are trained health care professionals. The occupational therapist holds a bachelor's or master's degree and has completed a clinical internship. The occupational therapy assistant has an associate degree and has also completed a clinical internship. Both occupational therapists and occupational therapy assistants must pass a certification examination. Many states require licenses of occupational therapy practitioners.

PAYMENT FOR HOME HEALTH SERVICES

Home health services are covered under Medicare and are included as a covered service in many health insurance plans. Services may also be covered under insurance policies when you are injured in an auto accident or by workers compensation if you are injured on the job. Contact your insurance company to determine coverage for your particular illness or disability.

FINDING HOME HEALTH SERVICES IN YOUR COMMUNITY

If you think you or a member of your family would benefit by receiving home health services contact:

your family physician

hospitals in your community

your local public health department

your local home health agency, or,

The American Occupational Therapy Association, Inc.
1383 Piccard Drive
P.O. Box 1725
Rockville, MD 20850-4375
(301) 948-9626

Occupational Therapy is important...

when you are recovering from

STROKE

This year, more than 500,000 Americans will have a stroke. In spite of the problems that result from stroke, many of these people will return to their homes and live independent, productive lives — with the skilled help of occupational therapy personnel.

Problems resulting from a stroke may include:

- temporary or permanent weakness of one side of the body
- problems with vision and reading
- difficulties with memory or speech

These problems may interfere with your ability to:

- care for personal needs like bathing and dressing
- prepare meals and care for your home
- move about in the community, drive a car or use public transportation
- participate in work, educational and leisure activities

While you are recovering, occupational therapy can help you:

- learn new ways to manage daily tasks such as eating, dressing and bathing
- obtain special assistive equipment to help you function more independently
- discover ways to increase your physical strength, endurance and mobility
- compensate for losses of sensation and vision
- develop the skills necessary to return to work, household tasks and community activities

To increase your independence, the occupational therapist may:

- recommend altering your home to eliminate hazards to walking or using a wheelchair
- recommend special devices or aids that help you to perform home and work tasks

- recommend methods of dressing and bathing
- recommend techniques and resources for improving your mobility in the home and community

Occupational therapy personnel are important members of the health care team working with people recovering from stroke. They teach individuals who have had strokes to cope with disability, and to become as independent as possible so they can continue their work and personal lives, manage stress and fatigue, and participate fully in family and community life.

The occupational therapist is a health care professional who has a bachelor's or master's degree and has completed a clinical internship. The occupational therapy assistant holds an associate degree and has also completed a clinical internship. Both occupational therapists and occupational therapy assistants must pass a national certification examination. Many states also require licenses of occupational therapy practitioners.

The goal of occupational therapy is to help individuals to become as independent as possible in daily life. Many people who have experienced strokes are meeting this goal with the help of occupational therapy.

Occupational therapy services are available in many hospitals and rehabilitation centers, and in home health programs. To find occupational therapy professionals in your community, contact the occupational therapy department at your local hospital or:

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QUESTIONS AND ANSWERS ABOUT OCCUPATIONAL THERAPY AND HOSPICE CARE

Q: What is a hospice?

A: Hospice is a concept of care designed to manage and relieve the emotional and physical stress of the terminally ill and their families.

Q: Where is hospice care provided?

A: Home is the usual care setting for hospice patients. Inpatient services may be provided in a hospital-based unit, freestanding independent facility, or nursing home. If home care and inpatient facilities are available, patients may spend time in both places, depending on their particular needs at a particular time.

Q: What services are included in hospice care?

A: Medicare regulations for hospice require that nursing, social services, and counseling be available on a 24-hour basis. The hospice is also required to provide occupational therapy, physical therapy, speech-language therapy, home health aides, homemaker services, medical supplies, dietary and bereavement counseling. Short-term inpatient care including both respite care and symptom management must be available if needed. Trained volunteers frequently augment staff services. The emphasis of care is on symptom control (physical, psychosocial, and spiritual) and on bereavement follow-up for the family.

Q: What is the goal of occupational therapy in hospice care?

A: The goal of occupational therapy is to assist in providing a comprehensive plan of care that adequately addresses issues relating to the patient and family in daily living activities of work, leisure, and self-care. By involving the patient and family in the adaptation process, the quality of life is enhanced and the patient is able to retain some degree of independence in life skills in the presence of advancing functional loss.

Q: What specialized education and experience do occupational therapy personnel bring to hospice care?

A: Education of occupational therapy personnel includes emphasis on the process of human growth and development, the psychological, sociological, and physiological aspects of illness, and the importance of occupation, self-care, and independence in maintaining a meaningful daily life during the course of terminal illness. The medical aspects of occupational therapy education include understanding the disease process and the changing functional capacities of the human mind and body.

Q: Is occupational therapy readily available where hospice care is provided?

A: A certified hospice must provide occupational therapy directly or under arrangement in both home and short-term inpatient settings.

Q: Who pays the cost of hospice care?

A: As of November 1983, an individual entitled to Medicare Part A and certified by a physician as "terminally ill" may use two 90-day periods and a subsequent 30-day period of hospice benefits when receiving services from a Medicare certified hospice program. Benefits for hospice care are also being included in increasing numbers of private insurance plans.

Q: Who decides if a hospice client will receive occupational therapy?

A: Occupational therapy services are provided upon referral from the patient's physician, or when designated as appropriate by the interdisciplinary team with approval of the patient's physician.

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- controlling pain and swelling in joints
- protecting joints from damage
- managing stress and fatigue
- obtaining special assistive devices

When arthritis is causing problems such as pain, stiffness and difficulty in performing daily tasks, an occupational therapist can:

- make custom splints to rest or support your limbs
- design special adaptive equipment to help you function
- recommend assistive devices to aid you in your tasks at home and work
- evaluate your home and workplace and suggest modifications so you can work independently and avoid stress to your joints
- teach you methods of carrying out daily tasks without causing pain or joint damage

If arthritis is causing difficulty in using your hands...an occupational therapist can:

- advise you on what exercises are best and what activities to avoid
- teach you to carry out daily tasks more easily
- provide equipment to ease your work and conserve energy

If you have arthritis in your hips and knees...an occupational therapist can:

- help you to rearrange and adapt your home to reduce pain and stress on your joints

When arthritis causes tiredness...an occupational therapist can:

- teach you methods of relaxation
- advise you on how to save energy while doing daily tasks
- help you to increase your endurance for home and work tasks

Occupational therapists are important members of the health care team working with people who have arthritis. By teaching people how to reduce stress in painful joints, everyday activities such as driving, housekeeping or simply getting dressed, can be performed with greater ease and less discomfort.

Occupational therapists can help by developing customized splints for joints in order to reduce pain and prevent damage. Treatment includes teaching individuals about activities which may be harmful and those which are beneficial.

OCCUPATIONAL THERAPY: A VITAL LINK TO PRODUCTIVE LIVING

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Occupational therapists also tell people about the many aids available for those with arthritis and often design customized adaptive devices for those with special problems.

The goal of occupational therapy is to help individuals become as independent as possible in their daily lives. Countless people with arthritis live easier, more comfortable lives with the aid of adaptive devices, a planned program of exercise and rest, and the help of occupational therapy.

The occupational therapist is a health professional who has completed a bachelor's or master's degree and clinical internship. The occupational therapy assistant has completed an associate degree and clinical internship. Both occupational therapists and occupational therapy assistants must pass a national certification examination. Many states also require licenses of those practicing occupational therapy.

Occupational therapy services are available in hospitals and rehabilitation centers as well as in conjunction with physician's offices and through home health services. To find an occupational therapist in your community, contact the occupational therapy department at your local hospital, state occupational therapy association, or:

The American Occupational Therapy Association
1383 Piccard Drive, P.O. Box 1725, Rockville, MD 20850-4375
(301) 948-9626

"In the course of living with rheumatoid arthritis for 24 years, I have discovered that the most useful—and often the most underused—source of help is the occupational therapist. I learned more about avoiding joint abuse in one hour with my occupational therapist than in all the years before with doctors. If I had received occupational therapy 15 years ago, I am sure I would have delayed damage to my joints."

Meredith Brenizer, Nantucket, MA

"Occupational therapy is essential in the treatment of the patient with arthritis and rheumatic disease. With occupational therapy, many of the damaging effects of the disease can be avoided."

Eric Gall, MD, Professor/Chairman, Division of Rheumatology, University of Arizona, Tucson

Specifically, treatment:

- Changes the way in which the brain functions so that learning becomes easier.
- Supplements, but does not duplicate an educational program.
- Relies on neurodevelopmental concepts known to be basic to the acquisition of motor and academic skills.
- Provides an individualized program for each child based on the specific sensory integrative profile.
- Recognizes the need to provide the child with the opportunity and means to organize the nervous system through purposeful movements.

The therapist does not "teach" the child how to perform specific skills. Instead, the child learns spontaneously while bending, turning, riding, rolling, and swinging on the simple equipment provided by the therapist. Gradually, becoming more relaxed and alert in any situation, children become more aware of their environment and respond more appropriately to it.

For further information contact:

The American Occupational Therapy Association
1383 Piccard Drive, PO Box 1725
Rockville, MD 20850-4375
(301) 948-9626

Information adapted from Bay Area Association for Sensory Integration pamphlet on Sensory Integration, and from information supplied by the Center For the Study of Sensory Integrative Dysfunction.

OCCUPATIONAL THERAPY AND THE SENSORY INTEGRATIVE APPROACH TO LEARNING DISORDERS

INFORMATION FOR PARENTS AND TEACHERS

The brain receives vast amounts of information from each of our senses. As children learn to move their bodies, balance themselves and relate to objects and people around them, the brain organizes the incoming sensory information. This organization—called "sensory integration"—enables us to direct our attention, to produce useful and well coordinated behavior, and to feel good about ourselves.

In the early life of children the brain develops the organization which will be the foundation for later learning and behavior. In these early years, the spontaneous movements of play involving the entire body are most effective in developing the nervous system.

The human brain has frequently been compared to a computer. The brain depends upon the information it receives from the environment through the sensory systems. It is dependent upon visual, auditory, and tactile input, as well as information about gravity and movement. The brain puts these various sensations together and organizes them into a meaningful plan of action.

Dysfunction in one area of the brain will affect performance in other areas. A child who is not receiving and organizing important information from the senses in a clear, adequate, concise manner may not be getting the input upon which the brain depends for the process of learning.

OCCUPATIONAL THERAPY: A VITAL LINK TO PRODUCTIVE LIVING

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CHILDREN WITH SENSORY INTEGRATIVE DYSFUNCTION MAY DISPLAY SOME OF THE FOLLOWING PROBLEMS:

1. lack of strength and tone in the muscles which may result in poor posture and fatigue.
2. poor spatial awareness and internal position sense resulting in insecurity while moving.
3. lack of coordination between the two sides of the body. The child may be clumsy and confused when both hands and feet must be used together.
4. lack of coordination between the eyes and the body, so there is ineffective use of the visual information to assist in performing actions.
5. poor attention span. The child often has difficulty focusing on a task.
6. threatened by unfamiliar motor tasks, and showing difficulty in their execution, the child handles a new task by thinking about each movement.
7. overactive behavior and restlessness. The problem is sometimes called hyperactivity.
8. a poorly developed sense of touch, sometimes showing discomfort when touched. The child may have difficulty learning the shape and texture of things.
9. difficulty using and understanding language with resulting problems in speaking, reading and writing.

In general, these children have difficulty both in play and in work. They may not succeed in getting along with their peers, or they have to use so much effort that they do not enjoy themselves.

TREATMENT FOR SENSORY INTEGRATIVE DYSFUNCTION

The child's brain can function more efficiently once it has developed certain processes which are necessary for learning. These processes are developed when children receive proper types of sensory stimulation in a well organized environment.

Jean Ayres, Ph.D., OTR, an occupational therapist who pioneered in the treatment of sensory integrative dysfunction, combined studies of the nervous system with years of experience with children. She found that by directing and controlling incoming sensory stimuli through sensory integrative therapy, children were able to learn more effectively at home, school, and play.

Sensory integration therapy is given by an occupational therapist who has had additional training in nervous system function and sensory integration. Since the brain develops in an orderly sequence, the therapist must follow that sequence, starting with the child's most basic difficulty. Each child is unique, and therapy is structured for the child's individual needs. Depending upon the child's progress, therapy may last from six months to two years or more.

Specific activities have been identified which produce improvement at each level of nervous system development, usually involving the entire body and many senses at once. They require skillful yet spontaneous body responses, since sensory integration occurs without deliberate concentration. It may appear that a child engaged in occupational therapy is merely playing or doing exercises. However, the therapist has organized the environment and the child's activities so that the sensory network is stimulated in the most effective way. Because of therapy, the child's nervous system begins allowing the child *to learn*.

OCCUPATIONAL THERAPY FOR LEARNING DISABILITIES

Why do some learning disabled children, adolescents and adults need occupational therapy?

These individuals may have deficits in sensory and motor functions which can lead to:

- impaired academic performance
- poor gross and fine motor coordination
- impaired visual and perceptual-motor skills
- poor organization of self and materials
- inadequate orientation in space
- stress reactions to new or unpredictable situations
- low self esteem
- poor peer relations
- distractibility/decreased attention span
- hyperactivity
- behavior problems
- delayed or atypical development

How does occupational therapy benefit individuals with learning disabilities?

Occupational therapy helps individuals maintain and develop skills that will lead to independence in personal, social, academic and vocational pursuits. These can include:

- more effective motor-performance for school or work tasks
- better organizational abilities for successful completion of assignments and job responsibilities
- increased capacities to perform self-care activities
- improved social skills required for interaction with others
- coping strategies to assist children in managing the classroom sensory environment

How is occupational therapy treatment administered?

Occupational therapy practitioners specialize in the analysis and adaptation of daily activities. Specially designed tasks are used in occupational therapy treatment to enable individuals to function in their daily environment, and are selected on the basis of their therapeutic value, such as:

- play activities which provide an opportunity for successful motor responses
- movement on suspended or mobile equipment to enhance posture, balance and orientation in space
- selected tasks to improve pre-writing skills and fine motor coordination

Where are occupational therapy services provided?

- public and private schools
- private practitioner offices
- wellness centers
- home health agencies
- hospitals
- day treatment centers
- community mental health centers
- clinics

What specialized education and experience do occupational therapy personnel bring to learning disabled individuals?

Occupational therapists hold bachelor or master degrees, and occupational therapy assistants are trained at the associate degree level. Occupational therapy education includes the study of human growth and development, with specific emphasis on the social, emotional, and physiological implications of illness and injury. Occupational therapy practitioners must complete supervised clinical internships in a variety of health care settings, and are required to pass a national certification examination.

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OCCUPATIONAL THERAPY SERVICES IN LONG-TERM CARE

What are the goals of occupational therapy treatment?

Occupational therapy treatment helps those whose lives have been disrupted by illness and injury to:

- restore, maintain, or improve daily living skills
- participate as fully as possible in meaningful work, leisure, and social activities
- cope with the physical and emotional effects of long term disability
- prevent further deterioration through health education such as energy conservation and joint protection
- access community resources and services to help promote independence
- organize the living environment and make use of adaptations which promote safety

Who should receive occupational therapy services in long term care?

- individuals who have limitations in their abilities to carry out self-care activities
- individuals whose strength and endurance are at risk
- those people whose ability to function in the community has been impaired
- individuals who would benefit from special adaptive equipment to aid in semi-independent or independent living

Where are occupational therapy services provided?

Occupational therapy is provided within the many different settings which comprise long-term care such as:

- individuals' home
- comprehensive outpatient rehabilitation facilities
- adult day care centers
- residential facilities
- health maintenance organizations
- hospitals
- nursing homes
- hospices

Who pays for occupational therapy services?

Medicare, Medicaid and private insurers pay for occupational therapy services depending upon the specifics of the case and the individual insurance policy.

What specialized education and experience do occupational therapy personnel bring to long term care?

Occupational therapy education is based on the physical and psychological implications of illness, injury, and aging, and analysis of the components of activity. The clinician's knowledge of adapting tasks and modifying the environment to compensate for functional limitations is used to increase the involvement of clients, and to promote safety and success.

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OCCUPATIONAL THERAPY IN MENTAL HEALTH

Who are the mental health clients treated by occupational therapy personnel?

Within the scope of mental health services, occupational therapy can benefit children, adolescents, adults and the elderly of varying functional levels and diagnostic categories. Among the diagnostic categories frequently treated are:

- schizophrenia
- depression
- manic depression
- borderline personality
- stress reactions
- chemical dependency
- eating disorders
- adolescent adjustment reaction
- antisocial personality
- autism

Where are mental health occupational therapy services provided?

- general and psychiatric hospitals
- community mental health centers
- day treatment centers
- clinics
- sheltered workshops
- group homes
- rehabilitation centers
- correctional institutions
- home health agencies
- places of business
- private homes
- wellness clinics

What is the goal of mental health occupational therapy treatment?

Occupational therapy is dedicated to helping individuals gain the highest possible degree of functional independence in the tasks of daily life.

For those whose lives are impaired by social or emotional problems occupational therapy aids in:

- improving the cognitive, social and organizational skills required for success in work, school and leisure activities.
- increasing the ability to perform self-care activities such as personal hygiene, for health and social acceptance.
- increasing skills in community living such as use of public transportation, to improve self-sufficiency.
- increasing recognition of stress indicators and developing coping skills.

What are some examples of treatment activities used by occupational therapy personnel?

- simulated or real activities such as a job interview, which provide an opportunity for individuals to practice life skills, recognize difficulties, and learn ways to improve performance. Whenever possible, activities are identical to those expected of individuals in their intended work or living situations.
- activities which enable the individual to use existing skills and interests or develop new skills and interests, to help in meeting basic needs for acceptance, achievement, and social interaction.

What specialized education and experience do occupational therapy personnel bring to the mental health setting?

Occupational therapists hold bachelor or master degrees, and occupational therapy assistants are trained at the associate degree level. Occupational therapy education includes a broad range of course work which emphasizes the social, emotional, and physiological implications of illness and injury. Occupational therapy practitioners must complete supervised clinical internships in a variety of health care settings, and are required to pass a national certification examination.

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Copied
in files

Kathy Huxley Registered Occupational
Therapist

~~AK~~ Alaska Occupational Therapy
Association

Testimony 4/30/87: HB 205

1. Request that the Physical Therapists clarify the specific issues that they have with HB 205.
2. Communication is going on between the Occupational and Physical Therapists to resolve differences about the bill.
3. Since the joint board situation has been proposed ^{in order for} ~~for~~ the Occupational Therapists to obtain licensure, I ^{believe} ~~feel~~ the legislature needs to mediate an arrangement that is agreeable to both professions.

K. H.

 * DELIVER TO: LHSCCLH *
 * ORIGINAL *
 * SENT: 04/30/87 TIME: 10:12 *
 * FROM: LIOCSSC *
 * SUBJECT: FINAL STATS,4-30 ANC *
 * PRINT DATE: 04/30/87 TIME: 10:13 *

*** FINAL TELECONFERENCE STATISTICS ***

DATE: _____APRIL 30, 1987_____

SITE: _____ANCHORAGE_____

SPONSOR: _____HOUSE HESS COMMITTEE_____

SUBJECT: _____HB 205---PHYSICAL THERAPISTS_____

LOCAL MODERATOR: _____DAVID_____

TESTIFIED:

NAME\REPRESENTING	ADDRESS	PHONE #
PATRICIA MCADOO-APTA	4660 REKA DRIVE #1	99508 333-1378
GARY MCCARTHY-APTA	11132 PLACER CR	99577 694-4590
KATHY HUXLEY-AKOTA	6841 SEQUOIA DR	99516 345-1601
JOHNNE SULLIVAN-ULC	4895 CORDOVA ST	99567 562-2281
MARGARET RIDDLE-OTR	5233 E 24TH AVE	99508 333-1050

OBSERVED:

NAME\REPRESENTING	ADDRESS	PHONE #
MARY MELISSA ROBINSON	13350 WESTWIND DR	99516 345-1005

TESTIFIED: _____05_____ START TIME: ___8:30AM

OBSERVED: _____01_____ END TIME: ___9:30AM

TOTAL: _____06_____

*
* DELIVER TO: LHSCCLH *
* *
* *
* ORIGINAL *
* SENT: 04/30/87 TIME: 10:10 *
* FROM: LIOCSSC *
* SUBJECT: FINAL STATS, 4-30, KTN *
* PRINT DATE: 04/30/87 TIME: 10:10 *
* *

TO: LHSCNMB, LIOCSSC
FROM: MODERATOR KETCHIKAN/EVELYN JOHNSON
FINAL STAT SHEET FOR:
HOUSE H.E.S.S. T/C ON HB 205/OCCUPATIONAL/PHYSICAL THERAPY
APRIL 30, 1987 - FINAL STATS - KETCHIKAN, ALASKA 99901
TESTIFIED:

1. JOANNA DESANTO, BOX 61, KETCHIKAN, AK 247-2415

TESTIFIED: 1
UNABLE TO TESTIFY: 0
OBSERVED: 0
TOTAL: 1

START TIME: 8:30 A
END TIME: 9:05 A
MODERATOR: EMJ

*
* DELIVER TO: LHSCCLH *
* *
* *
* ORIGINAL *
* SENT: 04/30/87 TIME: 10:14 *
* FROM: LIOCSSC *
* SUBJECT: FINAL STATS, 4-30 HOMER *
* PRINT DATE: 04/30/87 TIME: 10:14 *
* *

TO: SHANA
FROM: JEAN IN HOMER

FINAL STATS--OCCUPATIONAL PHYSICAL THERAPISTS 4-30-87
TESTIFIED:

610 HOMER, AK 99603 235-6998

BEVERLY INGRAM BOX

Original sponsor: Navarre

1 IN THE HOUSE BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 CS FOR HOUSE BILL NO. 205 (HESS) .

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to regulation of the practice of
7 occupational therapy and physical therapy; and pro-
8 viding for an effective date."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 * Section 1. AS 08.01.010(15) is amended to read:

11 (15) State Physical Therapy and Occupational Therapy Board
12 (AS 08.84.010);

13 * Sec. 2. AS 08.02.010(a) is amended to read:

14 (a) An audiologist licensed under AS 08.11, a person licensed in
15 the state as a chiropractor under AS 08.20, a dentist under AS 08.36,
16 a medical practitioner or osteopath under AS 08.64, a registered nurse
17 under AS 08.68, an optometrist under AS 08.72, a registered pharmacist
18 under AS 08.80, a registered physical therapist or occupational thera-
19 pist under AS 08.84, or a psychologist under AS 08.86, shall use as
20 professional identification appropriate letters or a title after that
21 person's name which represents that person's specific field of prac-
22 tice. The letters or title shall appear on all signs, stationery, or
23 other advertising in which the person offers or displays personal
24 professional services to the public. In addition, a person engaged in
25 the practice of medicine or osteopathy under AS 08.64.380(2) or a
26 person engaged in any manner in the healing arts who diagnoses,
27 treats, tests, or counsels other persons in relation to human health
28 or disease and uses the letters "M.D." or the title "doctor" or "phy-
29 sician" or another title that tends to show that the person is willing

1 or qualified to diagnose, treat, test, or counsel another person,
2 shall clarify the letters or title by adding the appropriate special-
3 ist designation, if any, such as "dermatologist", "radiologist",
4 "audiologist", "naturopath", or the like.

5 * Sec. 3. AS 08.03.010(c)(8) is amended to read:

6 (8) State Physical Therapy and Occupational Therapy Board
7 (AS 08.84.010) -- June 30, 1989.

8 * Sec. 4. AS 08.84.010 is amended to read:

9 Sec. 08.84.010. STATE PHYSICAL THERAPY AND OCCUPATIONAL THERAPY
10 BOARD. (a) There is created the State Physical Therapy and Occupa-
11 tional Therapy Board, which consists of seven [FIVE] members appointed
12 by the governor. The membership consists of one physician licensed to
13 practice medicine in the state, three physical therapists licensed in
14 the state or two physical therapists and a physical therapy assistant
15 licensed in the state, two occupational therapists licensed in the
16 state or an occupational therapist and an occupational therapy assis-
17 tant licensed in the state, and one lay person with no direct finan-
18 cial interest in the health care industry. Members of the board shall
19 be United States [U.S.] citizens domiciled in the state and shall be
20 appointed for a term of four years, and until their successors are
21 appointed. A member may not serve more than two terms in succession.
22 The governor may remove a member from the board for neglect of duty,
23 incompetence, dishonorable conduct, or suspension or revocation of
24 license.

25 (b) The board [PHYSICAL THERAPY BOARD] shall control all matters
26 pertaining to the licensing of physical therapists, [AND] physical
27 therapy assistants, occupational therapists, and occupational therapy
28 assistants and the practice of physical therapy and the practice of
29 occupational therapy. The board shall

- 1 (1) pass upon the qualifications of applicants;
- 2 (2) provide for the examination of applicants [CONDUCT
3 EXAMINATIONS];
- 4 (3) issue temporary permits and licenses to persons [PHYS-
5 ICAI THERAPISTS AND PHYSICAL THERAPY ASSISTANTS] qualified under this
6 chapter;
- 7 (4) suspend, revoke, or refuse to issue or renew a license
8 under [IN ACCORDANCE WITH] AS 08.84.120;
- 9 (5) keep a current register listing the name, business
10 address, date, and number of the license of each person [PHYSICAL
11 THERAPIST AND PHYSICAL THERAPY ASSISTANT] who is licensed to practice
12 under this chapter [IN THIS STATE];
- 13 (6) keep a record and minutes of its meetings, proceedings,
14 and hearings and submit an annual report of its activities to the
15 governor and other interested parties;
- 16 (7) limit or condition the authority to practice physical
17 therapy or occupational therapy, or discipline a practitioner, under
18 [IN ACCORDANCE WITH] AS 08.84.185(a); and
- 19 (8) adopt regulations under AS 44.62 necessary to carry out
20 the purposes of this chapter including regulations establishing quali-
21 fications for licensure and renewal of licensure under this chapter
22 [AS A PHYSICAL THERAPIST OR PHYSICAL THERAPY ASSISTANT].

23 * Sec. 5. AS 08.84.030 is amended by adding a new subsection to read:

24 (b) To be eligible for licensure by the board as an occupational
25 therapist or occupational therapy assistant, an applicant, unless a
26 graduate of a foreign school of occupational therapy located outside
27 the United States, shall

28 (1) have successfully completed a curriculum of occupa-
29 tional therapy approved by the Committee of Allied Health Education

1 and Accreditation of the American Medical Association, and the Ameri-
2 can Occupational Therapy Association appropriate to the license being
3 sought;

4 (2) submit proof of successful completion of supervised
5 field work approved by the board

6 (A) for an occupational therapist, a minimum of six
7 months of supervised field work;

8 (B) for an occupational therapy assistant, a minimum
9 of two months of supervised field work;

10 (3) pass, to the satisfaction of the board, an examination
11 prepared by a national testing service approved by the board or an
12 examination recognized by the American Occupational Therapy Asso-
13 ciation to determine the applicant's fitness for practice as an occu-
14 pational therapist or an occupational therapy assistant, or be enti-
15 tled to licensure without examination under AS 08.84.060; and

16 (4) meet qualifications for licensure established in regu-
17 lations adopted by the board under AS 08.84.010(b).

18 * Sec. 6. AS 08.84.032 is amended by adding a new subsection to read:

19 (b) To be eligible for licensure by the board as an occupational
20 therapist or occupational therapy assistant, an applicant who is a
21 graduate of a school of occupational therapy that is located outside
22 of the United States shall

23 (1) have completed, to the satisfaction of the board, a
24 resident course of study and professional instruction equivalent to
25 that provided by a curriculum approved by the Committee of Allied
26 Health Education and Accreditation of the American Medical Association
27 and the American Occupational Therapy Association, and have furnished
28 documentary evidence of compliance with this paragraph, translated, if
29 necessary, into the English language by a person verifying the

1 accuracy of the translations;

2 (2) have completed, to the satisfaction of the board,
3 supervised field work equivalent to that required under AS 08.84.-
4 030(b);

5 (3) have met applicable requirements under 8 U.S.C. 1101 -
6 1503 (Immigration and Nationality Act) unless a United States citizen;

7 (4) pass an [THE] examination administered or approved by
8 the board under AS 08.84.030; and

9 (5) pay the fee required under AS 08.84.050.

10 * Sec. 7. AS 08.84.040 is amended to read:

11 Sec. 08.84.040. APPLICATION FOR LICENSE. To be licensed under
12 this chapter to practice physical therapy or occupational therapy [AS
13 A PHYSICAL THERAPIST OR PHYSICAL THERAPY ASSISTANT], an applicant
14 shall apply to the board on a form prescribed by the board. An appli-
15 cant shall include in the [HIS] application [,] evidence under oath
16 that the applicant [HE] possesses the qualifications required by
17 AS 08.84.030 or 08.84.032.

18 * Sec. 8. AS 08.84.050 is amended to read:

19 Sec. 08.84.050. FEES. The Department of Commerce and Economic
20 Development shall set fees under AS 08.01.065 for the following:

- 21 (1) application;
22 (2) license by examination;
23 (3) license by acceptance of credentials;
24 (4) renewal;
25 (5) temporary permit;
26 (6) limited permit.

27 * Sec. 9. AS 08.84.060 is amended to read:

28 Sec. 08.84.060. LICENSURE BY ACCEPTANCE OF CREDENTIALS. The
29 board may license without examination an applicant who is a physical

1 therapist, [OR] physical therapy assistant, occupational therapist, or
2 occupational therapy assistant licensed under the laws of another
3 state [OR TERRITORY OR THE DISTRICT OF COLUMBIA], if the requirements
4 for licensure in that state [OR TERRITORY OR THE DISTRICT OF COLUM-
5 BIA], were, at the date of the applicant's licensure, substantially
6 equal to the requirements in this state.

7 * Sec. 10. AS 08.84.065(c) is amended to read:

8 (c) A temporary permit issued to an applicant for licensure as a
9 physical therapist or physical therapy assistant by examination is
10 valid for eight months or until the results of the first examination
11 for which the applicant is scheduled are published, whichever occurs
12 first. If the applicant fails to take the first examination for which
13 the applicant is scheduled the applicant's temporary permit lapses on
14 the day of the examination.

15 * Sec. 11. AS 08.84.065(d) is amended to read:

16 (d) A temporary permit issued to an applicant who is a graduate
17 of a foreign school of physical therapy or occupational therapy locat-
18 ed outside the United States is valid until the results of the first
19 examination for which the applicant is scheduled are published follow-
20 ing completion of the internship required under AS 08.84.032 [AS 08.-
21 84.032(2)].

22 * Sec. 12. AS 08.84.065 is amended by adding a new subsection to read:

23 (e) A temporary permit issued to an applicant for licensure as
24 an occupational therapist or occupational therapy assistant by exam-
25 ination is valid for eight months or until the results of the ex-
26 amination for which the applicant is scheduled are published, which-
27 ever occurs first. If the applicant fails to take an examination for
28 which the applicant is scheduled the applicant's temporary permit
29 lapses on the day of the examination.

1 * Sec. 13. AS 08.84 is amended by adding a new section to read:

2 Sec. 08.84.075. LIMITED PERMIT. (a) The board may issue a
3 limited permit to a person to practice occupational therapy in the
4 state as a visiting, nonresident occupational therapist or occupation-
5 al therapy assistant, if the person

6 (1) applies on the form provided by the board;

7 (2) has not previously been denied occupational therapy
8 licensure in the state;

9 (3) is licensed to practice occupational therapy in another
10 state or satisfies the requirements for certification by the American
11 Occupational Therapy Association;

12 (4) provides proof satisfactory to the board that the
13 person will not practice in the state for more than 120 days in the
14 calendar year for which the permit is issued; and

15 (5) pays the fee required under AS 08.84.050.

16 (b) The board may issue a limited permit to a person to practice
17 physical therapy in the state as a visiting, nonresident physical
18 therapist or physical therapy assistant, if the person

19 (1) applies on the form provided by the board;

20 (2) has not previously been denied physical therapy
21 licensure in the state;

22 (3) is licensed to practice physical therapy in another
23 state;

24 (4) provides proof satisfactory to the board that the
25 person will not practice in the state for more than 120 days in the
26 calendar year for which the permit is issued; and

27 (5) pays the fee required under AS 08.84.050.

28 (c) A limited permit is valid for a period not exceeding 120
29 days in a calendar year.

1 (d) A person may not receive more than three limited permits to
2 practice occupational therapy or physical therapy during the person's
3 lifetime.

4 * Sec. 14. AS 08.84.080 is amended to read:

5 Sec. 08.84.080. EXAMINATIONS. The board shall examine appli-
6 cants for licensure under this chapter [AS PHYSICAL THERAPISTS OR
7 PHYSICAL THERAPY ASSISTANTS] at the times and places it determines.

8 * Sec. 15. AS 08.84.090 is amended to read:

9 Sec. 08.84.090. LICENSURE. The board shall license an applicant
10 who meets the qualifications for licensure under this chapter. It
11 shall issue a license certificate to each person licensed. A license
12 certificate is prima facie evidence of the right of the person to hold
13 out as a licensed physical therapist, [OR] licensed physical therapy
14 assistant, occupational therapist, or occupational therapy assistant.

15 * Sec. 16. AS 08.84.100 is amended to read:

16 Sec. 08.84.100. RENEWAL OF LICENSE. (a) A person licensed
17 under this chapter [PHYSICAL THERAPIST OR PHYSICAL THERAPY ASSISTANT]
18 shall renew the [A] license [ISSUED UNDER THIS CHAPTER] every two
19 [FOUR] years with the Department of Commerce and Economic Development
20 on or before the date set by the department under AS 08.01.100(a). If
21 the license is not renewed on or before that date, it lapses.

22 (b) Before reinstatement of a license that remains lapsed for
23 more than 60 days, the applicant must pay all delinquent renewal fees
24 and a [ANY] penalty established under AS 08.01.100(b). If a license
25 remains lapsed for more than three years, the board may require the
26 applicant to submit proof, satisfactory to the board, of continued
27 competency [TAKE AND PASS THE EXAMINATION GIVEN UNDER AS 08.84.-
28 030(3)].

29 (c) A license may not be renewed unless the applicant

1 demonstrates competence to practice [AS A PHYSICAL THERAPIST OR]
2 physical therapy or occupational therapy [ASSISTANT] in a manner
3 established by the board in regulations adopted under AS 08.84.010(b)
4 [AS 08.84.010(b)(8)].

5 * Sec. 17. AS 08.84.120(a) is amended to read:

6 (a) The board may refuse to license an applicant, may refuse to
7 renew the license of a person, and may suspend or revoke the license
8 of a person who

9 (1) has obtained or attempted to obtain a license by fraud
10 or material misrepresentation;

11 (2) uses drugs or alcohol in a manner that affects the
12 person's ability to practice physical therapy or occupational therapy
13 competently and safely;

14 (3) has been convicted of a state or federal felony or
15 other crime that effects the person's ability to practice competently
16 and safely;

17 (4) is guilty, in the judgment of the board, of gross
18 negligence or malpractice or has engaged in conduct contrary to the
19 recognized standards of ethics of the physical therapy profession or
20 the occupational therapy profession;

21 (5) has continued to practice physical therapy or occupa-
22 tional therapy after becoming unfit due to physical or mental disabil-
23 ity;

24 (6) has failed to refer a patient to another qualified
25 professional when the patient's condition is beyond the training or
26 ability of the person [PHYSICAL THERAPIST]; [OR]

27 (7) as a physical therapy assistant, has attempted to
28 practice physical therapy that has not been initiated, supervised, and
29 terminated by a licensed physical therapist; or

1 (8) as an occupational therapy assistant, has attempted to
2 practice occupational therapy that has not been supervised by a li-
3 icensed occupational therapist.

4 * Sec. 18. AS 08.84.130 is amended by adding new subsections to read:

5 (c) A person not licensed as an occupational therapist, or whose
6 license is suspended or revoked, or whose license is lapsed, who uses
7 in connection with the person's name the words "Licensed Occupational
8 Therapist," or other letters, words, or insignia indicating or imply-
9 ing that the person is a licensed occupational therapist, or who
10 orally or in writing, directly or by implication, holds out as a
11 licensed occupational therapist is guilty of a class B misdemeanor.

12 (d) A person not licensed as an occupational therapy assistant,
13 or whose license is suspended or revoked, or whose license is lapsed,
14 who orally or in writing, directly or by implication, holds out as a
15 licensed occupational therapy assistant is guilty of a class B misde-
16 meanor.

17 * Sec. 19. AS 08.84.150 is amended to read:

18 Sec. 08.84.150. LICENSURE OF PHYSICAL THERAPISTS. It is unlaw-
19 ful for a person [ANYONE] to practice physical therapy without being
20 licensed under [IN ACCORDANCE WITH] this chapter unless the person is

21 (1) a student in an accredited physical therapy program;
22 (2) [OR] a graduate of a foreign school of physical therapy
23 fulfilling the internship requirement of AS 08.84.032(2), and then
24 only unless under the continuous direction and immediate supervision
25 of a physical therapist; or

26 (3) issued a limited permit under AS 08.84.075.

27 * Sec. 20. AS 08.84.150 is amended by adding a new subsection to read:

28 (b) A person may not practice occupational therapy without being
29 licensed unless the person is

1 (1) a student in an accredited occupational therapy program
2 or in a supervised field work program;

3 (2) a graduate of a foreign school of occupational therapy
4 fulfilling the internship requirement of AS 08.84.032, and then only
5 unless under the continuous direction and immediate supervision of an
6 occupational therapist;

7 (3) an occupational therapist or occupational therapy
8 assistant employed by the United States Government while in the dis-
9 charge of official duties; or

10 (4) granted a limited permit under AS 08.84.075.

11 * Sec. 21. AS 08.84.160 is amended to read:

12 Sec. 08.84.160. PRACTICE OF LICENSED PHYSICAL THERAPIST OR
13 LICENSED OCCUPATIONAL THERAPIST. This chapter does not authorize a
14 [ANY] person to practice medicine, osteopathy, chiropractic [AS DE-
15 FINED IN AS 08.20.220], or other method of healing, but only to prac-
16 tice physical therapy or occupational therapy [AS DEFINED IN AS 08.-
17 84.190(3)].

18 * Sec. 22. AS 08.84.185 is repealed and reenacted to read:

19 Sec. 08.84.185. DISCIPLINARY SANCTIONS. (a) The board may
20 impose the following sanctions singly or in combination:

- 21 (1) permanently revoke a license or permit to practice;
22 (2) suspend a license for a stated period of time;
23 (3) censure a licensee;
24 (4) issue a letter of reprimand;
25 (5) impose limitations or conditions on the professional
26 practice of a licensee;
27 (6) impose peer review;
28 (7) impose professional education requirements until a
29 satisfactory degree of skill has been attained in those aspects of

1 professional practice determined by the board to need improvement;

2 (8) impose probation and require the licensee to report
3 regularly to the board upon matters involving the basis for the pro-
4 bation;

5 (9) impose a civil fine of not more than \$5,000;

6 (10) accept a voluntary surrender of a license.

7 (b) The board may withdraw probation status if it finds that the
8 deficiencies that required the sanction have been remedied.

9 (c) The board may summarily suspend a license before final
10 hearing or during the appeals process if the board finds that the
11 licensee poses a clear and immediate danger to the public health and
12 safety. A person whose license is suspended under this section is
13 entitled to a hearing by the board within seven days after the effec-
14 tive date of the order. If, after a hearing, the board upholds the
15 suspension, the licensee may appeal the suspension to a court of
16 competent jurisdiction.

17 (d) The board may reinstate a license that has been suspended or
18 revoked if the board finds, after a hearing, that the applicant is
19 able to practice with skill and safety.

20 (e) The board may return a license that has been voluntarily
21 surrendered if the board determines that the licensee is competent to
22 resume practice and that applicable renewal fees are paid.

23 (f) The board shall seek consistency in the application of
24 disciplinary sanctions. A significant departure from prior decisions
25 involving similar situations shall be explained in the findings of
26 fact or order.

27 * Sec. 23. AS 08.84.190(1) is amended to read:

28 (1) "board" means the State Physical Therapy and Occupa-
29 tional Therapy Board;

1 * Sec. 24. AS 08.84.190 is amended by adding new paragraphs to read:

2 (5) "occupational therapist" means a person who practices
3 occupational therapy;

4 (6) "occupational therapy" means the use of purposeful
5 activity, evaluation, treatment, and consultation with human beings
6 whose ability to cope with the tasks of daily living are threatened
7 with, or impaired by developmental deficits, learning disabilities,
8 aging, poverty, cultural differences, physical injury or illness, or
9 psychological and social disabilities to maximize independence, pre-
10 vent disability, and maintain health; "occupational therapy" includes

11 (A) developing daily living, play, leisure, social,
12 and developmental skills;

13 (B) facilitating perceptual-motor and sensory integra-
14 tive functioning;

15 (C) enhancing functional performance, prevocational
16 skills, and work capabilities using specifically designed exer-
17 cises, therapeutic activities and measures, manual intervention,
18 and appliances;

19 (D) design, fabrication, and application of splints or
20 selective adaptive equipment;

21 (E) administering and interpreting standardized and
22 nonstandardized assessments, including sensory, manual muscle,
23 and range of motion assessments, necessary for planning effective
24 treatment; and

25 (F) adapting environments for the disabled;

26 (7) "occupational therapy assistant" means a person who
27 assists in the practice of occupational therapy under the supervision
28 of an occupational therapist.

29 * Sec. 25. AS 08.84.200 is amended to read:

1 Sec. 08.84.200. SHORT TITLE. This chapter may be cited as the
2 Physical Therapists and Occupational Therapists Practice Act.

3 * Sec. 26. AS 09.55.560(1) is amended to read:

4 (1) "health care provider" means an audiologist licensed
5 under AS 08.11; a chiropractor licensed under AS 08.20; a dental
6 hygienist licensed under AS 08.32; a dentist licensed under AS 08.36;
7 a nurse licensed under AS 08.68; a dispensing optician licensed under
8 AS 08.71; a naturopath licensed under AS 08.45; an optometrist
9 licensed under AS 08.72; a pharmacist licensed under AS 08.80; a
10 physical therapist or occupational therapist licensed under AS 08.84;
11 a physician licensed under AS 08.64; a podiatrist; a psychologist and
12 a psychological associate licensed under AS 08.86; and a hospital as
13 defined in AS 18.20.130, including a governmentally owned or operated
14 hospital; a corporate entity covered under AS 21.88.050(b)(11); and an
15 employee of a health care provider acting within the course and scope
16 of employment;

17 * Sec. 27. AS 18.23.070(3) is amended to read:

18 (3) "health care provider" means a chiropractor licensed
19 under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist
20 licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing
21 optician licensed under AS 08.71; an optometrist licensed under
22 AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist
23 or occupational therapist licensed [REGISTERED] under AS 08.84; a
24 physician licensed under AS 08.64; a podiatrist; a psychologist and a
25 psychological associate licensed under AS 08.86; and a hospital as
26 defined in AS 18.20.130, including a governmentally owned or operated
27 hospital; a corporate entity covered under AS 21.88.050(b)(11); and an
28 employee of a health care provider acting within the course and scope
29 of employment;

1 * Sec. 28. AS 21.88.900(9) is amended to read:

2 (9) "health care provider" means an audiologist licensed
3 under AS 08.11; a chiropractor licensed under AS 08.20; a dental
4 hygienist licensed under AS 08.32; a dentist licensed under AS 08.36;
5 a nurse licensed under AS 08.68; a dispensing optician licensed under
6 AS 08.71; an optometrist licensed under AS 08.72; a pharmacist li-
7 censed under AS 08.80; a physical therapist or occupational therapist
8 licensed under AS 08.84; a physician licensed under AS 08.64; a podia-
9 trist; a psychologist and a psychological associate licensed under
10 AS 08.86; a hospital as defined in AS 18.20.130, including a govern-
11 mentally owned or operated hospital; a corporate entity covered under
12 AS 21.88.050(b)(11); an employee of a health care provider acting
13 within the course and scope of employment;

14 * Sec. 29. AS 21.88.900 is amended by adding a new paragraph to read:

15 (17) "occupational therapist" means a person licensed under
16 AS 08.84.

17 * Sec. 30. AS 47.17.070(9) is repealed and reenacted to read:

18 (9) "practitioner of the healing arts" includes audiolo-
19 gists, chiropractors, dental hygienists, dentists, health aides,
20 hearing aid dealers, naturopaths, nurses, nurse practitioners, optome-
21 trists, osteopaths, occupational therapists, physical therapists,
22 physicians, physician's assistants, psychiatrists, psychologists,
23 psychological associates, religious healing practitioners, and sur-
24 geons;

25 * Sec. 31. TRANSITION. (a) Until June 30, 1988, the Department of
26 Commerce and Economic Development may issue a provisional license for the
27 practice of occupational therapy to a person engaged in the practice of
28 occupational therapy as an occupational therapist or occupational therapy
29 assistant, if the person

1 (1) pays a fee set by the department;

2 (2) certifies to the department that the person is of good moral
3 character; and

4 (3) provides proof of either employment in the state as an
5 occupational therapist or occupational therapy assistant and certification
6 as an occupational therapist or occupational therapy assistant by the
7 American Occupational Therapy Association.

8 (b) A provisional license issued under (a) of this section is valid
9 until June 30, 1988, until revoked by the department, or until the provi-
10 sional licensee is issued a license or temporary permit by the State Phys-
11 ical Therapy and Occupational Therapy Board to practice occupational thera-
12 py, whichever occurs first.

13 (c) The department may adopt regulations under the Administrative
14 Procedure Act (AS 44.62) to implement this section.

15 * Sec. 32. LICENSING BY CREDENTIAL. (a) Notwithstanding AS 08.84.-
16 030(b), enacted by sec. 5 of this Act, the State Physical Therapy and
17 Occupational Therapy Board may license a person as an occupational thera-
18 pist or occupational therapy assistant who

19 (1) has engaged in the practice of occupational therapy or is
20 currently engaged in the practice of occupational therapy in the state;

21 (2) holds an appropriate certificate from the American Occupa-
22 tional Therapy Association as a certified occupational therapist or a
23 certified occupational therapy assistant; and

24 (3) applies for the license before January 1, 1989.

25 (b) A license issued under this section is for all purposes a license
26 issued under AS 08.84.

27 * Sec. 33. EXPERIENCE-BASED LICENSURE OF OCCUPATIONAL THERAPISTS. (a)
28 Notwithstanding AS 08.84.030(b), enacted by sec. 5 of this Act, a person is
29 eligible for licensure as an occupational therapist if before July 1, 1988,

1 the person

2 (1) submits proof of completion of four years of board approved
3 practice as an occupational therapy assistant before January 1, 1988;

4 (2) submits proof of successful completion of a minimum of six
5 months of supervised field work approved by the board; and

6 (3) passes to the satisfaction of the board an examination
7 approved by the board.

8 (b) A license issued under this section is for all purposes a license
9 issued under AS 08.84.

10 * Sec. 34. Notwithstanding AS 08.84.100(a), as amended by sec. 16 of
11 this Act, a license issued under AS 08.84 that is in effect on the effec-
12 tive date of this Act is valid for the period for which it was issued
13 unless revoked or suspended under procedures set out in AS 08.84.

14 * Sec. 35. INITIAL APPOINTMENTS. The governor shall fill the positions
15 created on the State Physical Therapy and Occupational Therapy Board by
16 this Act before March 1, 1988, and shall appoint one person to a term of
17 four years and one person to a term of two years.

18 * Sec. 36. Section 31 of this Act takes effect immediately under
19 AS 01.10.070(c).

20 * Sec. 37. Sections 1 - 30, and 32 - 35 of this Act take effect
21 January 1, 1988.
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