Approved 2-27-86
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on February 24, 1986 in room 423-S of the Capitol.

All members were present except:

Committee staff present:
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Secretary to Committee

Conferees appearing before the committee:

Representative Dale Sprague
Byron M. Fry, President Kansas Art Therapy Association
Dr. Fulsum, Phychiatrist, Veteran's Hospital, Topeka, Ks.
Barbara Sabol, Secretary Department of Health and Environment
Deborah C. Horning, National Association for Music Therapy
Kay Metzger, Registered Music Therapist
Richard Mattson, Professor of Horticulture, Director/Horticultural Therapy curriculum at Kansas State University.
Alan F. Alderson, Kansas Recreation & Parks Association
Elizabeth Taylor, Kansas Occupational Therapy Association
Michael J. Byington, Topeka Resource Center for Handicapped/Outreach Advocate/Case Mgr.

Visitor's register, see (Attachment No. 1).

Chairman called meeting to order when quorum was present, asking members to give attention to bill requests. He had been in contact with Secretary on Aging this date and Ms. Romero requests that a bill we had requested for that Department in regard to Adult Family Homes now be withdrawn. They do not wish to pursue the bill at this time.

Chair recognized Rep. Dale Sprague for a Resolution request. Rep. Sprague gave handout to members, (see Attachment No.2.) for details. He asked that a Resolution be introduced that would speak to requesting and directing SRS to draft rules and regulations governing the funding of human liver transplants by the State in coordination with matching Federal funds. In the attachment presented were materials from Mrs. Jan Albrecht, from Rep. Sprague's district that requests such considerations. He answered questions from committee members, i.e., liver transplants no longer considered experimental; yes, matching funds would be used; perhaps an Interim Study on this problem would be advisable. At this point, Rep. Foster moved to have this bill introduced as a House Concurrent Resolution, seconded by Rep. Hassler. Discussion ensued i.e., questioning setting up rules and regulations for payment of said transplants, possibility of Interim Study perhaps being a more favorable approach at this time. Vote taken, motion carried.

Representative Jerry Friedeman spoke to members in regard to bill request, see (Attachment No.3), for details. This request stems from legislation that is presently bogged down in Senate Judiciary Committee, SB 664. He asked for introduction of the bill that would provide that a child born as a result of an attempted abortion who exibits any sign of a live birth be considered in need of care under Kansas code. Rep. Friedeman moved to introduce this bill, motion seconded by Rep. Williams, motion carried.

Revisor Norman Furse explained at request of Chair a proposal to create a Board of Allied Health Professions. This would provide a General Board for Physical Therapists, Physician's Assistants, Mental Health Technicians. Administrative functions for registering would be done through this Board. He answered questions i.e., yes, this is a new agency. Also it would be the Governing Board for any group going through the credentialing process to receive registaration or licensure. This has been drafted with language similar to the Board of Behavioral Sciences.

At this point, Rep. Green moved to introduce a bill to set up Board of Allied Health Professionsals, seconded by Rep. Neufeld, motion carried.

Chair announced that Rep. Branson has had hand surgery, and all hope she will soon be back with us.

Chair noted hearings continued on HB 2498:--

Byron Fry, Art Therapy Association, (see Attachment No. 4), for details. Mr. Fry had agreed to return today after time did not permit his testimony last week. He stated their Association cannot support HB 2498, and if passed, they feel it will set a precedent the State will later regret. Separately credentialing organizations that have an overlap of services is not a good idea. Kansas Art Therapy Association believes the State should work on the concept of coordinating licensure for all related therapies. Further, he urged for more difinitive language that would create a separate umbrella regulatory agency which would handle credentialing of ancillary health care personnel where overlapping of service exists. This would save tax dollars. He referred to highlighted items in his hand-out, i.e., insurance providers were aware licensing health professionals was method of determining what constituted a responsible profession, furthermore, medicaid information indicated state could determine eligibility for payment of service by requiring the provider to be licensed. He spoke to phases involved in obtaining third party payments; problems of OT service delivery in mental health and learning disabilities were not directly addressed. He answered questions, i.e., there are 50-60 persons registered with American Art Therapy Association; there are about 20 practicing that are not members of this Association. He urged committee to kill HB 2498.

Dr. Fulsum, Phychiatrist, Veteran's Hospital, Topeka, spoke of his support of HB 2498, feels that OT's are a vital part of team effort in the program of treatment of many. He sees that damage could be done if someone does not have proper qualifications. This bill would protect the public in that it would prevent Nursing Homes to put a sign on the door, OT, when in fact there is not a qualified person to deliver that service. A new program is being developed in regard to Altzheimer's disease where many disciplines work together along with many volunteers in therapy for these persons. He answered numerous questions, i.e., yes, he thought all groups should be licensed, however he thought they should ask and go through the process as the OT's have.

Secy. Barbara Sabol, gave hand-out to members, see (Attachment No.5). Their Dept. is in favor of HB 2498 which provides for licensure of OT's and their OT Assistants by the State Board of Healing Arts, and the bill reflects concerns and recommendations of the technical committee and SHCC and her Department as well. She answered questions, i.e., logic on licensing the OT's and OT Assistants at same level, and she stated that the Assistants would be working only under the supervision of the OT.

Deborah Horning, National Association of Music Therapists, gave hand-out, (see Attachment NO.6), for details. She spoke in Opposition of HB 2498, then made recommendations for numerous changes which are outlined in her attachment. She stated concern that the bill does not adequately address licensing OT's as a means to protect the public, feels language is vague in this regard. Would recommend that OT's submit to committee, clear evidence that harm has been done to the public by their not being licensed. Further, she feels the bill in its current form has potential for setting OT above other therapy disciplines, thereby setting OT at odds with other health care providers. She answered questions, i.e., there are approximately 70 practicing musical therapists in Kansas, and yes, eventually they would like to be credentialed. She was asked to define autonomous health care profession.

Ms. Kay Metzger, Registered Music Therapist, gave hand-out,(Attachment No.7). She stated she does not wish to object or inhibit licensure of OT's, but to raise the question concerning language in HB 2498 that might affect the practice of music therapy in this state. If the bill implies that OT's will be given preference over a music therapist for employment, or that they must supervise a music therapist in administering evalutaions, developing sensory integration skills, using therapeutic activities, or adapting the environments, it would adversely affect clients that are served by music therapy. Further, the bill needs language clarification, and she asked what is the advantage of licensure. She spoke to numerous changes in HB 2498, that are outlined in her hand-out on second page. She answered questions.

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on February 24, 19 86

Hearings continue on HB 2498:--

Dr. Richard Mattson, Director of Horticultural Therapy, Ks. State University gave hand-out to members, see (Attachment No. 8), for details. He gave his credentials, and stated their branch of therapy is a new adjunctive therapy and utilizes horticulture activities to improve psychological, social, educational or physical adjustment. He spoke to the education requirements, i.e., 3½ years of coursework in behavioral science and horticulture, as well as 6-months internship at institutional sites. Upon completion of B.S. or M.S. graduates of the program are qualified to become Registered Horticultural Therapists (HRT) through a national accrediting organization, the National Council for Therapy and Rehabilitation through Horticulture (NCTRH). The registration process is peer review, equivalency-based system, but the NCTRH is moving toward a competency-based certification examination system. He stated concerns with HB 2498 in that if it is passed, and only OT's are allowed to perform these skills many adjunctive therapists may be excluded from practicing their professions or will be required to work under the direction of an OT. He feels this will cause increased costs. He feels this bill will seriously discriminate against other adjunctive therapists in Kansas and asked the bill to be defeated. He answered questions.

Mr. Alan Alderson, Kansas Recreation and Parks Association gave hand-out, (see Attachment No. 9), for details. He spoke in opposition to HB 2498, and because of the time constraint limited his remarks, however did stress several concerns to members. Stating HB 2498 would need to be amended so drastically and still would not speak to all concerns within the bill. It is the belief of their Association that it is not possible to provide for the licensure and regulation of one segment of the therapeutic health care profession without substantially or completely undercutting the others. To allow the licensing of only occupational therapists is tantamount to de-credentialing all other related health care professionals. There is some overlapping of functions, and herein lies the major flaw of HB 2498. He cited specific flaws, lines 36-37 would qualify the OT to administer everything from psychiatric tests to medical tests; "homemaking" in line 39 should not be included; lines 40-42 need to be clarified; all of sub section 4 of Sec. 2, line 43 should be deleted, as well as subsection 5 of Sec. 2, and subsection 6 and subsection 7. His attachment indicates the education required from Ks. State and Ks. University. He answered questions.

Elizabeth Taylor, Kansas Occupational Therapy Association gave hand-out, (see Attachment No.10), for details. She expressed concerns, i.e., potential or real harm; cost containment. She stated the medical team agrees with the level of licensure of OT's, and she stressed the licensure is the appropriate level of credentialing. It is only at this level she said that legal responsibility can be directed. She made recommendations for changes in HB 2498, i.e., language in lines 28-32 should state, "in medical setting only; pg.2, lines 53-54, OT's assistants work under supervision of OT's and not in consultation with; biggest change in line 67, page 2, change "or" to "and"; and there were other small technical changes that she would not indicate because of lack of time.

Michael Byington, Outreach advocate/Case Manager gave hand-out to members, (see Attachment No.11), for details. He had previously given printed testimony to members and asked them to consider this as a supplement and agreed with amendments proposed by Ms. Taylor and the Music Therapists, and he would wish to add Drama Therapy to that as well. He stated case management is a managerial term and defined as overall coordination of services necessary to assist individuals, and can also include administration of recreational services as well. This indicates how impossible it would be to limit the scope of practice, having only one modality of training. If this bill passes he said, half of the services in the state will have to be shut down. If OT's are licensed and others are not, it doesn't seem very fair.

Meeting adjourned 3:05 p.m.

GUEST REGISTER

DATE 2-24-86

HOUSE

pg 1 of 2

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
Meredith Mahler	KOTA	5219 SW 22 Pl - Topeka
Harold C. Pitts	TARTA	2606 Chelsea DR - Topeka
Gene Pissiali	KOTA	RT 1 Lecompton
Kathy Hartley	KOTA	2007 Mission #16 - Topeka
J. C. Olson, M.D.	Veterans Administration	VA Medical Center Topeka, KS 66622
D. Kay Metzger, RMT	NAMT, Inc.	731 Lawrence Ave, Lawrence, Ks. 66044
Melissa Burnam	UUNS	Box 141 Linwood, KS 66052
Richard Matteson	NCTRH / HORT. THERAPY	5410 TERRA HGTS MANHATTAN, KS 66502
Linda Baker Nobles	Kansas Occupational Therapy A	Overland Park, Ks
Steven E. Curtis	Ks. Resp. Thera Soc.	Ks. City, Ks.
Janet Heuder, OTR	KOTA	2907 SE Burton Topeka
Pamela Cumley, OTR	KOTA	1142 SW Randolph Topeka
Kathleen Draskovich	K.O.T.A.	1321 New Hampshire, Lawrence
Valerie Smith	KOTA	1320 W. 27th Topeka Ks
Sue Merryfield	KOTA	9507 Granada, Overland Park, Ks
Larry Buening	Healing Arts Bd	503 Kansas Ave, Suite 500 Topeka, KS 66603
Charlene Caldwell	" " "	" "
ALAN ANDERSON	KAN. REC. & PARKS ASSN	TOPEKA
Bette Loper	Kan. Rec & Parks Assoc.	Topeka
Michael D. Byington	Topeka Resource Center for the Handicapped	Topeka

Attachment 1
2-24-86
Hs. PHW

GUEST REGISTER

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PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	TOPEKA
Marsha Hutchison	KS Medical Society	Topeka
Andrea Stevens	KS Hospital Assoc.	Topeka
Melissa Hungerford	"	"
Joe Monge	KS Respiratory Therapy Society	Prat
Galen D. Greenwood	Consumer	Topeka
Ed Kern	Right to Life of Ks. Inc.	Topeka
Sandy Rose	Right to Life of Ks.	Topeka
Cyrta L Wolf	KDHE	Topeka
Paul M. Klotz	Assoc. of CMHCs of Ks.	TOpeka

STATE OF KANSAS

DALE M. SPRAGUE
REPRESENTATIVE, SEVENTY-THIRD DISTRICT
McPHERSON COUNTY
P.O. BOX 119
McPHERSON, KANSAS 67460
(316) 241-7112

STATE CAPITOL
ROOM 112-S
TOPEKA, KANSAS 66612
(913) 296-7682

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE CHAIRMAN: INSURANCE
MEMBER: FEDERAL AND STATE AFFAIRS
GOVERNMENTAL ORGANIZATION

TO: House Public Health and Welfare Committee

RE: Drafting request: Liver Transplant Fundings.

DATE: February 24, 1986

Chairman Littlejohn, I request the Committee introduce a House Concurrent Resolution (HCR) requesting and directing Social and Rehabilitation Services to draft rules and regulations governing the funding of human liver transplants by the State in coordination with matching Federal funds. The Committee may, at its discretion, wish to broaden the scope of the requested HCR to include other specific organs and/or transplants in general.

I am fully aware of the potential impacts of this request, however I feel imperative that the State study and adopt policies regarding transplants which are consistent with medical state-of-the-art techniques.

Attached are materials from a constituent, Jan Albrecht, whose ten year old daughter has just received a liver implant to save her life. I am hopeful that her experience may be the basis for commencing State policy considerations on future transplants and their funding.

Respectfully,

Dale Sprague

Dale M. Sprague
State Representative
District Seventy-three

Attm. #2
2-24-86
Hs. PHW

STATE OF KANSAS

JOHN CARLIN, GOVERNOR

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

INCOME MAINTENANCE AND MEDICAL SERVICES

ROBERT C. HARDER, SECRETARY

STATE OFFICE BUILDING
TOPEKA, KANSAS 66612

Janyary 16, 1986

Mrs. Janis Albrecht
343 North First Street
Lindsborg, Kansas 67456

Dear Mrs. Albrecht:

This letter is being written following an inquiry from Representative Larry Turnquist in regard to coverage for a liver transplant.

To receive help at the state level, your daughter would have to be eligible to receive Medicaid. Eligibility is determined at the local office and is based on financial status. However, according to regulations K.A.R. 30-5-88, the Kansas Medicaid/MediKan program does not cover reimbursement for heart, lung, pancreas, or liver transplant. To receive help at the federal level, one would have to be eligible for Medicare. According to Medicare regulations 42 CFR 405.310(k), a liver transplant is covered only for children under age 18 with extra hepatic biliary atresia or any other form of end stage liver disease.

It is unfortunate that our answer could not have been more favorable, but it is not possible for Medicaid/MediKan to provide reimbursement for all procedures.

If you have further questions, you may contact me by calling (913) 296-3981 or by writing.

Sincerely,

Elaine M. Hacker, M.D.

Elaine M. Hacker, M.D.
Medical Services Coordinator

EMH:mg
cc: Representative Turnquist
Dr. Robert C. Harder

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Adm. .ation

6325 Security Boulevard
Baltimore, MD 21207

JAN 10 1985

FQA-421

Mrs. Janis Albrecht
343 North First Street
Lindsborg, Kansas 67456

Dear Mrs. Albrecht:

The President has asked us to thank you for your letter which he is sharing with us because we administer the Medicare and Medicaid programs. As much as he would like to personally answer all the letters he receives, his heavy workload makes this impossible. I regret the delay in my response.

I was sorry to learn of the problems Lily was having with her health, Mrs. Albrecht, and was glad to hear that she is making a speedy recovery from her transplant surgery. While I can understand your desire to obtain funding to help with her medical expenses, you should be aware that we have explored the possibilities for covering the liver transplantation under existing government-financed programs, principally the Medicare and Medicaid programs. Under the Medicare program, experimental procedures are excluded from coverage; liver transplantation has been considered an experimental procedure, and therefore not covered based on evaluations conducted by the Public Health Service.

The Medicaid program, as you may know, is a joint Federal-State program administered by the individual States and financed by State and Federal funds. Under the Medicaid law, the decision as to which services are covered under Medicaid is generally left to the individual States. Where a State Medicaid program decides to cover liver transplants, the Federal government will pay its share of the costs associated with the transplant in the form of the Federal "matching" funds. However, under the Medicaid law, where a State decides not to cover a service, Federal matching funds are not available.

I recognize that it is small comfort to the beneficiaries and families affected by State policies that deny coverage of experimental medical procedures, that the considerations underlying those decisions are complex and difficult ones. Yet, it remains a State decision under the structure of the Medicaid program whether or not to cover liver transplants. For information about coverage for

the State of Kansas, you may wish to contact Dr. Robert C. Harder, Department of Social and Rehabilitation Services, Sixth Floor, State Office Building, 915 Harrison Street, Topeka 66612, telephone (913) 296-3271.

Please be assured that I share your concern for Lily's well-being and regret that my reply could not be more favorable.

Sincerely yours,

Robert A. Streimer

Robert A. Streimer
Acting Director
Bureau of Eligibility,
Reimbursement and Coverage

November 14, 1985, Lily Williams, a ten year old girl received a liver transplant at the University of Minnesota Hospital for Alpha I Anti Trypsin Deficiency, a disease that destroys the liver. In the course of this event, we, her parents, became immediately aware of the difficulty (impossibility) of financing the life saving surgical procedure. Having been told by the financial office at the hospital that Medicare and Kansas Medicaid would not cover liver transplants, we wrote to President Reagan requesting any possible help. We received the two letters included, briefly stating the same answers. One is from the Department of Health and Human Services and one is from the State of Kansas S.R.S.

In 1983 the National Institutes of Health (NIH) designated liver transplants as theripeutic meaning transplantation was no longer considered experimental. With this result, some insurance companies and <u>some</u> state Medicaid programs cover liver transplants on a case-by-case basis. Missouri is one such state.

We are not asking for personal assistance from the Kansas Legistature. What we are asking at this time is that you consider making Kansas one of the states that will cover liver transplants on a case-by-case basis. This could be funded through the existing Federal "matching funds" program, 51% being allotted by the Federal Government. We appreciate your cooperation in this matter. Thank you.

Jan Albrecht and Anthony Albrecht

AN ACT concerning children; providing that a child born as a result of an attempted abortion is a child in need of care under the Kansas code for care of children.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act, "secretary" means the secretary of social and rehabilitation services.

Sec. 2. A child born as a result of an attempted abortion who exhibits any sign of a live birth as defined in K.S.A. 65-2401 and amendments thereto shall be considered a child in need of care under the Kansas code for care of children.

Sec. 3. The secretary shall adopt rules and regulations to carry out the provisions of this act.

Sec. 4. This act shall take effect and be in force from and after its publication in the Kansas register.

Attm. # 3

2-24-86

Hs. PHW

attm. #4
2-24-86

TO: Public Health and Welfare Committee - 1986

FROM: Byron M. Fry, M.S., A.T.R.--President Kansas Art Therapy Association

DATE: 24 February 1986

SUBJECT: House Bill Number 2498

At this point in time, our organization cannot support the efforts of our occupational therapy colleagues in regard to House Bill 2498. We believe that this bill if passed will set a precedent that the State will later regret. The precedent that I am addressing is that of separately credentialing organizations that have an overlap of services.

However, if licensure in your judgement is deemed to be the appropriate level of credentialing for the states Occupational Therapists then we believe there are many other providers which should be licensed as well, due to the overlap of services that exist among providers. After all, the primary agenda for licensure should be protection for the people. This includes the emotional health, safety and welfare as well as the physical health, safety and welfare for the people.

When I sat in on the review in which the occupational therapists presented their material before the special committee on public health and welfare on Tuesday, October 15 of last year and again heard testimony on 2498 last Wednesday, February 19, 1986, there were several inquiries from the special committee in October as well as this body as to whether or not overlap of services exist between physical therapists and occupational therapists. Strangly enough from my point of view, there were no inquiries about overlap among other existing services. This led me to conclude that the question of licensure in this case is an issue that impacts on more people than I believe the committee is aware of.

These other people and professional health care providers include art therapy, which I represent, horticultural therapy, dance movement therapy, physical therapy, music therapy, psychodrama, recreation therapy, special education and others. In this regard, I listened with interest last week when the representative asked about the term occupational therapy, so I looked it up myself. Occupational therapy is therapy by means of activity, ("purposeful activities," as the occupational therapists have stated that have come before this body,) especially creative activity prescribed for its effect in promoting recovery or rehabilitation. I stand before you today to tangibly represent the "purposeful activities" of art. Art Therapists use the modality of Art as a tool to help people with learning disabilities, cognitive deficits, emotional problems, social dysfunction and physical limitation. Overlap does exist between the respective professions of art therapy and occupational therapy, and I suggest it exists among the other providers that I have mentioned as well.

Therefore, the Kansas Art Therapy Association believes that the state of Kansas should not credential these related health occupations separately but work more actively on the concept of coordinating licensure for all related therapies. This has been done in the states of Virginia and Florida. Perhaps the issue of overlap which has been brought to my awareness through HB 2498 should be referred to the staff of public health and welfare for further study and

attm. #4
2-24-86
Hs. PHW

proposals. We would urge such a body to consider more difinitive language that would create a separate umbrella regulatory agency which would handle the credentialing of ancillary health care personnel where a good amount of overlap of service exists. The Kansas Art Therapy Association feels that such language would save tax money in that separate boards would not have to be created for each ancillary health care provider. In addition and perhaps more importantly we believe this language would actually promote numerous ancillary health care providers to work together rather than at cross purposes.

Lastly, the Kansas Art Therapy Association would like to express its awareness and appreciation to the committee for its work on House Bill 2663. We believe that the 2663 language addresses concerns that we had earlier raised in regard to the bill before us today (HB 2498). However, we feel more can be done around the issue of overlap of services.

I want to thank the committee for consideration of the points that I have raised today. The Kansas Art Therapy Association appreciates the opportunity to have input into this process.

: an occurrence or condition that brings something about; *esp* : the immediate inciting circumstance as distinguished from the fundamental cause <his insulting remark was the ~ of a bitter quarrel> 4 **a** : HAPPENING, INCIDENT **b** : a time at which something happens 5 **a** : a need arising from a particular circumstance **b** *archaic* : a personal want or need — usu. used in pl. 6 *pl* : AFFAIRS, BUSINESS 7 : a special event or ceremony : CELEBRATION *syn* see CAUSE — **on occasion** : from time to time

²occasion *vt* **oc·ca·sioned; oc·ca·sion·ing** \-'kāzh-(ə-)niŋ\ : to bring about : CAUSE

oc·ca·sion·al \-'kāzh-nəl, -ən-ᵊl\ *adj* 1 : of or relating to a particular occasion <a budget able to meet ~ demands as well as regular ones> 2 : acting as the occasion or contributing cause of something 3 : composed for a particular occasion <~ verse> 4 : met with, appearing, or occurring at irregular or infrequent intervals <~ visitors> <takes an ~ vacation> 5 : acting in a specified capacity from time to time 6 : designed or constructed to be used as the occasion demands <~ furniture>

oc·ca·sion·al·ly \-ē\ *adv* : now and then : SOMETIMES

Oc·ci·dent \'äk-səd-ənt, -sə¬dent\ *n* [ME, fr. MF, fr. L *occident-, occidens*, fr. prp. of *occidere* to fall, set (of the sun)] : WEST 2a

oc·ci·den·tal \ˌäk-sə-'dent-ᵊl\ *adj, often cap* 1 : of, relating to, or situated in the Occident : WESTERN 2 : of or relating to Occidentals — **oc·ci·den·tal·ly** \-ᵊl-ē\ *adv*

Occidental *n* : a member of one of the occidental peoples; *esp* : a person of European ancestry

Oc·ci·den·tal·ism \ˌäk-sə-'dent-ᵊl¬iz-əm\ *n* : the characteristic features of occidental peoples or culture

oc·ci·den·tal·ize \-ᵊl¬īz\ *vt* **-ized; -iz·ing** *often cap* : to make occidental (as in culture)

oc·cip·i·tal \äk-'sip-ət-ᵊl\ *adj* : of or relating to the occiput or the occipital bone — **occipital** *n* — **oc·cip·i·tal·ly** \-ᵊl-ē\ *adv*

occipital bone *n* : a compound bone that forms the posterior part of the skull and bears a condyle by which the skull articulates with the atlas

occipital condyle *n* : an articular surface on the occipital bone by which the skull articulates with the atlas

occipital lobe *n* : the posterior lobe of the cerebral hemisphere that bears the visual areas and has the form of a 3-sided pyramid

oc·ci·put \'äk-sə-(ˌ)pət\ *n, pl* **occiputs** *or* **oc·cip·i·ta** \äk-'sip-ət-ə\ [L *occipit-, occiput*, fr. *ob-* against + *capit-, caput* head — more at OB-, HEAD] : the back part of the head or skull

oc·clude \ə-'klüd, ä-\ *vb* **oc·clud·ed; oc·clud·ing** [L *occludere*, fr. *ob-* in the way + *claudere* to shut, close — more at CLOSE] *vt* 1 : to stop up : OBSTRUCT <a thrombus *occluding* a coronary artery> 2 : PREVENT, HINDER 3 : SORB 4 : to cut off from contact with the surface of the earth and force aloft by the convergence of a cold front on a warm front <*occluded* warm air> ~ *vi* 1 : to close with the cusps fitting together <his teeth do not ~ properly> 2 : to become occluded — **oc·clud·ent** \-'klüd-ᵊnt\ *adj* — **oc·clu·sive** \-'klü-siv, -ziv\ *adj*

occluded front *n* : OCCLUSION 2

oc·clu·sal \ə-'klü-səl, ä-, -zəl\ *adj* : of or relating to the grinding or biting surface of a tooth or to occlusion of the teeth

oc·clu·sion \ə-'klü-zhən\ *n* [prob. fr. (assumed) NL *occlusion-, occlusio*, fr. L *occlusus*, pp. of *occludere*] 1 : the act of occluding : the state of being occluded: as **a** : the complete obstruction of the breath passage in the articulation of a speech sound **b** : the bringing of the opposing surfaces of the teeth of the two jaws into contact; *also* : the relation between the surfaces when in contact **c** : the inclusion or sorption of gas trapped during solidification of a material 2 : the front formed by a cold front overtaking a warm front and lifting the warm air above the earth's surface

¹oc·cult \ə-'kəlt, ä-\ *vb* [L *occultare*, fr. *occultus*, pp.] *vt* 1 : to hide from sight : CONCEAL 2 : to conceal by occultation ~ *vi* : to become concealed or extinguished — **oc·cult·er** *n*

²oc·cult \ə-'kəlt, ä-; 'äk¬əlt\ *adj* [L *occultus*, fr. pp. of *occulere* to cover up, fr. *ob-* in the way + *-culere* (akin to *celare* to conceal) — more at OB-, HELL] 1 : not revealed : SECRET 2 : not easily apprehended or understood : ABSTRUSE 3 : not able to be seen or detected : CONCEALED 4 : of or relating to the occult 5 : not manifest or detectable by clinical methods alone <~ carcinoma>; *esp* : not present in macroscopic amounts — **oc·cult·ly** *adv*

³occult *like*²\ *n* : matters regarded as involving the action or influence of supernatural agencies or some secret knowledge of them — used with *the*

oc·cul·ta·tion \äk-(ˌ)əl-'tā-shən\ *n* 1 : the state of being hidden from view or lost to notice : ECLIPSE 2 : the shutting off of the light of one celestial body by the intervention of another; *esp* : an eclipse of a star or planet by the moon

oc·cult·ism \ə-'kəl¬tiz-əm, ä-; 'äk¬əl-\ *n* : occult theory or practice : belief in or study of the action or influence of supernatural powers — **oc·cult·ist** \-təst\ *n*

oc·cu·pan·cy \'äk-yə-pən-sē\ *n, pl* **-cies** 1 : the act of taking and holding possession 2 **a** : the act of becoming an occupant : the state of being an occupant **b** : the condition of being occupied 3 : the use to which property is put <industrial ~> 4 : an occupied building or part of a building (as an apartment or office)

oc·cu·pant \-pənt\ *n* 1 : one who acquires title by occupancy 2 : one who occupies a particular place; *esp* : RESIDENT

oc·cu·pa·tion \äk-yə-'pā-shən\ *n* [ME *occupacioun*, fr. MF *occupation*, fr. L *occupation-, occupatio*, fr. *occupatus*, pp. of *occupare*] 1 **a** : an activity in which one engages <in the first three grades learning to read is perhaps the major ~ of the pupil —J. B. Conant> **b** : the principal business of one's life : VOCATION 2 **a** : the possession, use, or settlement of land : OCCUPANCY **b** : the holding of an office or position 3 **a** : the act or process of taking possession of a place or area : SEIZURE **b** : the holding and control of an area by a foreign military force **c** : the military force occupying a country or the policies carried out by it

oc·cu·pa·tion·al \-shnəl, -shən-ᵊl\ *adj* 1 : of, relating to, or resulting from a particular occupation <~ hazards> 2 : of or relating to a military occupation — **oc·cu·pa·tion·al·ly** \-ē\ *adv*

occupational therapy *n* : therapy by means of activity; *esp* : creative activity prescribed for its effect in promoting recovery or rehabilitation — **occupational therapist** *n*

oc·cu·py \'äk-yə¬pī\ *vt* **-pied; -py·ing** [ME *occupien* to take possession of, occupy, modif. of MF *occuper*, fr. L *occupare*, fr. *ob-* toward + *-cupare* (akin to *capere* to seize) — more at OB-, HEAVE] 1 : to engage the attention or energies of 2 : to fill up (an extent in space or time) 3 : to take or hold possession of 4 : to reside in as an owner or tenant — **oc·cu·pi·er** \¬pī(-ə)r\ *n*

oc·cur \ə-'kər\ *vi* **oc·curred; oc·cur·ring** \-'kər-iŋ\ [L *occurrere*, fr. *ob-* in the way + *currere* to run — more at OB-, CURRENT] 1 : to be found or met with : APPEAR 2 : to take place 3 : to come to mind *syn* see HAPPEN

oc·cur·rence \ə-'kər-ən(t)s, -'kə-rən(t)s\ *n* 1 : something that takes place usu. unexpectedly and without design <a startling ~> 2 : the action or process of happening <the repeated ~ of petty theft in the locker room>

syn OCCURRENCE, EVENT, INCIDENT, EPISODE, CIRCUMSTANCE, HAPPENING *shared meaning element* : something that happens or takes place

¹oc·cur·rent \ə-'kər-ənt, -'kə-rənt\ *adj* [MF, fr. L *occurrent-, occurrens*, prp. of *occurrere*] 1 : occurring at present : CURRENT 2 : INCIDENTAL

²occurrent *n* : something that occurs as distinguished from something that continues to exist

OCDM *abbr* Office of Civil and Defense Mobilization

ocean \'ō-shən\ *n* [ME *ocean*, fr. L *oceanus*, fr. Gk *Ōkeanos*, a river thought of as encircling the earth, ocean] 1 : the whole body of salt water that covers nearly three fourths of the surface of the globe 2 : one of the large bodies of water into which the great ocean is divided 3 : an unlimited space or quantity

ocean·ar·i·um \ō-shə-'nar-ē-əm, -'ner-\ *n, pl* **-iums** *or* **-ia** : a large marine aquarium

ocean·front \'ō-shən¬frənt\ *n* : an area that fronts on the ocean

ocean·go·ing \¬gō-iŋ\ *adj* : of, relating to, or designed for travel on the ocean

oce·an·ic \ō-shē-'an-ik\ *adj* 1 : of, relating to, produced by, or frequenting the ocean and esp. the open sea as distinguished from littoral or neritic waters 2 : VAST, GREAT

Oce·anid \ō-'sē-ə-nəd\ *n* [Gk *ōkeanid-, ōkeanis*, fr. *Ōkeanos* Oceanus] : any of the ocean nymphs that are daughters of Oceanus and Tethys according to Greek myth

oceanog *abbr* oceanography

ocean·og·ra·phy \ˌō-shə-'näg-rə-fē\ *n* [ISV] : a science that deals with the oceans and includes the delimitation of their extent and depth, the physics and chemistry of their waters, marine biology, and the exploitation of their resources — **ocean·og·ra·pher** \-fər\ *n* — **ocean·o·graph·ic** \-nə-'graf-ik\ *also* **ocean·o·graph·i·cal** \-i-kəl\ *adj* — **ocean·o·graph·i·cal·ly** \-i-k(ə-)lē\ *adv*

ocean·ol·o·gy \ˌō-shə-'näl-ə-jē\ *n* : OCEANOGRAPHY; *specif* : the science of marine resources and technology — **ocean·o·log·ic** \-nə-'läj-ik\ *or* **ocean·o·log·i·cal** \-i-kəl\ *adj* — **ocean·o·log·i·cal·ly** \-i-k(ə-)lē\ *adv* — **ocean·ol·o·gist** \-'näl-ə-jəst\ *n*

ocean sunfish *n* : a large deep-bodied truncated marine fish (*Mola mola*) of warm and temperate seas

Oce·anus \ō-'sē-ə-nəs\ *n* [L, fr. Gk *Ōkeanos*] : a river in Greek mythology that encircles the earth and is personified as a Titan who is the progenitor with Tethys of the gods

ocel·lat·ed \'ō-sə¬lāt-əd, ō-'sel¬āt-\ *or* **ocel·late** \'ō-sə¬lāt, ō-'sel-ət\ *adj* 1 : having ocelli 2 : resembling an ocellus — **ocel·la·tion** \ˌō-sə-'lā-shən\ *n*

ocel·lus \ō-'sel-əs\ *n, pl* **ocel·li** \-'sel¬ī, -(ˌ)ē\ [NL, fr. L, dim. of *oculus* eye — more at EYE] 1 : a minute simple eye or eyespot of an invertebrate 2 : a spot of color encircled by a band of another color — **ocel·lar** \ō-'sel-ər\ *adj*

oce·lot \'ās-ə-lät, 'ō-sə-\ *n* [F, fr. Nahuatl *ocelotl* jaguar] : a medium-sized American wildcat (*Felis pardalis*) that ranges from Texas to Patagonia and has a tawny yellow or grayish coat dotted and striped with black

ocher *or* **ochre** \'ō-kər\ *n* [ME *oker*, fr. MF *ocre*, fr. L *ochra*, fr. Gk *ōchra*, fr. fem. of *ōchros* yellow] 1 : an earthy usu. red or yellow and often impure iron ore used as a pigment 2 : the color of ocher; *esp* : the color of yellow ocher — **ocher·ous** \'ō-k(ə-)rəs\ *or* **ochre·ous** \'ō-k(ə-)rəs, -krē-əs\ *adj*

och·loc·ra·cy \ä-'kläk-rə-sē\ *n* [Gk & MF; MF *ochlocratie*, fr. Gk *ochlokratia*, fr. *ochlos* mob + *-kratia* -cracy] : government by the mob : mob rule — **och·lo·crat** \'äk-lə¬krat\ *n* — **och·lo·crat·ic** \ˌäk-lə-'krat-ik\ *or* **och·lo·crat·i·cal** \-i-kəl\ *adj*

-ock \ək, ik, äk\ *n suffix* [ME *-oc*, fr. OE] : small one <hill*ock*>

Ock·ham's razor \'äk-əmz-\ *n* : OCCAM'S RAZOR

o'clock \ə-'kläk\ *adv* [contr. of *of the clock*] 1 : according to the clock <the time is three ~> 2 — used for indicating position or direction as if on a clock dial that is oriented vertically or horizontally <an airplane approaching at six ~>

oco·ti·llo \ˌō-kə-'tē-(ˌ)(y)ō\ *n, pl* **-llos** [MexSp] : a thorny scarlet-flowered candlewood (*Fouquieria splendens*) of the southwestern U.S. and Mexico

OCR *abbr* optical character reader; optical character recognition

OCS *abbr* officer candidate school

oct *abbr* octavo

Oct *abbr* October

octa- *or* **octo-** *also* **oct-** *comb form* [Gk *okta-, oktō-, okt-* (fr. *oktō*) & L *octo-, oct-*, fr. *octo* — more at EIGHT] : eight <*octa*merous> <*octa*ne> <*octo*roon>

oc·ta·gon \'äk-tə¬gän\ *n* [L *octagonum*, fr. Gk *oktagōnon*, fr. *okta-* + *-gōnon* -gon] : a polygon of eight angles and eight sides — **oc·tag·o·nal** \äk-'tag-ən-ᵊl\ *adj* — **oc·tag·o·nal·ly** \-ᵊl-ē\ *adv*

oc·ta·he·dral \ˌäk-tə-'hē-drəl\ *adj* 1 : having eight plane faces 2 : of, relating to, or formed in octahedrons — **oc·ta·he·dral·ly** \-drə-lē\ *adv*

oc·ta·he·dron \-drən\ *n, pl* **-drons** *or* **-dra** \-drə\ [Gk *oktaedron*, fr. *okta-* + *-edron* -hedron] : a solid bounded by eight plane faces

oc·tal \'äk-tᵊl\ *adj* : of, relating to, or being a number system with a base of eight

Payment of Occupational Therapy by Legislative Mandate

(Connecticut statutes for coverage, marketing, reimbursement)

Irene L. Herden

This article reviews the process that the Council on Government Affairs of the Connecticut Occupational Therapy Association undertook from 1979 to 1982 to obtain payment mandated by legislation for occupational therapy. The process included learning the Connecticut legislative system, marketing occupational therapy as a profession in the health arena, and coordinating, planning, and communicating all phases of activity to reach a final objective of mandated payment.

Machiavelli, the alleged master of political intrigue, noted, "There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things." (1) To establish a new order of things in Connecticut, occupational therapists had to enter the political and economic systems on a local level. They also had to interrupt a "Catch 22" syndrome: Consumers do not receive occupational therapy, therefore the value and need for occupational therapy is not recognized, and demand decreases.

The Government Affairs Council of the Connecticut Occupational Therapy Association sought to have occupational therapy recognized as a vital part of the health care system, fully entitled to reimbursement, and worthy of the professional recognition afforded other health care providers. In 1982 the Council succeeded when the state legislature enacted a law requiring third party payers to pay for occupational therapy services on an equal basis with physical therapy. The statute did not address reimbursement by Medicare, Medicaid, or other state entitlements, but it required Connecticut Blue Cross/Blue Shield (BC/BS) and other Connecticut commercial health insurance providers to pay occupational therapists for therapy rendered.

The Problem

Payment for occupational therapy services was a major issue for three reasons. First, we were concerned about the welfare and quality of life of Connecticut citizens for whom the availability of treatment was restricted when an illness resulted in physical and/or emotional debilitation.

The other two reasons were economic factors that hindered the growth and development of the profession: the lack of an assured mechanism for payment and institutions that did not identify occupational therapy as paying for itself.

During a health-related crisis, consumers may not be fully aware of the appropriate treatment and health care services available. They therefore rely on physicians for direction. Also, physicians generally seek and prescribe treatment and services that are familiar to them, are readily available, are easily accessible to the consumer, and, if possible, are not a financial burden to the client. Therefore, if readily established reimbursement mechanisms for occupational therapy services do not exist, physicians will not prescribe them or substitute alternative therapies.

In Connecticut, patients who were discharged from a hospital or who had a chronic debilitating illness were unable to receive occupational therapy. Although occupational therapy might have been initiated during hospitalization and the discharge plan had identified the continuation of therapy as a need, most community agencies and providers were unable to offer occupational therapy, chose not to offer it, or substituted an alternative therapy to the discharge plan.

Lack of an available and an as-

Irene L. Herden, OTR/L, FAOTA, is Supervising OT/PT Consultant, Monitoring and Evaluation Unit, Connecticut Department of Health Services, Hartford, CT 06115.

Table 1
Breakdown of Coverage for the Population of Connecticut in 1980

Blue Cross/Blue Shield (BC/BS)	1,500,000	51%	(3)
Commercial Insurance	726,000	22%	(3)
Medicaid (Title XIX)	225,000	8%	(4)
Medicare (Title XVIII)	365,000	11%	(4)
No Coverage	264,000	8%	

sured mechanism for payment also restricted occupational therapy programs in some psychiatric day treatment programs, extended care facilities, and in all convalescent and nursing homes. Consequently consumers were unable to obtain complete and appropriate treatment for their disabilities in the environment most suited to their immediate need, and they could not develop adequate potential to attain a suitable lifestyle. Further, therapists could work only in institutions that had identified programs. This meant they could not provide comprehensive therapy programs to patients once they were discharged from inpatient status, and therapists were unable to enter private practice because payment on a fee-for-service basis was not available.

Finally, institutions, primarily hospitals, did not identify occupational therapy as paying for itself, which left a department vulnerable in times of a budget reduction. Occupational therapists often worked in programs where treatments were paid as physical therapy, which ensured the institution of obtaining reimbursement, but did not identify occupational therapy as part of the institution's services.

It became clear to us in Connecticut that occupational therapists needed to increase needy consumers' demand for treatment, and to ensure reimbursement for services rendered.

Historical Perspective

With the advent of Medicare in 1965 and the ensuing importance of medical insurance coverage, fee-for-service has been the dominant form of payment. Insurance providers were aware that licensing a health professional was the acceptable, legal method of determining what constituted a responsible profession. Therefore, the need to be identified within Connecticut as an individual, independent, licensed provider was a requirement for receiving payment, or a fee-for-service. Furthermore, Medicaid information indicated that a state could determine eligibility for payment of a service by requiring the provider to be licensed (2).

For occupational therapists in Connecticut, the action plan included two goals: to ensure their identification as professionals by enacting a licensure for occupational therapists; and to obtain payment of services from third party payers through amending the Connecticut insurance code mandating coverage for occupational therapy services.

In 1978 the Connecticut Occupational Therapy Association successfully completed their first goal. Public Act 78-253 was signed into law. This article will describe how the second goal was achieved.

Status of Medical Coverage in Connecticut

To ensure credibility in the pursuit of third party payment for occupational therapy services, it was necessary to identify the status of health coverage in occupational therapy. As of 1980, the population in Connecticut was approximately 3.3 million, of whom 3 million had health/medical insurance coverage, however minimal. The breakdown of coverage is shown in Table 1 (3,4).

This information indicates that if payment for occupational therapy services at all levels of care could be obtained from BC/BS and commercial insurers, 73 percent of the Connecticut population would have access to occupational therapy services upon need.

Phase 1: Marketing Occupational Therapy. There were five phases involved in obtaining third party payment, the first of which was to market occupational therapy. The objectives of this strategy were the following:

(1) to define occupational therapy and its role vis-a-vis physical therapy, since this was the most frequently requested point of clarification by lay and professionals;

(2) to increase awareness of occupational therapy by identifying its nature and scope of practice and its uniqueness as a health profession; and

(3) to provide to third party payers a unified interpretation of treatment and function relative to occupational therapy practice.

Discussion with insurance claims persons revealed that they were unable to discern what effective treatment activities were, and this affected their attempts to make appropriate decisions regarding the effectiveness of the therapy intervention.

The Government Council chose a proactive rather than a defensive stance by developing a brochure that identified what occupational therapists do (5). This was to help other allied health professionals and lay persons to interpret better the responsibilities of occupational therapy. Also, it emphasized how a disabled person's quality of life could be enhanced through skills gained in a treatment program provided by an occupational therapist. Finally, it presented the nature and the type of disabilities that therapists treat, and the purpose of each area of treatment was followed by a case presentation

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that could be readily understood by both professionals and nonprofessionals.

The following six skill areas were selected for illustrating settings where occupational therapists practice: (1) developmental; (2) psychosocial; (3) self-care or activities of daily living; (4) physical; (5) work; and (6) elimination of barriers to functional skills. Specific techniques to promote each skill area were addressed.

Another brochure was developed to detail the terminology generally used by therapists (6). It was an abbreviated version of AOTA's Uniform Reporting System (7). The brochure described categories by which third party payers could identify the specific areas of expertise that can be expected from occupational therapists.

Both brochures were used with other professionals. They were also presented to third party payers to assist in explaining occupational therapy costs and benefits in a readable format.

Phase 2: Inclusion in Available Health Insurance. In 1976, the National Association of Insurance Commissioners adopted a resolution recommending the inclusion of occupational therapy in health care policies. However, this resolution appeared to have little impact in Hartford, Connecticut, the acknowledged "Insurance Capital of the United States." A spokesperson for the Insurance Association of Connecticut contended that this inclusion would increase costs to the people of Connecticut for health coverage and encourage an uncontrolled spiraling of health costs.

A few commercial insurers were contacted regarding coverage, added costs, and procedures for occupational therapy given in nonhospital settings. Prudential Insurance Company, the largest commercial health insurance provider in the United States, was asked to identify whether or not the inclusion of occupational therapy in their group major medical plans had increased costs or usage. Their claims consultant indicated that inclusion of occupational therapy on an outpatient basis was based on the rationale that lower rehabilitation costs would result (8), and this would prove to be both beneficial and desirable to policyholders. A telephone conversation revealed that the cost of claims for occupational therapy was miniscule, and, therefore, any concern regarding increased health care costs was not warranted.

Aetna Life and Casualty included coverage of occupational therapy as part of a group major medical and comprehensive plan. Although statistical data were not available nationwide, a review of one of their larger group policies revealed that charges for occupational therapy were less than 1 percent of total covered expenses and that changes in utilization had been relatively stable over a period of time (9). For health care reimbursement, Aetna did not require prior approval provided these guidelines were followed:

1. A medical referral must be made.
2. A medical review must be done every three months.
3. Progress must be consistently documented.

A representative from Connecticut General Life Insurance stated that they neither specifically included nor would they exclude occupational therapy. They would cover costs to restore important body function (10). It was not clear whether they required prior approval. Further contact with agencies that had a majority of clients having group coverage with Connecticut General revealed an inconsistency in the acceptance or rejection of claims for occupational therapy treatment.

Blue Cross/Blue Shield, the provider of health insurance to the majority of Connecticut residents, did not cover occupational therapy as a separate service, but did as part of physical therapy or rehabilitation. They also established agreements with selected agencies in which occupational therapy was reimbursable. However, it was not clear whether the therapy was identified as occupational therapy upon application for reimbursement.

Information about the costs of including occupational therapy in health insurance contracts by commercial, nonprofit, and/or federal and state third party reimbursers was meager, and attempts to clarify costs were problematic. Occupational therapy was frequently not identified as a separate service, but was usually included in a global service component, such as rehabilitation or psychiatric treatments. Also, third party payers who presently reimbursed occupational therapy through group policies were unable to identify the costs of such inclusion. Finally, data collection of costs by third party payers focused on hospital length-of-stay and physician fee-for-service. Therefore, data regarding occupational therapy services were not available.

Phase 3: Survey of Occupational Therapy Payments. Since it was not clear how occupational therapists were being reimbursed, we con-

ducted a survey of 35 facilities in Connecticut providing occupational therapy to identify their existing rationale and methods of payment. From the few facilities that responded, we found that inpatient programs were reimbursed by Blue Cross, Medicaid, Medicare, and commercial policies that specifically included occupational therapy and/or physical therapy. After further discussion with therapists, however, it became apparent that the occupational therapy services being reimbursed were probably identified as rehabilitation or physical therapy. This appeared to be consistent with a Blue Cross policy rescinded shortly after its publication, which stated that specific treatments provided by an occupational therapist would be paid as physical therapy (11).

To obtain more specific information, a second survey was conducted over a two-year period of the same 35 facilities. The intent was to identify the availability of outpatient occupational therapy to patients who needed treatment (12). These findings were shared with the Insurance and Real Estate Commission via the Joint Committee on Legislative Management (13). The results identified treatments relative to age groups and disability areas; showed the specific places of treatment, that is, outpatient facilities, home care agencies, or psychiatric day treatment centers; and provided information regarding length of treatment and approximate costs. The survey did not ascertain the number and type of clients who were unable to receive occupational therapy due to lack of sufficient funds.

Phase 4: Proposal for Mandated Occupational Therapy Coverage. After holding discussions with a member of the insurance commissioner's office, the claims director of an insurance company that provided health coverage, and the co-chair of the Public Health Committee of the Connecticut legislature, we concluded that commercial and nonprofit health insurers would continue to procrastinate about the inclusion of occupational therapy in their basic policies. We decided to develop a proposed bill that would require occupational therapy services to be reimbursed by health insurance companies in policies written within the state of Connecticut.

There were three previous state statutes that identified precedents for mandating payment of health services. One included a professional group. The second was an agency program with restrictions on the number of treatments given. The third statute identified comprehensive health programs with a mandated minimum amount of benefits and dollar value.

The demonstration of a medical/health need, that is, physician prescription and referral for treatment and routine review of plan of care by a physician, was the essential element of the proposal. Also included in the bill were all types of customary practice areas where occupational therapy was generally rendered.

The problems of occupational therapy service delivery in mental health and learning disabilities were not directly addressed. Many legislators were apprehensive about mandated coverage of mental health because of various interpretations and coverage offered by insurance providers under global psychiatric treatment. Treatment for learning disability also was not included in the bill because it was a controversial area. Medicaid and commercial insurers were not willing to cover treatment for this disability after the enactment of P.L. 94-142, the Education of All Handicapped Children Act, and Connecticut's special education state statute, P.L. 10-76A.

The bill also addressed the need identified by legislative leaders to place a "cap" on services. We chose to limit the number of treatments rather than fix a dollar amount. The number "50" appeared to cover adequately most physical disability needs identified in our two-year survey, but only 74 percent of the mental disability needs.

Our bill had the following three advantages:

1. It indicated that occupational therapy would be mandated in all areas of practice including inpatient hospital programs and in skilled and intermediate care facilities.
2. It indicated that occupational therapy services would be reimbursed directly rather than be included under the "umbrella" of rehabilitation or being identified as physical therapy. This would afford therapists an opportunity to reinforce the value of their programs administratively, not only in relation to client outcome, but also as a financial resource to the facility.
3. It provided for coverage of occupational therapy as a direct service in a partial hospitalization program, which was relevant to the psychiatric day treatment programs.

Phase 5: The Legislative Effort. It took three legislative sessions to enact our bill. Between the first and second sessions, we began to

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doubt the feasibility of challenging insurance providers in a state known for its insurance companies. Two action plans were essential to achieving success. The first was the orientation and mobilization of occupational therapists and consumers to assist effectively on a local level and to become re-educated to the legislative process. The second plan was to spend time with legislators, who from the previous experience understood our concerns and would support our efforts to increase the knowledge and awareness of occupational therapy and its importance to consumer needs.

The initial mobilization of and communication with occupational therapists, other professionals, and consumers was accomplished by developing an information packet. The packet included a copy of the proposed bill, identification of the general strategy we planned to use, the details of a letter writing campaign, the proposed timing and tentative outline for public hearings, a method of contacting legislators by telephone accompanied by conversational guidelines, and responses to probable questions.

Another information packet was prepared for individuals who would be participating in a public hearing. Consumer involvement, both in public hearings and as part of a comprehensive lobbying effort, is extremely effective. The packet included an outline of how we planned to "stage" the hearing; a detailed explanation of what, why, and how such a legislative mandate would be beneficial to the practice of occupational therapy; and collected excerpts, comments, and other information that supported the bill and detailed the prospective gain from successful passage of the legislation. Whenever possible, we arranged for a member of the Government Affairs Council to be a contact and support person for the individual who volunteered to speak at the public hearing.

In addition to our occupational therapy colleagues, we introduced the proposed bill to other allied health professionals, briefly stated our cause, and asked for their support. Health professionals who might be less supportive to our effort were personally contacted. If they were unable to support our bill, we tried to diminish their active lobbying against it by clarifying and documenting our position.

To work effectively with legislators a wide variety of information tools needed to be available. These included documentation of the bill's impact on the citizens of the state, financial implications of the bill, and information about the nature and scope of occupational therapy and its uniqueness as a health profession. Also, the AOTA calendars were used at the beginning of the calendar and legislative year. Various factsheets and resource materials were developed that identified key elements, issues, problems, and quality of life needs.

Rapport with, support of, and accessibility to the cochairs and committee members where the bill was initiated were critical. The presentation of a position paper to the committee identifying the status and present methods of reimbursement was also effective (14). The cochairs' request for definitive information from insurance providers regarding the costs of additional benefits on availability versus mandated coverage provided facts that had a positive impact. Blue Cross/Blue Shield estimated that monthly costs for available coverage would be $.03 per individual and $.04 per family, and costs for mandated coverage would be $.02 per individual and $.03 per family (15). The commercial insurers could not give any specific estimates.

The public hearing in the legislative process is critical because it aligns the consumer with the professional in achieving similar ends, which increases legislators' understanding of the issues in the bill. The issues consistently reinforced in the hearings were:

1. Inclusion of occupational therapy reimbursement was needed.
2. Inclusion carried the potential of long-range money savings for both consumer and state resources.
3. Inclusion would not increase total health care costs.
4. The availability inclusion was not a feasible alternative to mandated inclusion.

Once one has a debilitating injury or illness that interferes with one's lifestyle, it is a little late to become insured.

Further, the public hearing permits issues to be personalized by the speakers, such as patients or patient-related consumers, or health and allied health professionals. Subjective statements relating to excess personal costs, ineffective continuity of care, inability to maximize one's potential for daily living skills, and inability to improve one's quality of life effectively and efficiently were all related concretely and realistically.

After the public hearing the bill went into legislative committee, and we hoped to receive a favorable report. We concentrated on

the committee chairs because only with their support is it possible to get a bill out of committee. We also polled favorable and negative responses from the committee members to help in the timing of the desired committee decision. Questions arose on whether to compromise on different aspects of the bill, that is, which areas were open or closed to negotiation. The available options were to remain with the proposed bill as written, to compromise on points that would not deter from the final goal, or to withdraw the proposed bill if changes contemplated would not be in the best interest of consumers or the profession.

Throughout the legislative session, the progress of the bill had to be tracked and monitored. The tactic we found most effective was to concentrate first on the committee chairs, second on the committee members, and then on the leadership of the General Assembly. Next we concentrated on the elected members of the House and Senate, depending on where the initial vote was to occur. Simultaneously, we asked therapists who resided or worked in critical constituencies to contact the influential members of the House or Senate by writing letters, talking directly, or telephoning. The number of letters and contacts are important to the legislators.

The use of selected lobbyists during our final effort was beneficial, not only because of their ability to empathize with consumer-oriented issues and our professional dilemma, but also because of their expertise in relating to legislators. They initiated discussion with legislators, shared the legislative responses with us, and offered support and guidance to our lobbying efforts. Their lobbying, when combined with ours, swayed many legislators to our viewpoint.

Table 2
Present Coverage for Occupational Therapy by Insurance Providers of Connecticut (1982)

A. **Blue Cross/Blue Shield:**
   1. There is no change in basic medical coverage during hospitalization.
   2. After hospitalization, 30 treatments are available for outpatient services (shared by physical therapy/occupational therapy).
   3. Nonhospitalized clients seeking treatment, referred by a physician, are eligible for $500 coverage shared with *many* other health services; for example, physical therapy/occupational therapy, lab procedures, appliances, and miscellaneous procedures.

B. **Major Medical** (dependent on individual contract):
   1. Most policies have a dollar deductible and then the remainder portion is coshared; for example, 80% insurance company/20% policy holder.
   2. The majority of these policies have unlimited coverage.
   3. Most group contracts have basic medical and major medical: once the basic medical treatments are exhausted, the client should seek unlimited coverage through major medical.

C. **Home Care** (Sec. 38-144K, all contracts issued in the state have included Home Health Care coverage):
   1. Patients discharged from the hospital with a physician referral for home care are eligible for coverage. This means 80 visits are shared by nursing; physical therapy and occupational therapy; and home health aides and speech therapy. This applies to people not covered by Medicare.

The Effect of Mandated Coverage

As a result of the enactment of Connecticut Statute, Chapter 681, Section 38-174q (PA 82-148), occupational therapists working in all types of health care facilities and in private practice in Connecticut may be reimbursed for services rendered on those hospital or medical expense insurance policies written in Connecticut only.

By statute an occupational therapist is identified as a provider of treatment eligible for fee-for-service on an equal basis with a physical therapist. Since some physical therapists were concerned by this exchange concept, we clarified the effect of this mandate before the bill proceeded to the General Assembly. The major medical policies of six commercial companies we contacted generally have unlimited coverage for therapy services during a lifetime. Blue Cross/Blue Shield's basic policy limits the number of allowable treatments that require sharing equally with physical therapy on an outpatient status. If extensive treatments are required, one would move from basic medical coverage to major medical coverage shortly after hospitalization. Since this puts limitations on consumers who have basic health care coverage only, we attempted to have BC/BS increase the number of therapy treatments available in the basic health policy, to no avail.

The impact of this statute and its application for payment by commercial and nonprofit providers is summarized in Table 2.

Conclusion

The effect of this legislative effort from 1979 to 1982 reinforced the capacity of Connecticut occupational therapists to institute change for the betterment of the citizens of the state. Awareness of the need to market and sell occupational therapy became apparent and highlighted the business component of health, in which therapists need to be involved.

This legislative process also revealed the need for both state and the national associations to develop a mechanism to support common issues that benefit the profession financially and professionally. It is difficult for any state association to afford the total expense for issues and concerns of this magnitude by its membership dues only. Since this type of issue affects all practicing professionals,

the committee chairs because only with their support is it possible to get a bill out of committee. We also polled favorable and negative responses from the committee members to help in the timing of the desired committee decision. Questions arose on whether to compromise on different aspects of the bill, that is, which areas were open or closed to negotiation. The available options were to remain with the proposed bill as written, to compromise on points that would not deter from the final goal, or to withdraw the proposed bill if changes contemplated would not be in the best interest of consumers or the profession.

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some type of cooperative subsidization with the national association is warranted.

Without question, therapists in Connecticut have achieved a higher level of expertise in the political and legislative process. We have and will continue to demonstrate competency in our effort to improve our profession as well as our ability to mobilize and influence decisions that affect us both personally and professionally.

Acknowledgments

Appreciation is extended to the following persons who contributed to the success of the legislative venture and the completion of this article: Valnere McLean, OTR/L; Christine Bradshaw, OTR/L; Helen Pierce, OTR/L; Janet Tredwell, OTR/L; Phyllis Zimmer, OTR/L, Judy Pelletier, OTR/L; Frederick Klimowicz, OTR/L; Freida Luftglas, OTR/L; Valerie Center, OTR/L; Marli Cole Shiraldi, OTR/L; Jean Rubin, OTR/L; James Boyd, OTR/L; and Everett L. Herden, M.S., CAGS.

REFERENCES

1. Spiegal AD, Hyman HH: *Basic Health Planning Methods*. Germantown, MD: Aspen Systems Corporation, 1978, p 9
2. Deputy Commissioner, U.S. Dept of Health, Education and Welfare: personal communication, September 1977
3. Feldman R, Greenberg W: The relation between the Blue Cross market share and the Blue Cross "discount" on hospital charges. *Journal of Risk and Insurance*, pp 235-246
4. Plant E, Mike JC: Report of the Governor's Commission on Mental Health Insurance. Hartford, CT: State of Connecticut, 1980
5. Government Affairs Council: *Connecticut Occupational Therapists Give Quality to Life*. Norwich, CT: Connecticut Occupational Therapy Association, 1980
6. Government Affairs Council: "Occupational Therapy" modification from AOTA Task Force on Uniform Reporting System. Norwich, CT: Connecticut Occupational Therapy Association, January 1979
7. AOTA Task Force on Uniform Reporting Systems: Unpublished report. Rockville, MD: AOTA, January 1979
8. Senior claims consultant, Prudential Insurance Company of America, personal communication, October 8, 1981
9. Research analyst, Aetna Life and Casualty: personal communication, October 26, 1981
10. Regional claim director, Connecticut General: personal communication, October 29, 1981
11. Provider relations, Blue Cross of Connecticut: personal communication, October 7, 1976, January 25, 1977
12. Joint Committee on Legislative Management: *OLR Selected Report 80-36*. Hartford, CT: Office of Legislative Research, Connecticut General Assembly, March 12, 1980
13. Government Affairs Council: *Summary of Survey for Third Party Payment for Occupational Therapy*. Norwich, CT: Connecticut Occupational Therapy Association, February 1981
14. Government Affairs Council: Position paper (untitled). Norwich, CT: Connecticut Occupational Therapy Association, Fall 1981
15. Government relations director, Blue Cross, Blue Shield of Connecticut: personal communication, November 18, 1981

attm. #
2-24-86

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON HOUSE BILL 2498
PRESENTED TO THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE, FEBRUARY, 1986

This is the official position taken by the Kansas Department of Health and Environment on H.B. 2498.

BACKGROUND INFORMATION:

In 1982, the Kansas Department of Health and Environment received an application from the Kansas Occupational Therapy Association for review through the credentialing process (K.S.A. 65-5001 et. seq.). The application seeks to license by the state of Kansas the practice of occupational therapy. Proposed licensing would allow two levels of practice: 1) the occupational therapist level, consisting of engaging a client in purposeful activity in conjunction with therapeutic methods, to achieve identified goals; and 2) the occupational therapist assistant level, consisting of working under the direction of an occupational therapist.

The application has been reviewed according to K.S.A. 65-5001 et. seq. by a five member technical committee, the Statewide Health Coordinating Council (SHCC) and the Secretary of Health and Environment.

The technical committee, SHCC and the Secretary found that:

- The applicant has met Criterion 1 of the need for credentialing by demonstrating that the unregulated practice of occupational therapy can harm or endanger the health, safety, or welfare of the public and that the potential for such harm is recognizable and not remote or dependent upon tenuous agrument.

- The applicant has met Criterion 2 of the need for credentialing by demonstrating that occupational therapists require specialized skill and training, and they provided the public with the assurance of the initial and continuing ability necessary for the practice of occupational therapy.

- The applicant has met Criterion 3 of the need for credentialing by demonstrating that no other means other than credentialing exists to protect the public from harm by the practice of occupational therapy.

- Because all three criteria for the need for credentialing have been met according to the statutes, it is concluded that the need for credentialing of occupational therapists does exist in Kansas.

- Therefore, it is recommended that occupational therapist and occupational therapy assistants be licensed by the state of Kansas.

DEPARTMENT'S POSITION:

KDHE supports the provisions of H.B. 2498 which provides for the licensure of occupational therapists and assistants by the State Board of Healing Arts. The bill reflects the concerns and recommendations of the technical committee, SHCC, and the department.

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2-24-86

Presented by: Barbara J. Sabol, Secretary
Kansas Department of Health
and Environment

#6
2-24-86

TO: Public Health and Welfare Committee - 1986

FROM: Deborah C. Horning - Government Relations Committee Representative for the National Association for Music Therapy

DATE: February 24, 1986

SUBJECT: House Bill Number 2498 Regarding The Occupational Therapy Act

I have reviewed HB 2498, and I wish to testify against the passage of this bill. The language of this bill is too general and could be interpreted as giving occupational therapists more power and responsibilities if this bill is passed. This would have an adverse effect on other activity therapies, including music therapy, art, horticulture, recreation, dance and drama therapies. I feel the following changes in the language should be instituted, thereby making the bill specific to occupational therapy:

1. Re-word lines 0036 and 0037 to read: Administering and interpreting tests specific to Occupational Therapy that are necessary for effective treatment planning related to occupational therapy. The current language implies OT's being able to interpret any tests.

2. Add to line 42: "or adaptive equipment for self-care and daily living skills." The current language stops at adaptive equipment and does not specify for what use.

3. Delete line 0043 until further definition. Occupational Therapy is not the only discipline that utilizes sensory integration.

4. Delete lines 0044 and 0045 unless they are further defined and clarified. "Therapeutic activity" is too general, and could be interpreted to incorporate music activities.

5. Line 0046 needs further clarification. Other activity therapy disciplines implement prevocational programs.

6. Delete line 0047. The current language reads "play/leisure skills." This is not specific to occupational therapy.

7. Delete line 0048: "adapting environment for the disabled." Adapting environments is not specific to occupational therapy.

8. Section f, lines 0103-0108: add music therapists to this section. The current language lists nurses, physical therapists, clinical psychologists and social workers as professions of the healing arts. Music therapists need to be listed as well, therby limiting the amount of supervision occupational therapists might have over music therapists. Additionally, music therapy needs to be listed, because music therapy is an autonomous health care profession.

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I also have a concern that this bill does not adequately address licensing OT's as a means to protect the public. Section 12 specifies "unprofessional conduct", however the language in lines 0208 and 0209 reads, "unprofessional conduct which has endangered or is likely to endanger the health....of the public." The language is vague re: the protectionof the public. The National Association for Music Therapy is not opposed to legislation that clearly exists for the protection of the public. However, protecting the pulbic is not clearly stated in this bill. I would recommend that occupational therapists seeking passage of HB 2498 submit before the Committee clear evidence that harm has been done to the public by not being licensed. Additionally, I have reviewed the interim studies on credentialing done by this Committee in 1980, and I quote:

> Additionally, conferees noted that the proposed credintialing of occupational therapists would preclude other providers from practicing occupations for which they have trained, that credentialing is sought to obtain occupational recognition rather than protection of the public, that licensing results in setting one ancillary health care occupation above other groups who are not licensed by the state, and that licensing should be granted only when extreme harm to the public can result from an unregulated practice of an occupation.

To summarize, I am against the passage of HB 2498. The bill in its current language is such that it is not specific enough in defining the services carried out by occupational therapists. The bill in its current form has the potential for setting OT above otheractivity therapy disciplines, thereby setting OT at odds with other health care providers. This would be detrimental both to the providers and most importantly to our clients in which we serve.

I appreciate the Committee for listening to my concerns on behalf of NAMT. I am very concerned about the future of this bill and would like to be informed of the outcome of this bill.

Respectfully submitted,

Deborah C. Horning, RMT-BC

Deborah C. Horning, RMT-BC
Government Relations Representative
for NAMT for the State of Kansas

#7
2-24-86

Testimony concerning House Bill #2498

to Committee on Public Health and Welfare

by (Lois) Kay Metzger
Registered Music Therapist
Board Certified

Febr. 24, 1986

This testimony in no way intends to object to or inhibit the licensure of occupational therapists in the State of Kansas. The intention is to raise questions concerning language in the Occupational bill that might affect the practice of music therapy in the State of Kansas.

If the bill implies that an occupational therapist will by definition be given preference over a music therapist for employment or that a music therapist must be supervised by an occupational therapist in administering evaluations, developing sensory integration skills, using therapeutic activities or adapting the environments, it could adversly affect clients who are served by music therapy. If clients in institutions or in the community are denied music therapy services because of the above restrictions, their health and welfare would be **adversely** affected.

Concerns can be directed toward two points:

(1) How would this bill be interpreted in conjunction with Bill #2663 which supports that certification and registration are sufficient in the the process of credentialing health care occupations.

(2) The bill contains some general and inclusive language that needs clarifying.

An elaboration of each of these points follows.

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2-24-86

The relationship of Bill #2498 to Bill #2663 raises the question of consistency of these two Bills. Would other health care professionals be advised to seek licensure even though #2663 states that certification and registration are sufficient in credentialing health care occupations? What does licensure allow that certification and registration do not? What is the advantage of licensure? If such licensure is granted to a specific occupation it seems important then that the language within the bill be kept specific to that occupation so as not to exclude or restrict other health care professionals especially in light of the Bill # 2663 which does not require licensure to practice.

This specific-ness of language brings us to the second point of this testimony. The following section is considered too general:

Section 2

** add underlined words**

L0036 Administering and interpreting specific Occupational Therapy
L0037 tests necessary for effective treatment planning related to occupational therapy.

L0040 ...designing...adaptive equipment for self care and daily
L0041 living skills such as feeding, dressing, hygiene and
L0042 homemaking.

L0043 define "sensory integrative skills" further as a specific technique of occupational therapy.

L0044 Either further define and clarify "therapeutic activity and
L0045 exercise," "developing...play/leisure skills," and"adapting
L0046 environment" as to specific occupational techniques or
L0047 preface services offered with specific occupational therapy
L0048 techniques in reference to these services . (All adjunctive recreation and creative arts therapies offer these services excluding # 3).

The following section requires an additional exclusion.

Section 5

L0108 Add (g) Persons registered and board certified to practice music therapy from administering assessments or evlauations and carrying out appropriate treatment plans when practicing their profession under the statutes applicable to their profession.

February 24, 1986 #8

My name is Richard Mattson and I am a Professor of Horticulture in the Department of Horticulture at Kansas State University. I direct the Horticultural Therapy curriculum and have worked with this program since it began in 1971 as a cooperative training agreement between K.S.U. and the Activity Therapy Department at the Menninger Foundation.

In preparing this statement on the Occupational Therapy Bill, I would like to mention that Horticultural Therapists are also concerned about professional recognition and job qualifications. Horticultural therapy is a new adjunctive therapy and utilizes horticultural activities directed by a horticultural therapist to improve psychological, social, educational, or physical adjustment in people through a relationship with plants. Horticultural therapy is recognized as an important aid for therapeutic and/or rehabilitative processes of people of all age groups and disabilities.

Horticultural therapy students at Kansas State University complete 3½ years of coursework in the horticultural and behavioral sciences, as well as a 6-month internship at institutional sites such as the Menninger Foundation or Veterans Administration Medical Centers. Upon completion of B.S. or M.S. degrees, graduates of the program are qualified to become Registered Horticultural Therapists (HTR) through a national accrediting organization, the National Council for Therapy and Rehabilitation through Horticulture (NCTRH). This registration process is a peer review, equivalency-based system, but the NCTRH is moving toward a competency-based certification examination system.

Graduates of the K.S.U. Horticultural Therapy program have been hired in the Kansas Civil Service System as Activity Therapists I or II. Within the Federal Civil Service, graduates are hired as Rehabilitation Medicine Specialists (RMS) or Manual Arts Therapists (MAT). Graduates are in high demand because of their unique type of training and their ability to run cost-effective activity therapy programs.

I have read the Occupational Therapy Bill and have discussed its content with Occupational Therapists and other Adjunctive Therapists, including Music, Art, Dance, Recreation, and Physical Therapists. In the O.T. Bill, job qualifications of an Occupational Therapist are defined. Other Adjunctive Therapists also do many of the same job skills. I am concerned that if the O.T. Bill is passed and only Occupational Therapists are allowed to perform these skills, many Adjunctive Therapists may be excluded from practicing their professions or required to work under the direction of an Occupational Therapist. This would be at an increased cost to the client and institutional program.

In Canada and England, activity therapy programs are primarily run by Occupational Therapists. Reports from my friends in these countries indicate that it is difficult for Horticultural Therapists to find work because of the control held by Occupational Therapists of activity therapy departments.

I am opposed to the Occupational Therapy Bill because I feel that it will seriously discriminate against other Adjunctive Therapists in Kansas. Almost all Adjunctive Therapists are health care providers with appropriate professional review systems in place and they provide beneficial service to clients. Additional regulation is not necessary. Thank you.

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2-24-86

attm. # 9.
2-24-86

MEMORANDUM

TO: MEMBERS OF THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

FROM: ALAN F. ALDERSON, KANSAS RECREATION AND PARKS ASSOCIATION

RE: HOUSE BILL NO. 2498

DATE: February 24, 1986

Mr. Chairman and members of the Committee, I am Alan Alderson, attorney for the Kansas Recreation and Parks Association. Our membership consists not only of city, county and school district recreation commissions, but also a group of individuals known as recreation therapists. We appear here today in opposition to House Bill No. 2498. At the outset, I must tell you that I am not thoroughly acquainted with either the concept of credentialing, the practice of the various professionals in related therapeutic modalities, such as therapeutic recreation specialists, occupational therapists and the others, and I have with me today Bette Lopez, a recreation therapist who will be able to answer many of the specific questions you might have with regard to her practice or the training required therefor.

Obviously, the interest of the Kansas Recreation and Parks Association is in the fact that many of these individuals are employed by recreation commissions and programs. While we would like to be able to stand before you today and advise you that some amendments to House Bill No. 2498 would cure our concerns, we are unable to do so. The flaws in this bill run so deep that we firmly believe that it is impossible to merely amend the bill

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to correct them. While I will attempt to point out some of our specific concerns in the bill, reference to particular portions of the bill should not be construed to mean we believe those portions can be fixed. Instead, we believe it is not possible to provide for the licensure and regulation of one segment of the therapeutic health care profession without substantially or completely undercutting the others. To allow the licensing of only occupational therapists is tantamount to de-credentialing all other related health care professionals.

House Bill No. 2498 defines "occupational therapy" as a "health care profession employed under the supervision of a person licensed to practice medicine and surgery in the therapy, rehabilitation, diagnostic evaluation, care and education of individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities or the aging process in order to maximize independence, prevent disability and maintain health." In the first instance, to require that all persons performing these functions practice under the supervision of a licensed physician or surgeon would have an immediate impact on the numerous agencies who now offer these services, but for whom it would not be feasible to have a physician on staff.

The definition of "occupational therapy" further enumerates several specific services as constituting occupational therapy. This enumeration overlaps significantly with the services provided by therapeutic recereation specialists, creative arts therapists and others. Section 4 of H.B. 2498 highlights the problem with such an enumeration. It would prohibit any person from practicing occupational therapy (as defined in

Section 2) unless such person was licensed under the act. It is simply not true that only occupational therapists are qualified to perform the services listed under the definition of "occupational therapy". While an occupational therapist may provide all of the services listed, they are not the only practitioners of a therapeutic modality trained and qualified in all of these areas. In fact, there are other therapeutic specialties actually better qualified to offer many of the listed services.

While I will not undertake to provide you with an extensive definition of a recreation therapist, I will tell you that a recreation therapist is generally an individual with a degree in recreation with a therapeutic emphasis or a degree in therapeutic recreation. We have provided you with a copy of a statement showing the degree requirements at both Kansas University and Kansas State University. A recreation therapist has a recognized vocation. Recreation therapists work in hospitals, many types of institutions and various recreation programs. We have also provided you with a copy of the philosophical position statement of the National Therapeutic Recreation Society to further enlighten you with respect to what a recreation therapist does. Bette Lopez, for example, is employed by Topeka Resource Center for the Handicapped, an independent living center, which operates under a federal grant. The cities of Lawrence and Topeka, for example, have a special populations department within their city recreation departments.

Recreation therapists do not study in the same areas as occupational therapists. Occupational therapists cannot do some of what recreation therapists do and recreation therapists cannot do what occupational

therapists do with regard to some functions. There is, however, a substantial overlap. Herein lies the major flaw of House Bill 2498.

We believe the basic conceptual flaw in the bill warrants adversely reporting it. However, we want to point out other concerns we have with specific provisions:

1. Lines 36 and 37 would qualify the occupational therapist to administer everything from psychiatric tests to medical tests normally administered by a physician. It is doubtful that this was the intent of your committee, but this would be the result.

2. "Homemaking" in line 39 should not be included. While there are certainly some occupational therapists who do daily living skills training in community-based settings, the vast majority of individuals doing this type of work are not occupational therapists and are not supervised by occupational therapists. There is no evidence to suggest that there are deficits caused by this situation in the quality of this training. Many occupational therapists, in fact, have been trained in the medical model system of services provision and would not be qualified to assist with homemaking training in the community.

3. Subsection (3) of Section 2 (lines 40-42) would need to be clarified by adding "or adaptive equipment for self-caring daily living skills such as feeding, dressing and hygiene".

4. All of Subsection (4) of Section 2 (line 43) should be deleted because this service is not adequately defined, and again, may be performed by many therapeutic modalities.

5. Subsection (5) of Section 2 should also be deleted unless it is made clear that these functions are not exclusively performed by occupational therapists.

6. Subsection (6) should also be deleted for the same reason, and in addition, it should be noted that occupational therapists have only 2 to 4 hours of recreation classwork, while recreation therapists have 18 to 24 hours plus an additional 10 to 15 hours of internship/field work. This is an example illustrating our statement that, in some instances, other therapeutic professionals are more qualified to perform those services which appear to be exclusively within the province of occupational therapists under this bill.

7. Subsection (7) should also be deleted for the same reasons previously stated.

While there are other specific provisions of the bill, that we believe would have to be substantially revised, we don't believe it is necessary to point out these individual provisions because we do not believe this bill can be made broad enough to encompass all of the therapeutic specialities. If House Bill No. 2498 were to be passed in its current form, we believe the following effects would be seen statewide:

1. Elimination of state civil service activity therapy positions and many essential services provided by these individuals in state facilities such as mental health hospitals, training centers for the mentally retarded and youth and adult centers for criminal offenders. Currently an activity therapist does not have to be an occupational therapist and does not have to be supervised by an occupational therapist. Under this legislation, one or the other of these two conditions would have to be the case.

2. Elimination of any community recreation programs for special populations not under the supervision of occupational therapists.

Occupational therapists are not qualified by training or classical experience to supervise a community recreation program. Under this legislation they would nonetheless be required to do so.

3. Elimination of all recreation and leisure services in long-term care facilities such as intermediate care facilities for the mentally ill, intermediate care facilities for the mentally retarded, intermediate care facilities for the aged, and juvenile and adult detention facilities. Again, under this legislation, occupational therapy supervision would be required and is not available or necessary.

4. Elimination of academic preparation programs in the private and public higher education institutions in Kansas in the fields of recreation therapy, creative arts therapy and horticulture therapy. Under occupational therapy supervision as required by this bill, there would be few professional level positions available in areas such as therapeutic recreation, art, dance, drama, music, industrial, vocational and horticultural therapy; therefore, the need for persons trained in these professions in Kansas would be virtually eliminated.

5. Community programs oriented to maintaining individuals outstide of institutions, at cost benefit to the taxpayers, would be severely limited in the repertory of service offered because many of these services would require occupational therapy supervision.

6. Elimination of all Rehabilitation Teacher for the Blind and Instructor for the Blind, positions in Kansas or the replacement of their supervisors with occupational therapists. The legislation would require

that all such positions be filled with occupational therapists or that those supervising such positions be occupational therapists. If this is to be done, however, then it will, of course, be necessary for the occupational therapists involved to immediately learn such specialties as teaching Braille or mobility and orientation. This is unrealistic.

In short, if this bill is passed in its current form, it will be necessary for the legislature to appropriate additional monies for the state institutions in order to provide for the new occupational therapist positions that would have to be created in order to adequately supervise the recreation therapy programs.

I will be happy to answer any questions I can or see that they are answered by Bette Lopez. We urge you to report House Bill No. 2498 adversely.

National Recreation and Park Association

Attm #9
a+b

PHILOSOPHICAL POSITION STATEMENT

OF THE

NATIONAL THERAPEUTIC RECREATION SOCIETY
(A Branch of the National Recreation and Park Association)

(Adopted, May 1982)

Leisure, including recreation and play, are inherent aspects of the human experience. The importance of appropriate leisure involvement has been documented throughout history. More recently, research has addressed the value of leisure involvement in human development, in social and family relationships, and, in general, as an important aspect of the quality of life. Some human beings have disabilities, illnesses, or social conditions which limit their full participation in the normative social structure of society. These individuals with limitations have the same human rights to, and needs for, leisure involvement.

The purpose of therapeutic recreation is to facilitate the development, maintenance, and expression of an appropriate leisure lifestyle for individuals with physical, mental, emotional, or social limitations. Accordingly, this purpose is accomplished through the provision of professional programs and services which assist the client in eliminating barriers to leisure, developing leisure skills and attitudes, and optimizing leisure involvement. Therapeutic recreation professionals use these principles to enhance clients' leisure ability in recognition of the importance and value of leisure in the human experience.

Three specific areas of professional services are employed to provide this comprehensive leisure ability approach toward enabling appropriate leisure lifestyles: therapy, leisure education, and recreation participation. While these three areas of service have unique purposes in relation to client need, they each employ similar delivery processes using assessment or identification of client need, development of a related program strategy, and monitoring and evaluating client outcomes. The decision as to where and when each of the three service areas would be provided is based on the assessment of client needs and the service mandate of the sponsoring agency. The selection of appropriate service areas is contingent on a recognition that different clients have differing needs related to leisure involvement in view of their personal life situation.

The purpose of the <u>therapy</u> service area within therapeutic recreation is to improve functional behaviors. Some clients may require treatment or remediation of a functional behavior as a necessary prerequisite to enable their involvement in meaningful leisure experiences. <u>Therapy</u>, therefore, is viewed as most appropriate when clients have functional limitations that relate to, or inhibit, their potential leisure involvement. This distinction enables the therapeutic recreator to decide when <u>therapy</u> service is appropriate, as well as to identify the types of behaviors that are most appropriate to address within the therapeutic recreation domain of expertise and authority. In settings where a comprehensive treatment team approach is used, <u>therapy</u> focuses on team identified treatment goals, as well as addressing unique aspects of leisure related functional behaviors. This approach places therapeutic recreation as an integral and cooperative member of the comprehensive treatment team, while linking its primary focus to eventual leisure ability.

purpose of the leisure education service area is to provide opportunities for the acquisition of skills, knowled and attitudes related to leisure involvement. For some clients, acquiring leisure skills, knowledge, and attitudes are priority needs. It appears that the majority of clients in residential, treatment, and community settings need leisure education services in order to initiate and engage in leisure experiences. It is the absence of leisure learning opportunities and socialization into leisure that blocks or inhibits these individuals from participation in leisure experiences. Here, leisure education services would be employed to provide the client with leisure skills, enhance the client's attitudes concerning the value and importance of leisure, as well as learning about opportunities and resources for leisure involvement. Thus, leisure education programs provide the opportunity for the development of leisure behaviors and skills.

The purpose of the recreation participation area of therapeutic recreation services is to provide opportunities which allow voluntary client involvement in recreation interests and activities. Human beings, despite disability, illness, or other limiting conditions, and, regardless of place of residence, are entitled to recreation opportunities. The justification for specialized recreation participation programs is based on the clients' need for assistance and/or adapted recreation equipment, limitations imposed by restrictive treatment or residential environments, or the absence of appropriate community recreation opportunities. In therapeutic recreation services, the need for recreation participation is acknowledged and given appropriate emphasis in recognition of the intent of the leisure ability concept.

These three service areas of therapeutic recreation represent a continuum of care, including therapy, leisure education, and the provision of special recreation participation opportunities. This comprehensive leisure ability approach uses the need of the client to give direction to program service selection. In some situations, the client may need programs from all three service areas. In other situations, the client may require only one or two of the service areas.

Equally important is the concern of generalizing therapeutic recreation service across diverse service delivery settings. The leisure ability approach of therapeutic recreation provides appropriate program direction regardless of type of setting or type of client served. A professional working in a treatment setting can see the extension of the leisure ability approach toward client needs within the community environment. Likewise, those within the community can view therapeutic recreation services within a perspective of previous services received or possible future needs.

All human beings, including those individuals with disabilities, illnesses or limiting conditions, have a right to, and a need for, leisure involvement as a necessary aspect of the human experience. The purpose of therapeutic recreation services is to facilitate the development, maintenance, and expression of an appropriate leisure lifestyle for individuals with limitations through the provision of therapy, leisure education, and recreation participation services.

The National Therapeutic Recreation Society is the acknowledged professional organization representing the field of therapeutic recreation. The National Therapeutic Recreation Society exists to foster the development and advancement of this field in order to ensure quality professional services and to protect the rights of consumers of therapeutic recreation services. In order to provide consistant and identifiable services throughout the field, the National Therapeutic Recreation Society endorses the leisure ability philosophy described herein as the official position statement regarding therapeutic recreation.

3101 Park Center Drive • Alexandria, Virginia 22302 • *(703) 820-4940*

KANSAS UNIV

Requirements for the Physical Education Minor. A minor in physical education is also offered to those students who choose to major in another area within the School of Education. The minor involves 24 hours of appropriate course work.

Note. Human physiology and anatomy are required for state certification in physical education.

Required for all minors (11 hours)
HPER 310 Evaluation of Physical Education Performance Tests 2
HPER 670 Kinesiology. 3
HPER 672 Physiology of Exercise. 3
HPER 675 Administration of Physical Education 3

Select one of the following courses: (1 hour)
HPER 210 Instruction and Analysis in Swimming
HPER 210 Instruction and Analysis in Folk and Square Dance

Recreation Services in Robinson Center organizes intramural sports and other informal recreation for all KU students.

Select two of the following courses: (4 hours)
HPER 210 Instruction and Analysis in Modern Dance and Women's Gymnastics
HPER 210 Instruction and Analysis in Weight-Training and Men's Gymnastics
HPER 210 Instruction and Analysis in Soccer-Speedball, Volleyball, Wrestling
HPER 210 Instruction and Analysis in Field Hockey, Soccer-Speedball, Volleyball
HPER 210 Instruction and Analysis in Golf, Tennis, Badminton, Archery

Select one of the following courses: (2 hours)
HPER 210 Instruction and Analysis in Basketball, Softball, Flag Football, Team Handball
HPER 210 Instruction and Analysis in Track and Field, Racquetball, Fencing

Select one of the following courses: (2 hours)
HPER 248 First Aid
HPER 428 Care and Prevention of Athletic Injuries
HPER 680 Adaptive Physical Education

Plus 4 hours of electives in physical education.

Professional Opportunities

Both the major and the minor fulfill certification requirements to teach physical education and to coach interscholastic sports in the public schools in the State of Kansas. Other opportunities are available in various non-school-oriented fitness and rehabilitation programs involving physical conditioning and personal development.

Non-Teacher-Certification Physical Education Programs

The Kinesiology-Biomechanics Laboratory is located in 174 Robinson Center.

Physical education programs preparing the student for related careers other than teaching are available. Emphases may be taken in sport administration, sport media, and movement sciences. Each of these programs involves 31-33 credit hours in physical education, with 32-36 hours in subject areas related to the emphasis selected.

General education requirements are as follows:

Language Arts (12 hours)
(See also English Placement Examination and Speech Requirement)
ENGL 101 Composition. 3
ENGL 102 Composition and Literature 3
ENGL 359 Grammar and Usage for Composition (3)
or
English elective 3
COMS 150 Personal Communication 3

Biological Science, Physical Science, and Mathematics (16-17 hours)
BIOL 104 Principles of Biology. 5
BIOL 300 Human Anatomy Lecture 3
BIOL 301 Human Anatomy Observation Laboratory. 2
BIOL 305 Human Physiology 3
Elective in physical science or mathematics. 3-5

Social Sciences (15 hours)
PSYC 104 General Psychology. 3
Electives in history, economics, psychology, sociology, political science, or anthropology 12

Plus recommended electives to provide a minimum of 124 credit hours for graduation.

A 16-hour internship during the professional semester is included for the program specialty selected.

Students should contact the Undergraduate Coordinator in HPER for the courses that are required for these non-teacher-certification physical education majors.

Recreation

Offered within the Department of Health, Physical Education, and Recreation
Wayne Osness, Chairman
104 Robinson Center, (913) 864-3371
Degree: B.S.E.

Admission

Freshmen may be admitted directly to the School of Education to major in recreation. See Admission in the General Information section of this catalog. Students may transfer into this program from the College of Liberal Arts and Sciences or another school within the University as freshmen or sophomores provided that they have a 1.8 grade-point average in all college-level work completed at the time of application.

Advising

A student majoring in recreation should contact the department office immediately upon admission to the University for assignment to an academic adviser.

Major in Recreation

This program does not lead to teacher certification. A bachelor's degree in recreation prepares the graduate to serve in a variety of community, private, governmental, and institutional settings and provide leadership in a dynamic profession. The curriculum develops general competency in recreation theory, philosophy, and skills, and provides professional field work experience for the student.

Activity Competencies. Students should plan to satisfy the prerequisite activity competencies for HPER 210 courses before the beginning of the third year. Competency may be satisfied by passing the competency examinations given during enrollment week each semester, or by completing basic instruction courses (HPER 108) with a grade of C or higher.

rements for the B.S.E. Degree. A min- of 124 credit hours is required with at least a 2.2 cumulative grade-point average, at least a 2.2 in course work taken at the University of Kansas, and a minimum of 2.5 in all health, physical education, and recreation department courses. This grade-point average is also necessary prior to enrolling in the internship.

The recreation major is composed of a 32-hour core of requirements plus options for specialization. These options, which require approximately 15 hours, include public recreation, correctional recreation, outdoor recreation, and therapeutic recreation. Students also take general education courses and complete an internship in recreation.

Professional Requirements:

Core Requirements (32 hours)
HPER 236 Practicum in: Recreation 1
HPER 248 First Aid 2
HPER 270 Historical and Philosophical Foundations of Recreation 3
HPER 275 Leisure Systems and Related Community Agencies 3
HPER 320 Recreation for Special Populations ... 3
HPER 426 Principles and Procedures of Recreation Programming 3
HPER 504 Recreation Leadership 3
HPER 506 Recreational Administration 3
Recreation Skills 6
(Skills included will be basic, intermediate, and advanced courses in art, music, drama, dance, physical activities, and other recreation or sport skills.)
HPER Electives (approved) 5
(These include content areas or methods courses in health, physical educaton, recreation, and dance.)

Public Option (15 hours selected from the following with adviser's approval)
POLS 110 Introduction to U.S. Politics (3)
POLS 410 U.S. Government and Politics (3)
POLS 614 Urban Politics and Administration (3)
ECON 104 Introductory Economics (4)
SOC 341 Modern Urban Society (3)
S W 550 Topics in Social Welfare: Rural Kansas (3)

Correctional Option (15 hours)
HPER 470 Introduction to Therapeutic Recreation 3
HPER 474 Therapeutic Recreation Program Design: Principles and Procedures 3
Approved Corrections and Sociology electives ... 9

Outdoor Option (15 hours from biology, botany, systematics, ecology, geology, and astronomy with adviser's approval)
Suggested courses:
BIOL 448 Kansas Plants (3)
BIOL 664 Animal Natural History (4)
BIOL 328 Biology and Society (2)
BIOL 330 Principles of Wildlife Conservation (3)
BIOL 350 Animals of Kansas (3)
GEOL 101 Introduction to Geology (5)
GEOL 301 Geology and Man (3)
GEOL 351 Environmental Geology (3)

Therapeutic Option (25 hours)
BIOL 300 Human Anatomy Lecture (3) **and**
BIOL 301 Human Anatomy Observation Laboratory (2) (apply to physical and biological sciences) 5
BIOL 305 Human Physiology 3
SPED 425 Introduction to Exceptional Children and Youth 3
HPER 470 Introduction to Therapeutic Recreation 3
HPER 474 Therapeutic Recreation Program Design: Principles and Procedures 3
HPER 680 Adaptive Physical Education 2
Approved Therapeutic Electives 6

Education (9 hours):
EP R 300 Educational Psychology (or appropriate substitute in education) 3
VAE 200 Recreational Arts 3
MEMT 275 Music in Recreation (or equivalent) . 3

General Education Requirements:

Language Arts (12 hours)
(See also English Placement Examination and Speech Requirement.)
ENGL 101 Composition 3
ENGL 102 Composition and Literature 3
ENGL 359 Grammar and Usage for Composition (3)
or
English elective 3
COMS 150 Personal Communication 3

Biological Science, Physical Science, and Mathematics (16-17 hours)
BIOL 104 Principles of Biology 5
BIOL 300 Human Anatomy Lecture 3
BIOL 301 Human Anatomy Observation Laboratory 2
BIOL 305 Human Physiology 3
Elective in physical science or mathematics 3-5

Social Sciences (15 hours)
PSYC 104 General Psychology 3
Electives in history, economics, psychology, sociology, political science, or anthropology 12

Plus recommended electives to provide a minimum of 124 credit hours for graduation.

Professional Semester (16 hours)
HPER 580 Internship in Recreation 16

The Timetable is the official listing of classes offered each semester. It is available through the Office of Student Records and Registration, Strong Hall.

Professional Opportunities

The public option prepares students for employment in various public recreation settings including leadership positions in recreation centers and playgrounds, as program supervisors and other entry-level recreation positions. The outdoor option allows students an opportunity to develop competencies which can qualify them for employment by municipal and state outdoor recreation programs. The therapeutic recreation option prepares students to enter institutional settings as an activity or recreation therapist where they may work with recreation for such special populations as the emotionally disturbed, physically handicapped, and mentally retarded. The corrections option prepares students for employment in institutions for incarcerated persons, in delinquent and pre-delinquent programs, and in other correctional facilities.

Secondary Education

Offered within the Department of Curriculum and Instruction
John Guenther, Chairman
205 Bailey Hall, (913) 864-4435
Degrees: B.S.E., M.A., M.S.Ed., Specialist in Education, Ed.D., Ph.D.

Secondary education students must take the English placement examination and fulfill the speech requirement of the school.

The following requirements apply **only** to those students who are juniors or seniors during the 1982-83 academic year. Those students who became freshmen subsequent to May 1981 must complete the requirements for the new teacher-education program. **See New Teacher-Education Program.**

Kansas State University

Educational Sociology		3
Methods (EDCI 476 or EDCI 469)		3
Introduction to Instructional Media (EDCI 316)		1
Psychology of Exceptional Children (EDAF 622) or The Exceptional Child in the Regular Classroom (EDAF 623)		3

The following Natural Science and Social Science courses should be taken by Physical Education majors:

BIOL 198	Principles of Biology	4
BIOL 240	Structure and Function of the Human Body	6
PHYS 115	Descriptive Physics	4
PSYCH 110	General Psychology	3
SOCIO 211	Introduction to Sociology	3

Recreation Major

For a degree in recreation students should take the following:

I. General education requirements—see Bachelor of Science degree or Bachelor of Arts degree, page 106.

II. Recreation core 23hrs

PE 206	Professional Orientation	1
PE 376*	First Aid and CPR	1
REC 320	Recreation Leadership	3
REC 390	Principles and Philosophy of Recreation	3
REC 480	Orientation in Recreation	2
REC 481	Participation in Recreation	2
REC 488	Recreation for Special Populations	3
REC 489	Recreation Program	3
REC 490	Recreation Administration I	3
REC 491	Recreation Seminar	2

*or minimum of current standard First Aid and CPR certification at time of petition

III. Recreation specialization

(select and complete A or B)

A. Recreation program administration (18 hours)

This option is designed for the person who will be conducting and operating a recreation/park program in a variety of leisure settings. Courses will be selected from the recreation major approved course list,* with at least one two-hour course taken from each of the three categories.

B. Special populations (18 hours) 9hrs

1. Therapeutic Recreation Service (required) 3 hrs.:

2. The student must take 6 hours from the following:

PSYCH 505	Abnormal Psychology
PSYCH 622 or EDAF 622	Psychology of Exceptional Children
SOCIO 560	Juvenile Delinquency
SOCIO 561	Criminology
SOCIO 744	Social Gerontology
PSYCH 715	Psychology of Aging
EDAF 628	Characteristics of the Emotionally Disturbed

3. Nine hours from Group I or II as listed on the Recreation major approved course list.*

47 hours total

IV. Directed field experience

(internship semester)

REC 492	Internship in Recreation	15

Internship is a minimum 15 week, 600 hour experience in an approved recreation/service agency

Student must meet the following qualifications:

A. 2.2 GPA in all course work attempted at KSU. 2.5 GPA in all recreation major core courses.

B. Recreation majors must have satisfactory pre-internship experiences in leisure/recreation field, minimum of 280 hours during college/university preparation

C. Physical examination required

DEPARTMENTAL OPTIONS

I. Coaching Certification Program

This program is designed to prepare coaches in all areas of varsity athletics, and is open to non-majors as well as students majoring in health, physical education, recreation, or dance. Students completing the following courses will receive an athletic coaching endorsement from the Department of Physical Education, Recreation, and Dance. Majors taking this program must also complete all requirements for a major in either physical education, recreation, or dance. The coaching program is not a substitute for specialization requirements. Non-majors are not required to take any work in the department in addition to the coaching program.

Coaching Program Requirements

PE 315	Treatment of Athletic Injuries	3
PE 359	Organization and Administration of Athletics	3
Select		
PE 202	Physiological Foundations of Coaching OR	2
PE 335	Physiology of Exercise	4
Select		
PE 203	Kinesiological Foundation of Coaching OR	2
PE 330	Kinesiology	3
Select		
PE 204	Psychological Foundations of Coaching OR	2
PE 320	Motor Behavior and Skill Learning	3

Four hours selected from the following

PE 298	Coaching and Officiating Wrestling	2
PE 299	Coaching and Officiating Swimming	2
PE 300	Coaching and Officiating Volleyball	2
PE 301	Coaching and Judging Gymnastics	2
PE 302	Coaching and Officiating Basketball	2
PE 303	Coaching and Umpiring Baseball	2
PE 304	Coaching and Officiating Track and Field	2
PE 305	Coaching and Officiating Football	2
PE 309	Coaching and Officiating Tennis and Golf	2

II. Athletic Training Certification Program

Athletic Training

This program is designed to prepare athletic trainers for all levels of athletics. It is especially applicable to those teacher preparation students desiring to serve as junior or senior high school athletic trainers. Physical Education majors taking this program must also complete the PE core and selected specialization area. Non-physical education majors are not required to take any work in the department in addition to the athletic training program.

A. Athletic Training Option for Physical Education Majors (any specialization)

FN 110	Basic Nutrition	3
PE 315	Treatment of Athletic Injuries	3
PE 550	Advanced Techniques of Athletic Training	3
PE 585	Internship in Techniques of Athletic Training (minimum of 150 hours each semester for 4 semesters)	8
FCD 201	Principles of Personal Health Maintenance	3
		20

B. Athletic Training Option for non-Physical Education majors

BIOL 240	Human Body	6
FN 132	Basic Nutrition	3
FCD 201	Principles of Personal Health Maintenance	3
PE 376	First Aid and CPR	1
PE 330	Kinesiology	3
PE 335	Exercise Physiology	3
PE 561	Adapted Physical Education	3
PE 315	Treatment of Athletic Injuries	3
PE 550	Advanced Techniques of Athletic Training	3
PE 585	Internship in Athletic Training (minimum of 150 hours each semester for 4 semesters)	8
		36

Graduate Study

Larry Noble, Coordinator

The Department of Health, Physical Education, and Recreation offers a Master of Science in Physical Education, Master of Science in Recreation, and a Ph.D. in Motor Behavior.

Ph.D. in Physical Education with Specialization in Motor Behavior

The Ph.D. program is designed to develop scholars and researchers in the disciplinary area of motor behavior. This area of physical education highlights the relationships between the behavioral sciences and physical activity. The strength of the program lies in the competence of the graduate faculty and is enhanced by the expertise and facilities of related departments on campus, such as psychology, sociology, and family and child development. Specific areas of concentration are: sport sociology, sport psychology, motor development, and motor learning.

Of the 93 minimum hours of graduate credit (beyond the bachelor's) required for the Ph.D., the department requires 30 hours of dissertation research; 15-16 hours credit for work in statistics and

PE 898. Master's Report. (1-4) PE-898-4-0835

PE 899. Master's Thesis. (1-6). PE-899-3-0835

PE 905. Sport and Human Behavior II. (3). On sufficient demand. Analysis and discussion of experimental results of research in sport and human behavior including a study of theoretical models for conducting research. Pr.: PE 805. PE-905-0-0835

PE 906. Advanced Motor Development. (3) On sufficient demand. Analysis and discussion of experimental results of motor development research including a study of theoretical models for conducting research. Pr.: PE 806. PE-906-6-0835

PE 907. Advanced Motor Learning and Performance. (3) On sufficient demand. Neurological and physiological factors involved in movement accuracy and related underlying variables. In depth investigation of the various theories that attempt to explain skilled motor learning and performance. Pr.: PE 807. PE-907-0-0835

PE 996. Advanced Topics in Motor Behavior. (1-3) On sufficient demand. Selected advanced topics in motor behavior. May be repeated with consent of supervisor committee. PE-996-0-0835

PE 997. Motor Behavior Seminar. (1-3). On sufficient demand. Intensive discussion of an area of current interest in motor behavior based on the class's study of pertiment original research. PE-997-0-0835

PE 999. Research in Motor Behavior. (Var.) I, II, S. Doctoral level research. PE-999-4-0835

Dance

Undergraduate Credit

DANCE 117. Social, Square, and Folk Dance. (1). DANCE-117-5-1008

DANCE 118. Social Dance. (1). DANCE-118-5-1008

DANCE 119. Square Dance. (1). DANCE-119-5-1008

DANCE 120. Modern Dance I. (1). DANCE-120-5-1008

DANCE 165. Ballet I. (1). DANCE-165-5-1008

DANCE 171. Jazz Dance I. (1) I, II. A basic course in jazz technique and style, focusing on isolations, rhythmic articulation, and the control and release of energy. Two hours lab a week. DANCE-171-5-1008

DANCE 205. Dance as an Art Form. (3) I. Dance in its religious, social, and artistic forms. Film, slides, demonstrations, and lectures will trace the function of dance in society, the influence of society on dance, how dance relates to other art forms, and current trends in the dance world. DANCE-205-0-1008

DANCE 222. Movement Improvisation I. (1). On sufficient demand. Provides the opportunity to: 1) discover personal creative sources for spontaneous movement; 2) increase movement self-confidence in an informal group settings; 3) rediscover "Play" through movement; and 4) explore basic principles of movement improvisation—space, weight, shape, and time. Pr.: Consent of instructor. DANCE-222-1-0-1008

DANCE 295. Dance Composition I. (3). On sufficient demand. Introduction to the principles of the choreographic craft. Practical experience in development of movement phrases. Culminating presentation and critique of work. DANCE-295-1-1-1008

DANCE 321. Variations and Partnering. (1) On sufficient demand. Introduction to the principles of repertoire performance using various styles and forms of choreography. Directed study in partnering. (Alternating years of modern and ballet incorporating pointe and classical variations and pas de deux.) Pr.: Consent of instructor. DANCE-321-1-0-1008

DANCE 322. Movement Improvisation II. (1) On sufficient demand. Continues exploration of principles of movement improvisation. Experience with props, architectural spaces, and improvisation as a tool for choreography and performance. Pr.: DANCE 222. DANCE-322-1-0-1008

DANCE 323. Modern Dance II. (2) I, II. May be repeated for a total of eight hours. Only two of these hours may be applied towards humanities requirements. Pr.: DANCE 120 and consent of instructor. DANCE-323-1-0-1008

DANCE 324. Modern Dance III. (2) I, II. May be repeated for a total of eight hours. Only two of these hours may be applied toward humanities requirements. Pr.: DANCE 323 and consent of instructor. DANCE-324-1-0-1008

DANCE 325. Ballet II. (2) I, II. May be repeated for a total of eight hours. Only two of these hours may be applied towards humanities requirements. Pr.: DANCE 165 and consent of instructor. DANCE-325-1-0-1008

DANCE 326. Ballet III. (2) I, II. May be repeated for a total of eight hours. Only two of these hours may be applied towards humanities requirements. Pr.: DANCE 325 and consent of instructor. DANCE-326-1-0-1008

DANCE 371. Jazz Dance II. (2) I, II. Intermediate course in jazz technique and style focusing on development of isolations, rhythmic articulation, and the control and release of energy. Performance of advanced movement sequences. May be repeated for a total of eight hours. Only two of these hours may be applied toward humanities requirements. Pr.: DANCE 171. DANCE-371-1-0-1008

DANCE 459. History of Dance in Its Cultural Setting. (3) II. The study of developments and changes in the style, technique, and purpose of ceremonial and theatrical dancing from the Greeks to the present. Emphasis on the interaction between this art and the total culture—social, religious, artistic, and political—in which it is performed. Pr.: Sophomore standing (same as HIST 459). DANCE-459-0-1008

DANCE 460. Dance Styles and Personalities. (3). On sufficient demand. Brief overview of dance, primitive to the Renaissance. Primary focus is on the contributions of persons and styles to the development of the dance, ballet de cour to contemporary trends. DANCE-460-0-1008

DANCE 495. Dance Composition II. (3). On sufficient demand. Advanced training and directed experiences in dance composition. Development of theme, phrasing, and style with particular emphasis on group forms. Pr.: DANCE 295. DANCE-495-1-1-1008

Undergraduate And Graduate Credit In Minor Field

DANCE 502. Dance Production. (1-2) I, II. Studies in the techniques of dance production and performance. Emphasis is on practical application. May be repeated four times. Pr.: Junior standing OR consent of instructor. DANCE-502-1-0-1008

DANCE 504. Dance Aesthetics, Philosophy, and Criticism. (3). On sufficient demand. Examination of dance in relation to the visual and performing arts. Analysis of form and content in aesthetic judgment. Practical experience in observation, and written and oral critiques of dance performances. Pr.: DANCE 205, DANCE 460. DANCE-504-0-1008

DANCE 505. Methods and Materials of the Dance. (3) On sufficient demand. A practical examination of dance in the classroom for its educative, artistic, disciplinary and therapeutic values. Emphasis on methods of teaching various techniques of all levels of ability under supervision of the instructor. Pr.: DANCE 205 and DANCE 323 or DANCE 325. DANCE-505-1-5-1008

DANCE 599. Independent Studies in Dance. (1-3). Selected topics in dance. Maximum of three hours applicable toward degree. Pr.: Consent of department head. DANCE-599-3-1008

Recreation

Undergraduate Credit

REC 220. Recreational Games. (2). On sufficient demand. Lead-up and recreational games suitable for use in both recreation and school settings. Four hours lab a week. REC-220-0-0835

REC 320. Recreational Leadership. (3) I Principles and methods of organizing communities for leisure activities. REC-320-0-0835

REC 382. Camp Counseling. (3) On sufficient demand. Basic principles and skills in camping for future counselors. Pr.: Sophomore standing or consent of instructor. REC-382-0-0835

REC 390. Principles and Philosophy of Recreation. (3) II. A study of the basic principles of recreation, including a survey of past and current trends in the recreation movement. REC-390-0-0835

REC 480. Orientation in Recreation. (2) I. To orient the student to recreation programs in voluntary, public, military, private, and commercial agencies. REC-480-2-0835

REC 481. Participation in Recreation. (2) II. Directed beginning experience in recreation/leisure service agencies. An evaluation and reports on experiences within the agencies will be done. Pr.: REC 320. REC-481-2-2103

REC 487. Recreation Facility Management. (3) II. Study of planning, operations, and management of public, private, voluntary, and commercial recreation facilities. Facilities examined include community centers, swimming pools, craft centers, roller and ice rinks, court areas, and game fields. Two hours lec. and two hours lab. Pr.: REC 320. REC-487-1-5-0835

REC 488. Recreation for Special Populations. (3) I Study of recreation programs for special populations. Characteristics of the disabled, disadvantaged, mentally ill, retarded, aged, physically handicapped, etc Pr.: REC 320 and consent of instructor REC-488-0-2103

REC 489. Recreation Program. (3) I, II. A study of the program forms and structures related to public, voluntary, military, private, and commercial agencies. Pr.: REC 480. REC-489-2-2103

REC 490. Recreation Administration I. (3) I. Development and evaluation of recreation patterns, programs, and structures. Pr.: REC 480 REC-490-0-2103

REC 491. Seminar in Recreation. (2) I, II. The study of current trends and issues in recreation Pr.: REC 481. REC-491-0-2103

REC 492. Internship in Recreation. (15) I, II, S. Intensive practical experience over a 15 week period in an approved recreation/leisure service agency. Pr.: REC 491. REC-492-2-2103

REC 493. Therapeutic Recreation Service. (3) II. The development of competencies in servicing special populations in public and institutional settings. Examination of medical and non-medical models of implementation service. Pr.: REC 488 or consent of instructor REC-493-0-2103

REC 599. Independent Studies in Recreation. (1-3) Selected topics in Recreation. Maximum of three hours applicable toward a degree. Pr. Consent of instructor. REC-599-3-0835

Undergraduate And Graduate Credit

REC 705. Recreation Theory and Policy. (3) I, II. On sufficient demand. Development of theory and resulting recreational policies for public, community, institutional, and private agencies Pr.: REC 489. REC-705-0-0835

REC 715. Recreation Program, Finance, and Budget. (3) I, II, S. On sufficient demand. Development of recreation programs and programmatic budgets for a recreation agency. Study of sources for financing recreational programs of all types and a study of money management systems for recreation agencies. Pr.: REC 489 or REC 705. REC-715-0-0835

REC 720. Organization and Administration of Intramural Programs. (3) II. Policies and procedures in organizing and administering an intramural program. REC-720-0-0835

REC 725. Recreation Administration II. (3) I. Development of administrative procedures as applied to programs, personnel, and facilities. Design administrative models and apply theories to the recreation/leisure field. Pr.: REC 490. REC-725-0-2103

REC 791. Seminar in Recreation. (1-3) I. Designed for recreation specialists. Discussion of current research and innovations. Evaluation of recreational programs. Small group interaction. May be taken with Internship in Recreation. REC-791-0-0835

REC 792. Internship in Recreation. (3-8) Supervised experiences with recreation services, such as city recreation, government agencies, and other leisure service agencies. May be completed in one of the following two ways, as directed by the student's adviser: a) summer assignment in an approved agency with concurrent enrollment in the summer school course designation, b) half-time assignment during a full semester, or full-time assignment during a semester in an approved or supervised recreation job, both with concurrent enrollment in the course designation. May be repeated once. REC 791 (may be taken concurrently) and consent of instructor. REC-792-2-0835

REC 799. Problems in Recreation. (Var.). Pr.: Background of courses needed for problem undertaken. REC-799-3-0835

Graduate Credit

REC 862. Leisure Counseling. (3) II. On sufficient demand. The development of leisure counseling models for use in community and institutional recreation programs and skills and competencies in assessing, interviewing, and counseling individuals and groups in the use of leisure experiences. Pr.: REC 725 or EDAF 858. REC-862-0-2103

REC 896. Topics in Recreation. (1-4) REC-896-3-0835

REC 897. Research in Recreation. (Var.) Pr. Sufficient training to carry on the line of research undertaken REC 897-4-0835

REC 898. Master's Report. (1-4) REC-898-4-0835

REC 899. Master's Thesis. (1-6) REC-899-3-0835

HISTORY

Joseph M. Hawes, Head of Department*

Professors Hawes,* Higham,* Jones,* Kaufman,* Kren,* Linder,* Socolofsky,* and Wilcoxon,* Associate Professors Ferguson,* Feyerharm, Frey,* Gray,* Hamscher,* McCulloh,* Mrozek,* Kipp,* Nieman,* and Page;* Assistant Professor Donovan;* Instructor Wheeler; Emeriti: Professors Carey,* Sageser;* Associate Professors Alsop,* Crawford,* and Riggs.*

History is the common possession of mankind. In the words of historian Carl Becker, "The value of history is . . . not scientific but moral: by liberalizing the mind, by deepening the sympathies, by fortifying the will, it enables us to control, not society, but ourselves,—a much more important thing; it prepares us to live more humanely in the present and to meet rather than to foretell the future." Historical understanding is the basic attribute of the educated person.

Many history majors pursue careers in law, medicine, business, religion, education, government, the armed services, historic preservation, journalism, and other professions. Undergraduate advisers in the history department maintain up-to-date information regarding requirements of graduate and professional schools and relevant course offerings in history and other departments.

The history program at Kansas State University appeals not only to majors but to all students seeking a rewarding educational experience. The curriculum includes courses in traditional and nontraditional fields of interest taught by a nationally respected faculty willing to try new and innovative teaching techniques. A program of speakers, seminars, colloquia, and films supplements the curriculum to stimulate student interest in the discipline of history and how it is expressed.

Transfer Students

Normally, the history department will accept transfer credit for history courses taught at accredited institutions of higher education. In the case of students transferring from community college, only courses equivalent to those taught at the freshman-sophomore level at Kansas State University (courses numbered HIST 100 through HIST 299) can receive credit for the history major.

Undergraduate Study

Requirements for a major in history consist of a minimum of 30 hours in history, including HIST 101 and 102, a minimum of 18 hours in courses numbered 500 and above and HIST 397 in the junior year. Students must distribute their upper division courses over at least three of the following fields:

I. Ancient, medieval, and early modern Europe.
II. Modern Europe (including Great Britain).
III. The third world (Asia, Africa, Latin America).
IV. The United States (including the colonial period).
V. Topical courses not focusing upon a specific geographical region, such as history of science, technology, dance, sport, military history, psychohistory, and other similar courses.

Advanced Program in History

Certain highly qualified students may elect to define their own programs for the major in consultation with a committee of three faculty members chosen by the student and approved by the head. This program of study should be broadly conceived, not narrowly circumscribed. This option is available only to students seeking a Bachelor of Arts (B.A.) degree in history. In order to enter this program students must have a grade point average of 3.5 at the end

KOTA

attm. #7
2-24-86

KANSAS OCCUPATIONAL THERAPY ASSOCIATION
SERVING KANSAS AND WESTERN MISSOURI

February 24, 1986

TO: House Public Health and Welfare Committee
FROM: Elizabeth E. Taylor, Legislative Consultant
RE: HB 2498 - Licensure of Occupational Therapists

KOTA has issued written support to this Committee for Licensure of Occupational Therapists in the following areas:

- Real-life situations where harm has been caused (physical, emotional, and financial);
- Cost containment information from other states where licensure of occupational therapists in the last few years has shown NO INCREASE in cost,
- Cost information which shows that the average cost for OT services among the 50 states shows that OT's in licensed states actually earn LESS THAN IN UNLICENSED states.
- Medical information showing that the appropriate level of credentialing for OT's is licensure.
- Other elements of the medical team agree that OT should be licensed.

Let me review each of these areas of concern.

POTENTIAL OR REAL HARM. Not only have you been presented with actual cases from occupational therapists who have been in a position to pick up the pieces where non-qualified practitioners have attempted to practice occupational therapy, but you have also heard from physicians who have shown that in actual cases, there has been loss of physical ability (both permanent and temporary), emotional harm caused from lengthened recovery or additional surgery needed due to unqualified occupational therapy services, as well as financial harm being caused due to prolonged services needed to make corrections from poor service.

COST CONTAINMENT. A major concern to any policy maker when you talk of increased qualifications for a trade is increased costs. The information provided by us during these past few days has shown that occupational therapists in licensed states have studied the effect of licensure on the salaries of occupational therapists and have found no substantial increase in salary. In addition, a tabulation of the average salary among occupational therapists in all fifty states shows that occupational therapists in licensed states actually earn a lower average salary than occupational therapists in unlicensed states. This clearly eliminates the argument for increased cost of occupational therapy services due to licensure.

LICENSURE IS THE APPROPRIATE LEVEL OF CREDENTIALING. It has been said during this hearing by Committee members that only occupations which operate completely alone should be licensed. However, in a large number of Kansas licensed professions this is not the case. For instance, dental hygienists are licensed yet they cannot even brush teeth without the <u>direct supervision</u> of a dentist; licensed practical nurses are licensed; yet they

attm. #10
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cannot function without the indirect supervision of the physician nor the direct supervision in most cases of the registered nurse. Registered nurses are licensed; yet they also do not function completely independently. The list goes on and on. Occupational therapists should be credentialed at the level of licensure. It is only under this level that legal responsibility can be directed. The question of which level is appropriate for occupational therapy is not a new one - licensure as the appropriate level has been decided by the TECHNICAL COMMITTEE of the SHCC, the FULL SCHH, as well as the Secretary of Health and Environment. THIS IS THE ONLY CREDENTIALING APPLICATION WHICH HAS BEEN APPROVED FOR THE LEVEL OF LICENSURE AT ALL LEVELS OF REVIEW!

As detailed by physicians in both written and oral testimony, occupational therapists receive an order (or prescription) from the physician. At this point the occupational therapists functions on her own as part of the medical team. The physician has little or no opportunity to supervise the work done by the occupational therapist. Further, as we heard in testimony, the occupational therapist is depended upon by the physician to offer alterations to the physician's order as needed to reach the ultimate end derived between the physician and the OT.

THE MEDICAL TEAM AGREES WITH THE LEVEL OF LICENSURE OF OT. As described by the physicians who presented testimony in writing and in person, the medical team utilized in situations where OT is a part, agree with the level of licensure. That team consists of the physician, the occupational therapist, and the physical therapist. Although there are some areas of necessary overlap, this licensure is desired.

attm #1
2-24-86

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED

TOPEKA RESOURCE CENTER FOR THE HANDICAPPED
MITCH COOPER, L.M.S.W.
Executive Director

West Tenth Professional Building
1119 West Tenth, Suite 2
Topeka, Kansas 66604-1105

Telephone
913-233-6323

TO: House Committee on Public Health and Welfare

FROM: Michael J. Byington, Outreach Advocate/Case Manager

SUB: House Bill 2498

DATE: February 24, 1986

This is supplemental testimony to that which I have already submitted. It is my understanding from talking with other lobbyists that the House Public Health and Welfare Committee has requested additional definitions materials concerning a number of therapeutic modalities whose representatives have concerns in reference to House Bill2498. It is my pleasure to offer definitions for a number of modalities.

The National Association for Drama Therapy defines drama therapy as follows. Drama therapy is the planned, systematic use of drama/theater processes, utilized to bring about improvement in functioning and positive change in personality. While drama therapy is related to creative drama as well as theater, it is different from each in that it is a form of therapy which utilizes drama as its primary tool. The goals of this modality, therefore, are defined by the therapeutic context within which the drama therapist works.

My previous testimony also references instructors for the blind and rehabilitation teachers for the blind. These modalities have lengthy definitions provided through state civil service as they are civil service positions and civil service titles. I do not have in my current possession copies of the unabridged job descriptions, but I am certain legislative research will be happy to provide this information for you. Upon receiving the information, you will discover that the duties of these civil service titled individuals are very similar to those described as being assigned to occupational therapy in HB-2949 except that the duties relate specifically to work with blind and visually impaired individuals.

I also, in previous testimony have referenced the term Case Manager. Case management is essentially a managerial term and is defined quite differently via the administrative and service delivery structures of community and institutional based agencies. In reference to Centers for Independent Living such as the Topeka Resource Center for the Handicapped,

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case management is defined as the overall coordination of services necessary to assist individuals in achieving and living at their maximum potential for independence. This can, in some cases, include the administration of initial assessment in testing tools to determine needs and appropriate referrals. It can certainly include the administration of direct recreational services and/or hands-on training in the use of adaptive equipment for purposes of improved independent function.

I think it becomes clear that it is impossible to limit the scope of practice in these areas to one group having only one modality of training.