Approved 4-1-86
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

10:00 a.m./~~p.m.~~ on March 24, 1986 in room 526-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Norman Furse, Legislative Research
Clarene Wilms, Committee Secretary

Conferees appearing before the committee:
Rita Wolf, KDHE - representative for Secretary Barbara Sabol
Elizabeth Taylor, Kansas Occupational Therapy Association
Linda Nobles, Occupational Therapy Association
Dick Hummell, Kansas Health Care Association
Steve Curtis, Kansas Respiratory Therapy Society
Written Testimony - Cam Wilson, President, Kansas Chapter American Physical Therapy Association

Others attending: See attached list

HB-2498 - An Act concerning occupational therapy; providing for registration of occupational therapists and occupational therapy assistants by the state board of healing arts;

Rita Wolf, KDHE testified and presented written testimony submitted by Secretary Barbara Sabol. Attachment I It was stated that KDHE supports the provisions of HB-2498. The written testimony stated that the department supported licensure. The bill was amended by the house committee to read "registration" rather than licensure. The written testimony stated that all 3 criteria for credentialing have been met according to the present statutes.

Elizabeth Taylor testified and presented written testimony in support of HB-2498. Attachment II Ms. Taylor stated the group supported licensure and presented an amendment to the bill. Attachment III She stated that the testimony supported licensure since that was the eventual goal of the group. Written information by the Kansas Occupational Therapy Association was presented in support of HB-2498. Attachment IV

Linda Noble testified representing the Occupational Therapy Organization covering the scope of duties the occupational therapists handle. She also covered the education involved in their training.

Dick Hummel testified and presented written testimony on HB-2498. Attachment V Mr. Hummel stated concerns that the provisions of this bill as written could result in unnecessary expenditure of monies in new health care costs. He also requested an amendment which would remove a person employed as an activity director in the adult care home. When questioned as to whether or not the occupational therapists had been consulted on this amendment he stated they had not. Elizabeth Taylor indicated that the occupational therapists would not want an amendment such as offered by Mr. Hummel if they looked at registration. She stated that it was her understanding that occupational therapy consultants were mandated federally.

HB-2533 - An Act concerning respiratory therapy; providing for registration of respiratory therapists by the state board of healing arts;

Steve Curtis testified and presented written testimony in support of HB-2533. Attachment VI Mr. Curtis stated they were interested in licensure but the house had requested they try registration first and they had agreed to that. The Respiratory Therapist Society requested that the legislators mandate a

a legal credentialing mechanism for respiratory therapists in Kansas. Mr. Curtis presented some requested amendments to HB-2533. Attachment VII The committee asked Mr. Curtis whether or not these amendments were presented to the house committee and he replyed no, that many changes were occurring as the bill was processed through the house and they were reluctant to add any more. He also stated that these changes were basically technical.

Rita Wolf testified and presented testimony as a representative of Secretary Sabol, KDHE. Attachment VIII The written testimony states that KDHE supports HB-2533 which provides for the licensure of respiratory therapists.

Written testimony in support of HB-2498 and HB-2533 by the American Physical Therapy Association was submitted. Attachment IX

Meeting adjourned at 10:47 a.m.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-24-86

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Dan V. Johnson, 3120 Ranger Dr. Lawrence, Ks.	Kans. Resp. Ther. Society
Steven E. Curtis KCK	Ks. Respiratory Ther. Soc.
Debbie J. Elder	Nat'l. Bd. for Respiratory Care
J. Michael Hinds, RRT	Ks. Resp. Ther. Society
Dick Hummel	Ks Health Care Assn.
Wes Worthington	" " "
Frances Kastner	Ks Physical Therapy Assn
Joanne Hill	Ks Physical Therapy Assn
Chris Wilson	Ks. Physical Therapy Assoc.
Tom Bell	KHA
Belva Ott	Planned Parenthood of Kansas Inc
Marilyn Bradt	KINH
Theresa Shively	Kansas NARAL
Peter J. Wolf	KDHE
Mary Gallagher	Ks Medical Society
Thelodith Mahlin OTR	KOTA
Elizabeth E. Saylor	KOTA
Kathleen Braskovich, Lawrence	K.O.T.A.
Verne Rosselot	KSNA
Keith R. Landis	Christian Science Committee on Publication for Kansas
Anne Moriarty	Ks Nat'l Org. for Women
Charlene K. Abbott	Bd. of Healing Arts
Larry Buening	Bd of Healing Arts

3-24-86

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON HOUSE BILL 2498
PRESENTED TO THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE, MARCH, 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.

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

Attachment I
3/24/86
S. PH&W

1

3-24-86

KOTA

KANSAS OCCUPATIONAL THERAPY ASSOCIATION
SERVING KANSAS AND WESTERN MISSOURI

March 24, 1986

TO: Senate 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 direct supervision of a dentist; licensed practical nurses are licensed; yet they

Attachment II
3/24/86 S. PH&W

II

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.

3-24-86

As Amended by House Committee

Session of 1985

HOUSE BILL No. 2498

By Committee on Public Health and Welfare

2-25

AN ACT concerning occupational therapy; providing for ~~licen-~~ ~~sure~~ registration of occupational therapists and occupational therapy assistants by the state board of healing arts; establishing an occupational therapist council; declaring certain acts to be unlawful and providing penalties for violations; amending K.S.A. 75-3170a and repealing the existing section.

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

New Section 1. This act shall be known and may be cited as the occupational therapy practice act.

New Sec. 2. As used in sections 1 to 18, inclusive:

(a) "Board" means the state board of healing arts.

(b) "Occupational therapy" is a health care profession whose practitioners are employed under the supervision of a ~~person licensed to practice medicine and surgery~~ physician 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. Specific occupational therapy services include:

when services are performed in a medical facility or who perform these services in a non-medical facility.

(1) Administering and interpreting tests necessary for effective treatment planning;

(2) developing self-care and daily living skills such as feeding, dressing, hygiene and homemaking;

(3) designing, fabricating, applying or training, or any combination thereof, in the use of selected orthotics, upper extremity prosthetics or adaptive equipment;

(4) developing sensory integrative skills and functioning;

(5) using therapeutic activity and exercise to enhance func-

Attachment III
3/24/86 S. PH&W

III

As Amended by House Committee

Session of 1985

HOUSE BILL No. 2498

By Committee on Public Health and Welfare

2-25

AN ACT concerning occupational therapy; providing for ~~licensure~~ registration of occupational therapists and occupational therapy assistants by the state board of healing arts; establishing an occupational therapist council; declaring certain acts to be unlawful and providing penalties for violations; amending K.S.A. 75-3170a and repealing the existing section.

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(4) developing sensory integrative skills and functioning;

(5) using therapeutic activity and exercise to enhance func-

when services are performed in a medical facility

or who perform these services in a non-medical facility.

3-24-86

TESTIMONY
PRESENTED TO SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
in support of HB 2498

by the Kansas Occupational Therapy Association
March 24, 1986

The data enclosed includes the following:

- Occupational Therapy work setting statistics
- Occupational Therapy educational program coursework
- Data Briefs which show the reduced cost of health care when O.T. is used
- Support letters showing that O.T. licensure in other states does not increase the cost of health care
- O.T. salary schedules for all 50 states showing that O.T.'s in unlicensed states earn a higher average salary than O.T.'s in licensed states

Other testimony will be presented during the hearing (copies of which will be given to the committee by conferees).

For more information, contact Elizabeth E. Taylor, Legislative Consultant to KOTA, 129 North Broadmoor, Topeka, KS 66606, 913-354-1605.

Attachment IV
3/24/86 S. PH&W

IV

KOTA

KANSAS OCCUPATIONAL THERAPY ASSOCIATION
SERVING KANSAS AND WESTERN MISSOURI

OCCUPATIONAL THERAPY IN KANSAS

A. OCCUPATIONAL THERAPY IS ONE OF THE NATION'S FASTEST GROWING ALLIED HEALTH PROFESSIONS.

In Kansas there are 512 Occupational Therapists, Occupational Therapy assistants, and students of Occupational Therapy. Presently there are 401 employed Occupational Therapists and 38 employed Occupational Therapy assistants. Currently, 300 Occupational Therapists are members of the Kansas Occupational Therapy Association.

B. OCCUPATIONAL THERAPY EDUCATION.

1. Entry Level Bachelors Program located at:
   University of Kansas
   318 Blake
   Lawrence, Kansas 66045
   (913) 864-3735
2. Occupational Therapy Assistant Program located at:
   Barton County Community College
   R.R. #4
   Great Bend, Kansas 67530
   (316) 792-2701 Ext. 156

   AND

   University of Kansas
   318 Blake
   Lawrence, Kansas 66045
   (913) 864-3735

C. WHAT IS OCCUPATIONAL THERAPY?

Occupational Therapy is a dynamic form of rehabilitation which is based upon the idea of healing through doing or "purposeful activity". Clinicians work with individuals who have had to adapt to a physical or emotional disability, or who experience impairment due to developmental delays or the aging process. The goal of treatment is to maximize functional independence. The therapist assists the client to regain the motor, cognitive and/or psychological skills necessary to perform the daily functional activities.

D. WHERE DO OCCUPATIONAL THERAPISTS WORK IN KANSAS?

1. 55.7% of Occupational Therapist and 50.2% of Occupational Therapy assistants work in the following Medical settings:

   Community Mental Health Centers
   Health Maintenance Organizations
   Home Health Agencies
   Hospices
   Hospitals
   Psychiatric Hospitals
   Public Health
   Rehabilitation Hospitals
   Sheltered Nursing Homes

2. 34.1% of Occupational Therapists and 50.1% of Occupational Therapy assistants work in the following Community settings:

   4-year Colleges
   2-year Colleges
   Day Care
   Corrections
   Private Industry
   Private Practice
   Residential Care
   School Systems
   Sheltered Workshops

E. DIAGNOSTIC CATEGORIES THAT OCCUPATIONAL THERAPISTS TREAT:

1. Behavioral Disorders
2. Developmental Delay
3. Learning Disabilities
4. Mental Retardation
5. Metabolic Disorders
6. Muscular-Skeletal Conditions
7. Neurological Disorders
8. Psychiatric Disorders
9. Traumatic Injuries
10. Visual and/or Hearing Impairments

F. REASONS FOR LICENSING OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS:

1. The unregulated practice of the profession can endanger the health, safety, or welfare of the public.
2. The practice of the profession requires specialized skill or training and the public needs will benefit from assurance of initial and continuing professional ability.
3. The public is not effectively protected from harm by means other than credentialing.

G. HISTORY OF THE LICENSURE EFFORT IN KANSAS:

1. In 1974, the American Occupational Therapy Association offically recognized the merits of licensure for the legal protection that it affords the consumer. There are currently 29 states licensed.
2. In 1977, a licensure committee was formed in Kansas. Shortly thereafter the Kansas Legislature put a moratorium on all licensure bills.
3. In 1980, House Bill 2755 was passed, authorizing a state credentialing program.
4. In 1980, the licensure committee began work on the application and in November, 1982 the notice of intent was submitted and accepted.
5. In December of 1983, a technical committee was chosed and from January of 1984 through May of 1984, four public hearings were held to review and analyze our application. In May of 1984, our technical committee recommended to the Statewide Health Coordinating Council that Occupational Therapy become a licensed profession.
6. In July of 1984, the Statewide Health Coordinating Council voted to recommend to the legislature that Occupational Therapy become licensed.
7. In October of 1984, the Department of Health and Environment concurred with the Statewide Health Coordinating Council recommendation.
8. In March of 1985, the Public Health and Welfare Committee of the House of Representatives voted to send the H.B. 2498 to Interim Committee for further study.

H. FOR MORE INFORMATION ABOUT OCCUPATIONAL THERAPY IN KANSAS, PLEASE CONTACT:

1. Sue Merryfield
   President
   9527 Granada
   Overland Park, Kansas 66207
   (913) 381-8680
2. Meredith Mohler
   Credentialing Chairperson
   5219 S.W. 2nd Pk #3
   Topeka, Kansas 66614
   (913) 273-3596
3. Linda Baker Nobles
   9924 Catalina
   Overland Park, Kansas 66207
   (913) 649-6735
4. Mary Anne McDowell
   Kansas University Medical Center
   39th and Rainbow
   Kansas City, Kansas 66103
   (913) 533-3128

Essentials and Guidelines of an Accredited Educational Program for the Occupational Therapist

Essentials initially adopted 1935;

revised 1943, 1949, 1965, 1973, and 1983

Adopted by the

AMERICAN MEDICAL ASSOCIATION
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.

Essentials, which present the minimum accreditation standards for an educational program, are printed in regular typeface. The extent to which a program complies with these standards determines its accreditation status; the *Essentials* therefore include all requirements for which an accredited program is held accountable.

Guidelines, explanatory documents which clarify the *Essentials*, are printed in italic typeface. Guidelines provide examples, etc, to assist in interpreting the *Essentials*.

PREAMBLE

OBJECTIVE

The American Medical Association and the American Occupational Therapy Association, Inc. cooperate to establish, maintain and promote appropriate standards of quality for educational programs in occupational therapy and to provide recognition for educational programs which meet or exceed the minimum standards outlined in these *Essentials*.

These *Essentials* are the minimum requirements for baccalaureate or post-baccalaureate occupational therapy entry-level professional programs. The sponsoring institution offering a professional education program in occupational therapy assumes responsibility for ensuring that the established *Essentials* contained herein will be met and maintained. Surveys are made by the appropriate recognized bodies and lists of accredited programs are published for public information.

DESCRIPTION OF THE PROFESSION

Occupational therapy is the art and science of directing man's participation in selected tasks to restore, reinforce and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity, diminish or correct pathology, and to promote and maintain health. Reference to occupation in the title is in the context of man's goal-directed use of time, energy, interest, and attention. Its fundamental concern is the development and maintenance of the capacity throughout the life span, to perform with satisfaction to self and others those tasks and roles essential to productive living and to the mastery of self and the environment.

Since the primary focus of occupational therapy is the development of adaptive skills and performance capacity, its concern is with factors which serve as barriers or impediments to the individual's ability to function, as well as those factors which promote, influence or enhance performance.

Occupational therapy provides service to those individuals whose abilities to cope with tasks of living are threatened or impaired by developmental deficits, the aging process, poverty and cultural differences, physical injury or illness, or psychological and social disability.

Occupational therapy serves a diverse population in a variety of settings such as hospitals and clinics, rehabilitation facilities, long-term care facilities, extended care facilities, sheltered workshops, schools and camps, private homes, housing projects, and community agencies and centers. Occupational therapists both receive from and make referrals to the appropriate health, educational, or medical specialists. Delivery of occupational therapy services involves several levels of personnel including the registered occupational therapist, the certified occupational therapy assistant, and aides.

Entry-level occupational therapy professional education programs prepare the individual to:

1. Provide occupational therapy services to prevent deficits and to maintain or improve function in daily living skills and in underlying components, e.g., sensorimotor, cognitive, and psychosocial.
2. Manage occupational therapy service.
3. Incorporate values and attitudes congruent with the profession's standards and ethics.

Entry-level professional education lays a foundation for c[illegible] roles of the experienced therapist, eg, consultant, educa[illegible], researcher, and health planner. The American Occupational Therapy Association maintains an entry-level role delineation.

REQUIREMENTS FOR ACCREDITATION

I. SPONSORSHIP

A. An occupational therapy professional education program shall be located in a college or university authorized to grant the baccalaureate or higher degree.

B. In programs where the academic and fieldwork phases are provided in two or more institutions, accreditation will be granted to the sponsoring institution that assumes primary responsibility for curriculum planning and selection of course content; coordinates classroom teaching and supervised fieldwork; appoints faculty to the program; receives and processes applications for admission; and grants the degree or certificate documenting completion of the program. The sponsoring institution shall be responsible for assuring that the activities assigned to students in fieldwork are educational.

C. Institutions involved in the education process shall be recognized
   1. The sponsoring university or college shall be recognized by regional accrediting bodies.
   2. Fieldwork centers shall be approved by recognized accrediting agencies or meet standards established by the educational program.

D. Responsibilities of the sponsoring institution and each fieldwork education center shall be clearly described in written documents.

Examples of such documents include letters, contracts, educational objectives, or informational forms.

Provision should be made for periodic review of same.

II. EDUCATIONAL PROGRAM

A. The statement of the mission and purpose of the Occupational Therapy program shall be consistent with that of the sponsoring institution.

B. The statement of philosophy of the occupational therapy program shall reflect the philosophy of the profession of occupational therapy.

C. A curriculum design shall be basic to the development, implementation, and continuing evaluation of the program and shall
   1. Describe the basis for the selection of content, scope, and sequence.
   2. Identify general objectives.
   3. Explain content sequencing as it relates to curriculum design.

A wide variety of curriculum patterns may serve as effective means of organizing the professional educational program.

D. The length of the educational program shall be sufficient to meet
   1. The profession's requirements.
   2. The requirements of the sponsoring institution at the Baccalaureate, Certificate, or Master's Level.

The profession's requirements refer to sufficient content for achievement of entry-level competencies and requirements for certification.

E. Content requirements shall include liberal and professional education

Documentation shall include instructional objectives, outlines, methods, and learning experiences.

   1. Liberal arts, sciences, and humanities.
      Prerequisite to or concurrent with professional education are those studies that encourage
      a. Broadening of intellectual powers and interests.
      b. Exploration of attitudes and values.

Studies may include English composition, literature, anthropology, psychology, sociology, philosophy, biology, and speech.

   2. Biological, behavioral, and health sciences.
      a. Structure and function of the human body and recognition of normal and abnormal conditions.

Content should include anatomy, kinesiology, physiology, neuroanatomy, and neurophysiology.

      b. Human development throughout the life cycle including sensorimotor, cognitive, and psychosocial components.
      c. Human behavior in the context of socio-cultural systems and beliefs, ethics, and values.

Studies may include the interaction between individuals and their social systems, and the affect of personal ethics and values on behavior.

      d. Effects of health and illness on person and society.

Studies may include the promotion of health and prevention of disease; the etiology, clinical course, management, and prognosis of congenital, developmental, acute, and chronic disease processes and traumatic injuries; and the effect of such conditions on human functioning and society.

   3. Occupational therapy theory and practice
      a. Human performance
         Occupation throughout the life cycle; human interaction, roles, values, and the influence of the non-human environment.
      b. Activity processes
         (1) Theories underlying the use of purposeful activity; the meaning and dynamics of activity—self-care, work, play, and leisure.
         (2) Performance of selected life tasks and activities.
         (3) Analysis, adaptation, and application of purposeful activity as therapeutic intervention.

Analysis of activities should include their sensorimotor, cognitive, and psychosocial components as well as their relevance to patients/clients.

(4) Use of self, dyadic, and group interaction.

c. Theoretical approaches including those related to purposeful activity, human performance, and adaptation.

d. Application of occupational therapy theory to practice

(1) Assessment and interpretation
Observation
Interviews
History
Standarized and non-standarized tests

(2) Directing, planning, and implementation

(a) Therapeutic intervention related to daily living skills and sensorimotor, cognitive, and psychosocial components.

(b) Therapeutic adaptation including methods of accomplishing daily life tasks, environmental adjustments, orthotics, and assistive devices and equipment.

(c) Health maintenance including energy conservation, joint protection, body mechanics, and positioning.

(d) Prevention programs to foster age-appropriate balance of self-care, work, and play/leisure.

(3) Termination
Program termination including re-evaluation, determination of discharge, summary of occupational therapy outcome, and appropriate recommendations to maximize treatment gains.

(4) Documentation

Content should include professional terminology, recording and reporting methods, and sharing information with other individuals.

e. Development and implementation of quality assurance.

f. Management of occupational therapy service.

(1) Planning services for client groups.

(2) Personnel management: Cota's, aides, volunteers, and Level I students.

Content should include roles and functions of various levels of occupational therapy personnel as well as interdisciplinary and supervisory relationships within the administrative hierarchy.

(3) Departmental operations: budgeting, scheduling, record keeping, safety, and maintenance of supplies and equipment.

4. Research

a. Critique of studies related to occupational therapy.

b. Application of research approaches to occupational therapy practice.

5. Values and attitudes congruent with

a. The profession's standards and ethics.

b. Individual responsibility for continued learning.

c. Participation in the promotion of occupational therapy through professional organizations, governmental bodies, and human service organizations.

d. Documentation and validation of occupational therapy practice through research, publication, and program evaluation.

6. Fieldwork education

a. Supervised fieldwork shall be an integral part of the professional education program.

(1) There shall be collaboration between academic and fieldwork educators.

Collaboration may be fostered by on-site visits, written and oral communication, reports from students, a fieldwork council, and other mechanisms for communication.

(2) Objectives for each phase of fieldwork shall be

(a) Developed collaboratively by academic and fieldwork educators.

(b) Documented.

(c) Known to the student.

(3) Fieldwork shall be conducted in settings approved by the program as providing experiences appropriate to the learning needs of the student and as meeting the objectives of fieldwork.

b. Level I Fieldwork shall be provided.

Level I Fieldwork includes those experiences designed as an integral part of didactic courses for the purpose of directed observation and participation in selected field settings. These experiences are not expected to emphasize independent performance or to be considered substitutes for or part of the sustained Level II Fieldwork.

c. Level II Fieldwork shall be required. It shall

(1) Include a minimum of six months of practice.

(2) Emphasize the application of an academically acquired body of knowledge.

The purpose of Level II Fieldwork is to provide an in-depth experience in delivering occupational therapy services to clients.

(3) Include experience with a wide range of client ages and a variety of physical and mental health conditions.

Within the six-month period there should be opportunities for supervised practice of occupational therapist entry-level roles. At least three months of the sustained fieldwork experience is desirable on a full-time basis. If equivalent time is used, it should be appropriate to the setting selected, student needs, and continuity of client services, eg, consecutive half days. To ensure continuity and meaningful application of academic concepts, all fieldwork experiences should be completed not later than 24 months following completion of academic preparation.

F. Evaluation of the educational program shall be conducted including

1. Student learning.

Methods for evaluation of student learning should be consistent with course objectives and methods of instruction. Prior to evaluation, the student should be made aware of the criteria, methods, and weight of measures to be used.

2. Instructor and course effectiveness.

3. Curriculum.

A variety of methods, procedures, and instruments may be used to obtain information on all aspects of instruction, eg, instructor effectiveness, curriculum design, sequence, and relevance. Information from student, instructor, and course evaluation should be used to make needed adjustments.

III. RESOURCES

Resources shall be provided to meet the purpose and objectives of the educational program.

A. Program Director

1. The director of the educational program shall be a registered occupational therapist who has relevant occupational therapy experience in administration, teaching, and direct service. In addition, the director shall hold the master's or doctoral degree, or have equivalent educational qualifications.

2. The director of the educational program shall be responsible for the organization, administration, evaluation, continued development, and general effectiveness of the program.

Administration should include such functions as budget development and control and faculty selection, development, and retention as congruent with institutional policy.

B. Instructional Staff
   1. The faculty shall include registered occupational therapists.
   2. The faculty shall be qualified, knowledgeable, and effective in teaching the content assigned.

Selection of faculty should assure expertise in keeping with the content inherent in an occupational therapy curriculum. Faculty should meet the standards of the sponsoring institution for their academic preparation.

   3. Faculty responsibilities shall be consistent with the mission of the sponsoring institution.

Faculty responsibilities may include teaching, community service, research, student advising, and participation in institutional activities.

   4. The faculty/student ratio shall
      a. Permit the achievement of the purpose and the stated objectives of the program.
      b. Be compatible with accepted practices of the institution.
   5. Continuing professional development for faculty shall include
      a. A plan for and commitment by faculty.
      b. Support for the implementation of the plan by the institution.

The plan should be documented and may be accomplished using institutional resources. This may include opportunities for participation in educational programs and workshops, research in the area of specialty, consultative appointments, and direct involvement with delivery of occupational therapy services. Support may include released time, funding, and recognition.

C. Fieldwork Educators
   1. The ratio of fieldwork educators to students shall be such as to ensure quality experience and maximal learning.
   2. Level I Fieldwork shall be supervised by qualified personnel.

Qualified personnel may include occupational therapy personnel and other appropriate personnel such as teachers, social workers, public health nurses, ministers, probation officers, and physical therapists.

   3. Level II Fieldwork shall be supervised by a registered occupational therapist who shall
      a. Collaborate with academic faculty.
      b. Have a minimum of one year of experience.

D. Support Services.
   Support services shall be provided to meet program and administrative requirements.

E. Financial Resources.
   A budget of regular institutional funds shall be sufficient to develop and maintain the program.

F. Physical Resources.
   1. Classrooms, laboratories, offices, and other facilities shall be provided.

Assigned space should be consistent with the program's educational objectives and teaching methods.

   a. Laboratory space shall be assigned to the occupational therapy program on a priority basis.

Space should be provided in the laboratory area to adequately store and secure equipment and supplies.

   b. Faculty, staff, and administrative offices shall allow for efficient operation of the program.
   c. Space shall be available for private advising of students.
   2. Equipment and supplies consistent with program objectives and teaching methods shall be available.
   3. A library shall be accessible, containing current standard texts, scientific books, periodicals, and other reference materials relevant to the program.

"Accessible" refers to convenient location, operating hours, and particular library policies, eg, borrowing, reserve. There should be adequate budgetary provision for purchase of pertinent reference materials to support occupational therapy education.

IV. STUDENTS

A. Program Description
   1. A description of the program and its content shall be made available to the student.
   2. Requirements for successful completion of the academic and fieldwork segments of the program, and for graduation, shall be made available to each student.

B. Selection
   Selection of students shall be made in accordance with generally accepted practices of the institution. These practices shall be defined and published.

The selection of students to the program and their retention should be a joint responsibility of the Director, the faculty of the program, and the appropriate administrative officials.

C. Advising
   1. Advising related to professional course work and fieldwork education shall be the responsibility of the occupational therapy faculty.
   2. Advising during and pertaining to fieldwork experience shall be a collaborative process between the faculty and the field-work educators.

D. Rights and appeal mechanisms
   Students' responsibilities and rights, including appeal mechanisms, shall be published and made available. These shall relate to both the academic and fieldwork components of the program.

E. Records
   Records shall be maintained in accordance with institutional policies for student admission, health, attendance, achievement, and evaluation.

V. OPERATIONAL POLICIES

A. An official publication including a current description of the educational program shall be provided.

B. There shall be accurate and available published statements of fair practice that have as their purpose the protection of the rights, privileges, and responsibilities of the student, faculty, and institution, as follows
   1. Nondiscrimination policies as they relate to student admission, matriculation, and faculty recruitment.
   2. Fee and tuition costs for all requirements of the education program.
   3. Policies and procedures regarding discontinuance, withdrawal, and refunds of tuition and fees.

4. Separate mechanisms for graduation and credentialing.

Certification with the American Occupational Therapy Association or licensure with the state are credentialing mechanisms separate from program completion.

VI. CONTINUING PROGRAM EVALUATION

There shall be systematic and periodic program evaluation.

Program evaluation should include data from faculty, fieldwork centers, students, graduates, employers, sponsoring institution, and professional associations. Such information (sometimes referred to as a Self-Study) should contribute to on-going program development and modifications.

VII. MAINTAINING ACCREDITATION

A. The annual report form provided by the Committee on Allied Health Education and Accreditation shall be completed, signed by an appropriate official, and returned by the established deadline.

B. If the Program Director of an accredited program is changed; prompt notification shall be sent to the Accreditation Section, American Occupational Therapy Association. A curriculum vitae of the new program official, giving details of education and experience in the field, shall be provided.

C. Upon recommendation of the American Occupation Therapy Association Accreditation Committee, the Committee on Allied Health Education and Accreditation may withdraw accreditation whenever the educational program is not maintained in substantial compliance with the standards or there are no students in the program for two consecutive years.

D. Accreditation shall be withdrawn only after notice has been given to the chief executive officer of the institution that such action is contemplated, with reasons for same, and with sufficient time to permit a considered response. Established procedures for appeal and review shall be available.

The sponsoring institution should provide students with notification of substantial noncompliance with *Essentials* that may jeopardize accreditation of the educational program.

ADMINISTRATION OF ACCREDITATION

1. Application for accreditation of a program should be made to:
   Accreditation Section
   American Occupational Therapy Association
   1383 Piccard Dr
   Rockville, MD 20850
2. The evaluation and accreditation of a program can be initiated only at the written request of the chief executive officer of the sponsoring institution or an officially designated representative.
3. A sponsoring institution may withdraw its request for initial accreditation at any time (even after the site visit) prior to final action.
4. The program being evaluated is given the opportunity to review the actual report of the visiting survey team and to comment on its accuracy before final action is taken.
5. The Committee on Allied Health Education and Accreditation (CAHEA) and the Accreditation Committee, American Occupational Therapy Association, will periodically resurvey educational programs for continued accreditation.
6. The chief executive officer of the sponsoring institution may request that a return on-site evaluation be made in the event of significant deficiencies in the performance of an earlier evaluation team.
7. Adverse accreditation decisions may be appealed by writing to the Committee on Allied Health Education and Accreditation (CAHEA). Due process will be followed.

aota

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.
1383 PICCARD DRIVE
ROCKVILLE, MD 20850

KANSAS EXAMPLES OF POTENTIAL FOR HARM THROUGH UNLICENSED PRACTICING OF OCCUPATIONAL THERAPY

Prepared by the Kansas Occupational Therapy Association January, 1986

These examples were actual complaints received by the American Occupational Therapy Association. Because the health care workers in question had not professional certification by AOTA and because no certification or educational requirements are required in Kansas to call your practice 'occupational therapy' there was no recourse.

Within the last 2 years

- Metropolitan hospital - uncredentialed allied health worker practicing occupational therapy and billing for services as occupational therapy. Patient was actually harmed and the worker was dismissed.
- Small town hospital - occupational therapy services are being billed to Medicare by a worker calling himself an occupational therapist when he has no qualifications to do so.
- Patient in a metropolitan area contacted an OTR to say the another OT had made a foot splint (which is not within the scope of practice of an occupational therapist) that was made incorrectly. The patient then required foot surgery to repair the damage to the foot.

Other financial concerns of the KOTA regarding hiring persons uneducated in occupational therapy surround the issue of insurance and governmental funding for reimbursement of occupational therapy services when these services are not being provided by registered or educated occupational therapists. Because much of the medical dollars are government funded, and thereby paid for by the public, occupational therapy services should be provided by those educated and licensed in occupational therapy.

The above actual examples of potential harm were gathered after the KOTA went through the SHCC process and thereby are not the ones used during SHCC testimony.

Quality Assurance Division
The American Occupational Therapy Association, Inc
Rockville, Maryland

REHABILITATION PROVES COST-EFFECTIVE IN TREATMENT OF MULTIPLE SCLEROSIS

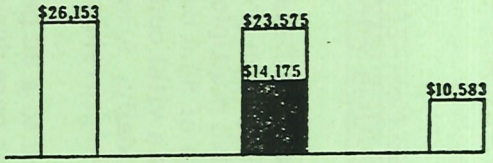
- A multidisciplinary team investigating treatment of 20 multiple sclerosis (MS) patients at a rehabilitation center found statistically significant improvements in functioning after treatment, along with measurable cost savings.
- As part of the rehabilitation team, an occupational therapist worked with each patient one or two times daily on upper extremity functioning, transfer activities, activities of daily living, homemaking, community involvement, and use of adaptive equipment.

Therapy Outcomes

Rated category	Level of statistical significance
Balance	$p < 0.001$
Self-care activities	$p < 0.000$
Bed mobility	$p < 0.000$
Wheelchair transfers	$p < 0.000$
Ambulatory transfers (for ambulatory patients)	$p < 0.041$
Wheelchair management	$p < 0.001$
Homemaking	$p < 0.000$
Real-life activities	$p < 0.001$

A comparison before and after rehabilitation, using the Multiple Sclerosis Functional Profile, shows statistically significant improvement in all categories. Note: "p" means probability. Any probability .05 or smaller is statistically significant, meaning that the likelihood of the results occurring by chance are extremely small, i.e., the results are due to the experimental treatments.

Analysis of Annual Care Costs



Year Before Rehabilitation: Average Costs of Home Care

Year Received Rehabilitation:
■ Average for Inpatient Program $14,175
□ Average Home Care Following Discharge $9,400

Year After Rehabilitation: Average Costs of Home Care

Study conclusions:

- "Data indicate that patients with fixed, chronic neurological deficits from longstanding multiple sclerosis can achieve significant functional improvement from intensive, multidisciplinary rehabilitation."
- "The therapeutic programs we provided... emphasized the role of skilled rehabilitation nursing and occupational therapy, since these groups usually provide the type of training that maximally benefits patients with multiple sclerosis."
- Rehabilitation which included occupational therapy was related to a 60 percent reduction in the cost of home care for multiple sclerosis patients.
- Overall costs of care during the year when intensive inpatient rehabilitation was received were less than the costs of home care in the previous year.

Sources: Feigenson JS, Scheinberg L, Catalono M, Polkow L, Mantegazza PM, Feigenson WD, LaRocca NG. "The cost-effectiveness of multiple sclerosis rehabilitation: A Model," Neurology, Vol. 31, No. 10, pp. 1316-1322,

Feigenson JS, McCarthy ML. "Guidelines for establishing a stroke rehabilitation unit," New York State Journal of Medicine, pp. 1430-1434, August 1977, (describes program also used with multiple sclerosis patients)

Personal communication March 1, 1983 with Linda Polkow, OTR, occupational therapist participating in the study (clarified nature of occupational therapy intervention).

USING OCCUPATIONAL THERAPY EFFICACY DATA FOR ADVOCACY AND QUALITY ASSURANCE

Rehabilitation Can Be Cost-Effective in Treatment of Multiple Sclerosis

The research study summarized in the attached Data Brief supports the utilization of occupational therapy as part of the rehabilitation program for individuals with fixed, neurological deficits. Twenty patients with multiple sclerosis who had not responded to outpatient regimes received an average of 52.6 days of concentrated, inpatient rehabilitation. Occupational therapy was a vital component of this program, with patients receiving one to two treatments daily. A multidisciplinary research team found statistically significant functional improvements in nine areas assessed.

The rehabilitation regime was also related to a 60 percent reduction in the cost of home care for these patients. The total cost for care during the year in which this intensive rehabilitation was received remained less than the total care costs for the year preceding participation in the study. As the data brief indicates, intensive rehabilitation, including occupational therapy, for multiple sclerosis patients has a role in improving function and ultimately reducing overall care costs.

This brief can be used in a variety of ways with policymakers at all levels. For legislators and third party payers, the study shows that for multiple sclerosis patients who have failed to respond to outpatient treatment, specialized inpatient rehabilitation, which includes occupational therapy, more than pays for itself in substantially reducing subsequent home care costs. Furthermore, patients can achieve higher levels of independent functioning and enjoy a less restricted lifestyle.

For referring physicians, this study links intensive rehabilitation including occupational therapy to improved functional outcomes for multiple sclerosis patients. Patients undergoing rehabilitation became more functionally independent and subsequently required less care at home. The implication for physicians is that patients with fixed, chronic neurological deficits can benefit from specialized inpatient rehabilitation, of which occupational therapy is a vital part.

This study, showing that rehabilitation which includes occupational therapy can make a difference for multiple sclerosis patients and save home care dollars, provides an excellent data base for a quality assurance study.

11/83

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.

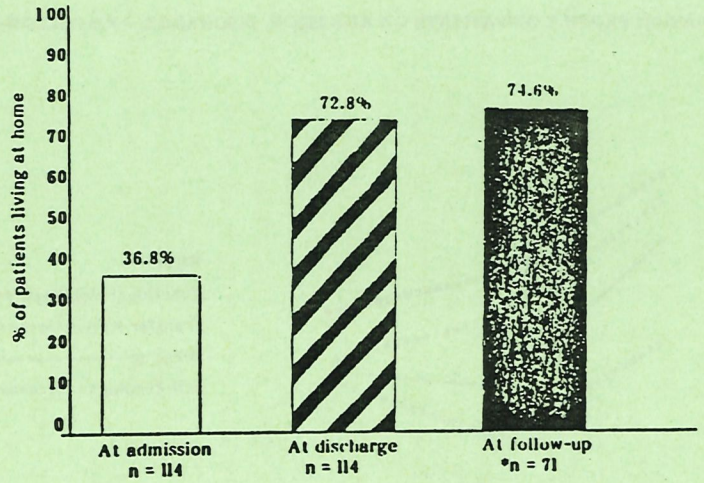
Quality Assurance Division

Quality Assurance Division
The American Occupational Therapy Association, Inc.
1383 Piccard Drive
Rockville, Maryland 20850 (301-948-9626)

STROKE REHABILITATION, INCLUDING OCCUPATIONAL THERAPY, REDUCES HEALTH CARE COSTS

- In a physician-directed study, 114 consecutively-admitted stroke patients were treated at a rehabilitation center. The mean time from stroke onset to rehabilitation center admission was 9.9 months. Seventy-one of these patients survived for functional evaluation at follow-up (mean time of follow-up, 28.7 months after discharge).
- "None of the patients admitted to the rehabilitation service was able to live independently at home."
- Patients were generally referred from other hospitals with severe involvement or after a long treatment period which produced little functional gain. However, functional gains at discharge from the rehabilitation center and at follow-up were statistically significant.

PATIENTS LIVING AT HOME
(VS INSTITUTION)



*n from 114 to 71 due to attrition at follow-up.

Study Conclusions:

- The proportion of patients able to live at home rose from 36.8 percent at admission to 72.8 percent at discharge to 74.6 percent at follow-up.
- An estimate of cost-benefit factors supports the idea that rehabilitating stroke patients reduces societal costs due to less need for nursing home placement.
- "...returning an institutionalized patient to the home results in a savings of $412 per month per patient." The ability to return home was largely dependent on functional status at discharge.
- Average survival rate of stroke patients is 51.2 months, while the break-even point offsetting rehabilitation costs for the entire study sample occurred at 21.5 months, meaning that "a substantial saving resulted from rehabilitating the patients."

Sources: Lehmann JF, DeLateur BJ, Fowler RS, et al. "Stroke: Does Rehabilitation Affect Outcome?" Archives of Physical Medicine and Rehabilitation, Vol. 56, pp. 375-382, September 1975.

Quality Assurance Division
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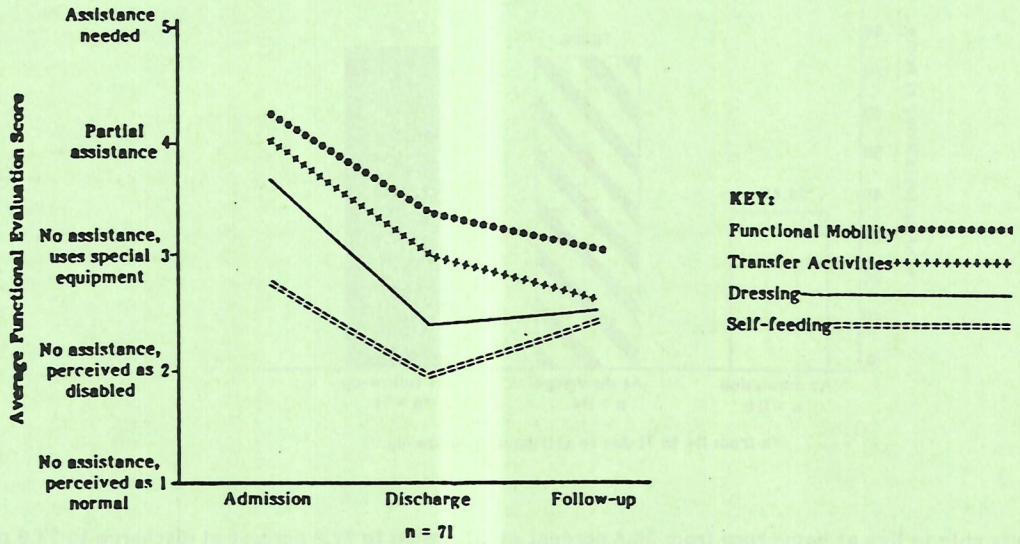
STROKE REHABILITATION, INCLUDING OCCUPATIONAL THERAPY AS PART OF TEAM, SHOWS STATISTICALLY SIGNIFICANT LONG-TERM FUNCTIONAL GAINS

- In a physician-directed study, 114 consecutively-admitted stroke patients treated at a rehabilitation center showed statistically-significant ($p < 0.01$) gains from admission to discharge in independence, as measured by a five-point scale, in areas of self-feeding, dressing, elimination, walking, transfer activities, and mobility.
- All patients in the study received a variety of treatments including two hours of occupational therapy daily, the latter consisting of re-education of upper extremities, when possible, and complete training in activities of daily living for all subjects.
- Seventy-one surviving patients, at a mean follow-up of 28.7 months after discharge, maintained these statistically significant gains ($p < 0.01$) with the exception of self-feeding in that subjects were no longer cutting their own meat.
- Even patients admitted six months (n = 24) and twelve months (n = 12) post-onset made statistically-significant gains ($p < 0.05$) from admission to follow-up in these areas.

FUNCTIONAL EVALUATION PROFILE OF PATIENTS ON ADMISSION, DISCHARGE, AND FOLLOW-UP



Study Conclusions:

- "These data support that there was a marked change in performance from admission to discharge, and that this improvement was largely maintained over the follow-up period with the exception of cutting meat (as part of the self-feeding item)."
- "It may be concluded that significant improvement occurred even at a time [6 to 12 months after stroke onset] when change can no longer be attributed to spontaneous recovery, thus proving that the rehabilitation process had an impact on improving the functional level of the patient."

Sources: Lehmann JP, DeLateur BJ, Fowler RS, et al. "Stroke: Does Rehabilitation Affect Outcome?" Archives of Physical Medicine and Rehabilitation, Vol. 56, pp. 375-382, September 1975.

Personal communication by letter with Dr. Justus F. Lehmann, March 3, 1983.

Stroke Data Brief

March 1983

Quality Assurance Division
The American Occupational Therapy Association, Inc.
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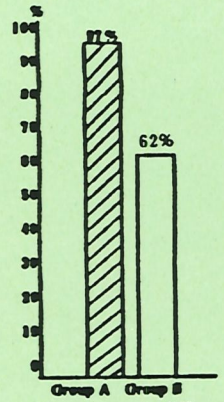
RESEARCH SHOWS SHORTER HOSPITALIZATION RELATED TO OCCUPATIONAL THERAPY

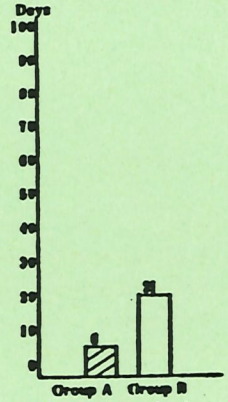
- **300 elderly stroke patients with equal severity of illness were referred randomly to either a stroke unit, Group A, or a medical unit, Group B. A physician-directed investigation found the following significant differences.**

Patients Receiving Occupational Therapy



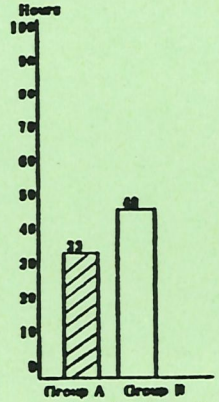
- There is a 35% difference between the groups in the number of patients receiving occupational therapy. ($p<0.001$)

Average Interval Between Admission and Occupational Therapy



- Group A received occupational therapy an average of 15 days earlier than Group B. ($p<0.001$)

Average Hours of Occupational Therapy

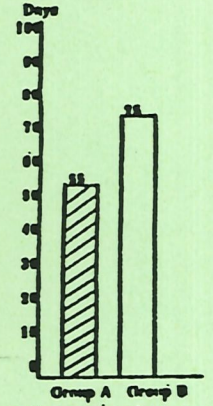


- Patients in Group A received fewer hours of treatment than Group B (early introduction of treatment may be more important than duration). ($p<0.05$)

Patients Functionally Independent at Discharge

- There is a 17% difference between the groups in the number of patients who could manage self-care without assistance. ($p<0.05$)

Length of Stay



- Group A patients were discharged an average of 20 days earlier.

Inferences: Full utilization of occupational therapy, employing early referral, is strongly related to:

- **Shorter hospital stays**
- **An increase in total self-care at discharge, which could reduce the need for nursing home placement**

Sources: Garraway WM, Akhtar AJ, Prescott RJ, Hockey L. "Management of Acute Stroke in the Elderly: Preliminary Results of a Controlled Trial," *British Medical Journal*, April 12, 1980, pp. 1040-1043.

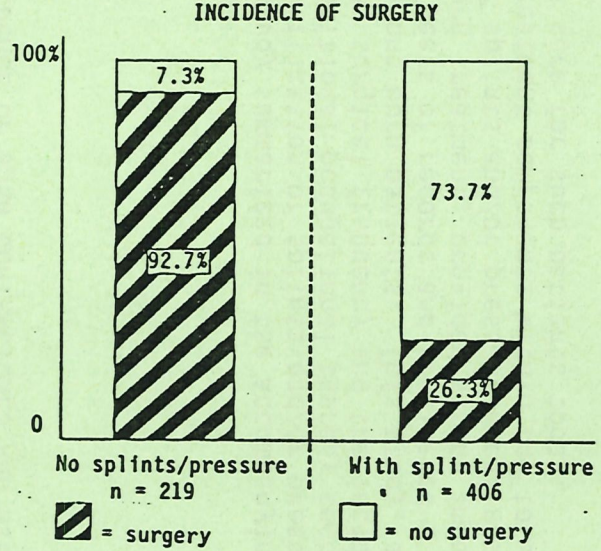
Smith ME, Garraway WM, Smith DL, Akhtar AJ. "Therapy Impact on Functional Outcome in a Controlled Trial of Stroke Rehabilitation," *The Archives of Physical Medicine and Rehabilitation*, Vol. 63, January 1982, pp. 21-24.

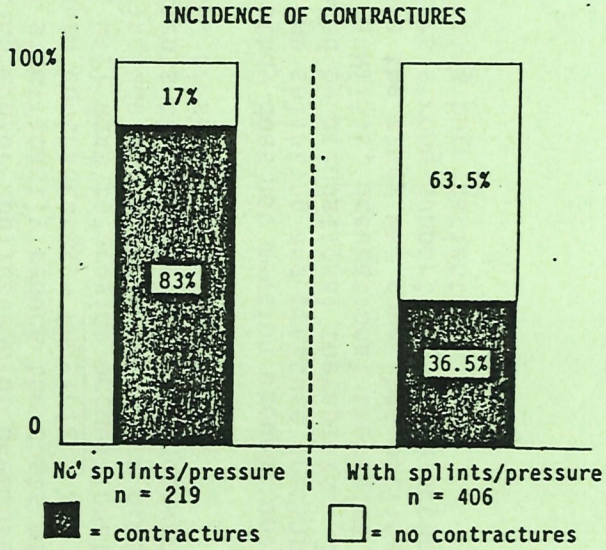
DRAFT

Quality Assurance Division
The American Occupational Therapy Association, Inc.
1383 Piccard Drive
Rockville, Maryland 20850 (301-948-9626)

BURN CARE TRADITIONALLY OFFERED BY OCCUPATIONAL THERAPISTS REDUCE INCIDENCE OF CONTRACTURES AND NEED FOR SURGERY

- A physician review of medical and photographic records for 625 burn patients treated at Shriners Burn Institute and University of Texas Medical Branch Hospitals over a ten-year period showed that 406 patients who had worn splints and/or pressure dressings had significantly lower incidence of burn contractures and need for surgery than 219 patients who had neither.
- Early splinting techniques for burn patients were described by Willis,[2,3] occupational therapist at Shriners Burn Institute. Most techniques used today are based on her work.[4]
- This traditional occupational therapy treatment approach, along with the application of external pressure, continues today as an important component in comprehensive burn care.[4]





Conclusions and Observations:

- The "data confirmed the clinical impression of the value of splints and pressure in minimizing contracture deformities."
- "The incidence of contracture deformity was inversely proportional to the length of time that splints and pressure were worn." (Patients who wore the splints or dressings less than six months showed little benefit; patients who wore the items six to twelve months showed considerable benefit and those wearing them more than twelve months showed the greatest benefit.)
- "... we found that 92.7 percent of the 219 patients who had not worn the splints and pressure required one or more surgical release procedures to restore joint mobility."

Sources:

1. Huang, TT; Blackwell, SJ; Lewis, SR. "Ten Years of Experience in Managing Patients with Burn Contractures of Axilla, Elbow, Wrist, and Knee Joints," Reprinted from Plastic and Reconstructive Surgery, Vol. 61, No. 1, pp. 70-76, January 1978.

2. Evans, EB; Larson, DL; Abston, S; Willis, B. "Prevention and Correction of Deformity after Severe Burns," Surgical Clinics of North America, Vol. 50, No. 6, pp. 1361-1375, December 1970.

3. Willis, B. "The Use of Orthoplast Isoprene Splints in the Treatment of the Acutely Burned Child: Preliminary Report," The American Journal of Occupational Therapy, Vol. 24, No. 1, pp. 57-61, 1969.

4. Fisher, SV; Helm, PA. Comprehensive Rehabilitation of Burns (Baltimore: Williams and Wilkins, pp. 64 and 95, 1984).

Data Brief

DRAFT

TREATMENTS TRADITIONALLY OFFERED BY OCCUPATIONAL THERAPISTS REDUCE INCIDENCE OF BURN CONTRACTURES AND NEED FOR SURGERY

The research study summarized in the accompanying data brief supports the utilization of splints and/or pressure dressings (which are traditional occupational therapy techniques) as a way of reducing surgical frequency and the incidence of contractures among burn patients. This study, a retrospective review of ten years of records and considered a watershed in the area of burn treatment, provided strong impetus to the routine use of splints and/or pressure dressings. These continue as treatment components within the total rehabilitative matrix of burn care for such patients today.

Consumers, legislators, and third party payers will note that routine splinting and/or application of pressure dressings may be able to significantly reduce the costs of surgery for treatment of burn contractures. Physicians and hospital administrators will want to provide occupational therapy services that include splinting or pressure dressings to spare burn patients the pain, risk, and inconvenience, as well as expense, of surgical intervention.

Although this study does not mention occupational therapy specifically, the splinting and pressure dressings discussed are commonly used by occupational therapists. In a separate article, Barbara Willis, occupational therapist at one of the facilities where the study was done, has outlined the techniques. This study offers strong support for these occupational therapy methods of treating burn patients.

10/84

THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.

Quality Assurance Division

USING OCCUPATIONAL THERAPY EFFICACY DATA FOR ADVOCACY AND QUALITY ASSURANCE

Outpatient Stroke Therapy Reduces Deterioration and Improves Functional Ability

The research study summarized in the accompanying data brief can be used in a variety of ways with policymakers at all levels. It supports the utilization of occupational therapy -- in combination with other therapies -- in outpatient stroke treatment, in terms of both improving functional abilities and preventing deterioration of function.

In discussing the study with policymakers, note that the sample consisted of 133 patients randomly assigned to one of three groups: Group 1, who underwent four full days per week of intensive outpatient occupational and physical therapy; Group 2, with therapy of the same types, offered three half-days per week; and Group 3, the "placebo" group, who received an average of seven friendly visits over the six-month period. All groups remained in the program six months.

Group 1, who received the greatest intensity of therapy, showed the most improvement three months into the outpatient program and at twelve-month followup (occurring six months after termination of the outpatient program). Group 2, with less therapy, deteriorated more, and Group 3, who received no therapy but still had an interested party making visits, showed the greatest deterioration. The beneficial effects of outpatient therapy were almost entirely achieved in the first three months.

As this study demonstrates, intensive outpatient treatment which includes occupational therapy (along with physical therapy) can slow the deterioration of stroke patients, an effect which persists even after therapy is discontinued.

3/83 THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC

Quality Assurance Division

The Efficacy of Occupational Therapy
Stroke Data Brief

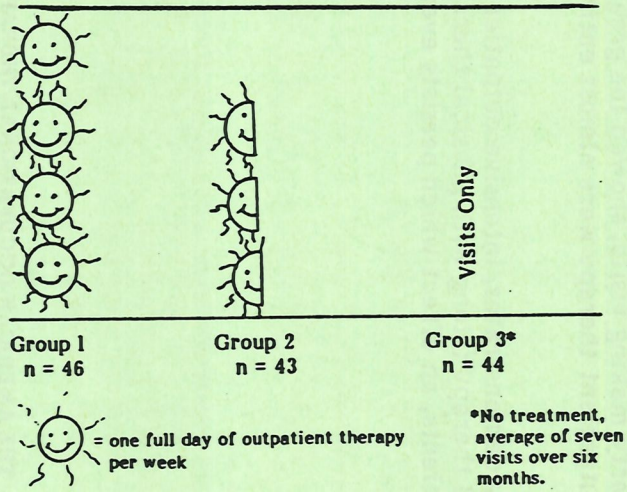
March 1983

Quality Assurance Division
The American Occupational Therapy Association, Inc.
1383 Piccard Drive
Rockville, Maryland 20850 (301-948-9626)

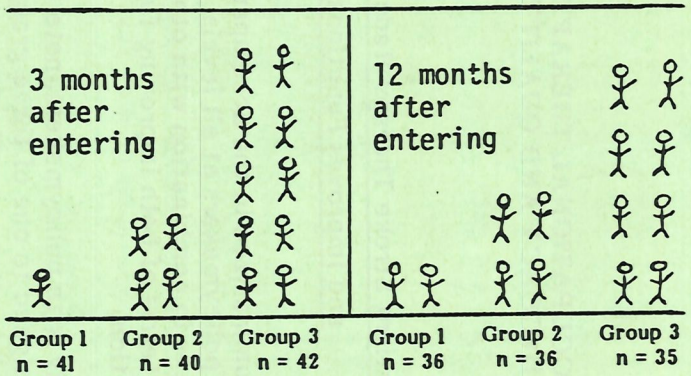
OUTPATIENT STROKE THERAPY REDUCES FUNCTIONAL DETERIORATION

- 133 stroke patients were randomly assigned at hospital discharge to one of three groups: Group 1, intensive outpatient occupational and physical therapy; Group 2, less intensive therapy of the same types; and Group 3, only friendly visiting. Treatment took place over a six-month period.
- A physician-directed investigation found the following statistically significant differences. Among Group 1 patients, who received four full days of therapy a week, only one person deteriorated at three-month and two at twelve-month assessments. The corresponding figures for Group 2, which received three half-days of therapy, were four patients at each assessment; while in Group 3, ten patients deteriorated at three months and eight by the twelve-month assessment.

Number of Days Per Week of Outpatient Therapy Received by Each Group



Number of Patients with Functional Deterioration After Entering Outpatient Program



Observations and Conclusions from the Study:

- "The beneficial effect of treatment was almost entirely achieved during the first three months."
- "...the trial was chiefly one of different intensities of the same treatment, not of qualitatively different treatments."
- "There is little doubt that decreasing amounts of treatment were associated with a greater tendency to deteriorate."
- "...functional assessments...strongly suggest that the more active the rehabilitation the greater the benefit ."
- "...intensive outpatient treatment for those who stand to benefit from it is a realistic policy."

Source: Smith DS, Goldenberg E, Ashburn A, Kinsella G, Sheikh K, Brennan PJ, Meade TW, Zutshi DW, Perry JD, Reeback JS. "Remedial therapy after stroke: a randomized controlled trial," British Medical Journal, Vol. 282, February 14, 1981.

efficacy
DataBrief
Vol. 1 Number 1, July 1985

Study Suggests Occupational Therapy Benefits Schizophrenics

While biochemical theories of brain function and drug treatment of mental disorders are considered state-of-the-art, there is evidence that drugs cannot do the complete job alone. Researchers have found that day treatment including occupational therapy adds significantly to the benefits of anti-psychotic drugs in the care of chronic schizophrenics. This conclusion was reported in a nation-wide study conducted by researchers from three medical schools.

In this study, reported by Linn and others[1], 162 schizophrenic patients were referred to day treatment centers at time of discharge from ten Veterans Administration hospitals located throughout the United States. These patients were randomly assigned to either day treatment plus drugs or to outpatient drug management, with the latter receiving drugs only.

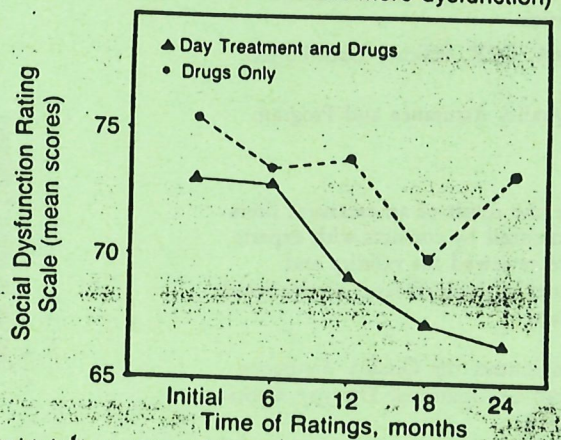
The study was designed to learn whether the day treatment centers added significantly to the benefits of antipsychotic drugs alone in the post-hospital care of schizophrenic patients. Various criteria, such as relapse rate, social functioning, symptoms, attitudes, and cost were established to determine treatment effectiveness and were measured every six months over a two-year period. The findings support day treatment as a cost-effective adjunct to drug therapy. In addition, occupational therapy was found to be a significant component of successful outpatient day treatment programs for schizophrenic patients.

Improved Social Function, No Extra Cost

In an analysis of changes over time between day treatment and drugs-only groups, social functioning shows statistically significant change in favor of day treatment center patients. This result fits with day treatment center goals: 1) to improve or maintain abilities to interact successfully with family and others; 2) to provide patients a place to socialize and engage in productive activities; and 3) to offer a sheltered environment that sustains patients sufficiently so they can live outside an institution.

During the two-year study, day treatment center patients show marked and continuously improving function while drugs-only patients improved only slightly (Figure 1).

Figure 1
Changes in Social Functioning
(Higher scores mean more dysfunction)



Reprinted with permission of the author, Margaret Linn, PhD, "Day Treatment and Psychotropic Drugs in the Aftercare of Schizophrenic Patients," Archives of General Psychiatry, 36: 1055-1068, September 1979.

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

"The less intensely personal and more object-focused activities of occupational therapy produced better outcomes than the intensive interpersonal stimulation often encountered in group therapy."

Specific Results

While social functioning showed significant ($p < .02$) change in favor of day treatment patients, it is important to note that day treatment did not increase costs, that is, there were no statistically significant differences between day treatment and drugs-only programs in terms of costs. According to the study's authors, day treatment "can help prevent relapse, enhance functioning and decrease symptoms," providing high quality care that is "less costly."

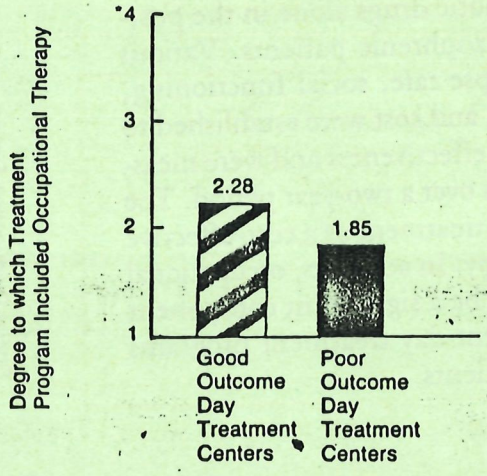
Day treatment is seen as offering "a sustained, nonthreatening social support in the community care of chronic schizophrenics." Thus, day treatment that includes occupational therapy appears to be a cost-effective addition to drug treatment alone for chronic schizophrenics, helping them remain in the community.

Characteristics of Successful Centers

There were differences among the ten hospitals involved in the study. Through post-hoc groupings, two types of centers emerged: six hospitals with good results for schizophrenic patients and four with poorer results in terms of relapse rate, social functioning, symptoms, and attitudes. Patients in both types of centers were similar in base-line data and personal characteristics, but the hospitals differed in their use of occupational therapy.

Good result centers used significantly more occupational therapy ($p < .05$), while centers with poor results for chronic schizophrenics had more professional counseling and counseled more of their patients (Figure 2). The authors' conclusion is that "the less intensely personal and more object-focused activities of occupational therapy produced better outcomes than the intensive interpersonal stimulation often encountered in group therapy."

Figure 2
Utilization of Occupational Therapy in Treatment Program



*Key: 1 = no patients received occupational therapy
4 = most patients received occupational therapy

Data Brief Staff:

Patricia C. Ostrow, MA, OTR, FAOTA, Director, Quality Assurance Division

Deborah Lieberman, MA, OTR, Efficacy Data Project Consultant

Barbara E. Joe, MA, Quality Assurance and Program Evaluation Specialist

Efficacy Data Briefs are the result of an extensive literature search that is agumented by contacts with experts in the field. Studies are reviewed for validity and heuristic value by a panel of doctoral-level occupational therapists and statisticians.

For further information contact the Quality Assurance Division of the American Occupational Therapy Association, Inc., 301/948-9626.

"This study's findings support the value of day treatment . . . and emphasize the important role of occupational therapy within these settings."

Reduced Symptoms and Relapse Rate in Centers With More Occupational Therapy

After two years, good result day treatment centers had about a 20% lower relapse rate than drugs-only centers (Figure 3). Furthermore, symptom levels, as measured by the Brief Psychiatric Rating Scale, suggested that good result day treatment centers were able to maintain hospital discharge levels over time (Figure 4).

Study Significance

The results of this study could be useful to cost-conscious legislators, consumers, and third-party payers because day treatment improved psychosocial functioning, while the cost of care was not statistically different from drug therapy only.

When centers were analyzed individually, it was found that patients in good-result centers showed higher participation in occupational therapy ($p < .05$), which suggests that inclusion of occupational therapy in day treatment programs for schizophrenic patients is beneficial as well as cost-effective.

Policymakers will be interested to know that for the large number of patients with chronic schizophrenia discharged from psychiatric hospitals, this study's findings support the value of day treatment as a cost-effective alternative or addition to other types of community care, and emphasize the important role of occupational therapy within these settings. For physicians, financial managers, and hospital administrators, the outcomes of this study would favor establishment of occupational therapy outpatient services and programs for schizophrenic patients. The authors of the study conclude, "what we are suggesting is a less costly method of care which, for once, is not synonymous with a lower quality of care."

References

1. Linn, MW; Caffey, EM; Klett, CJ; Hogarty, GE: and Lamb, R "Day Treatment and Psychotropic Drugs in the Aftercare of Schizophrenic Patients," *Archives of General Psychiatry*, 36: 1055-1066, September 1979.

Figure 3
Cumulative Relapse Rates for Treatment Groups
(Higher percentage means higher relapse rate)

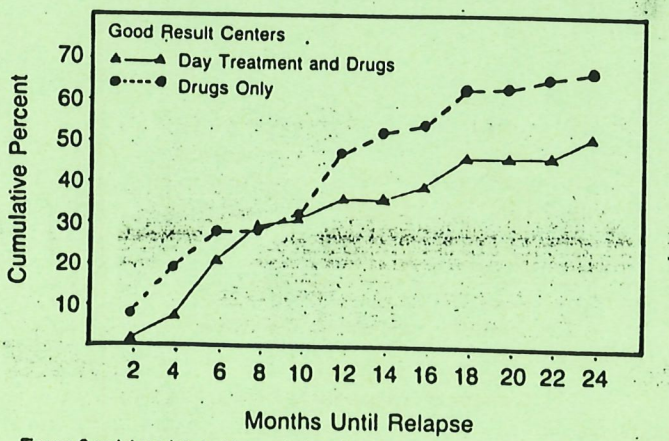
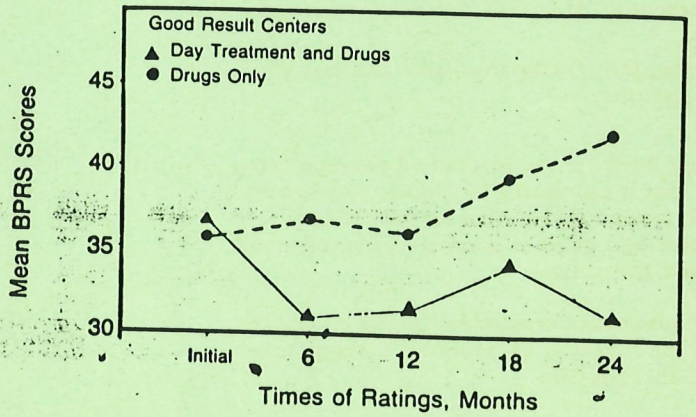


Figure 4
Changes on Brief Psychiatric Rating Scale (BPRS)
(Higher scores mean more symptoms)



Figures 3 and 4 reprinted with permission of the author, Margaret Linn, PhD, "Day Treatment and Psychotropic Drugs in the Aftercare of Schizophrenic Patients," Archives of General Psychiatry, 36: 1055-1066, September 1979.

RESOURCE 'a'

HEALTH INSURANCE ASSOCIATION of AMERICA

● *Chicago* ● *New York* ● *Washington*

MEDICAL ECONOMICS BULLETIN

New York Office
919 Third Avenue
New York, New York 10022

No. 3-77--June 8, 1977

OCCUPATIONAL THERAPY AND HEALTH INSURANCE

In December, 1976, the National Association of Insurance Commissioners passed a resolution recognizing the role of the Occupational Therapist as a provider of health care services and recommending that any plan or program which reimburses or provides benefits for health care services consider for inclusion licensed M. D. or D. O. referred Occupational Therapy services as delivered by a licensed, certified, or otherwise qualified Occupational Therapist and, that such services be specifically identified in the coverage provided.

Members of the HIAA staff along with members of the Allied Health Services Committee and the Comprehensive Coverage Subcommittee subsequently met with representatives of the American Occupational Therapy Association to discuss mutual concerns, and to explore how Occupational Therapy fits into today's health care delivery system. This information bulletin on Occupational Therapy was prepared by the HIAA Comprehensive Coverage Subcommittee to provide guidance to member companies in considering coverage for such services.

What is Occupational Therapy?

Because of it's title, many people unfamiliar with the full scope of OT practice erroneously associate it with being primarily an educational or vocational training service rather than a health care profession that is concerned with restoring useful physical function following disabling accidents and sickness. OT is, in fact, an important component of medical care. The Occupational Therapist works as a member of the rehabilitation team, headed by the physician, along with other health professionals such as psychologists, physical therapists, social workers, speech pathologists and audiologists.

The goal of OT is to assist the patient in achieving the maximum level of independent function by mobilizing those capacities which remain after accidents, disease, or deformity. Patients include persons suffering from cerebro-vascular accidents (strokes), arthritis, cerebral palsy, spinal cord injuries, hand injuries, amputations and burns, people with visual, auditory and speech disorders, and those with psychiatric problems.

Occupational Therapy is directed at improving:

- Impaired muscle strength, range of motion, and physical endurance.
- Impaired eye-motor coordination, sensory integration and motor planning.
- Impaired concentration, attention span, thought organization, problem solving.
- Impaired visual - spatial relationships, body schema, figure ground discrimination.

The Occupational Therapist also seeks to prevent muscle atrophy, minimize and prevent deformity and increase pain tolerance.

Occupational Therapy vs. Physical Therapy

A question which is frequently asked is, "What is the difference between Occupational Therapy and Physical Therapy?" Both professions seek to improve muscle strength, range of motion, physical endurance, and various other functions. There are many areas of overlap, and any explanation of the difference might be an oversimplification. The chief difference however lies in the treatment modalities used and in the specific focus of treatment. The Physical Therapist uses modalities such as heat, hydrotherapy, ultra sound, massage and exercise to improve general neuro-muscular function and coordination. The primary tool of the Occupational Therapist is the active involvement of the patient in specially designed therapeutic tasks and activities which while improving function, also help the patient learn to apply the newly restored or impaired function to meeting the demands of daily living, including vocational activities. The Occupational Therapist is also involved in the design and use of splints, and orthotic and functionally assistive devices.

Education

There are approximately 90 colleges and universities in the United States that have training programs and award degrees or certificates in Occupational Therapy. Programs at the baccalaureate and graduate levels are accredited jointly by the American Medical Association and the American Occupational Therapy Association. This coordinated program dating back to 1933 is the oldest joint accreditation program of the AMA and an independent health profession. The OT curriculum includes medical, biological, behavioral, and social sciences. Education requirements for a Registered Occupational Therapist (OTR) include in addition to a 4 year baccalaureate or master's

program, a minimum of 6 months clinical experience. Education requirements for a Certified Occupational Therapy Assistant (COTA) are completion of an Associate Degree program (2 years) in an accredited university or junior/community college, or a certificate program (1 year) in an accredited educational institution, and a minimum of two months supervised field work experience.

Certification and Licensing

The national certification program for credentialing Occupational Therapists was established over 50 years ago. The certification examinations are administered by a private testing firm in collaboration with the American Occupational Therapy Association. The certificate program is recognized in federal regulations.

State licensing laws for Occupational Therapists have been enacted in recent years in Georgia, New York, Florida, Ohio, Utah and Arkansas and in Puerto Rico, and are pending in several other states. The educational, training and examination requirements in all of the licensing laws enacted so far are identical to the AOTA certification requirements.

Patterns of Practice

Occupational Therapists work in general and pyschiatric hospitals, rehabilitation centers, skilled nursing facilities, community mental health centers, clinics, home care programs, day care programs, school systems, and in private practice. Most Occupational Therapists are salaried employees of the institution or agency for which they work. Only a few (approximately 600) are in independent private practice, charging directly on a fee for service basis. Charges for OT services by hospitals or nursing homes may either be built into the daily service (room & board) charge, or billed as an ancillary service charge.

The American Occupational Therapy Association

The professional association representing the Occupational Therapy profession is the:

American Occupational Therapy Association, Inc.
1383 Piccard Drive
Rockville, Maryland 20850

Telephone: (301) 948-9626
Executive Director: James J. Garibaldi

The membership of AOTA in 1976 consisted of 15,989 Registered Occupational Therapists, 3,832 Certified Occupational Therapy Assistants, and 3,382 students.

Together with its forerunner, The National Society for the Promotion of Occupational Therapy, Inc., it has represented OT and served the public since 1917.

AOTA and its affiliated state associations are engaged in a variety of programs aimed at improving patient care and maintaining standards of ethics and quality in the provision of OT services. These include continuing education programs, peer review programs, and cooperation with professional standards review organizations (PSRO's) in outlining standards of OT care.

A variety of publications which may be of interest to insurers, outlining the history and scope of OT, schools offering OT programs, standards for care, etc. can be obtained by writing to AOTA.

Currently Existing Insurance Coverage for Occupational Therapy

Benefits for Occupational Therapy Services are included in many federal and state third party reimbursement programs such as Medicare, Medicaid, Workers' Compensation Acts, the Rehabilitation Act of 1973, the Maternal and Child Health and Crippled Children Services Act, the Older Americans Act, the National Arthritis Act of 1974, CHAMPUS, and the Community Mental Health Centers Act. OT is also included within several options offered under the Federal Employees Health Benefits Program.

Benefits for OT services under private health insurance plans vary widely. Most Basic Hospital and Major Medical policies provide benefits for hospital in-patient OT services where the charge appears on the hospital bill as an ancillary service, but coverage for out-patient or out of hospital services is more sporadic.

Some Major Medical policies and Home Health Care Benefit plans specifically identify Occupational Therapy as an eligible expense. Other Major Medical policies make no specific mention of Occupational Therapy, but pay benefits for OT services "administratively" where the policy provides benefits for a broad spectrum of services such as physical therapy on an in-patient or out-patient basis. Still other policies do not mention Occupational Therapy and refuse to pay on the basis that it is not specifically included as an eligible expense.

Recommendations of the Comprehensive Coverage Subcommittee

HIAA cooperated with the American Occupational Therapy Association in drafting the wording of the NAIC resolution, and offered supporting testimony at the open hearings.

The HIAA Comprehensive Coverage Subcommittee feels that Occupational Therapy is a professional health care service which when properly used can be instrumental in decreasing hospital confinement, disability, and the ultimate cost of health care. It also feels that Occupational Therapy which is recommended by a physician as part of a course of treatment in connection with a non-occupational accidental bodily injury or non-occupational disease, and provided by a qualified Occupational Therapist (or a qualified Occupational Therapy Assistant under the direct supervision of an Occupational Therapist) is a type of service which properly lies within the intended scope of broad Major Medical policies.

The Comprehensive Coverage Subcommittee therefore recommends that insurers consider covering such services "administratively" under existing Major Medical policies which are silent about Occupational Therapy, and also that they consider adding benefit provisions to cover such services when new policy forms are issued.

The term "qualified occupational therapist" means an individual who is licensed to provide occupational therapy, by the jurisdiction where the services are performed, if such licensing is required in such jurisdiction, or, in the absence of such licensing requirements, such therapist is certified as a registered occupational therapist (OTR) by the American Occupational Therapy Association.

SETTING	PERCENTAGE		
	OTR	COTA	COTA/OTR
Residential Care	3.4	6.3	
School System	18.5	25.0	
Sheltered Workshop			1.0
Other	2.4	18.8	
TOTALS:	34.1	50.1	4.9 *

KANSAS DATA

SETTINGS WHERE PHYSICIAN SUPERVISION WOULD BE ANTICIPATED

SETTING	PERCENTAGE		
	OTR	COTA	COTA/OTR
Community Mental Health Center	2.0	6.3	
HMO			.5
Home Health	4.9	6.3	
Hospice			.5
Hospital	37.6	18.8	
Psychiatric Hospital	7.3	12.5	
Public Health			.5
Rehabilitation Hospital			3.9
Sheltered Nursing Home	3.9	6.3	
TOTALS:	55.7	50.2	5.4 *

* Totals do not equal 100% due to some therapist reporting work in more than one type of setting.

OCCUPATIONAL THERAPY

PRIMARY WORK SETTING

NATIONAL DATA				KANSAS DATA
	1973	1977	1982	1984
College, 2 yr. (%)				.5
College, 4 yr. (%)				7.8
Community Mental Health Center				
OTR (%)				2.0
COTA (%)				6.3
Corrections (%)				.5
Day Care Center (%)				.5
Home Health Agency				
OTR (%)	.9	2.2	3.8	4.9
COTA (%)				6.3
Hospice (%)				.5
General Hospital				
OTR (%)	39.5	34.2	43.3	37.6
COTA (%)				18.8
Psychiatric Hospital				
OTR (%)				7.3
COTA (%)				12.5
Private Industry (%)				.5
Private Practice (%)	6.0	12.3	15.0	3.9
Public Health				.5
Rehabilitation Hospital (%)				3.9
Residential Care				
OTR (%)				3.4
COTA (%)				6.3

1982 MEMBER DATA SURVEY

Median Annual Professional Income By State
(Full-Time Employed Only)

	OTRs		COTAs
U.S. TOTAL	$19,547		$12,930
Alabama	18,462		10,857
Alaska	27,300		7,000
Arizona	19,404		12,562
Arkansas	18,700	Licensed	--
California	22,208		13,743
Colorado	18,900		13,500
Connecticut	18,346	Licensed	12,625
Delaware	19,200	Licensed	10,000
Dist. of Col.	20,393	Licensed	15,000
Florida	19,570	Licensed	13,125
Georgia	18,442	Licensed	12,875
Hawaii	19,607		11,500
Idaho	17,833		12,250
Illinois	19,758	Licensed	13,409
Indiana	19,100		13,333
Iowa	19,043	Licensed	10,667
Kansas	18,372		11,667
Kentucky	19,222		13,500
Louisiana	18,844	Licensed	9,000
Maine	16,500	Licensed	12,250
Maryland	20,144	Licensed	13,431
Massachusetts	17,239	Licensed	12,885
Michigan	20,606		13,038
Minnesota	18,840		11,657
Mississippi	20,500		9,000
Missouri	19,134		11,500
Montana	19,167	Licensed	13,500
Nebraska	21,643	Licensed	11,625
Nevada	23,250		18,000
New Hampshire	15,937	Licensed	10,917
New Jersey	19,105		12,962
New Mexico	16,847	Licensed	13,500
New York	19,683	Licensed	13,528
North Carolina	17,500	Licensed	12,250
North Dakota	18,187	Licensed	12,955
Ohio	19,708	Licensed	13,500
Oklahoma	20,684	Licensed	12,667
Oregon	19,156	Licensed	13,017
Pennsylvania	19,934	Licensed	13,009
Rhode Island	17,611	Licensed	13,500
South Carolina	18,000	Licensed	12,667
South Dakota	17,000		10,000
Tennessee	19,750	Licensed	10,625
Texas	19,242	Licensed	12,750
Utah	17,750	Licensed	11,000
Vermont	14,750		9,000
Virginia	17,453		13,250
Washington	19,306	Licensed	11,250
West Virginia	19,500	Licensed	12,875
Wisconsin	12,892		11,946

As of January, 1986, 29 states plus the District of Columbia and Puerto Rico license occupational therapists.

An average of these salaries shows that states which license OT's have a lower average salary than states which do not license OT's.

The average licensed OT salary is 19,510.

The average unlicensed OT salary is 20,523

NATIONAL DATA				KANSAS DATA
	1973	1977	1982	1984
School Systems				
OTR (%)	11.0	14.0	18.3	18.5
COTA	3.6	6.2	11.3	25.0
Sheltered Workshop				1.0
Skilled Nursing Home				
OTR (%)	6.2	7.9	6.0	3.9
COTA (%)				6.3
Other				
OTR (%)				2.4
COTA (%)				18.8
Mental Health, OTR (%)	34.6	31.6	27.0	
In-Patient Setting, OTR (%)	55.0		38.0	
Community Setting, OTR (%)	45.0		62.0	

Kansas Total Therapists (AOTA Certified active)

401 OTR

38 COTA

VICTOR ATIYEH
GOVERNOR

Department of Human Resources
HEALTH DIVISION
1400 S.W. 5th AVENUE, PORTLAND, OREGON 97201 PHONE 229-5160
Occupational therapy Licensing Board

August 24, 1981

TO WHOM IT MAY CONCERN:

We have been asked to assess whether the cost of occupational therapy services has increased in Oregon due to the licensing of occupational therapists in 1977.

A survey of facilities and occupational therapists in the state of Oregon indicates that the cost of occupational therapy has not increased to the consumer due to the licensure of occupational therapists.

There was no change in the cost of occupational therapy services when the licensure law went into effect in 1978. Within a facility the cost of services for occupational therapy and physical therapy were the same before licensure and remained the same after licensure. The cost of occupational therapy services has increased but this is tied to inflation and fiscal problems within the facilities/hospitals. There has been an increase in cost to the individual occupational therapists due to licensure fees, but the therapists feel licensure is worth this cost.

Sincerely,

Kay Rhoney, OTR

Kay S. Rhoney, OTR
Occupational Therapy Licensing Board

STATE OF UTAH

DEPARTMENT OF BUSINESS REGULATION
DIVISION OF REGISTRATION
330 East Fourth South St., Salt Lake City, Utah 84111
Profession Licensing 533-5711
Nurse Licensing 533-5718

SCOTT M. MATHESON
Governor

PAUL T. FORDHAM
Director

December 18, 1981

The American Occupational Therapy Association
1383 Piccard Drive
Rockville, Maryland 20850

ATTN: Jane Davy, Mary Peters
Government and Legal Affairs

Dear Ms. Davy and Peters:

The Utah State Board of Occupational Therapy practice has been asked to respond to the question: has licensure of O.T.'s caused an increase in O.T. charges to the consumers in Utah?

The latest information suggests no correlation between the 1976 Utah licensure and fee setting practices in medical institutions, public school systems or in private practice in the state.

Respectfully,

DIVISION OF REGISTRATION

Paul T. Fordham
Director

PTF:dct
cc: Nancy Fischer/OTR
Chairperson
Utah State Board of O.T. Practice

Department of Professional Regulation

Governor
Bob Graham
Secretary
Samuel R. Shorstein

Board of Medical Examiners
130 N. Monroe Street, Tallahassee, Florida
(904) 488-0595

June 11, 1982

Ms. Jane Davy
Government and Legal Affairs
The American Occupational
Therapy Association, Inc.
1383 Piccard Drive
Rockville, MD 20850

Dear Ms. Davy:

Recently the following question has been raised:

Does the licensure of occupational therapists cause an increase in costs to the consumer?

Occupational therapists in the State of Florida have been licensed since 1975. It is apparent that the licensure of occupational therapists in the State of Florida does not cause an increase in costs to the consumer.

Sincerely,

Louise Samson, OTR

Louise Samson, Chairman
Occupational Therapy Council

Jane Slaymaker OTR/L

Jane Slaymaker, Secretary
Occupational Therapy Council

..../ld

JUN 1 1 1982

OHIO OCCUPATIONAL THERAPY AND PHYSICAL THERAPY BOARD

James A. Rhodes
Governor

April 13, 1981

APR 17 1981

TO WHOM IT MAY CONCERN:

Recently the following question has been raised:

Does the licensure of occupational therapists cause an increase in costs to the consumer?

Occupational therapists in the state of Ohio have been licensed since 1977. Following a recent survey of health care facilities, it is apparent that the licensure of occupational therapists in the state of Ohio does not cause an increase in costs to the consumer.

Sincerely,

Martha S. Cameron, OTR/L

Martha S. Cameron
Chairman
Occupational Therapy Section

65 South Front Street Room 217 Columbus, Ohio 43215

Secretary of State
Examining Boards Division
166 Pryor Street, S.W.
Atlanta 30303

David B. Poythress
SECRETARY OF STATE

Michael R. Fowler
JOINT SECRETARY
STATE EXAMINING BOARDS
(404) 656-3900

MAY 06 1981

April 29, 1981

Ms. Mary Peters
Government and Legal Affairs Division
American Occupational Therapy Association
1383 Piccard Drive
Rockville, Maryland 20850

Dear Ms. Peters:

In reply to your inquiry concerning the affect occupational therapy licensure has on the cost of occupational therapy services in Georgia, please be advised that there is not any evidence of a cost increase for occupational therapy services in Georgia due to the requirement of licensure.

The Board would like for you to be aware of Section 84-7102 of the Board laws.

84-7102 - The Georgia State Occupational Therapy Licensing Act is enacted to safeguard the public health, safety, and welfare and to assure the availability of occupational therapy services of high quality to persons in need of such services. It is the purpose of this Chapter to provide for the regulation of persons offering occupational therapy services to the public.

The following are examples of how the Board provides protection to the consumer.

1) A consumer informed the Board that she was billed for occupational therapy services at a hospital and never received the occupational therapy services. The Board requested an investigation. After the Board's investigation, the hospital changed the consumer's bill, and she was not charged for the occupational therapy services.

2) The Board received a brochure in reference to a nursing home offering occupational therapy services. The Board requested an investigation. After the Board's investigation, the nursing home changed their brochure and stopped advertising occupational therapy services, since there was not a licensed occupational therapist at the nursing home.

If the Board can be of any further assistance to you, please do not hesitate to contact us.

Sincerely yours,

GEORGIA STATE BOARD OF OCCUPATIONAL THERAPY

Linda Stephens

Ms. Linda phens
President

State of Maryland

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE BOARD OF OCCUPATIONAL THERAPY PRACTICE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • AREA CODE 301 • 383-7024

HARRY HUGHES
GOVERNOR

CHARLES R. BUCK JR. ScD
SECRETARY

May 21, 1981

To Whom It May Concern:

The Maryland State Board of Occupational Therapy Practice has been asked to respond to the question: Has licensure of occupational therapists caused an increase in occupational therapy charges to the consumers in Maryland?

It is the opinion of the Board that since the passage of the Maryland licensure law in 1979 that there have been no increases in service charges due to licensure. This can be substantiated by the fact that the licensure requirements for occupational therapists and occupational therapy assistants are the same as those previously accepted by state and private health care facilities.

Respectfully submitted,

Carol Haynes, OTR/L
Maryland State Board of Occupational Therapy
Practice

3-24-86

Kansas Health Care Association

Member of ahca

TESTIMONY PRESENTED BEFORE THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

By
Dick Hummel, Executive Director
Kansas Health Care Association

March 24, 1986

HOUSE BILL NO. 2498

"AN ACT concerning occupational therapy; providing for registration of occupational therapists and occupational therapy assistants...."

Senator Ehrlich and Committee Members:

On behalf of the Kansas Health Care Association, a voluntary, non-profit organization of over 200 licensed adult care homes in Kansas, representing both for-priofit and nonproprietary entities, thank you for this opportunity.

We submit for your consideration an amendment (attached) to make it clear that the provisions of this bill do not apply to activity directors who are employed in Kansas nursing homes.

If the provisions do, it could result in the unncessary expenditure of hundreds of thousands of dollars in new health care costs.

Our concerns are primarily with some of the terms in the bill in comparison to the duties of activity directors:

LINE 0029 - Occupational therapy is...of individuals who are limited by physical injury...or the aging process in order to maximize independence, prevent disability and maintain health.

LINE 0046 - using therapeutic activity and exercise to enhance functional or motor performance, or both.

"We Care"

Attachment V
3/24/86 S. PH&W

221 SOUTHWEST 33rd ST. • TOPEKA, KANSAS 66611 • 913/267-6003

V

LINE 0057 - Occupational therapy aide...who works under the direct supervision of an occupational therapist or occupational therapy assistant.

The definition of and responsibilities of an activity director are spelled-out in the Regulations for the Licensure and Operation of Adult Care Homes, Kansas State Department of Health and Environment. A copy is attached.

An activity director may be an O.T., an O.T.A., a Therapeutic Recreational Specialist, or a nurse aide who has completed a state approved course in resident activities. The majority fall within the latter category.

An activity director is officially responsible for:

"Provisions of Services. The activity director shall develop a schedule for group and independent activities. There shall be opportunities for residents to participate in activities of interest inside and outside the facility through educational, social, recreational, and religious resources."

With the average nursing home resident age at 83 years old, activity directors perform one of the most important functions in a nursing home, that is, to provide ongoing mentally and physically stimulating programs. They have performed in an outstanding manner; we're aware of no evidence to the contrary.

The bill would place activity directors under the "direct supervision" of an O.T. or O.T.A. We read this to mean new consultative fees totally unnecessary, and additional health care costs.

We also wish to mention that federal nursing home regulations do not require anything as we see that may be required by H.B. 2498.

Your approval of the amendment is respectfully requested.

~~tional~~ or ~~motor~~ performance, or both;

(6) developing prevocational/vocational work capacities and play/leisure skills; and

(7) adapting environment for the disabled.

(c) "Occupational therapist" means a person ~~licensed~~ registered to practice occupational therapy as defined in this act.

(d) "Occupational therapy assistant" means a person ~~licensed~~ registered to assist in the practice of occupational therapy under the supervision or with the consultation of an occupational therapist.

(e) "Occupational therapy aide" means a person who assists in the practice of occupational therapy, who works under the direct supervision of an occupational therapist or an occupational therapy assistant and whose activities require an understanding of occupational therapy but do not require professional or advanced training in the basic anatomical, biological, psychological and social sciences involved in the practice of occupational therapy.

(f) "Person" means any individual, partnership or unincorporated organization of corporate body.

(g) "Physician" means a person licensed to practice medicine and surgery.

New Sec. 3. The board, in the manner hereinafter provided, shall administer the provisions of this act.

New Sec. 4. (a) ~~No~~ **On and after July 1, 1987, no** person shall ~~practice occupational therapy or~~ hold oneself out as an occupational therapist or an occupational therapy assistant~~, or hold oneself out as being able to practice occupational therapy or to render occupational therapy services in the state,~~ unless such person is ~~licensed~~ registered in accordance with the provisions of this act.

(b) Only an individual may be ~~licensed~~ registered under this act.

New Sec. 5. Nothing in this act shall be construed as preventing or restricting the practice, services or activities of:

(a) Any person employed as an occupational therapist or occupational therapy assistant by the government of the United

ADD NEW SECTION: (1) This definition shall not include a person employed as an activity director in an adult care home.

28-39-76. DEFINITIONS.

(a) "Activities director" means an individual who meets one of the following requirements:

(1) Is a resident activities coordinator as defined in subsection (jj) of this regulation;

(2) Has two years of experience in a social or recreational program within the last five years, one year of which was full time in a resident activities program in a health care setting; or

(3) Is a nurse aide who has completed a course approved by the Kansas department of health and environment in resident activities coordination and who, during the first year as activities director, receives consultation from a resident activities coordinator.

(b) "Administrator" means any individual who is charged with the general administration of an adult care home whether or not the individual has an ownership interest in the adult care home. Each administrator of an adult care home shall be licensed in accordance with K.S.A. 65-3501, et seq., and any amendment to those statutes.

(c) "Alteration" means any addition, modification, or modernization in the structure or usage of a facility.

(d) "Ambulatory resident" means any resident who is physically and mentally capable of getting in and out of bed and walking in a normal path to safety in a reasonable period of time, including the ascent and descent of stairs without the aid of another person.

(e) "Audiologist" means a person who meets one of the following requirements:

(1) Has completed the requirements of education and experience for a certificate of clinical competence in audiology as promulgated by the American speech-language and hearing association and in effect July 1, 1981; or

(2) Has completed the educational requirements for certification prescribed in the preceding paragraph and is in the process of accumulating the experience required for certification under the requirements described in the preceding paragraph.

(f) "Change of ownership" means any transaction that results in a change of control over the capital assets of a facility.

(g) "Charge person" means an individual who is a registered nurse, licensed practical nurse, medication aide, or certified nurse aide, and who is directly responsible for resident care on any shift.

(i) "Controlled substance" means any drug or drugs listed in part 308 of the code of federal regulations, as in effect on July 1, 1981.

(j) "Day care" means a program in an adult care home for providing services for less than a 24 consecutive hour basis.

(k) "Day shift" means an eight-hour tour of duty within the period 6:00 a.m. to 9:00 p.m.

(l) "Dietetic services supervisor" means any person who has at least one of the following qualifications:

(1) Is a dietitian as defined in subsection (m) of this regulation;

(2) Is a graduate of a dietetic technician or dietetic assistant training program that is approved by the American dietetic association. Such programs may be conducted on either a classroom or correspondence basis. Each dietetic services supervisor who qualifies under this paragraph shall consult with a dietitian on a regular basis;

(3) Is a graduate of a state-approved course that provided 90 or more hours of classroom instruction in dietetic services supervision and has a minimum of six months' experience as a supervisor in a health care institution. Each dietetic services supervisor who qualifies under this paragraph shall consult with a dietitian on a regular basis; or

(4) Has training and experience in dietetic services supervision and management that is determined by the secretary of health and environment to be equivalent in content to the program in paragraphs (2) or (3) of this subsection. Each dietetic services supervisor who qualifies under this paragraph shall consult with a dietitian on a regular basis.

(m) "Dietitian" means a person who received a baccalaureate degree with major studies in foods and nutrition or dietetics and who has completed the requirements of education and experience for registration as promulgated by the American dietetic association and in effect on July 1, 1981.

(n) "Director of nursing" means a person who:

(1) Is licensed in Kansas as a registered professional nurse;

(2) Is employed, full time, in a licensed adult care home; and

(3) Has the responsibility, administrative authority, and accountability for the supervision of the functions, activities, and teaching of the nursing process.

(o) "Drug administration" means an act in which a single dose of a prescribed drug or biological is given by injection, inhalation, ingestion, or by any other means to a resident by an authorized person in accordance

with all laws and regulations governing the administration of drugs or medications. Drug administration shall entail removing an individual dose from the labeled container, including a unit dose container, verifying it with the physician's orders, giving the dose to the proper resident, and promptly recording the time and dose given.

(p) "Drug dispensing" means the delivery of one or more doses of drugs by a registered pharmacist or physician. The drugs shall be dispensed in a container and labeled in compliance with the state and federal laws and regulations.

(q) "Existing facility" means a facility or section of a facility licensed or approved for licensing before the effective date of these rules and regulations.

(f) "Full time" means 32 or more hours per week.

(s) "Health services supervisor" means a person who:

(1) Is licensed in Kansas as a registered nurse or licensed practical nurse;

(2) Is employed full time, in an adult care home; and

(3) Has the responsibility, administrative authority, and accountability for the functions and activities of the nursing staff.

(t) "Licensed nurse" means a registered professional nurse or a licensed practical nurse.

(u) "Licensed practical nurse (L.P.N.)" means an individual who is licensed in Kansas as a licensed practical nurse.

(v) "Licensee" means an individual, firm, partnership, association, company, corporation, or joint stock association authorized by a license obtained from the secretary of health and environment to operate an adult care home.

(w) "Medical records practitioner (qualified consultant)" means a person who has completed the requirements of education and experience for a certificate as a registered record administrator (R.R.A.) or an accredited record technician (A.R.T.) as promulgated by the American medical records association and in effect on July 1, 1981.

(x) "Medication" means any drug defined by K.S.A. 65-1626 that is administered to a resident of an adult care home.

(y) "Medication aide" means a person who has completed a training program in medication administration approved by the Kansas department of health and environment and who is certified as a medication aide.

(z) "Nonambulatory resident" means any resident who is not physicially or mentally capable of getting in and out of bed and walking a normal path to safety without the aide of another person.

(aa) "Nurse aide" means a person who has completed a training program for persons who provide direct, individual care to residents that is approved by the Kansas department of health and environment and who is certified by the Kansas department of health and environment as a nurse aide.

(bb) "Nurse aide trainee" means a person who has been employed in an adult care home for less than six months and who provides direct, individual care to residents but is not certified by the Kansas department of health and environment as a nurse aide.

(cc) "Nursing personnel" means the director of nursing, health services supervisor, and all registered and licensed practical nurses, medication aides, nurse aides, and nurse aide trainees under the direct supervision of the director of nursing or health services supervisor.

(dd) "Nursing unit" means a distinct area of the facility which contains not more than 60 resident beds and which includes the service areas and rooms described in K.A.R. 28-39-104(b) and K.A.R. 28-39-109(b).

(ee) "Occupational therapist (qualified consultant)" means a person who received a baccalaureate degree in a program in occupational therapy and who has completed the requirements of education and experience for registration as promulgated by the American occupational therapy association and in effect on July 1, 1981.

(ff) "Occupational therapy assistant" means a person who has completed the requirements of education and experience for certification as a certified occupational therapy assistant (C.O.T.A.) as promulgated by the American occupational therapy association and in effect July 1, 1981.

(gg) "Physical therapist" means a person registered in Kansas as a physical therapist.

(hh) "Physical therapy assistant" means a person certified in Kansas as a physical therapy assistant.

(ii) "Registered nurse (R.N.)" means an individual who is licensed in Kansas as a registered professional nurse.

(jj) "Resident activities coordinator" means a person who meets one of the following requirements:

(1) Is a therapeutic recreation specialist as defined in subsection (oo) of this regulation;

(2) Has two years of experience in a social or recreational program within the last five years. One year of this experience shall have been on a full-time basis in a resident activities program in a health care setting; or

(3) Is an occupational therapist or occupational therapy assistant.

(kk) "Restraint" means any apparatus, article, device, or garment which interferes with the free movement of a resident or any drug administered to a resident for the purpose of modifying the behavior of the resident.

(ll) "Social services designee" means a person who is a:

(1) Social worker as defined in subsection (mm) of this regulation;

(2) College graduate who has completed a program in social work education; or

(3) Nurse aide who has completed a course approved by the Kansas department of health and environment in social services.

(mm) "Social worker" means a person who is licensed in Kansas as a social worker and who has one year of social work experience in a health care setting.

(nn) "Speech pathologist" means a person who meets one of the following requirements:

(1) Has completed the requirements of education and experience for a certificate of clinical competence in speech pathology as promulgated by the American speech-language and hearing association and in effect on July 1, 1981; or

(2) Has completed the educational requirements for certification prescribed in the preceding paragraph and is in the process of accumulating the experience required for certification under the requirements prescribed in the preceding paragraph.

(oo) "Therapeutic recreation specialist" means a person who has completed the requirements for education and experience for a certificate of clinical competence in therapeutic recreation as promulgated by the national therapeutic recreation society and in effect on July 1, 1981.

(Authorized by and implementing K.S.A. 39-932; effective May 1, 1982; amended May 1, 1984.)

3-24-86

Kansas
Respiratory
Therapy
Society
P.O. Box 3357 / Kansas City, Kansas 66103

LEGAL CREDENTIALING FOR RESPIRATORY THERAPY

Attachment VI
3/24/86 S. PH&W

VI

RESPIRATORY THERAPY LEGAL CREDENTIALING

INTRODUCTION

Need for Legal Credentialing

The practice of Respirtory Therapy poses a substantial risk to the patient's health and safety regardless of whether care is delivered in an acute care facility, a chronic care facility or in a patient's home. Procedures that pose significant risk include:

1. The administration of potent drugs that may produce significant reactions in vital organs including changes in blood pressure, heart rhythm, mental condition, and function.
2. Physically invading vital organ systems (pulmonary and cardiovascular) with instruments and materials which can cause injury or damage to the tissues, structures, or the function of those organs.
3. The application and maintenance of life support equipment which is used to assist, control, or otherwise augment ventilation (breathing) for extended periods of time. Failure of such equipment or inappropriate use could cause permanent brain damage or even death.
4. Performing tests and reporting laboratory data which form the basis for treatment decisions made by physicians relating to vital organs. Inaccurate lab data can cause inapporpriate treatment to be ordered and administered, with potential for serious harm or death.

Although government regulation is often considered an intrusion, the precedent of governmental regulation of health care practitioners for consumer protection is well established. When one considers how Respiratory Therapy has grown in the past ten years, there are virtually no allied health professions that perform services with greater risk and responsibility.

The Kansas Respiratory Therapy Society requests that the Legislature mandate a legal credentialing mechanism for Respiratory Therapist in Kansas. The mechanism to institute this legal requirement is available through the examination system of the National Board for Respiratory Care (NBRC). The state would not have to embark on the costly and time consuming project of developing examinations.

RESPIRATORY THERAPY LEGAL CREDENTIALING

GENERAL BACKGROUND OF RESPIRATORY THERAPY AND NATIONAL ORGANIZATIONS

(AART) Respiratory Therapy began evolving as profession in the early years of the twentieth century. Its development paralleled the development of methods of administering oxygen and mechanical ventilation. During the mid-1940s a group of interested physicians and "inhalation therapists" established a national association, "Inhalation Therapy Association" with 59 members. Since that time, Respiratory Therapy has continued to develop, especially in the areas of critical care and most recently, home care. The "American Association for Respiratory Therapy (AART)" has evolved from the original ITA and the number of Respiratory Therapy personnel has soared to nearly 100,000 nationally according to the results of the AART Manpower Survey in 1981.

(JRCRTE) During the 1950s, schools for Respiratory Therapy began to develop under specific guidelines or "Essentials". A group of physicians spearheaded the development of these essentials and promoted the need for education of Respiratory Therapy personnel through the A.M.A.s Council on Medical Education. In the 1970s a formal body, the Joint Review Committee for Respiratory Therapy Education (JRCRTE), was organized to survey education programs and make recommendations through the Committee on Allied Health Education and Accreditation of the American Medical Association. Sponsoring organizations included (and still include) the American College of Chest Physicains, American Thoracic Society, the American Society of Anesthesiologists and the American Association for Respiratory Therapy. (see position statements) At the present time JRCRTE reviews over 400 Respiratory Therapy programs in the country and provides "Essentials" for the programs.

RESPIRATORY THERAPY LEGAL CREDENTIALING

GENERAL BACKGROUND OF RESPIRATORY THERAPY AND NATIONAL ORGANIZATIONS

(NBRC) An individual "voluntary" credentialing (examination) system began development in the 1960s for identifying "CRTTs", Certified Respiratory Therapy Technicians and "RRTs", Registered Respiratory Therapists. The organization, the National Board for Respiratory Care (NBRC), has now grown to become one of the most respected health care credentialing organizations; "The respiratory therapy exam has greater validity than many comparable evaluation instruments in other health care professions".[1] The exams given by the NBRC are based on a job analysis of Respiratory Therapy.

The NBRC has agreed to allow individual states to use the "CRTT or Entry Level" examination for registry purposes. This facilitates the licensing process by providing a valid examination for use without requiring the states to embark on the costly and time consuming project of developing their own exams.

In summary, the Respiratory Therapy field has a strong national framework through:

1. The American Association for Respiratory Therapy (AART) of which the Kansas Respiratory Therapy Society is a Chartered Affiliate
2. Joint Review Committee for Respiratory Therapy Education (JRCRTE)
3. National Board for Respiratory Care (NBRC)

1. Weisfield N, Falk D, "Professional Credentials Required". Hospitals, February 1, 1983. (article included in NBRC section)

RESPIRATORY THERAPY LEGAL CREDENTIALING

QUESTIONS AND ANSWERS

1. "What will be the cost to the taxpayers of Kansas if this proposed legislation is enacted?"

   a. The legislation proposed by the KRTS for enactment has been developed and written with the intent of levying sufficient annual fees for licensing of Respiratory Therapy practitioners to ensure self-support via said fees.

   b. An examination system is already available through the NBRC so the state will not have to develop exams which are costly to prepare.

   c. There exists no evidence to suggest that salaries for Respiratory Therapy practitioners will increase as a result of this proposed legislation being enacted. In fact, a comprehensive study entitled "Has Occupational Licensing Reduced Geographic Mobility and Raised Earnings?" was published in 1980 by B. Peter Pashigian in Occupational Licensure and Regulation; the author of which made the following observations relative to data collected for 157 occuaptions:

      > "The failure to find a significant effect of licensing on earnings is surprising."
      >
      > "The second-stage estimates also indicate that licensing... has little direct effect on either the intrastate migration rate or on earnings."
      >
      > "Average earnings in licensed occupations have not been found to be significantly higher than in unlicensed occupations."

      The author finished with the following conclusion:

      > "Members of licensed occupations do not have significantly higher earnings."

   d. The use of qualified Respiratory Therapy practitioners is commonly acknowledged as very cost-effective. Mac McIntyre, Maternal Child Health Consultant to the Medical Center of Tarzana, California testified as follows during licensure hearings held in California, December, 1981.

      > "One of the things that happens...is that generally they (nurses) are relegated to one-to-one care, which means one nurse to one patient on the most acutely ill ventilator patients. Where (Respiratory) Therapists are used in intensive care units, it has been found that one nurse to two patients can be used, and one therapist to four patients can be used. The savings is one whole person to four patients."

RESPIRATORY THERAPY LEGAL CREDENTIALING

QUESTIONS AND ANSWERS

1. d. continued

A recent study from the University of California at San Diego found a significant drop in mean mechanical ventilation time per patient ventilated occurred concurrent with the presence of trained (neonatal) Respiratory Therapists.

The assurance of the presence of qualified Respiratory Therapy practitioners has been shown repeatedly to be effective in reducing costs to the patient through effective staff utilization and reduced hospital stay.

2. "What effect will this proposed legislation have on current Respiratory Therapy practitioners?"

Those practitioners holding the NBRC credentials will be able to receive registration to practice by endorsement (without taking an examination). Those practitioners not holding an NBRC credential (OJTs and school graduates who have not passed NBRC examinations) will have a 2 year period during which time they may obtain a license by examination. Those individuals who do not obtain a license prior to the end of the "grandfather" period may not practice Respiratory Therapy until they do so.

3. "How can practitioners without NBRC credentials prepare for their registry examination?"

There are a number of well developed self-assesment examinations available. Particulary, the NBRC itself offers a "self-assessment" examination at a reasonable fee and provides a detailed description of strengths and weaknesses following completion of the examination. The same is true of commercially available examinations.

In addition, Respiratory Therapy schools, as well as the Kansas Respiratory Therapy Society offer periodic review programs and symposiums to assist in preparation of examinations and provide continuing education seminars to keep Therpaists abreast of current developments in Respiratory Care.

4. "Where will this registry examination come from? Who will develop it?"

The NBRC has agreed to allow access to its Entry-Level Examination for use as state administered licensing examinations. This exam has been carefully developed and validated, and is considered in the health care community as a standard against which others are measured. The state will not need to bear the cost of developing a new examination. This test was constructed to determine a minimal competence for Respiratory Therapists.

5. "How will the licensing of Respiratory Therapy practitioners effect other allied health practitioners?"

The proposed legislation has been developed with the intent of being "non-restrictive". It has been written to recognize the respective regulation of other professions whose scope of practice may "overlap" that of Respiratory Therapy and exempt these individuals from regulation by the proposed legislation.

6. "How will this proposed legislation permit the public to identify qualified Respiratory Therapy practitioners?"

At the hospital bedside, the public at present has no assurance of the qualifications of the practitioner providing treatment, and no resonable means of choice. By virtue of enactment of the proposed legislation, the public is assured the practitioner at the bedside has met the minimal competency requirements to practice, as employment will be illegal without a registration. In the home care setting, if Respiratory Therapy services are to be applied, the public may request the practitioner to produce evidence of registration. This will provide reasonable assurance of competency to practice.

RESPIRATORY THERAPY LEGAL CREDENTIALING

SUMMARY

In examining the health care team that commonly provides patient care at the bedside, whether it is in an acute care facility, a chronic care facility, or in a patient's home, four primary members of the team can easily be identified: the physician, the nurse, the physical therapist, and the respiratory therapist. Of the four groups, the Respiratory Therapist is the only one in Kansas who has no legally mandated minimal requirements for entry into practice. The type of care being given by Respiratory Therapy practitioners is of a curcial and often life sustaining nature.

Potent drugs are administered, vital organ systems are invaded, life support equipment is utilized (including mechanical ventilation and in some hospitals intraortic balloon counterpulsation), and diagnostic testing performed by Respiratory Therapy practitioners.

It is difficult, if not impossible, for the patient and other members of the health care team to identify the competent practitioner: several lawsuits have involved Respiratory Therapy departments due to poor care delivered by Respiratory Therapy practitioners. The cost of health care has been rising partially due to the increase in malpractice claims and the unregulated practice of Respiratory Therapy may be adding to this increase.

The Kansas Respiratory Therapy Society believes it is in the public's best interest to establish legal requirements for the safe practice of Respiratory Therapy. Legal requirements are necessary for entry into practice as well as to provide a recourse in the case of incompetent practitioners. The mechanism to institute this legal requirement is available through the examination system of the NBRC. The state would not have to embark on the costly development of an examination.

The Kansas Respiratory Therapy Society asks that the legislature ensure safe practice by legal credentialing Respiratory Therapy practitioners via state licensure.

4 Parts

Tuesday morning, December 11, 1984

Panel probing death of VA hospital patient

By Anne Waukau

A medical panel at Veterans Administration Medical Center is investigating whether a patient died Friday because a respiratory therapist forgot to turn on an alarm that would have warned nurses when the patient's respirator was disconnected, officials said Monday.

Franklin D. Cole, 49, of Fargo, N.D., was pronounced dead at the hospital at 6:03 p.m. Friday, according to the medical examiner's report.

William Matousek, the hospital's chief of staff, attributed the death to respiratory failure caused by disconnection of the respirator, the report said.

"We're talking about uncertain elements until the investigation is conducted," Matousek said during an interview Monday night.

After a preliminary review by him and another hospital official, he said, it was believed the respiratory therapist might have forgotten to turn on the alarm Friday after servicing the respirator.

Matousek said Cole might have had a coughing episode that dislodged the tubes connecting him to the respirator. Because the alarm did not go off, hospital personnel did not know the machine was disconnected, Matousek said.

The alarm was on when a nurse checked on Cole earlier in the day, about 4:30 p.m., he said. It is standard procedure for the alarm to be turned off during servicing, he said.

A panel made up of a physician, a registered nurse and a representative of the hospital administration is investigating the circumstances surrounding the death, according to the medical examiner's report. A preliminary finding is expected Wednesday.

Death Turn to Page 8

SENTINEL

Tuesday, December 11, 1984

Panel probing patient's death

Death From Page 1

and will be forwarded to the district attorney's office for review.

What disciplinary action, if any, will be taken against the therapist will be determined after the investigation is completed, Matousek said.

Cole was admitted to the hospital July 30 after being involved in a car accident May 26 in North Dakota. Cole was not expected to live when he was admitted, the report said.

Dist. Atty. E Michael McCann said Monday night that based on available information, "We anticipate there will not be a criminal charge" filed in the case.

McCann said he would discuss with Medical Examiner Chesley P. Erwin whether an autopsy should be performed by Erwin's office.

The medical examiner's office was not notified of Cole's death until Monday because it was under investigation at the hospital, according to the report.

A spokesman for the medical examiner's office said hospitals were allowed a reasonable time to inform the office of a patient's death.

2 to participate in Senate program

Washington, D.C. —AP— Sen. Robert W. Kasten Jr. (R-Wis.) has announced that two Wisconsin high school students — Georgie Holder Boge, of Three Lakes, and PaSoua Juliette Yang, of Eau Claire — have been named to participate in the Senate Youth Program in the first week of February.

Participants study US government, especially involving Senate operations, and receive $2,000 college scholarships from the William Randolph Hearst Foundation.

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MILWAUKEE SENTINEL **Local News**

Thursday, December 20, 1984 Page 5, Part 1

#1

Probe of death finds no foul play

An investigation into the death of a comatose patient at the Veterans Administration Medical Center revealed no evidence of criminal wrongdoing, an official said Wednesday.

Medical Examiner Chesley P. Erwin said his office concluded its investigation into the Dec. 8 death of Franklin D. Cole, 49, of Fargo, N.D.

The office was unable to determine how Cole's respirator tube became disconnected, Erwin said.

Dist. Atty. E. Michael McCann said he would ask the hospital for additional information about Cole's death.

According to the medical examiner's report, the hospital determined Cole died from respiratory failure, which occurred when a tube from an artificial respirator was disconnected from a tracheotomy tube in Cole's neck.

An alarm that would have warned hospital personnel the tube was disconnected was found in the "off" position after Cole was discovered dead, the report said.

Hospital personnel responsible for Cole's care denied to investigators they had anything to do with turning off the alarm or disconnecting the tube, according to the report.

They also gave conflicting accounts of whether it was standard practice for personnel to switch off the alarm when servicing Cole, then turn it on before leaving his room, according to the report.

"I think we've gone about as far as we can go," Erwin said. "I think in all probability, it (Cole's death) was accidental. There was no evidence of any intention to disconnect the tube."

Erwin said Cole could not have accidentally disconnected the tube since he was paralyzed.

Two nurses told the investigator the tube "popped off" by itself several times in the past after fluid buildups, the report said.

One of the nurses said a rubber band normally was used to keep the tubes connected, according to the report.

The nurses said they checked Cole regularly, clearing away any fluid buildup when necessary, the report said.

McCann said that without further information from the hospital he would be unable to decide whether an inquest into Cole's death was warranted.

McCann said he would ask hospital officials for a report on the autopsy conducted by their staff.

He said he also would request a report on an internal investigation conducted by a hospital medical panel. The investigation probably would not be completed until next week, a hospital spokesman said.

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Nurse deactivated alarm on respirator

(Nov. 1979 Milwaukee Journal)

By KENNETH STOFFELS

A nurse at St. Luke's Hospital disabled an alarm on a respirator machine sometime before the machine's oxygen supply was cut off to a terminally ill cancer patient, it was learned Sunday.

The patient, Alvin J. Gall, 67, of 1312 E. Seeley St., was found dead in his bed on the eighth floor of the hospital at 6 a.m. Saturday.

The alarm on the respirator was designed to provide a warning if a breathing tube linking the patient to the respirator became disconnected or the patient stopped breathing.

However, a nurse at the hospital, worried that the alarm would awaken other patients while she treated Gall, wedged a small plastic cap into the respirator to hold the switch in the off position, according to a medical examiner's investigator.

The nurse then forgot to remove the plastic cap after she was through drawing fluid from the patient's tracheal tube, the investigator said.

Dr. Lawrence Clowry, who performed an autopsy on Gall Sunday, said the results gave no sign of suffocation. The results showed Gall died of cancer and pneumonia, Clowry said.

Gall, a widower, was admitted to St. Luke's Sept. 25 and placed on a respiratory machine, a device that aided his breathing by pumping oxygen through a tube inserted in a hole cut in his throat.

At 3 a.m. Saturday, the nurse deactivated the alarm while working on Gall.

Gall was checked at 4:45 a.m. by a respiratory therapist and again at 5:15 a.m. by a second nurse, both of whom failed to notice the plastic cover in the alarm switch, according to a medical examiner's report.

At 6 a.m., respiratory therapist Regina Shutta found Gall dead in bed and saw that his tracheal tube was not connected to the respiratory machine.

Gall's hands were restrained by

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Nurse deactivated alarm

Continued From Page 1

wrist straps because earlier Saturday morning Gall, irritated by feeding tubes in his nose, had pulled them out.

It was not explained how the tube became disconnected, but one medical source said that a patient coughing could cause that to happen.

Ms. Shutta also found the plastic cap used to deactivate the alarm. She then summoned a nursing supervisor and doctor.

Clowry told a reporter, "I think he was on the verge of dying and would have died about the same time as the incident anyway."

A St. Luke's spokesman said the hospital would take no disciplinary action against the nurse who deactivated the alarm.

"The nurse is aware of the implications of what transpired and certainly felt the weight of the situation," the spokesman said.

The spokesman stressed that the practice of bypassing the alarm switch on a respirator was not condoned by the hospital, was contrary to normal procedure and was not a common practice at St. Luke's.

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from Bacha's office contacted them. By that time, Lucas had been embalmed and laid out at a Canonsburg funeral home.

"It's been rough. I'm very, very, very upset about the whole thing," said Joseph Jr.

Lucas, 32, said his father had been suffering from amyotrophic lateral sclerosis, a nerve affliction more commonly known as Lou Gehrig's Disease, for the past two years.

The elder Lucas entered the nursing home Jan. 8 to participate in a respiratory care program that Murray Manor operates in conjunction with the Forbes Health System.

Bacha said Lucas, formerly a self-employed auto mechanic, was unable to breathe on his own and had to be placed on a respirator.

According to a report filed by Johns, Ms. Akers of Jeannette and respiratory technician Elizabeth Petrulak of White Oak were making rounds early on the morning of Feb. 6.

At 4:20 a.m., the women stopped to suction fluid from Lucas's trachial tube.

"After the procedure was finished," Johns said, "they both left the room and went to attend to another patient."

Both women said that when they left, they were unaware that the respirator was not operating. Twenty minutes later, Lucas's intravenous bag had emptied and an alarm sounded. Ms. Akers told Johns she returned to Lucas's room to change the bag.

She found Lucas "unresponsive and noticed the ventilator was off. She immediately turned it on, and called for assistance," Johns said.

Murray Manor records filed with Johns' report indicate that before the incident, Lucas's condition had deteriorated to the point where he could not move anything but his eyes.

"He was completely dependent on the machine," Bacha said. "He was in pretty bad shape."

A Plum Borough physician, Dr. K.Y. Ou, pronounced Lucas dead at the scene at 5:30 a.m.

Under state law, suspicious or accidental deaths must be reported to the county coroner. But Murray Manor officials waited two days before contacting Bacha.

Murray Manor is owned by Beverly Enterprises of Pasadena, Calif., one of the nation's largest nursing home chains, with more than 900 homes.

Jane Redicker, director of communications for Beverly Enterprises, said administrators investigated the incident, but assumed the doctor had notified Bacha. "When we found out that the doctor had not notified the coroner, we did."

Ms. Redicker said Ou is not employed at Murray Manor, and Lucas's son said Ou was not his father's doctor.

Ou declined to comment. A receptionist in his office, however, said the doctor was at the home Feb. 6 treating other patients.

Joseph Lucas Jr. said Murray Manor administrators did not explain the circumstances surrounding his father's death. He said when Frank Sciortilli, the home's acting administrator, called to tell him his father was dead, he "wouldn't tell me what had happened."

But, Ms. Redicker said: "We didn't know then what had happened. We didn't have all of our facts together."

On Feb. 8, Murray officials asked Lucas's widow and son to come to the home so that they could explain the incident. "We did not want to tell them what had happened over the phone," Ms. Redicker said.

Lucas refused, explaining that his father had been laid out at a Canonsburg mortuary and that he had to make funeral arrangements.

The family did not learn the whole story until an official from the coroner's office contacted Lucas, gave the details, and said that an autopsy was necessary.

The coroner's office claimed the body after a funeral service Feb. 9. An autopsy was conducted by Dr. Cyril H. Wecht, former Allegheny County Coroner. Bacha's staff then returned Lucas's body to Washington County for burial.

Ms. Akers told investigators that this was the first time she had turned off a ventilator.

"She should never have turned it off. They are taught never to turn it off," Bacha said. The coroner decided not to file criminal charges, because Ms. Akers had promptly reported her mistake.

"When she walked back into the room, she could've turned the machine back on, and she could have walked away. No one would have known. I give her credit for her honesty."

Beverly Enterprises placed Ms. Akers on administrative leave until the coroner completed his investigation. She is now back on the job.

"She has a superior record at the facility," Ms. Redicker said. "This was a tragic accident. We train our people the best way we possibly can, so that accidents don't happen. But we hire human beings."

A spokeswoman for the Forbes Health System said Ms. Petrulak, an employee of the system, also was placed on a two-day administrative leave.

Lucas said he had last seen his father three weeks before he died, being unable to visit after that time because of bad weather. "We had known he was doing fine. We had called (the home) the day before the incident, Lucas said.

Nearly six weeks after the incident, Lucas said he is "miserable" over the circumstances surrounding his father's death.

(1)

Fatal error on patient kept quiet for 2 days

By Tim Vercellotti

The Pittsburgh Press

The family of a Washington County man who died in a Murrysville nursing home after his respirator was accidentally turned off did not learn of the circumstances of his death until a coroner's deputy told them two days later.

Joseph Lucas, 65, of Canonsburg, was found dead early Feb. 6 in the Murray Manor Convalescent Center, 3300 Logans Ferry Road, after a nurse turned off the man's respirator and forgot to restart it.

"During the procedure, she (registered nurse Karen Akers) said she turned off the ventilator because of the disturbing noise it produced," Deputy Coroner Dennis A. Johns said. "After the procedure was finished, they both left the room and went to attend to another patient."

Westmoreland County Coroner Leo Bacha has ruled the death accidental, labeling it "a therapeutic misadventure." He said no criminal charges will be filed.

Officials at the nursing home did not report the incident to Bacha until two days after it had happened, and did not explain the circumstances to Lucas's widow, Mary, and son, Joseph Jr., when they called to tell them Lucas had died.

The family did not learn of the mistake until officials

Please see Error, A19

p. 11

Hospital, insurer ask court to lower award to patient

By AVRAM GOLDSTEIN
Herald Staff Writer

Attorneys in Florida's most spectacular medical malpractice suit — a $16.9-million Broward case that touched off a liability insurance crisis and a physician revolt last year — clashed again Friday.


Schlesinger

For four hours they argued at the Fourth District Court of Appeal in West Palm Beach about whether the $12.47-million jury award and a $4.4-million court-ordered fee for Fort Lauderdale lawyer Sheldon Schlesinger were excessive.

Attorneys for Florida Medical Center and its insuror, the state Patient's Compensation Fund (PCF), were outraged that the trial judge reimbursed Susan Ann Von Stetina for so huge an attorney's fee. She now lies semi-comatose and helpless in a Broward nursing home.

Broward Circuit Judge Robert Lance Andrews presided over the two-week trial last year.

The defendants fear that if the court affirms Andrews' decisions, it could strain the solvency of the state fund and force Von Stetina to take over the hospital to collect her judgment.

Precedents set in this case could shape the future of malpractice litigation in Florida, several lawyers said.

Von Stetina, 27, was taken to Florida Medical Center in Lauderdale Lakes in November 1980 after a severe car accident.

She was recovering in the intensive care unit when her respirator failed. By the time nurses noticed,

Please turn to AWARD / 5BR

$16.9-million award is termed excessive

AWARD / *From* 1BR

some 15 or 20 minutes later, the lack of oxygen damaged her brain. Later, she also was blinded in one eye and suffered a broken leg at the hospital — both unrelated to the original injuries.

PCF lawyer Talbot D'Alemberte said the $12.47-million jury award was too high. Von Stetina, he said, is too far gone to enjoy the money. The jury awarded her $188,000 a year over her 40-year life expectancy for medical care.

"The money simply can't be appreciated or comprehended, and it's not going to help her at all," D'Alemberte said.

Schlesinger called that view callous and showed the three judges and 15 opposing attorneys a videotape of Von Stetina receiving physical therapy in her bed.

"I want to rebut the [portrayal] of Susan Ann Von Stetina as some mindless bit of protoplasm who is unable to appreciate her circumstances," he said. "She responds to the painfulness of the treatment itself. She reacts to a tender touch. She indeed feels."

The defense lawyers also asked the appellate judges to:

- Reduce the jury verdict.
- Rule that Andrews shouldn't have let Schlesinger read to the jury an emotional article in a nursing journal about what it might feel like to be a patient whose respirator failed. D'Alemberte said the article, used by the hospital to train its nurses, prejudiced the jury.
- Throw out the statute that requires the losing side in a medical malpractice case to pay the winner's attorney fees. The Florida Medical Association in 1980 shepherded the law through the Legislature to stem frivolous lawsuits. But because of Andrews' $4.4-million fee award in this case, the doctors now want to dump it.

D'Alemberte said Schlesinger spent no more than 1,000 hours working on the case, and labeled a $4,400-an-hour fee a "sham." The defense lawyers suggested a court-ordered fee of $500,000 and said the fee should be based on how much time Schlesinger devoted to the case.

But Schlesinger's appellate counsel, Joel Eaton, disagreed: "When you look at the economic reality of this case, it makes perfect sense. Unlike other kinds of cases, medical malpractice lawyers are not hired on an hourly basis."

On one issue the hospital and the insuror are split.

Andrews ruled that a state law limiting PCF payouts to no more than $100,000 was unconstitutional. Either way, one of the defendants is in big trouble.

Without the limit, the fund could be ruined financially by having to pay all the money at once.

But if the court allows the limit to stand, the hospital then might have to pay off the rest of the $16.9 million at once.

2-12

30 unit delivered high O_2 concentrations with or without an O_2 reservoir. The Hope II, new Laerdal, and PMR2 units did not deliver high O_2 concentrations without O_2 reservoirs, but did deliver high O_2 concentrations with a reservoir and O_2 flow rates of 0.15 L/min or greater. The Hope I, old Laerdal, PMR1, and new and old Vitalograph units could not deliver high O_2 concentrations with or without O_2 reservoirs. The older Ambu Model NR unit without a reservoir delivered moderately high O_2 concentrations when the O_2 flow rate was as low as 15 L/min, but the patient valve began to stick in the inspiratory position at a flow rate of 30 L/min.

Source: Barnes TA, Watson ME. Evaluation of new and old designs to improve the oxygen delivery performance of adult resuscitation bags [Abstract]. 1981 Respiratory Care Open Forum Abstracts. AART Annual Convention, Anaheim. *Respir Care* 26:1132, 1134; 1981 Nov.

Comment: In ECRI's evaluation of current models of these resuscitators (*HEALTH DEVICES*, Vol. 8, p. 133), we found that oxygen concentrations greater than 0.9 could be delivered by most units by using a slow bag refill technique at an O_2 flow rate of only 15 L/min.

Accession No.: 04557

TRANSFUSION KITS [14-126]

Device: Transfusion Tubes

Abstract: Suit was filed, alleging that a disconnected transfusion tube was undetected, and an infant receiving a transfusion nearly bled to death through negligence. The suit alleged that the duty nurse turned off the alarm system of the unit before the incident occurred.

Source: Alleged undetected disconnected transfusion tube leads to negligence suit. *Biomed Saf Stand* 11:128; 1981 Nov 15.

Accession No.: 04634

TUBES, TRACHEAL [14-085]

Device: Endotracheal and Esophageal Obturator Airways

Abstract: Endotracheal and esophageal obturator airways were compared in a review of 276 patients with prehospital cardiac arrest. The endotracheal airway was associated with a higher incidence of unsuccessful placements and immediate airway complications. 8.5% of patients autopsied who had esophageal obturator airways had esophageal lacerations.

Source: Campion BC, Beyer R, Smith G, et al. Evaluation of esophageal obturator airway and endotracheal tube in prehospital [illegible] [Abstract]. Abstracts of the Fourth Purdue Conference on Cardiac Defibrillation and Cardiopulmonary Resuscitation, Purdue University, September 15-17, 1981. *Med Instrum* 15:321; 1981 Sep-Oct.

Accession No.: 04564

TUBES, TRACHEAL [14-085]

Device: Tracheal Tubes

Abstract: A case is reported of bilateral vocal cord paralysis following endotracheal intubation. The authors believe that the paralysis was caused by a pressure neuropraxia by the tracheal tube and use of a too large tracheal tube in relation to the subglottic region.

Source: Gibbin KP, Egginton MJ. Bilateral vocal cord paralysis following endotracheal intubation. *Br J Anaesth* 53:1091-1092; 1981 Oct.

Accession No.: 04565

VENTILATORS [15-613]

Device: Ventilators

Abstract: A case is reported in which a patient became disconnected from a ventilator, and no alarm sounded. The patient did not have a palpable pulse when discovered by a nurse. 3 members of the nursing and respiratory therapy staff had accidentally triggered the ventilator's alarm, and all 3 had the occasion to turn off the alarm temporarily in order to complete their care measures without the annoying sound of the alarm. Several questions are posed, the answers to which may have altered the outcome.

Source: Disconnected ventilator discovered on routine rounds. *Case Alerts* [Pennsylvania Hospital Insurance Company/Pennsylvania Casualty Company, Camp Hill, PA], No. 81-8, Nov, p 1.

Accession No.: 04639

VENTILATORS [15-613]

Device: Ventilators

Abstract: Suit was filed, alleging that a malfunctioning ventilator caused a patient's death. The patient's husband was awarded an out-of-court settlement of $245,000 and received a verbal agreement that alarms would be installed on the machines to prevent future incidents.

Source: Malfunctioning ventilator allegedly causes death: Settlement to survivor. *Biomed Saf Stand* 11:127; 1981 Nov 15.

Accession No.: 04640

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#1

...ive and could not be enforced.

Large award to patient upheld

Knight-Ridder Newspapers

West Palm Beach, Fla.—Florida's largest medical malpractice verdict—$12.47 million awarded to a Fort Lauderdale woman who suffered severe brain damage when a hospital respirator failed—has been upheld by the 4th Florida District Court of Appeal.

The damages jurors awarded to Susan Ann Von Stetina, 29, were not excessive, a three-judge panel has decided. However, the appellate judges ruled Wednesday that the record $4.4 million in fees that Judge Robert Lance Andrews awarded to Ms. Von Stetina's attorney was too much.

They ordered the fees awarded to a Fort Lauderdale lawyer, Sheldon J. Schlesinger, reduced to $1.5 million.

Talbot D'Alemberte, attorney for the Florida Patients Fund, a state-created malpractice insurance fund that would have to pay the award, said an appeal to the Florida Supreme Court is "highly likely."

Ms. Von Stetina went into a semicoma on Dec. 3, 1980, at Florida Medical Center in Lauderdale Lakes. She was in the hospital's intensive-care unit recovering from a severe automobile accident when a respirator failed, cutting off her oxygen.

1981 Book 583 pg 141

[redacted], a minor, by and through [redacted], his father and next friend, Plaintiff-Appellant, v.

[redacted] M.D., and St. Louis Children's Hospital, Defendants - Respondents
Supreme Court of Missouri

Medical Malpractice action brought against hospital and physician on behalf of minor patient. Negligent administration of oxygen causing patient to suffer from retrolental fibroplasia, total blindness of right eye.

At Circuit Court, City of St. Louis the case was in behalf of defendants but because the Court of Appeals believes the trial court committed prejudicial errors to the plaintiff's rights the decision was reversed and remanded.

Charge-negligent administration of oxygen to the minor while he was a patient in the hospital under the care of Dr. [redacted]

No jobless benefits for therapist who reported dead were alive

Iowa City Press Citizen

By The Associated Press

DES MOINES — A respiratory therapist who reported pulses on two dead people has been denied jobless benefits.

"I didn't know they were dead," said Eric Skuster, now of Coralville, who was fired from a job in Waverly last July when Medicaire investigators discovered the discrepancy.

The appeal board of Job Service of Iowa said it believed Skuster was unaware the patients were dead, but it said he should not have falsified the reports.

"It was an error in judgment," said Skuster, who now is a respiratory therapist at University Hospital. The appeal board decision upholds a hearing officer's finding that Skuster should pay back $1,700 in jobless benefits already collected. Skuster said he would appeal the decision.

Skuster blamed the situation on pressure from his former employer, the Inhalation Therapy Services Inc., a company formed by UC Consultants of Nashville, Tenn. UC Consultants declined comment on the case.

Skuster's job was to make home visits to ill people, taking pulses and making other medical checks, then forwarding the results to the Waverly Municipal Hospital, which would seek reimbursement from Medicare.

On two occasions, once when he was on vacation, Skuster filled out reports on people who had died several days previously. "I should have just said that they hadn't returned from the hospital yet," he said.

He said he felt pressure from Inhalation Therapy to fill in the reports, even though he had not visited the patients. "They'd call and give a big hassle," he said.

Skuster said that as a result of the false reports, he received $40 that he wasn't entitled to get. He said he gave the hospital a check to cover the amount but that it was never cashed.

The hospital maintained Skuster's action jeopardized the hospital's financial status with Medicare and the appeal board agreed.

#1

p.15

4510 13th Avenue S W
Fargo North Dakota 58121-4510
701 / 282-1100

January 30, 1985 #3.

Mr. Gary Brown
Respiratory Therapy
St. Luke's Hospitals
Fargo, North Dakota 58122

RESPIRATORY THERAPY SERVICES

Respiratory therapy services in the state of North Dakota have been observed in the audit process and also in the individual group studies of cost per hospital day.

It is apparent by these studies that respiratory therapy in some areas has been used excessively with possibly little professional expertise to monitor or deliver these services. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient.

It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when the services are delivered by the uneducated individual.

Actual statistics for a past year for a particular bed-sized hospital were $7.04 per day for educated providers and $22.76 for the uneducated provider. Another bed-sized hospital statistic was $12.50 for the educated provider while $20.87 for the uneducated provider.

It appears the proper training and education are vital for the proper delivery of respiratory services while keeping the safety and well-being of the patient in mind as well as the total dollar spent for this service.

Marlene Moderow R.N.

MARLENE MODEROW, R.N.
Medical Review Field Auditor

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3-24-86

Requested amendments to HB 2533 by the Kansas Respiratory Therapy Society.

The Kansas Respiratory Therapy Society would ask that the members of the Senate Public Health and Welfare committee consider the following amendments to HB 2533.

Section 5: This is an exclusionary clause allowing other professions to "cross over" during the normal practice of their trade.

ACTION: Please amend to denote Registered Physical Therapists, Pulmonary Function Technologist, and Medical Technicians.

Section 6: Refers to the formation of the Respiratory Therapy Council which will advise the Board in carrying out the provisions of this act.

It details the process for replacing vacancies to the council.

It does not detail the original appointment of Respiratory Therapists to the council.

ACTION: Please amend to include process for orginal appointments of therapists to the council.

Section 10: Grandfather clause - will determine who will continue to practice under the title of "Respiratory Therapist" following inactment of this bill.

ACTION a: Amend to include those individuals that have been certified as a Respiratory Therapy Technician by the National Board for Respiratory Care.

b: Amend to include the requirement of a test for those individuals that have not demonstrated competency by a written examination approved by the Board.

Section 11: Concerning fees -- If the Board were to determine that the entry level exam (administered by the National Board for Respiratory Care) were to be the standard in this state, the 40 dollar limitation is less than the current cost of this test.

ACTION: Amend to "not more than ... $100."

Section 16: Title Protection - determines titles to be protected under this act.

ACTION a: Remove Registered Respiratory Therapist.

b: Add Respiratory Therapist Registered by the State.

c: Include 'Inhalation Therapist'

Attachment VII
3/24/86
S. PH&W

VII

3-24-86

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

TESTIMONY ON HOUSE BILL 2533

PRESENTED TO THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE, MARCH, 1986

This is the official position taken by the Kansas Department of Health and Environment on H.B. 2533.

BACKGROUND INFORMATION:

In 1983, the Kansas Department of Health and Environment received an application from the Kansas Respiratory Therapy Society 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 respiratory therapy.

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

- The applicant has met Criterion 1 of the need for credentialing by demonstrating that "the unregulated practice of respiratory 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 argument."

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

- The applicant has not met Criterion 3 of the need for credentialing since the public is effectively protected from harm by the practice of respiratory therapy through supervision and laws governing the occupation's devises and substances. (Criterion 3 states that the applicant must demonstrate that there are no other means other than credentialing exists to protect the public.)

The Secretary of Health and Environment reviewed the application, information obtained through the technical committee meetings and public hearing, and the report and recommendations submitted by the technical committee and SHCC and concluded:

- The applicant has met all three criteria for need of credentialing.

- The rationale for non-concurrence with the technical committee's and SHCC's recommendation on Criteria 3 is as follows:

Attachment VIII
3/24/86 S. PH&W

VIII

1. No laws govern the standard of practice of respiratory therapy and effective enforcement in Kansas;

2. Standards for professional performance are not enforceable because organization involvement is on a voluntary basis;

3. Certification, licensing or accreditation of facilities is not necessarily correlated to employing competent respiratory therapist staff;

4. No federal government credentialing mechanisms exist;

5. All members of the applicant group are not required to graduate from an accredited educational institution or training program;

6. There are no legal or professional requirements for on-the-job training progams for respiratory therapists; and

7. A previous application for credentialing by occupational therapists was approved by the technical committee and SHCC. The practices of respiratory therapists could lead to untoward health effects at least as serious as those of occupational therapists.

- Therefore, the Secretary forwarded to the legislature a recommendation that respiratory therapists be licensed by the State of Kansas.

DEPARTMENT'S POSITION:

KDHE supports the provisions of H.B. 2533 which provides for the licensure of respiratory therapists.

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

3-24-86

The Kansas Chapter
American Physical Therapy Association
1237 Belle Terrace
Topeka, KS 66604

To the Senate Public Health and Welfare Committee

Re: HB 2498 and HB 2533

The Kansas Chapter of the American Physical Therapy Association supports the passage of HB 2498, registration of occupational therapists, and HB 2533, registration of respiratory therapists, as passed by the House of Representatives.

Cam Wilson

Cam Wilson
Kansas Chapter President

Attachment IX
3/24/86 S. PH&W

IX