

Texas Legislative Session—Update From The Texas Occupational Therapy Association

■ **Mary Hennigan**

The Texas Legislature meets in odd numbered years for 140 days. Over the course of a regular session, more than 7,000 bills will be filed, about half of them will be heard in committee, and about 1,400 bills will be signed by the governor or become law without his signature. The 82nd Regular Legislative Session began January 11, 2011, at noon and will end May 30, 2011, on the 140th day. Needless to say, there is a tremendous amount of work to be accomplished over these 140 days for such a large state. Much of this work occurs between sessions, but the session itself moves at a fast pace once committees are appointed.

During the 82nd Regular Legislative Session, Texas legislators will be dealing with a budget shortfall of almost \$27 billion. The Texas Occupational Therapy Association (TOTA) will be working collaboratively with the senators and representatives as they deal with funding cuts proposed to nursing home reimbursement, state mental health programs, the Children's Health Insurance Program, and Medicaid funding. This very difficult financial environment poses challenges for the majority of legislators who were elected on promises to not raise taxes or other forms of revenue, but rather to balance the budget with cuts.

Throughout the 82nd session, TOTA will also be building relationships in preparation for the 83rd Legislative Session (2013), during which the Texas Board of Occupational Therapy Examiners (TBOTE) will undergo Sunset Review. In 1977, the Texas Legislature created the Sunset Advisory Commission to identify and eliminate waste, duplication, and inefficiency in government agencies. The 12-member commission was formed as a legislative body that reviews the policies and programs of more than 150 government agencies every 12 years. The commission questions the need for each agency, looks for potential duplication of other public services or programs, and considers new and innovative changes to improve an agency's operations and activities.

Although agencies are supposed to be reviewed on a 12-year cycle, the Texas Board of Occupational Therapy Examiners was last reviewed in 1993. The Sunset review of TBOTE has been postponed several times. As part of the preparation for the review, TBOTE and TOTA will be looking at the OT Practice Act, AOTA's Model Practice Act and Practice Framework to determine if we should bring forth any recommendations for practice changes. TOTA has created a Sunset Task Force charged with leading this effort for the association.

TOTA is supporting SB 57 relating to the licensing and regulation of

post-acute care acquired brain injury rehabilitation facilities. Occupational therapists are included in this legislation as a required therapeutic discipline.

TOTA hosts a Day at the Capitol event in Austin every session, with this year's Day held February 11, 2011. TOTA's executive director Mary Hennigan and legislative advisor Deidra Garcia provided more than 50 participants with an overview of the key issues facing the legislature this session, explained the Sunset process and how occupational therapists and certified occupational therapy assistants can be involved in that process, and explained the issues that TOTA wants them to discuss with their state senators and representatives. After orientation, the participants traveled to the Capitol to visit with their legislators. The participants discussed with their legislators their concerns about the proposed budget cuts; licensing of postacute brain injury rehabilitation facilities; and the upcoming Sunset review of TBOTE, our licensure board.

For more information about TOTA's legislative initiatives, please contact Mary Hennigan at mary@tota.org.

Mary Hennigan, OTR, MBA, is the executive director of the Texas Occupational Therapy Association.



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Maryland Occupational Therapy Association Lobby Night

■ Cheryl Morris, OTR/L

The Maryland Occupational Therapy Association (MOTA) held its annual Lobby Night in early February. Nearly 40 practitioners and students arrived in the state capital of Annapolis to discuss issues relevant to occupational therapy with their state legislators. Those in attendance were able to meet with up to four of their state representatives to advocate for occupational therapy and the populations we serve.

The evening began with training by the MOTA lobbyist, Robyn Elliott, on how to talk with the delegates: focusing on concise and direct statements relating the impact to real-life situations. She also gave an overview of current legislation that addresses issues relevant to occupational therapy. During our bimonthly bill review teleconferences held between Elliott and members of MOTA, we had decided to support expanding the ban on Bisphenol A (BPA) in products for infants and the increased alcohol tax with revenues supporting programs for developmental disabilities, both from a wellness and public health perspective. Attendees of lobby night were briefed on the MOTA stance for these bills in addition to changes expected to occur in the state budget, health reform, and upcoming legislation still in committee.

Attendees were able to role-play a meeting with a legislator by giving an introduction, defining OT, explaining the important issues, and asking for their support. This portion of the evening was capped off by a surprise visit from Shawn Tarrant, delegate from Baltimore City, who was gracious enough to allow Jessica Barth, a student from nearby Towson University, to practice her meeting speech with him. Delegate Tarrant also took questions from the group regarding his support of issues relevant to OT and how day-to-day business of the legislature was carried out.

After this excellent introduction, attendees were able to go out into the Senate and House buildings for meetings with their representatives that were scheduled by our lobbyist. This was definitely the highlight of the evening, and there seemed to be unanimous agreement that these meetings had gone well. Jutta Brettschneider, OTR, described a long conversation she had with delegate Doyle Niemann regarding the importance of community services and how OT is integral to serving people where they live. Tanya DeKona, OTR/L, reported that she had a successful meeting with Senator Jamie Raskin, describing OT's broad scope and importance. Tanya credits a reference folder prepared prior to the event filled with documents regarding OT and the MOTA stance

on current bills, and a follow-up e-mail sent after the event with cementing the affect of the original meeting. Personally, I felt that my senator, Lisa Gladden, was most impressed, not by the information I provided to her, but the practical advice given to her secretary who had a degree in exercise physiology but was searching for a new direction.

After the meetings, attendees met for networking and debriefing at a local restaurant. Many took advantage of this time to discuss issues with our lobbyist Robyn Elliott and Marcy Buckner, AOTA State Policy Analyst. The atmosphere was one of success, with everyone sharing their stories of how they had brought occupational therapy to the attention of their state policymakers. Tanya DeKona stated, "I can't tell you how much impact one person can have by having a short, sweet meeting with a legislator. Simply making an appointment to meet with them conveys that we value ourselves and think our profession is important." Continuing to represent our profession at a state and national level will help keep OT relevant through legislation.

Cheryl Morris, OTR/L is the Vice President of Advocacy for the Maryland Occupational Therapy Association.

The American Occupational Therapy Association's State Affairs Group

Purpose

The State Affairs Group is responsible for all of the Association's state legislative and regulatory activities. This department monitors and provides analysis of proposed legislation and regulations affecting occupational therapy in the states, conducts outreach and provides assistance to state OT associations on key state issues such as professional regulation/scope of practice. The department also provides day-to-day liaison with state OT regulatory boards on professional trends and issues such as supervision and continuing competence requirements.

Resources

Department staff provide research, technical assistance, and consultation on a wide range of state legislative and regulatory issues, and function as a clearinghouse for information useful to state regulatory boards. Staff members work with the state regulatory boards, analyze proposed legislation and regulations on key issues, provide testimony and recommend appropriate strategies for handling issues that affect the profession.

Staff and Contact Information

Please contact us if there are any issues that you would like to learn more about or require technical assistance. The department also invites suggestions for future newsletter articles.

Chuck Willmarth, Director

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2011 State Regulatory Entity Survey Results: Number of Licensed/Regulated OTs/OTAs

State	# of regulated OTs	# of regulated OTAs	2011 Totals
Alabama	1,148	572	1,720
Alaska	256	20	276
Arizona	1,835	593	2,428
Arkansas	1,162	269	1,431
California	11,650	2,100	13,750
Colorado*	1,994	290	2,284
Connecticut	2,029	663	2,692
Delaware	444	203	647
District of Columbia	562	25	587
Florida	7,112	2,595	9,707
Georgia	2,694	727	3,421
Hawaii*	597	70	667
Idaho	615	158	773
Illinois	5,340	2,094	7,434
Indiana	2,638	1,078	3,716
Iowa	1,059	427	1,486
Kansas	1,422	377	1,799
Kentucky	1,979	544	2,523
Louisiana	1,631	494	2,125
Maine	1,034	227	1,261
Maryland	2,565	556	3,121
Massachusetts	5,043	1,863	6,906
Michigan	4,709	1,382	6,091
Minnesota	2,965	918	3,883
Mississippi	822	369	1,191
Missouri	3,036	1,027	4,063
Montana	303	71	374
Nebraska	830	119	949
Nevada	537	147	684
New Hampshire	1,162	258	1,420
New Jersey	4,423	586	5,009
New Mexico	821	280	1,101
New York	10,381	3,904	14,285
North Carolina	2,958	1,302	4,260
North Dakota	437	148	585
Ohio	4,408	2,988	7,396
Oklahoma	780	690	1,470
Oregon	1,400	251	1,651
Pennsylvania	6,796	2,746	9,542
Puerto Rico	629	325	954
Rhode Island	577	320	897
South Carolina	1,547	713	2,260
South Dakota	335	98	433
Tennessee	1,938	1,012	2,950
Texas	6,784	2,790	9,574
Utah	573	232	805
Vermont	326	95	421
Virginia	2,737	778	3,515
Washington	2,805	614	3,419
West Virginia	540	320	860
Wisconsin	3,100	1,226	4,326
Wyoming	283	102	385
2011 Totals	123,751	41,756	165,507

* OTA Bureau of Labor Estimated Statistics May 2009
OTA State Affairs Group, January 2011

Notice of Open Hearing on ACOTE Standards

The ACOTE Educational Standards Review Committee (ESRC) will hold an Open Hearing at the AOTA Annual Conference and Expo in Philadelphia, Pennsylvania to receive comments on the proposed revisions to the ACOTE *Accreditation Standards for a Doctoral-Degree-Level Educational Program for the Occupational Therapist*, *Accreditation Standards for a Master's-Degree-Level Educational Program for the Occupational Therapist*, and the *Accreditation Standards for an Educational Program for the Occupational Therapy Assistant*. The proposed revisions to the ACOTE accreditation standards will be available on the ACOTE Accreditation Web site at <http://www.acoteonline.org/>.

ESRC representatives will be presenting highlights of the Standards survey results and anticipated revisions of the Standards. This open hearing will provide participants with an opportunity for comment and questions. Based on comments from the communities of interest, the draft Standards will undergo further revision.

All interested parties are invited to attend the hearing, which is open to the public. (Participants will not be required to register for AOTA's Annual Conference & Expo in order to attend the Open Hearing). The hearing will be held as follows:

THURSDAY, APRIL 14, 2011 (1:00-3:00 pm)

Philadelphia Marriott Downtown, 1201 Market Street,
Philadelphia, Pennsylvania 19107 • Room: Liberty Ballroom

RA Considers Revised *Definition of Occupational Therapy Practice for the Model Practice Act*

■ Marcy M. Buckner

The *Definition of Occupational Therapy Practice for the AOTA Model Practice Act* is an important document that asserts the scope of practice of occupational therapy for state regulation. Any changes to this document must be adopted by the Representative Assembly (RA). States are encouraged to adopt this language in their practice acts because it reflects the current appropriate scope of practice as defined by the standard-setting body of the profession. Defining a scope of practice legally articulates the domain of occupational therapy practice and provides guidance to facilities, providers, consumers, and major public and private health and education facilities on the appropriate use of occupational therapy services and practitioners.

A profession's definition of practice must be broad enough to include its full and appropriate scope, yet specific enough to indicate unique aspects that distinguish it from other professions as well as those that may appropriately overlap. Scope of practice, as reflected in this legal definition, should directly relate to the standards for education, training, and clinical application for that profession.

The *Definition of Occupational Therapy Practice for the AOTA Model Practice Act* was last updated in 2004. Since that time, several states including Colorado, the District of Columbia, Idaho, Michigan, New Mexico, North Carolina, Oregon, Tennessee, and West Virginia have introduced, adopted, or adapted that language in their practice acts. Other states have used previous versions of the model definition in their

practice acts. As states upgrade their practice acts, AOTA will recommend use of the *Definition of Occupational Therapy Practice for the AOTA Model Practice Act* as well as other aspects of AOTA's Model Practice Act.

The Occupational Therapy Practice Framework was revised in 2008 which facilitated the necessity to update the *Definition of Occupational Therapy Practice for the AOTA Model Practice Act* in order to reflect the changes in the framework and changes in practice since the development of the current definition in 2004. The current definition was sent to a broad spectrum of stakeholders via email, the AOTA website, and an article in *OT Practice*. Stakeholders included state regulatory boards and councils, educators, state association presidents, RA representa-

tives, and Board members. The State Affairs Group coordinated a cross-functional team of AOTA staff to review stakeholder comments and to draft a revised definition. The revised definition was then sent to the stakeholders for a second call for comments. Stakeholder comments were again thoroughly reviewed and integrated into the revised definition.

The revised draft of the *Definition of Occupational Therapy Practice for the AOTA Model Practice Act* will be published as part of the Report of the President to the RA in the this issue of *OT Practice* (March 14, 2011). RA representatives will be seeking input on this motion from their constituents prior to the RA meetings in April. If approved by the RA, this definition will be distributed to state regulatory

boards, state associations, and other interested parties. Note: the revised definition will not replace the definition of occupational therapy practice in state practice acts without the adoption of the definition by individual state legislatures.

AOTA members are encouraged to review the RA reports in *OT Practice* and online, and to share their thoughts about action items with their RA representatives.

The suggested changes to the *Definition of Occupational Therapy Practice for the AOTA Model Practice Act* are published below and continue on page 5.

Marcy M. Buckner, JD, is a state policy analyst at AOTA. She can be reached at mbuckner@aota.org.

Note: Text with a ~~strikethrough~~ has been deleted and text with an underline has been added.

Definition of Occupational Therapy Practice for the AOTA Model Practice Act

The practice of occupational therapy means the therapeutic use of occupations, including everyday life activities (~~occupations~~) with individuals, ~~or~~ groups, populations, or organizations for the purpose of to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided ~~for the purpose of promoting~~ for habilitation, rehabilitation, and promoting the promotion of health and wellness and to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations ~~everyday life activities~~ that affect physical and mental health, well-being, and quality of life.

The practice of occupational therapy includes:

- A. Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep education, work, play, leisure, and social participation, including:
 1. Client factors, including body functions (such as ~~neuromuscular neuromusculoskeletal~~, sensory and pain, visual, mental, perceptual, cognitive) and body structures (such as cardiovascular, digestive, nervous, integumentary, genitourinary systems, and structures related to movement), values, beliefs, and spirituality.
 2. Habits, routines, roles, rituals, and behavior patterns.
 3. Physical and social environments, ~~C~~cultural, personal, temporal, ~~physical, environmental, social,~~ and spiritual virtual contexts and activity demands that affect performance.
 4. Performance skills, including motor and praxis, ~~process~~, sensory-perceptual, emotional regulation, cognitive, and communication/~~interaction~~ and social skills.
- B. Methods or ~~strategies approaches~~ selected to direct the process of interventions such as:
 1. Establishment, remediation, retention, or restoration of a skill or ability that has not yet developed ~~or~~ is impaired, or is in decline.
 2. Compensation, modification, or adaptation of activity or environment to enhance performance, or to prevent injuries, disorders, or other conditions.
 3. ~~Maintenance~~ Retention and enhancement of ~~capabilities~~ skills or abilities without which performance in everyday life activities would decline.
 4. ~~Health promotion~~ Promotion of health and wellness, including the use of self-management strategies, to enable or enhance performance in everyday life activities.
 5. Prevention of barriers to performance and participation, including injury and disability prevention.

- C. Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep, education, work, play, leisure, and social participation, including:
1. Therapeutic use of occupations, exercises, and activities.
 2. Training in self-care, self-management, health management and maintenance, home management, ~~and~~ community/work reintegration, and school activities and work performance.
 3. Development, remediation, or compensation of ~~physical, mental, cognitive, neuromuscular, sensory functions~~ neuromusculoskeletal, sensory and pain, visual, mental, perceptual, cognitive functions, and behavioral skills.
 4. Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process.
 5. Education and training of individuals, including family members, caregivers, groups, populations, and others.
 6. Care coordination, case management, and transition services.
 7. Consultative services to groups, programs, organizations, or communities.
 8. Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles.
 9. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices.
 10. Assessment, recommendation, and training in techniques to enhance functional mobility, including wheelchair management of wheelchairs and other mobility devices.
 11. Low vision rehabilitation.
 12. Driver rehabilitation and community mobility.
 13. Management of feeding, eating, and swallowing to enable eating and feeding performance.
 14. Application of physical agent modalities, and use of a range of specific therapeutic procedures (such as wound care management; techniques interventions to enhance sensory, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills.
 15. Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and the adaptation of processes.

2011 State Legislative Forecast

■ Marcy M. Buckner

Several state occupational therapy associations this year will amend their practice acts, continue with licensure efforts, or monitor the efforts of other professions to expand their scope of practice. New this year will be efforts by state governments to implement the federal health care reform law. States will continue to see legislation to mandate coverage for the treatment of autism spectrum disorders (ASDs).

Health Care Reform

President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law in March 2010. Implementing PPACA will take several years and affect each state with the expansion of Medicaid and the increased number of insured. Although many questions remain at the federal level about implementation, many states

created task forces to begin planning implementation of the reforms. State associations are encouraged to monitor and engage with the task forces in their state in order to become involved in the process of their state's implementation of health care reform. AOTA has hired the state government relations consulting firm Stateside Associates to monitor the work of these state task forces. AOTA is committed to working with state associations as health care reform is implemented at the state level.

State Regulation of OT

AOTA continues to work with state associations to enact licensure laws in all states and jurisdictions for occupational therapists (OTs) and occupational therapy assistants (OTAs) as well as to prevent efforts to repeal the state regulation of the OT profession.

OTAs are licensed in 46 states, the District of Columbia, and Puerto Rico.

Indiana and New York have certification for OTAs. Colorado and Hawaii do not regulate OTAs. Looking forward, the New York Occupational Therapy Association and the Indiana Occupational Therapy Association will both pursue legislation to license OTAs.

Wound Care and Sharp Debridement

Last year, the Washington State Attorney General issued opinion AGO 2010 No. 2, stating that "sharp debridement is not within the scope of practice for occupational therapists." The Washington Occupational Therapy Association (WOTA) worked with legislators to have legislation introduced to specifically add wound care and sharp debridement to the OT scope of practice. The 2010 legislative session ended without the adoption of WOTA's

2011 State Legislative Forecast *Continued from page 5*

legislation; however, WOTA has already introduced similar legislation in 2011.

Physical therapists (PTs) also seek to amend their state practice acts to include wound care and sharp debridement. Such legislation has already been introduced in Alabama and Oklahoma. The concern is that if a state PT practice act includes wound care and sharp debridement, but the OT practice act does not, the law may be interpreted as restricting these procedures to the practice of PTs.

Recreational Therapists

Recreational therapists (RTs) are licensed in Oklahoma, New Hampshire, North Carolina, and Utah. RTs have proposed legislation to define recreational therapy as “a treatment service designed to restore, remediate, and

rehabilitate a person’s level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition.” Additional legislation is expected this year and has already been introduced in New York.

Physical Therapists

State PT chapters are being encouraged to adopt the American Physical Therapy Association’s (APTA’s) *Guide to Physical Therapist Practice*. Of concern is the addition of “functional training and self-care and in home, community, or work re-integration” to the model definition of PT. The limited context addressing functional training is not clearly defined, potentially misleading consumers and encroaching on OT’s traditional domain. PT legislation based on the APTA guide was recently introduced in Oklahoma.

Insurance Coverage for ASDs

Autism Speaks, a national organization dedicated to addressing problems related to ASDs, has developed model legislation that recognizes the important role of OT in treatment. AOTA has worked with state associations in support of mandate initiatives that include coverage for OTs, and a number of states should expect to see mandated coverage bills. In total, 23 states have enacted autism insurance reform legislation, 19 of which include OT.

Although the 2011 legislative session will be challenging, AOTA and the state associations are working hard to ensure the profession’s continued growth. Your membership in AOTA and your state association provides us with the resources to actively engage in these issues on your behalf.

Marcy Buckner, JD, is a state policy analyst at AOTA. She can be reached at mbuckner@aota.org.

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