Information Summary and Recommendations

Physical Therapy Sunrise Review

December 1999

Health Systems Quality Assurance

Information Summary and Recommendations

Physical Therapy Sunrise Review

December 1999

Washington State Department of Health

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Mary Selecky
Secretary of Health

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The Sunrise Review Process

It is the Legislature's intent that all qualified individuals should be permitted to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession.

The Sunrise Act, RCW 18.120.010, states that a health care profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;

- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and

- The public cannot be effectively protected by other means in a more cost-beneficial manner.

After evaluating the criteria, if the Legislature finds that it is necessary to regulate a health profession not previously regulated by law, the least restrictive alternative method of regulation should be implemented, consistent with the public interest. There are five types of regulation to be considered:

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions and criminal prohibitions are not sufficient to eradicate existing harm.

2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business when a service being performed for individuals involves a hazard to the public health, safety or welfare.

3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registrant is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

4. *Certification.* A voluntary process by which the state grants recognition to an individual who has met certain qualifications. Non-certified persons may perform the same tasks, but may not use "certified" in the title. A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to persons who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensee is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

Overview of Proceedings

The Department of Health notified the applicant group, all professional associations, interested parties and staff of the sunrise review. Meetings and discussions were held and documents were circulated. A review panel, including staff from the Department of Health and one public member, was created.

Regulatory agencies in other states were requested to provide sunrise reviews, regulatory standards, or other information that would be useful in evaluating the proposal. Literature and Internet reviews were conducted. Staff and the review panel reviewed all information received.

The review panel conducted a public hearing on October 13, 1999. Interested persons were allowed to present testimony. There was an additional ten-day written comment period following the public hearing.

A recommendation was made based upon all information received. The proposed final draft was reviewed and approved by the Health Systems Quality Assurance Assistant Secretary and the Department of Health Secretary. The final report was transmitted to the Legislature via the Office of Financial Management.

Executive Summary

Background

House Bill 2183 was introduced in the 1999 Legislative Session. The bill is the "model practice act" being put forward by the national association in states across the country. The department was asked to review this proposal under the sunrise criteria.

The bill does several major things. First, it redefines physical therapy practice. Second, it adds "manipulation of the spine and limbs" back into the scope of practice (it had been removed in the mid-1980s). Third, it provides for licensure of physical therapy assistants who can only be supervised by a physical therapist. Fourth, it provides for a wide range of changes in the administrative and fiscal structure of the physical therapy program at the department.

Recommendations

The department's recommendations are divided into the three main components of the HB 2183: new scope of practice, assistant licensure, and administrative changes. A fourth special recommendation is also provided.

1. **The new scope of practice should be enacted with changes that would:**

- In Section 2, paragraph 4, clarify the types of orthotics that are included and prohibit the custom manufacture and fitting of prosthetics (as defined in RCW 18.200.010(9));
- Allow PTs to do spinal manipulations (Section 2, paragraph (4)(b) under a license endorsement process where education and competency are demonstrated. This would require a new fee subject to the provisions of Initiative 695;
- Clarify the description of "self-care" assistance in Section 2, paragraph (4)(b);
- Limit the purchase and storage of drugs (Section 16, paragraph (7)) to a few specified topical medications, such as hydrocortisone, using the statutory model provided for licensed midwives; and
- Not limit the provision of physical therapy services by other practitioners acting within their scope of practice (Section 6 and 17).
- Remove the "penetrate the tissue" language in Section 16, paragraph 5 – and make the concept of an endorsement for this the subject of further study.

1. **Physical therapist assistants should not be regulated at the level of Licensure. At this time the department is not recommending any regulation.**

3. **None of the administrative changes proposed in HB 2183 – specifically Sections 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 paragraph (1), 17 paragraph (1), and 18 -- should be enacted.**

Background

House Bill 2183 was introduced in the 1999 Legislative Session. The bill is the "model practice act" being put forward by the national association in states across the country. The department was asked to review this proposal under the sunrise criteria.

The bill does several major things. First, it redefines physical therapy practice. Second, it adds "manipulation of the spine and limbs" back into the scope of practice (it had been removed in the mid-1980s). Third, it provides for licensure of physical therapy assistants who can only be supervised by a physical therapist. Fourth, it provides for a wide range of changes in the administrative and fiscal structure of the physical therapy program at the department.

Current Regulation

Physical Therapists have been regulated for many decades, with some of the original statutes going back to the 1940s. In 1984, a physical therapist was allowed to treat "with consultation" (rather than a referral). In 1988, full direct access to physical therapist services was allowed, and the authority to do spinal manipulations was removed.

Physical therapist assistants and aides are not regulated by the state of Washington. Assistants are regulated in most of the other states.

There are very few disciplinary cases involving Physical Therapists.

Summary of Information Gathered by and Presented to the Department During the Review

Scope of Practice

Many of those who testified either at the hearing or in writing complained that the proposed scope of practice for physical therapists infringed upon the existing scope of practice of one health care provider or another. Under the sunrise criteria, a scope of practice may be expanded into another's provided that the provider is qualified, and the training is available. Therefore, under the sunrise criteria, the department discounted such complaints, other than to consider if the types and levels of regulation of similar providers may confuse the public.

It is important to consider the type and amount of training physical therapists receive when considering whether a proposed scope of practice is appropriate. Part of this discussion needs to focus on those currently licensed physical therapists, as opposed to those that may become trained and licensed after a new scope of practice is enacted. For

example, if manipulation were added back into the scope of practice, would those therapists who were trained only five years ago be able to perform that task safely? Proponents testified that they would be, as therapists receive training, and perform other services related to manipulation. They also argued that therapists would not perform services for which they were not adequately trained. This issue also points out how state regulation is focused on newly graduated professionals, rather than taking into consideration the abilities and experience of those already licensed.

Information provided by Eastern Washington University and the University of Puget Sound indicate that physical therapists do receive training sufficient to support an expanded scope, along the lines proposed in the model practice act. For example, therapists are trained to examine "arousal, cognition and mentation," tasks that are specifically listed in the model practice act. Representatives of those two institutions concluded that the language in the model practice act is "accurate" and "correct" and that the educational background provided to physical therapists supports an expanded scope of practice.

Spinal Manipulation

The Chiropractic Association is concerned that manipulation requires education and training beyond that which physical therapists obtain. For those physical therapists who were educated and licensed prior to 1983, manipulation was in the scope of practice. Aside from perhaps being "rusty" from not having performed manipulations, it would seem they could be qualified. For those trained after the scope of practice was changed in 1983, it would similarly be hard to justify adding manipulation back into the scope without some sort of qualification to practice or limitation on the practice.

Occupational Therapy/Physical Therapy Overlap

It does appear that the kinds of activities engaged in by both Occupational Therapists and Physical Therapists are similar. Some view this as conflicting scopes of practice, others view it as a legitimate, useful overlap. Areas where this "overlap" exists, as suggested by participants, include patient assessment, and using a wide range of treatments and knowledge to treat a patient who has a problem with falling. The applicant argued: "in order to determine what type of instruction is the best, what level of complexity the patient can understand, and the prognosis for success or change, the physical therapist must assess issues of motivation and cognition and adapt the instruction the patient's level/ability to understand…there is also need to assess psychosocial issues, especially if there is a caregiver or family member that the patient is dependent on."

The Occupational Therapy Association suggested different language to clarify any differences between the two fields. Specifically, they suggested adding "functional limitations in physical movement and mobility" and "functional training in physical movement and mobility as related to self-care."

The questions surrounding the use of the terms "orthotics" and "prosthetics" in the model practice act are significant. This could be due to the fact that the model act has been

developed at the national level, and few other states have licensure of orthotists and prosthetists. In any event, the Orthotics and Prosthetics licensure law does contain exemptions from licensure from other professionals acting within their scope of practice. The concern, therefore, needs to center on whether physical therapists are properly trained, and whether the definitions are sufficiently clear to both the providers and the public. The applicant has agreed to work out definitions and other language that would clarify these concerns.

However, until there is such an agreement among the parties, there remains significant disagreement as to what physical therapists can legally do now under the scope of practice. At issue are the definitions found in RCW 18.200.010.

Physical Therapist Assistants
The department raised the issue of increasing supervision of physical therapist assistants, instead of regulating them directly as proposed by the applicant. The applicant believes that this will not work. "The idea behind using physical therapist assistants is to allow physical therapists to delegate those tasks, where appropriate, to them so that the therapist can have more time to perform the more difficult treatments." Direct supervision, they say, will make the use of assistants inefficient and not cost-effective. This would lead to limited access to treatment.

Participants in the review generally supported regulation of assistants, although not necessarily at the level of licensure. The Osteopathic Medical Association recommended registration. Occupational Therapists withdrew their support for assistant regulation during the review process. The applicant also indicated during the hearing that the term used in the model practice act and their report – "physical therapy assistant" – should have been "physical therapist assistant."

The Washington State Medical Association was concerned that some physicians currently supervise physical therapy assistants, and that the proposed new law would prohibit that. The applicant responded that by changing the terminology to "physical therapist assistant" and defining that person as someone who was delegated to by a physical therapist, that issue would be eliminated. A physician could, they argue, still hire such an assistant, who would not need an assistant license as someone was delegating them to other than a physical therapist. From the point of view of public protection, it would seem that if an assistant performs certain functions, and those functions necessitated regulation by the state, that regulation should take effect regardless of who does the delegating.

Department's Findings

- The applicant is to be commended for working toward a national model of practice. The applicant cites the Pew Commission report as supporting this. Pew specifically

recommended that such national standards be developed by the states, including all the interested parties, not just the national association.

- Occupational Therapists, Chiropractors, and Prosthetists and Orthotists object to the wording in the model practice act, believing the proposed scope of practice for Physical Therapists infringes on their own scopes of practice. The areas of "self-care," manipulation, and the provision of orthotics and prosthetics are the major areas of disagreement. The department did find some of the definitions confusing or lacking in detail to the point that they were unable to be fully understood. The Washington State Medical Association objects to the requirement that only physical therapists can supervise licensed physical therapist assistants. This aspect of the model practice act does raise access-to-care issues.

- The department twice in the last 15 years has reviewed regulation of physical therapy assistants. Both times, the department recommended against any regulation based on the lack of potential harm to the public. Under the proposed model practice act, the role of these assistants, and the supervision they receive, may present a greater potential for harm than under current regulation. Assistants may visit a home or otherwise have access to vulnerable patients. Physical therapist supervision is only required every six visits.

- Under the "magnet theory" (which states that incompetent providers migrate to states with no regulation) there could be some concern as well.

- The numerous administrative changes that are proposed conflict with uniform procedures and processes that govern the regulation of health professions.

- This review, along with the one conducted on the recreational therapists' proposal, points out a number of problems. We now have exclusive scopes of practice created in licensing statutes that have been subject over the years to piece-by-piece amendments and changes. Added to that mix is frequent turf battles and associated political compromises. This has left a set of statutes that is confusing, complicated, and becoming outdated as technology advances. As one statute is modified even slightly, it creates confusions and problems in other statutes because each profession considers their scope to be "exclusive" to them. Problems also occur when a scope of practice is enlarged based on new technology and new education standards, but previously licensed and trained professionals do not have a way to show they are also competent to provide these new services.

Recommendations

The department's recommendations are divided into the three main components of the HB 2183: new scope of practice, assistant licensure, and administrative changes.

1. The new scope of practice should be enacted with changes that would:

- In Section 2, paragraph 4, clarify the types of orthotics that are included and prohibit the custom manufacture and fitting of prosthetics (as defined in RCW 18.200.010(9));
- Allow PTs to do spinal manipulations (Section 2, paragraph (4)(b) under a license endorsement process where education and competency are demonstrated. This would require a new fee subject to the provisions of Initiative 695;
- Clarify the description of "self-care" assistance in Section 2, paragraph (4)(b);
- Limit the purchase and storage of drugs (Section 16, paragraph (7)) to a few specified topical medications, such as hydrocortisone, using the statutory model provided for licensed midwives; and
- Not limit the provision of physical therapy services by other practitioners acting within their scope of practice (Section 6 and 17);
- Remove the "penetrate the tissue" language in Section 16, paragraph 5 – and make the concept of an endorsement for this the subject of further study.

Rationale:

- PTs currently have some authority to provide some orthotics and this should continue. In fact, there would be benefit to more clearly defining what is allowed under the scope of practice. The training and education received by PTs seems appropriate for the provision of exempted orthotic services as defined in RCW 18.200.010(6). Prosthetics also requires a level of skill and training that the legislature recently determined required licensure by the state. The training a physical therapist receives does not support the full range of prosthetic services as defined in RCW 18.200.010(9). In fact, the list of items that are not included in the definition of orthotics and prosthetics was specifically developed with the practice of physical therapy in mind.
- The legislature removed manipulation from the scope of practice at the same time it removed the requirement for a PT to have a referral before performing any services. Because many years have passed since this occurred, and to assure the public is adequately protected, an endorsement to the license would make sure that adequate training and competency is possessed by the PT before the PT does a spinal manipulation.
- While the sunrise criteria certainly allow overlapping scopes, clarifying language on the issue of "self-care" will help make regulation easier to understand among the department, the providers and the public. There is the potential to confuse this with a recently enacted law relating to "self-directed care." This clarifying language should emphasize what is rehabilitative therapy and what is to be considered nursing care.

- Purchase and storage of drugs should be limited to a few specific topical medications because pharmacists, physicians and others are with the potential for misuse or inappropriate use or storage of drugs. While it makes sense to have some drugs available, it might be more appropriate for PTs to have the authority to administer certain drugs that have been prescribed for the patient by a person who is authorized by law to do so. In this way, this prescriber would have access to the records of all the drugs that an individual patient is taking to watch for drug duplication, drug-drug interactions, etc. The midwives model (RCW 18.50.115) should be used as it sets an initial program and allows for rules to implement expanded authority to purchase, use and store drugs. This flexibility is needed as it is impossible to know at this time exactly what types of drugs might be appropriate a few years from now.
- The model practice act includes wording in Section 6 and Section 17 that can be interpreted to be a prohibition on other health professionals from providing or billing for physical therapy services. It prohibits others, even under a licensed scope of practice, from representing themselves as "providers of physical therapy." As long as these professionals are acting legally within their scope of practice, there should be no prohibitions on services or billing in the physical therapist statute.

2. Physical therapist assistants should not be regulated at the level of licensure. At this time the department is not recommending any regulation.

Rationale:

- No evidence was submitted to support full licensure of assistants as proposed by the applicant.

3. None of the administrative changes proposed in HB 2183 – specifically Sections 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 paragraph (1), 17 paragraph (1), and 18 -- should be enacted.

Rationale:

- The proposed changes are inconsistent with the uniform administrative procedures that the legislature recently enacted for health profession regulation. This would result in confusion and additional costs that are not justified.
- The proposal assigns new roles and responsibilities to board members that go beyond their statutory authority. People are appointed to boards because of their professional expertise, or their insights as public members. They are to focus on practice issues, not financial and other issues envisioned in the proposal. Boards are not intended to be agency oversight bodies.

APPENDIX: A

HOUSE BILL 2183

APPENDIX: B

PUBLIC HEARING SUMMARY

PUBLIC HEARING SUMMARY

October 13, 1999

PHYSICAL THERAPIST SUNRISE REVIEW

Review Panel:

Tammy Benson, DOH
Bob Peterson, public member
Karen Jarvis, Department of Licensing

Department of Health staff:

Steve Boruchowitz
Colleen Cain

Applicant:

Washington State Physical Therapy Association

(Slides)
(References)

Chuck Martin, Pres., WSPTA

Gave background to PTs. They are licensed in all states; educated by normative model (goals, no set program), they have specialties, practice in hospitals, critical care, ICUs, private practice, outpatient clinics, with OTs and others in private offices; rehab, extended care, in-home, schools, specialty centers, corporate/industrial, hospice, fitness centers.

Scope: impairments, changes in physical function, from injury, or disease. Collaborative. Health screening, education. Supportive personnel work under supervision. After physician takes care of injury/disease, for example, the PT works on getting any limitation/impairment taken care of.

PT Assistants have AA degree. Same settings. There are three schools in Washington state. They work under indirect supervision. (Not same building; available by phone.)

There was a question from the panel on what kinds of PT specialties exist. Answer: Sports, orthopedic, pediatrics, geriatrics, neurology, cardiopulmonary,

electrophysiology. Five year minimum experience and tests to gain private certification as a specialist.

Patty Van Wagner, WSPTA

Washington State Association maintains integrity of practice. Protection of public goes hand in hand with that. First PT practice act was passed in 1949 and revised in 1961. In 1983 there was a major change to give the board disciplinary powers. Assistants were proposed; certification was recommended, so the association opted for nothing. In 1985 the act was changed to allow an evaluation without physician referral, and in 1988 a change to allow practice without referral (1991 sunset, not eliminated). There was a requirement that a PT was to refer back if they were not able to treat. Continuing competency authority was given; (the board uses CE now). Title protection important. Shows world there is a body of knowledge, that PT is not just cold packs or exercise. The Model Practice Act (MPA) is designed, among other things, to promote uniformity among states, it helps mobility and protects states rights. MPA across country will use similar standards.

There was a question asked about overlap of scopes. Answer: Physicians can do PT, but there is a question whether they can delegate it. Usual exclusions for licensed professions acting within their scope if they don't call themselves PTs.

MPA background: Federation of state boards of physical therapy was formed because health policy people felt that the association (professional) should not have ownership of the exam. 12 years ago it was founded. MPA was designed over several years, 1994 board of federation established a task force to write it. In 1997 a draft was approved, published. There was a revised version in February 1999.

Should be Physical therapist assistants (not physical therapy assistants). Shows relationship - not an assistant to the practice, but the person.

Changes to practice act that are proposed in this MPA are under review: PT Assistant licensure (regulation for protection, uniform with other states). This adds back in spinal manipulation, for which there is a history of education, clinical practice and statutory authority. In 1984 this was removed from statute, but has always been included in education programs. In practice up to 1984.

Susan Chalcraft, WSPTA

No major changes except definition. The MPA makes it clear who is a PT. New legislation has clear definition, including examination, documentation treatment, research, education, etc.

Clear definition helps protect the public by letting public know what services they are actually going to get, what they aren't. Lets them know what a PT is. Gives board better definition for disciplinary actions and interpretations.

PT assistant regulation is currently in WACs, but not statute. Adds education, licensing, etc. for PT assistants. Also defines supportive personnel who are unlicensed.
Why assistant licensing? Federation included it in MPA – entry-level exam, disciplinary authority, etc. Compared registration, certification and licensing. Registration did not allow education, and didn't assure they wouldn't go somewhere else to work. Certification not required. Public not generally aware of difference with certified and non-certified.

Licensing only available to give level of protection. In 1997 there were more association actions per PTA than PT. If a PTA is fired then can come here and be hired. This raises the "magnet" theory that bad performers come to a state where there is no regulation.

Spinal manipulation and the use of foot/ankle Orthoses without referral are two areas being changed. (Orthotics not really an increase, just removes need for prescription).

Steve Allen, WSPTA

Manipulation: history goes back many centuries. Osteopathy and chiropractic. Early 1900s in PT practice. In Washington state, the manipulation part was removed. (Agreement with chiropractors). No public safety reason to do that. (10 states limit – exclude chiropractic but allow others…or totally exclude manipulation in PT statutes)

CPT codes for federal billing include PTs doing manipulation. Manipulation has shown to have very good outcomes. Benefits: Uses advanced skills for better outcomes and patient satisfaction. Don't have to refer out to second practitioner …reduces overall health care expenditures.

Anna Neil, WSPTA

Assistants have AA degrees…some have BAs. Three schools in WA – Green River, Watcom, Bellingham, Spokane Falls. 75-100 graduates per year. Contact hours during clinical instruction, under supervision of assistant and PT.

Work with children, elderly, head injuries, heart patients, etc. In school setting, for example indirect supervision can be up to 6 visits; therapist needs to check after those 6 visits. Licensure has been ongoing issue. 33 states license; 5 registration; 5 certification, the rest nothing. PT license on line if wrongdoing. One Oregon case, charged there, came to Washington to work. Also makes assistants accountable for their actions. Reimbursement is difficult; if not a regulated profession.

States with licensure have not had PTAs trying to move to an independent scope, moving away from supervision.

There is no record of disciplinary actions for other states. Nationally in 1997, PTAs had 31 cases out of 26,000 assistants (this is private, not state, actions).

Janet Peterson, WSPTA

Public access issue:…needs best met when easily available, cost effective, and covered by insurance. Proposal helps do that. If PTAs were required to have direct supervision, it would impede access to physical therapy services. Rural areas, in particular, might suffer more if PTAs were not readily available with indirect supervision. Access: new definition is better than old definition because it is the nationally recognized standard. They clarify rather than obscure PT practice…cited case of podiatrist advertising that they do PT without having a license or a PT on staff…gives board better base for disciplinary actions.

PTAs licensed – restrict getting jobs? Does not change definitions, just regulates. Insurance has been denied or limited due to lack of licensing. It becomes access issue if/when insureds do not get appropriate care or pay out of pocket.

Current WAC states that one PT can supervise no more than two “assistive personnel”.

Chuck Martin, WSPTA

Work with other stakeholders. MDs oppose any new expansion of scope of practice. OTs have different interpretation and have problems. Podiatrists have not responded. Orthotists have problems, trying to resolve.

Term “mobilization” has caused some problems (vs. manipulation). So new law proposed includes it.

OT language was not intended to cause real problems. Willing to look at language.

SUMMARY: Changes are sought to protect the public and language we use currently is old (1949 and 1961) and needs updating.

Sylvia Kauffman, WOTA

WOTA supports the licensure of PT assistants. However, they oppose the additional language in the definition of physical therapy that includes functional aspects.

Lori Stephens-Gadler, President, WOTA

Support PTA – OT Assistant is similar in training and expertise….OT asssitant and PTA would be held to same disciplinary standard. Direct supervision would not solve problem. Staff cutbacks, etc., give PTs consultation, etc., and more services given by PTAs. OTs see the new language as the same as teaching "everyday living skills"…which is OTs scope.

Dr. George Tomlin, (UPS) Training

Circular definition of PT in new law creates new problems. Broad definition of scope to include functional limitations implies comprehensive coverage of many types of limitations from many causes. PT students are not prepared to evaluate and treat…perception, including vision, cognition, etc. and psychosocial…as well as the environment in which they work. If limitations caused by physical limitations, then in current PT scope…if not (motivation, etc.), then should be an OT…. curricula do not support these additions to scope.

Good thing to make function limitations go away…

National organizations are debating these questions.

Jan Thompson, WOPA and panel

Washington Orthotics and Prosthetics Association
Especially opposes page 2, line 21/22 that includes Orthotics and prosthetics. Should be included in applicant report as an effected profession.
2 PTs have applied under O&P grandfather clause, one has been approved.
O&P statute defines orthotics. This is well beyond what PTs should be expected to do. O&Ps are the ones to make these devices. They also view fact that they learn about certain techniques doesn't mean they should be added to the scope or to practice outside the scope.

Carl Entenmann, WOPA

Support PTA licensing but not as written. Needs limitations on O&P portion
Education does not include O&P training other than brief overview.

Dr. Nordstrom, WA State Chiropractic Association

PTs are valued partners in health care.
We are concerned about manipulation. Have board of directors statement opposing.
Need experience and training. Functional versus pathology problems…spinal gets into pathology.

Summary by applicant:

While PTs and OTs look at things differently, PTs should not be limited to doing things a certain way. Wound prevention for example, gets to how to get dressed, etc. This should be OK. The new model act puts burden on PT to be competent…not to step beyond training or expertise…that should not be a way out, though…new law puts responsibility on PT …
Relationship to options: we need to look at best for patient and the public seeking access…having PTs and OTs due similar things is OK…If PT can't teach a patient how to locked their wheelchair, that's a problem. "Functional" versus "occupational"

We will work together with everyone for benefit of patients.

APPENDIX: C

PARTICIPANT LIST

Participant List

NAME	*ORGANIZATION*
Susan Chalcraft	Washington State Physical Therapy Association
Caryn Porter	Washington State Physical Therapy Association
Anna Neil	Washington State Physical Therapy Association
Patty Van Wagner	Washington State Physical Therapy Association
Melissa Johnson	Washington State Physical Therapy Association
Chuck Martin	Washington State Physical Therapy Association
Christine Larson	Washington State Physical Therapy Association
Steve Allen	Washington State Physical Therapy Association
Janet Peterson	Washington State Physical Therapy Association
Sylvia Kauffman	Washington Occupational Therapy Association
Lori Stephens-Gadler	Washington Occupational Therapy Association
George Tomlin	Washington Occupational Therapy Association
Kathy Stewart	Washington Occupational Therapy Association
Kim Levin	Washington Occupational Therapy Association
Jan Thompson	Washington Orthotic and Prosthetic Association
Karl Entenmann	Washington Orthotic and Prosthetic Association
Dan McNamara	Washington Orthotic and Prosthetic Association
Patty Van Den Broek	Washington Orthotic and Prosthetic Association
Cheryl French Nevin	Washington State Physical Therapy Association
Becky Bogard	Washington State Physical Therapy Association
Janet Peterson	Washington State Physical Therapy Association
Dr. Douglas Nordstrom	Washington State Chiropractic Association
Bruce Frickelton	Washington State Chiropractic Association
Carl Nelson	Washington State Medical Association
Steve Wehrls	Washington State Chiropractic Association
Gale Anderson	Washington State Physical Therapy Association
George Tomlin	University of Puget Sound – School of Physical Therapy

Review Panel

Tammy Benson
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Karen Jarvis
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Robert Peterson
Public Member

Staff

Steve Boruchowitz
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Department of Health

APPENDIX: D

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APPENDIX: E

REBUTTALS

Washington Occupational Therapy Association

Sylvia Kauffman, PhD., OTR/L

We disagree with you on page 6 that physical therapy receives the education and training to support their broad definition of physical therapy as originally proposed. If you review the curricula in depth and if you review the literature published by the two fields in depth you will see that occupational therapy addresses aspects of functional evaluation and treatment not covered in physical therapy.

Physical Therapy Association of Washington (PT-WA)

PT-WA disputes the Department of Health's contention that Sections 6 and 17 would limit the provision of physical therapy services by other practitioners acting within their scope of practice. "Physical therapy" is not a generic term; "rehabilitation" is the generic term. Any provider is free to render any rehabilitation service within their scope of practice. The procedures themselves do not belong exclusively to physical therapy from either legal or reimbursement perspectives, but the term "physical therapy" should be protected as a separate body of knowledge. Section 17 introduces nothing new into the practice act. In fact it mirrors a current provision's (RCW 18.74.090) statement that it is unlawful for anyone to use the words "physical therapy" and "physical therapist" without being licensed as such.

PT-WA disputes the Department's contention that licensure is not warranted for physical therapist assistants (PTAs). The sunrise report states that PT-WA did not submit evidence to support licensure of PTAs. In fact, our applicant report provided 10 cases in Washington where patients were harmed by PTAs. These PTAs are free to harm more patients because the Department does not regulate them. In addition, due to the number of calls to the Licensing Board asking whether physical therapist assistants are licensed, PT-WA believes that the magnet theory holds true: that bad actors will come to Washington, knowing that they will not be regulated. What more does it take to show evidence of harm to the public?

PT-WA disputes the Department's contention that the "penetrate the tissue" language in Section16, paragraph 5, expands the current physical therapy scope of practice. In fact, this language is nothing new: WAC 246-915-010 (1) defines neuromuscular function tests as including the performance of electroneuromyographic examinations. These examinations include penetrating the tissue. Thus, penetrating the tissue is allowed in the current scope of practice and HB 2183 simply reiterates this.

APPENDIX: F

MIDWIFERY LAW RELATING TO USE OFLEGEND DRUGS
RCW 18.50.115

APPENDIX F

Midwifery law relating to use of legend drugs

RCW 18.50.115

A midwife licensed under this chapter may obtain and administer prophylactic ophthalmic medication, postpartum oxytocic, vitamin K, Rho immune globulin (human), and local
anesthetic and may administer such other drugs or medications as prescribed by a physician. A pharmacist who dispenses such drugs to a licensed midwife shall not be
liable for any adverse reactions caused by any method of use by the midwife.

The secretary, after consultation with representatives of the midwife advisory committee, the board of pharmacy, and the medical quality assurance commission, may adopt rules
that authorize licensed midwives to purchase and use legend drugs and devices in addition to the drugs authorized in this chapter.