Occupational Therapy

Facilitating ***participation*** *of New Mexicans in meaningful activities they want, need and have to do*

Occupational Therapists & Occupational Therapy Assistants are:

Healthcare professionals who focus on a person's ability to ***participate in meaningful activities*** as impacted by...

- Socioeconomic, cultural, and physical environment
- Personal values, health, and performance
- Medical condition or disease

We can establish or restore a person's skills, adapt equipment or modify the environment to promote health, productivity and quality of life through therapeutic application of occupation.

Occupations include:

Meaningful everyday activities people ***need, want, or have*** to do.

Occupational Therapy for YOU

- Social Participation
- Education & Employment
- Leisure & Recreation
- Activities of Daily Living: bathing, eating, dressing
- Life & Home Management: shopping, budgeting, driving

Occupational Therapy Professionals provide services in a variety of settings for individuals across the lifespan.

Rehabilitation & Disability
- Hospitals
- Rehabilitation facilities
- Long Term Care facilities

Children & Youth
- Schools
- Early Intervention
- Neonatal Intensive Care Unit (NICU)

Productive Aging
- Home Healthcare
- Adult Day Centers

Health & Wellness
- Community Centers
- Health Fairs

Work & Industry
- Homeless Shelters
- Ergonomic Assessment

Mental Health
- Community services
- Stress Management
- Self-Sufficiency
- Judgment & Planning
- Supported Employment
- Medication Management
- Social Skills

More About OT & Mental Health

New Mexico Occupational Therapy Association
Scope of Practice Bill, 53rd Legislative Session, Year 1

Occupational Therapy

The following evidence-brief provides specific evidence-based references for updates to the occupational therapy scope of practice from peer-reviewed articles, national publications, and independent third-party researchers.
The data and facts provided below include: outcome-based efficacy measurements, quality of life and functional participation assessments, long-term implications, cost-savings measurements, academic achievement, decreased symptomatology of mental illness, increased successful transition from inpatient psychiatric and acute hospital stays to homes, reduced fall risk, and readmission rates for hospitals and inpatient treatment programs.

A recent independent study by a group of health policy researchers, published efficacy outcomes citing skilled occupational therapy as the only 1 of 19 total distinct spending categories to effectively and statistically reduce readmission rates to hospitals. (Rogers, Bai, Lavin, & Anderson, 2016)

"[O]ccupational therapy is the only spending category where additional spending has a statistically significant association with lower readmission rates" for the three health conditions studied: heart failure, pneumonia, and acute myocardial infarction (Rogers, Bai, Lavin & Anderson, 2016). Occupational therapy places a unique and immediate focus on patients' functional and social needs, which can be important drivers of readmission if left unaddressed" (Rogers, Bai, Lavin, & Anderson, 2016).

The research design included:

- Evaluation of 19 outcomes: distinct spending categories (including occupational therapy)
- Sample size: 2,791 hospitals for the heart failure analysis; 2,818 hospitals for the pneumonia analysis; and 1,595 hospitals for the acute myocardial infarction analysis.
- Data analysis completed using Medicare claims and cost data to examine the association between hospital spending for specific services and 30-day admission rates for heart failure, pneumonia, and acute myocardial infarction
- Johns Hopkins University & University of Maryland School of Medicine

Final Conclusions and Outcomes: " Occupational therapy is one spending category that affects both the clinical and social determinants of health" and note that "investing in OT has the potential to improve care quality without significantly increasing overall hospital spending. "

All references for Areas in Scope of Practice Clarified and Redefined in the 2017 Occupational Therapy Scope of Practice Bill (AOTA, 2016) as well as the within the 3rd edition of the Occupational Therapy Practice Framework: Domain and Process (AOTA, 2014). Please note that each listed clarification of the scope of practice bill, listed below, has been (1) taken from the American Occupational Therapy Association's Model Definition of Practice, compared to neighboring states scope of practice (Arizona, California, Texas, Colorado) as well as (3) Cross-referenced with state associations for professions whose scope of practice closely aligns including:

- New Mexico School for the Blind (referenced and collaborated with in 2015 to clearly define vision assessment, with amendments incorporated and carried over for 2017).
- New Mexico Association of Case Managers (2017)

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- New Mexico Physical Therapy Association (2017)
- New Mexico Speech Language and Hearing Association (2017)

OT's Role in Mental Health (AOTA, 2014):
The roots of occupational therapy are well grounded in psychiatry and mental health (Gordon, 2009), where persons living in an in-patient psychiatric ward showed significantly greater gains in functional performance on every day activities (e.g. self care, self-feeding, expressing wants and needs) following "work with hands" and "purposeful participation" (Gordon, 2009).

The moral treatment movement, from 11 which the profession evolved, sought to replace the brutality and idleness of earlier treatment for 12 disorders of the mind with attention to establishment of healthy routines and participation in 13 meaningful occupation (Christiansen & Haertl, 2014). In the early 20th century, the founders and early 14 writers in occupational therapy created a body of literature that supported the therapeutic value of 15 occupation. They embraced the ideas of physician Adolph Meyer (1922), who provided a holistic and 16 practical emphasis on the importance of helping people with mental illness reorganize their daily habits 17 and applied the therapeutic use of occupation across settings ranging from psychiatric hospitals to 18 reconstruction hospitals for soldiers returning from war (Christiansen & Haertl, 2014)

Through the use of everyday activities, occupational therapy practitioners promote mental health and 17 support full participation in life for people with or at risk of experiencing psychiatric, behavioral, and 18 substance use disorders. As in all occupational therapy practice, services in mental health are client- 19 centered. The client may be a person, a group, or a population (AOTA, 2014c). Occupational therapy 20 practitioners collaborate with clients to determine what is currently important and meaningful and what 21 he or she wants or needs to do. Together, they collaborate to identify factors that may be barriers or 22 supports to healthy participation in desired and necessary daily occupations.

Through the clinical reasoning process, occupational therapy practitioners select and apply different 24 theoretical perspectives and approaches informed by evidence. These perspectives and approaches are 25 drawn primarily from occupational therapy and occupational science but also from other fields and 26 areas of practice such as physical and psychiatric rehabilitation, psychology, school mental health, 1When the term occupational therapy practitioner is used in this document, it refers to both occupational therapists and occupational therapy assistants (American Occupational Therapy Association [AOTA], 2015b). Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. Occupational therapy assistants deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a). DRAFT NOT FOR DISTRIBUTION 3 1 sociology, psychiatry, neuropsychiatry, and anthropology. This clinical reasoning process guides 2 occupational therapy evaluation and intervention.

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House Bill xxx

53 RD LEGISLATURE-STATE OF NEW MEXICO – FIRST SESSION-2017

INTRODUCED BY

Deborah A. Armstrong

AN ACT

RELATING TO PROFESSIONAL LICENSURE; AMENDING SECTIONS OF THE OCCUPATIONAL THERAPY ACT TO MAKE CHANGES TO THE SCOPE OF PRACTICE OF PERSONS LICENSED OR CERTIFIED PURSUANT TO THAT ACT. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 61-12A-3 NMSA 1978 (being Laws 1996, Chapter 55, Section 3, as amended) is amended to read:

"61-12A-3. DEFINITIONS.—As used in the Occupational Therapy Act:

A. "board" means the board of examiners for occupational therapy;

B. "censure" means a formal expression of disapproval that is publicly announced;

C. "denial of license" means that a person is barred from becoming licensed to practice in accordance with the provisions of the Occupational Therapy Act either indefinitely or for a certain period;

D. "licensee" means an occupational therapist or occupational therapy assistant, as appropriate;

E. "occupational therapist" means a person who holds an active license to practice occupational therapy in New Mexico;

F. ~~[H.]~~ "occupational therapy assistant" means a person having no less than an associate degree in occupational therapy and holding an active license to practice occupational therapy in New Mexico who assists in the practice of occupational therapy[~~, who works~~] under the supervision of the occupational therapist;

~~G. ["occupational therapy aide or technician" means an unlicensed person who assists in occupational therapy, who works under direct supervision of an occupational therapist or occupational therapy assistant;]~~

G. "Occupation" means the daily life activities in which people engage by themselves or with others (AOTA, 2014; AOTA 2016).

H. [F.] "occupational therapy" means the therapeutic use of occupations, including everyday life activities with individuals~~, persons or~~ groups (AOTA, 2014, pS1), populations, or organizations to support participateion, performance, and function (AOTA, 2014, pp S7-S8) in roles and situations in home, school, workplace, community and other settings to promote health and wellness to those ~~in clients~~ who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation or participation restriction. "Occupational therapy" includes addressing the physical, cognitive, psychosocial, sensory-perceptual (AOTA, 2016, 1), and other aspects of performance skills and patterns (AOTA, 2016,

1) in a variety of contexts and environments (AOTA, 2016, 1) to support [~~a client's~~] engagement in [~~everyday life activities that affect health,~~] occupations that affect physical and mental health, well-being and quality of life;

I. "activity of daily living" means an activity that is oriented toward taking care of one's own body, including but not limited to bathing, showering, bowel and bladder management, dressing, eating, feeding, functional mobility, personal device care, personal hygiene and grooming, sexual activity, sleep, rest, and toilet hygiene(AOTA, 2016, 1);

J. "instrumental activity of daily living" means an activity that; is oriented toward interacting with the environment and that may be complex; is generally optional in nature and may be delegated to another person; and includes but is not limited to care of others, care of pets, child-rearing, communication management, community mobility, driving, financial management, health management and maintenance, home establishment and management, meal preparation and cleanup, religious and spiritual activities and expression, education, safety procedures and emergency responses, work, productivity, retirement, volunteerism, play, leisure, social participation, and shopping (AOTA, 2016, 1);

K. [~~I.~~] "person means an individual, association, partnership, unincorporated organization or corporate body;

K. ~~[J.]~~ "probation" means continued licensure is subject to fulfillment of specified conditions such as monitoring, education, supervision or counseling;

L. [~~.~~ ~~K.~~] "reprimand" means a formal expression of disapproval that is retained in the licensee's file but not publicly announced;

M. [L.] "revocation" means permanent loss of licensure; and

N. [~~L.~~] "suspension" means the loss of licensure for a certain period, after which the person may be required to apply for reinstatement.

61-12A-4. Occupational therapy services.

Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness (AOTA, 2014, pS1). The practice of o[~~O~~]ccupational therapy [~~services~~] includes:

A. [~~B.~~] Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), rest and sleep (AOTA, 2014, pS20;AOTA, 2016, 1), education, work, productivity (AOTA, 2014, S20-21), play, leisure and social participation, including:

(1) observation, selection and use of specific assessments to measure performance skills and performance patterns, assessments to identify and measure environments and activity demands (AOTA, 2014, S12-S14);

(2) [~~1~~] assessment of client factors, including body functions (such as neuromusculoskeletal[~~ar~~] (AOTA, 2016, 1), sensory-perceptual (AOTA, 2014, S7; AOTA, 2016, 1), visual, mental (AOTA, 2014, S4; AOTA, 2016, 1 &

1:C3), [~~perceptual and~~] cognitive, and pain factors) and body structures (such as [functions and] cardiovascular, digestive, nervous, integumentary, [~~and~~] genitourinary systems, and structures related to movement) (AOTA, 2014, S24);

(3) evaluation, management and care of a client's mental functioning and performance; where "evaluation, management and care of a client's mental health" means the provision of skilled therapy to support community participation, stress management, self-sufficiency, judgment and planning, supported employment, social skills development, self-advocacy, self-care, and safety awareness, as it affects the client's occupational performance; (AOTA, 2014, S4; AOTA, 2016, 1 & 1:C3) *** See packet of 12 additional peer-reviewed, evidence-based publications, AOTA model scope of practice definitions and independent researcher publications related to occupational therapy's role in mental health****

(4) [~~2~~]assessment of habits, routines, roles, rituals, values, beliefs, spirituality, interests (AOTA, 2014, S8, S20, S27, S34, S39, S 44, S45), and behavior patterns;

(5) [~~3~~][~~Cultural~~] assessment of physical and social environments, cultural, personal, temporal, and virtual contexts and ~~environmental, social, spiritual, and virtual contexts and~~ activity demands that affect performance; and

(6) ~~[4]~~ assessment of performance skills, including motor and praxis (AOTA, 2014, S7, S22), sensory-perceptual, emotional regulation (AOTA, 2014, S7, S8, S12, S22, S27) cognitive, process and communication~~,~~ and ~~[interaction]~~ social skills; (AOTA, 2014, S4-S8, S12, S14, S16, S18, S21, S26, S29-S38) and

(7) analyzing activities to understand the typical demands of activities or occupations, the range of skills involved in its performance, the meaning of the activity, and the specific body structures, body functions, performance skills, and performance patterns that are required, and the effect of the activity on the person, including (AOTA, 2014, S10):

(i) the tools and resources needed to engage in the activity;

(ii) the physical space requirements and social interaction demands;

(iii) the process, sequence, and timing of steps used during performance of the activity, and;

(iv) the meaning the client derives from the activity;

(7). Synthesizing information, interpreting assessment data, selecting outcome measures, creating goals in collaboration with the client, delineating intervention approaches based on best practices and available evidence, modifying outcomes and interventions to accommodate changing needs, contexts, and performance abilities, and (AOTA, 2014, S14);

B. ~~[A]~~. methods or approaches (AOTA, 2014, S14) s[S]elected ~~[strategies]~~ to direct the process of intervention, such as:

(1) establishment, remediation 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 physical and/or social environment to enhance performance, or to prevent injuries, disorders, or other conditions (AOTA, 2014, S44);

(3) retention, m[M]aintenance, and enhancement of skills and [cap]abilities without which performance in everyday life activities would decline;

(4) ~~[Health]~~ promotion of health and wellness, including the use of self-management strategies (AOTA, 2014, S15), to enable or enhance~~d~~ performance in everyday life activities; and

(5) prevention of barriers to performance, including injury and disability prevention;

(6) planning for discharge, discontinuing services, providing follow up, or referrals, and (AOTA, 2014, S9, S15, S17, S34)

C. interventions and procedures to promote or enhance safety and performance in activities of daily living and instrumental activities of daily living ~~education, work, play, leisure and social participation~~, including, but not limited to:

(1) therapeutic use of occupations, activities, and exercises;

(2) training in self-care, self-management, health management and maintenance (AOTA, 2016, 1), home management, [~~and~~] community-work reintegration, school activities and work performance (AOTA, 2016, 1);

(3) development, remediation or compensation of neuromusculoskeletal, sensory-perceptual, visual, mental (AOTA, 2016, 1; AOTA, 2014, S4-9, S11, S14,

S15, S19-20,S 22, S27, S29, S30-38, S42), and(AOTA, 2016, 1) ~~physical,~~ cognitive functions, [~~neuromuscular and sensory functions~~] pain tolerance and management (AOTA, 2016, 1), and behavior 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 persons, including family members, caregivers, groups, populations (AOTA, 2014, S2-11, S14-17, S34; AOTA, 2016, 2), and others;

(6) care coordination, case management, and transition services (AOTA, 2016, 1);

(7) consultative services to groups, programs, organizations or communities (AOTA, 2016, 1);

(8) modification of environments (home, work, school, social, or community) (AOTA, 2016, 1-2) and adaptation of processes, including the application of ergonomic principles;

(9) assessment, design, fabrication, application, fitting and training in seating and positioning (AOTA, 2014, S29; AOTA, 2016, 1:C:10), 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 management of wheelchairs and other mobility devices (AOTA, 2014, S8, S19, S25-26, S29; AOTA, 2016, 1:C:10);

(11) low vision rehabilitation; where "low-vision rehabilitation service" means the evaluation, management, and care of a low-vision client in visual acuity and

visual field as it affects the client's occupational performance (edited in 2015, with New Mexico School for the Blind; AOTA, 2016, 1:C:11);

(12) driver rehabilitation and community mobility (AOTA, 2014, S12, S19, S31; AOTA, 2016, 2:C:12;

(13) management of feeding, eating, and swallowing to enable eating and feeding performance; where "management of feeding, eating and swallowing " means the evaluation, management and care of oral motor processes, motor planning, and sensory processing as it affects the client's occupational performance (AOTA, 2014; S19-20; AOTA, 2016, 2:C:13)

(14) application of physical agent modalities, and use of a range of specific therapeutic procedures (such as wound care management; intervention to enhance sensory-perceptual, and cognitive processing; and manual therapy) to enhance occupational performance skills; and (AOTA, 2014, S29; AOTA, 2016, 2:C:14)

(15) achieving satisfactory occupational functioning, performance outcomes, or basis for decision-making as the end of the intervention process, including appropriate selection and use of (AOTA, 2014, S4):

a. outcomes and measures of occupational performance, role competence, quality of life, results of prevention efforts, surveys, or client satisfaction surveys or questionnaires;

b. valid, reliable, and appropriately sensitive outcome measures of the client's occupational performance and which are congruent with client's goals and ;

c. comparisons of progress toward goal achievement.

D. Nothing in the occupational therapy practice act shall be construed as limiting the practice of other licensed and qualified health professionals in their specific discipline;

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 with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health and wellness 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 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 neuromusculoskeletal, sensory-perceptual, visual, mental, cognitive, and pain factors) 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, cultural, personal, temporal, and virtual contexts and activity demands that affect performance.
   4. Performance skills, including motor and praxis, sensory-perceptual, emotional regulation, cognitive, communication and social skills.

B. Methods or approaches selected to direct the process of interventions such as:
   1. Establishment, remediation, or restoration of a skill or ability that has not yet developed, 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. Retention and enhancement of skills or abilities without which performance in everyday life activities would decline.
   4. 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, community/work reintegration, and school activities and work performance.
   3. Development, remediation, or compensation of neuromusculoskeletal, sensory-perceptual, visual, mental, and cognitive functions, pain tolerance and management, 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 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; interventions to enhance sensory-perceptual, and cognitive processing; and manual therapy) to enhance performance skills.
15. Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and the adaptation of processes.

Adopted by the Representative Assembly 4/14/11 (Agenda A13, Charge 18)