Committee Report

CONSENT CALENDAR

May 25, 2021

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on Executive Departments and Administration to which was referred SB 133-FN,

AN ACT adopting omnibus legislation relative to occupational licensure. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. Carol McGuire

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**Executive Departments and Administration**
Bill Number:	**SB 133-FN**
Title:	**adopting omnibus legislation relative to occupational licensure.**
Date:	**May 25, 2021**
Consent Calendar:	**CONSENT**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT 2021-1579h**

STATEMENT OF INTENT

This is an omnibus bill on professional licensing, consisting of 13 unrelated sections, plus one added via a non-germane amendment. Each is described below with the effect of the committee amendment. Part I specifies the State Fire Marshall's ability to grant an assembly permit in an area without another authority. Part II repeals the interstate compact for emergency medical technicians. Part III expands who can chair a hearing of the Board of Nursing to any qualified person appointed by the board. All of these parts were all accepted with no further amendment. Part IV more narrowly specifies the representation of some members of the professional standards board in the Department of Education. The amendment deleted this part as unnecessary. Part V adopts the Audiology and Speech-Language Pathology interstate compact and the Occupational Therapy compact. This part was amended to confirm that any cost due to these compacts would be covered by the Office of Professional Licensure and Certification (OPLC) from its license fees. Part VI creates a new board and licenses music therapists. This part was deleted as unnecessary. HB 209, which had a similar intent, had been found Inexpedient to Legislate by the committee earlier this year. Part VII establishes a standard procedure for investigations, hearings, and appeals within the OPLC. This part was amended to clarify that this procedure did not replace existing investigation procedures for the boards that already have them. Part VIII narrowed the scope of "skilled professional medical personnel" to registered nurses for the purpose of qualifying patients for in-home Medicaid services. This part was deleted as too restrictive. Part IX provides "temporary health partners" a path towards licensure as nursing assistants. This part was amended to eliminate the deadline for having completed at least 100 hours of work and clarify that their on-the-job experience was equivalent to the necessary classroom training. Part X allows emergency medical service units to receive letters of concern, if appropriate, rather than limiting the options for disciplinary action to license suspension or revocation. It was accepted as submitted. Part XI allows schools of barbering and cosmetology to be parts of other schools, (Concord High School, for one) and establishes an apprenticeship certificate (not a license) for training which does not require submitting social security numbers. This part was amended slightly to incorporate the House position from HB 575 and include the certificate language in other parts of the cosmetology statute. Part XII adds a new license level for remote-only psychology treatments from out-of-state professionals. It was amended to better define this license and provide a path to full licensure. Emergency license holders can convert to this "tele-pass" license with minimal additional requirements. Part XIII establishes some exemptions to the requirement for certified food protection managers and was not changed by the committee. Part XIV allows child care workers to qualify as assistant teachers by "life experience," rather than formal education. The committee amendment specifies the types of experiences we considered appropriate. This section was added to the bill via a non-germane amendment. To a large degree, this bill, as amended, consists of administrative changes rather than policy decisions. All are supported by the OPLC and the relevant boards.

Original: House Clerk

Cc: Committee Bill File

Vote 19-0.

Rep. Carol McGuire
FOR THE COMMITTEE

Original: House Clerk
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CONSENT CALENDAR

Executive Departments and Administration
SB 133-FN, adopting omnibus legislation relative to occupational licensure. **OUGHT TO PASS WITH AMENDMENT.**
Rep. Carol McGuire for Executive Departments and Administration. This is an omnibus bill on professional licensing, consisting of 13 unrelated sections, plus one added via a non-germane amendment. Each is described below with the effect of the committee amendment. Part I specifies the State Fire Marshall's ability to grant an assembly permit in an area without another authority. Part II repeals the interstate compact for emergency medical technicians. Part III expands who can chair a hearing of the Board of Nursing to any qualified person appointed by the board. All of these parts were all accepted with no further amendment. Part IV more narrowly specifies the representation of some members of the professional standards board in the Department of Education. The amendment deleted this part as unnecessary. Part V adopts the Audiology and Speech-Language Pathology interstate compact and the Occupational Therapy compact. This part was amended to confirm that any cost due to these compacts would be covered by the Office of Professional Licensure and Certification (OPLC) from its license fees. Part VI creates a new board and licenses music therapists. This part was deleted as unnecessary. HB 209, which had a similar intent, had been found Inexpedient to Legislate by the committee earlier this year. Part VII establishes a standard procedure for investigations, hearings, and appeals within the OPLC. This part was amended to clarify that this procedure did not replace existing investigation procedures for the boards that already have them. Part VIII narrowed the scope of "skilled professional medical personnel" to registered nurses for the purpose of qualifying patients for in-home Medicaid services. This part was deleted as too restrictive. Part IX provides "temporary health partners" a path towards licensure as nursing assistants. This part was amended to eliminate the deadline for having completed at least 100 hours of work and clarify that their on-the-job experience was equivalent to the necessary classroom training. Part X allows emergency medical service units to receive letters of concern, if appropriate, rather than limiting the options for disciplinary action to license suspension or revocation. It was accepted as submitted. Part XI allows schools of barbering and cosmetology to be parts of other schools, (Concord High School, for one) and establishes an apprenticeship certificate (not a license) for training which does not require submitting social security numbers. This part was amended slightly to incorporate the House position from HB 575 and include the certificate language in other parts of the cosmetology statute. Part XII adds a new license level for remote-only psychology treatments from out-of-state professionals. It was amended to better define this license and provide a path to full licensure. Emergency license holders can convert to this "tele-pass" license with minimal additional requirements. Part XIII establishes some exemptions to the requirement for certified food protection managers and was not changed by the committee. Part XIV allows child care workers to qualify as assistant teachers by "life experience," rather than formal education. The committee amendment specifies the types of experiences we considered appropriate. This section was added to the bill via a non-germane amendment. To a large degree, this bill, as amended, consists of administrative changes rather than policy decisions. All are supported by the OPLC and the relevant boards. **Vote 19-0.**

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Cc: Committee Bill File

House Executive Departments and Administration
May 19, 2021
2021-1579h
05/04

Amendment to SB 133-FN

1 Amend the bill by replacing all after the enacting clause with the following:

2

3 1 Sponsorship. This act consists of the following proposed legislation:

4 Part I: LSR 21-0964, relative to the definition of "licensing agency" for purposes of licensing
5 places of assembly, sponsored by Sen. Carson, Prime/Dist 14.

6 Part II: LSR 21-0506, repealing the emergency medical services personnel licensure
7 interstate compact, sponsored by Sen. Rosenwald, Prime/Dist 13, Sen. Cavanaugh, Dist 16; Sen.
8 Carson, Dist 14; Rep. Goley, Hills. 8; Rep. Milz, Rock. 6; Rep. O'Brien, Hills. 36; Rep. S. Pearson,
9 Rock. 6.

10 Part III: LSR 21-0207, relative to hearings of the New Hampshire board of nursing,
11 sponsored by Sen. Ward, Prime/Dist 8.

12 Part IV: LSR 21-0846, adopting the Audiology and Speech-Language Pathology Compact
13 and the Occupational Therapy Licensure Compact, sponsored by Sen. Sherman, Prime/Dist 24; Sen.
14 Soucy, Dist 18; Sen. Carson, Dist 14; Rep. March, Carr. 8.

15 Part V: LSR 21-0899, relative to the authority of the office of professional licensure and
16 certification for administration, rulemaking, and enforcement of investigations, hearings, and
17 appeals, sponsored by Sen. Reagan, Prime/ Dist 17, Sen. Carson, Dist 14; Sen. French, Dist 7; Sen.
18 Kahn, Dist 10; Sen. Prentiss, Dist 5; Sen. Rosenwald, Dist 13; Sen. Bradley, Dist 3; Sen.
19 D'Allesandro, Dist 20; Sen. Ward, Dist 8; Sen. Soucy, Dist 18; Sen. Giuda, Dist 2; Rep. Spillane,
20 Rock. 2; Rep. McGuire, Merr. 29; Rep. Seaworth, Merr. 20.

21 Part VI: LSR 21-0973, relative to temporary licensure of certain licensed nursing assistants,
22 sponsored by Sen. Hennessey, Dist 1; Sen. Rosenwald, Dist 13; Rep. Dostie, Coos 1; Rep. Thompson,
23 Coos 1.

24 Part VII: LSR 21-1011, relative to the revocation of licensure for licensed emergency medical
25 service units and emergency medical service vehicles, sponsored by Sen. Prentiss, Prime/Dist 5; Rep.
26 Merchant, Sull. 4; Rep. Goley, Hills. 8; Rep. McGuire, Merr. 29.

27 Part VIII: LSR 21-1050, relative to schools for barbering, cosmetology, and esthetics,
28 sponsored by Sen. Reagan, Prime/Dist 17; Sen. Rosenwald, Dist 13; Sen. Prentiss, Dist 5; Sen.
29 Carson, Dist 14; Sen. Bradley, Dist 3; Sen. D'Allesandro, Dist 20; Sen. Gannon, Dist 23; Rep.
30 McGuire, Merr. 29; Rep. Roy, Rock. 32; Rep. Harrington, Straf. 3.

31 Part IX: LSR 21-0277, relative to telemedicine provided by out-of-state psychologists,
32 sponsored by Sen. Reagan, Prime/Dist 17; Sen. Carson, Dist 14; Sen. Bradley, Dist 3; Sen. Prentiss,

Dist 5; Sen. French, Dist 7; Sen. Giuda, Dist 2; Sen. Hennessey, Dist 1; Sen. D'Allesandro, Dist 20; Rep. Spillane, Rock. 2; Rep. Tudor, Rock. 1.

Part X: LSR 21-1049, establishing program rules within the department of health and human services for sanitary production and distribution of food, sponsored by Sen. Giuda, Prime/Dist 2; Sen. Gannon, Dist 23.

Part XI: relative to minimum qualifications for certification as a child care associate teacher.

2 Legislation Enacted. The general court hereby enacts the following legislation:

PART I

Relative to the definition of "licensing agency" for purposes of licensing places of assembly.

1 Places of Assembly; Definition of Licensing Agency. Amend RSA 155:17, II to read as follows:

II. "Licensing agency" shall mean the chief of the fire department, the firewards or engineers, if any, otherwise the selectmen of the town or the commissioners of village district as the case may be***, or the state fire marshal, as he or she deems necessary, in consultation with the local licensing agency, if any***.

2 Places of Assembly; License Required. Amend RSA 155:18 to read as follows:

155:18 License Required. No person shall own or operate a place of assembly within this state unless licensed so to do by the licensing agency of the ***state,*** city, town, or village district where said place of assembly is located, including assemblies occurring on state waters or ice formed on state waters, in accordance with the regulations herein promulgated. In the application of this act to existing places of assembly the licensing agency may modify such of its provisions as would require structural changes if in his or her opinion adequate safety may be obtained otherwise and provided that a permanent record is kept of such modifications and the reasons therefor.

3 Effective Date. Part I of this act shall take effect 60 days after its passage.

PART II

Repealing the emergency medical services personnel licensure interstate compact.

1 Repeal. The following are repealed:

I. RSA 153-A:36 and the subdivision heading preceding RSA 153-A:36, relative to the emergency medical services personnel licensure interstate compact.

II. RSA 153-A:20, XXIV, relative to rulemaking by the department of safety regarding implementation of the compact.

2 Effective Date. Part II of this act shall take effect 60 days after its passage.

PART III

Relative to hearings of the New Hampshire board of nursing.

1 Board of Nursing; Adjudicative Hearings. Amend 326-B:38, VIII to read as follows:

VIII. The board may hold adjudicative hearings concerning allegations of misconduct or other matters within the scope of this chapter. Such hearings shall be public proceedings. Any member of the board [~~other than the public members~~], or any other qualified person appointed by the board, shall have authority to preside at such a hearing and to issue oaths or affirmations to witnesses.

2 Effective Date. Part III of this act shall take effect upon its passage.

PART IV

Adopting the Audiology and Speech-Language Pathology Compact
and the Occupational Therapy Licensure Compact.

1 New Paragraph; Office of Professional Licensure and Certification; Fees; Financing of Interstate Compacts. Amend RSA 310-A:1-e by inserting after paragraph II the following new paragraph:

III. The office of professional licensure and certification shall be responsible for the financing of any interstate compact joined by the state that affects a profession governed by a board listed in 310-A:1-a. Such financing shall be from money deposited in the office of professional licensure and certification fund.

2 New Section; Speech-Language Pathology Practice; Audiology and Speech-Language Pathology Compact. Amend RSA 326-F by inserting after section 8 the following new section:

326-F:9 Interstate Compact Adopted. The state of New Hampshire hereby adopts the provisions of the Audiology and Speech-Language Pathology Compact as follows:

SECTION 1: PURPOSE

The purpose of this Compact is to facilitate interstate practice of audiology and speech-language pathology with the goal of improving public access to audiology and speech-language pathology services. The practice of audiology and speech-language pathology occurs in the state where the patient/client/student is located at the time of the patient/client/student encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other member state licenses;

2. Enhance the states' ability to protect the public's health and safety;

3. Encourage the cooperation of member states in regulating multistate audiology and speech-language pathology practice;

4. Support spouses of relocating active duty military personnel;

5. Enhance the exchange of licensure, investigative and disciplinary information between member states;

1 6. Allow a remote state to hold a provider of services with a compact privilege in that state
2 accountable to that state's practice standards; and
3 7. Allow for the use of telehealth technology to facilitate increased access to audiology and
4 speech-language pathology services.
5 SECTION 2. DEFINITIONS
6 As used in this Compact, and except as otherwise provided, the following definitions shall apply:
7 A. "Active duty military" means full-time duty status in the active uniformed service of the
8 United States, including members of the National Guard and Reserve on active duty orders
9 pursuant to 10 U.S.C. Chapter 1209 and 10 U.S.C Chapter 1211.
10 B. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a
11 state's laws which is imposed by a licensing board or other authority against an audiologist or
12 speech-language pathologist, including actions against an individual's license or privilege to practice
13 such as revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee's
14 practice.
15 C. "Alternative program" means a non-disciplinary monitoring process approved by an audiology
16 or speech-language pathology licensing board to address impaired practitioners.
17 D. "Audiologist" means an individual who is licensed by a state to practice audiology.
18 E. "Audiology" means the care and services provided by a licensed audiologist as set forth in the
19 member state's statutes and rules.
20 F. "Audiology and Speech-Language Pathology Compact Commission" or "Commission" means
21 the national administrative body whose membership consists of all states that have enacted the
22 Compact.
23 G. "Audiology and speech-language pathology licensing board," "audiology licensing board,"
24 "speech-language pathology licensing board," or "licensing board" means the agency of a state that is
25 responsible for the licensing and regulation of audiologists and/or speech-language pathologists.
26 H. "Compact privilege" means the authorization granted by a remote state to allow a licensee
27 from another member state to practice as an audiologist or speech-language pathologist in the
28 remote state under its laws and rules. The practice of audiology or speech-language pathology
29 occurs in the member state where the patient/client/student is located at the time of the
30 patient/client/student encounter.
31 I. "Current significant investigative information" means investigative information that a
32 licensing board, after an inquiry or investigation that includes notification and an opportunity for
33 the audiologist or speech-language pathologist to respond, if required by state law, has reason to
34 believe is not groundless and, if proved true, would indicate more than a minor infraction.
35 J. "Data system" means a repository of information about licensees, including, but not limited
36 to, continuing education, examination, licensure, investigative, compact privilege and adverse action.

1 K. "Encumbered license" means a license in which an adverse action restricts the practice of
2 audiology or speech-language pathology by the licensee and said adverse action has been reported to
3 the National Practitioners Data Bank (NPDB).
4 L. "Executive committee" means a group of directors elected or appointed to act on behalf of, and
5 within the powers granted to them by, the Commission.
6 M. "Home state" means the member state that is the licensee's primary state of residence.
7 N. "Impaired practitioner" means individuals whose professional practice is adversely affected
8 by substance abuse, addiction, or other health-related conditions.
9 O. "Licensee" means an individual who currently holds an authorization from the state licensing
10 board to practice as an audiologist or speech-language pathologist.
11 P. "Member state" means a state that has enacted the Compact.
12 Q. "Privilege to practice" means a legal authorization permitting the practice of audiology or
13 speech-language pathology in a remote state.
14 R. "Remote state" means a member state other than the home state where a licensee is
15 exercising or seeking to exercise the compact privilege.
16 S. "Rule" means a regulation, principle or directive promulgated by the Commission that has the
17 force of law.
18 T. "Single-state license" means an audiology or speech-language pathology license issued by a
19 member state that authorizes practice only within the issuing state and does not include a privilege
20 to practice in any other member state.
21 U. "Speech-language pathologist" means an individual who is licensed by a state to practice
22 speech-language pathology.
23 V. "Speech-language pathology means the care and services provided by a licensed speech-
24 language pathologist as set forth in the member state's statutes and rules.
25 W. "State" means any state, commonwealth, district or territory of the United States of America
26 that regulates the practice of audiology and speech-language pathology.
27 X. "State practice laws" means a member state's laws, rules and regulations that govern the
28 practice of audiology or speech-language pathology, define the scope of audiology or speech-language
29 pathology practice, and create the methods and grounds for imposing discipline.
30 Y. "Telehealth" means the application of telecommunication technology to deliver audiology or
31 speech-language pathology services at a distance for assessment, intervention and/or consultation.
32 SECTION 3. STATE PARTICIPATION IN THE COMPACT
33 A. A license issued to an audiologist or speech-language pathologist by a home state to a
34 resident in that state shall be recognized by each member state as authorizing an audiologist or
35 speech-language pathologist to practice audiology or speech-language pathology, under a privilege to
36 practice, in each member state.

1 B. A state must implement or utilize procedures for considering the criminal history records of
2 applicants for initial privilege to practice. These procedures shall include the submission of
3 fingerprints or other biometric-based information by applicants for the purpose of obtaining an
4 applicant's criminal history record information from the Federal Bureau of Investigation and the
5 agency responsible for retaining that state's criminal records
6 1. A member state must fully implement a criminal background check requirement, within a
7 time frame established by rule, by receiving the results of the Federal Bureau of Investigation record
8 search on criminal background checks and use the results in making licensure decisions.
9 2. Communication between a member state, the Commission and among member states
10 regarding the verification of eligibility for licensure through the Compact shall not include any
11 information received from the Federal Bureau of Investigation relating to a federal criminal records
12 check performed by a member state under Public Law 92-544.
13 C. Upon application for a privilege to practice, the licensing board in the issuing remote state
14 shall ascertain, through the data system, whether the applicant has ever held, or is the holder of, a
15 license issued by any other state, whether there are any encumbrances on any license or privilege to
16 practice held by the applicant, whether any adverse action has been taken against any license or
17 privilege to practice held by the applicant.
18 D. Each member state shall require an applicant to obtain or retain a license in the home state
19 and meet the home state's qualifications for licensure or renewal of licensure, as well as, all other
20 applicable state laws.
21 E. For an audiologist:
22 1. Must meet one of the following educational requirements:
23 a. On or before, Dec. 31, 2007, has graduated with a master's degree or doctorate in audiology,
24 or equivalent degree regardless of degree name, from a program that is accredited by an accrediting
25 agency recognized by the Council for Higher Education Accreditation, or its successor, or by the
26 United States Department of Education and operated by a college or university accredited by a
27 regional or national accrediting organization recognized by the board; or
28 b. On or after, Jan. 1, 2008, has graduated with a Doctoral degree in audiology, or equivalent
29 degree, regardless of degree name, from a program that is accredited by an accrediting agency
30 recognized by the Council for Higher Education Accreditation, or its successor, or by the United
31 States Department of Education and operated by a college or university accredited by a regional or
32 national accrediting organization recognized by the board; or
33 c. Has graduated from an audiology program that is housed in an institution of higher education
34 outside of the United States (a) for which the program and institution have been approved by the
35 authorized accrediting body in the applicable country and (b) the degree program has been verified
36 by an independent credentials review agency to be comparable to a state licensing board-approved
37 program.

1 2. Has completed a supervised clinical practicum experience from an accredited educational
2 institution or its cooperating programs as required by the commission;
3 3. Has successfully passed a national examination approved by the Commission;
4 4. Holds an active, unencumbered license;
5 5. Has not been convicted or found guilty, and has not entered into an agreed disposition, of a
6 felony related to the practice of audiology, under applicable state or federal criminal law;
7 6. Has a valid United States Social Security or National Practitioner Identification number.
8 F. For a speech-language pathologist:
9 1. Must meet one of the following educational requirements:
10 a. Has graduated with a master's degree from a speech-language pathology program that is
11 accredited by an organization recognized by the United States Department of Education and
12 operated by a college or university accredited by a regional or national accrediting organization
13 recognized by the board; or
14 b. Has graduated from a speech-language pathology program that is housed in an institution of
15 higher education outside of the United States (a) for which the program and institution have been
16 approved by the authorized accrediting body in the applicable country and (b) the degree program
17 has been verified by an independent credentials review agency to be comparable to a state licensing
18 board-approved program.
19 2. Has completed a supervised clinical practicum experience from an educational institution or
20 its cooperating programs as required by the Commission;
21 3. Has completed a supervised postgraduate professional experience as required by the
22 Commission
23 4. Has successfully passed a national examination approved by the Commission;
24 5. Holds an active, unencumbered license;
25 6. Has not been convicted or found guilty, and has not entered into an agreed disposition, of a
26 felony related to the practice of speech-language pathology, under applicable state or federal
27 criminal law;
28 7. Has a valid United States Social Security or National Practitioner Identification number.
29 G. The privilege to practice is derived from the home state license.
30 H. An audiologist or speech-language pathologist practicing in a member state must comply
31 with the state practice laws of the state in which the client is located at the time service is provided.
32 The practice of audiology and speech-language pathology shall include all audiology and speech-
33 language pathology practice as defined by the state practice laws of the member state in which the
34 client is located. The practice of audiology and speech-language pathology in a member state under
35 a privilege to practice shall subject an audiologist or speech-language pathologist to the jurisdiction
36 of the licensing board, the courts and the laws of the member state in which the client is located at
37 the time service is provided.

1 I. Individuals not residing in a member state shall continue to be able to apply for a member
2 state's single-state license as provided under the laws of each member state. However, the single-
3 state license granted to these individuals shall not be recognized as granting the privilege to practice
4 audiology or speech-language pathology in any other member state. Nothing in this Compact shall
5 affect the requirements established by a member state for the issuance of a single-state license.
6 J. Member states may charge a fee for granting a compact privilege.
7 K. Member states must comply with the bylaws and rules and regulations of the Commission.
8 SECTION 4. COMPACT PRIVILEGE
9 A. To exercise the compact privilege under the terms and provisions of the Compact, the
10 audiologist or speech-language pathologist shall:
11 1. Hold an active license in the home state;
12 2. Have no encumbrance on any state license;
13 3. Be eligible for a compact privilege in any member state in accordance with Section 3;
14 4. Have not had any adverse action against any license or compact privilege within the previous
15 2 years from date of application;
16 5. Notify the Commission that the licensee is seeking the compact privilege within a remote
17 state(s);
18 6. Pay any applicable fees, including any state fee, for the compact privilege;
19 7. Report to the Commission adverse action taken by any non-member state within 30 days from
20 the date the adverse action is taken.
21 B. For the purposes of the compact privilege, an audiologist or speech-language pathologist shall
22 only hold one home state license at a time.
23 C. Except as provided in Section 6, if an audiologist or speech-language pathologist changes
24 primary state of residence by moving between two-member states, the audiologist or speech-
25 language pathologist must apply for licensure in the new home state, and the license issued by the
26 prior home state shall be deactivated in accordance with applicable rules adopted by the
27 Commission.
28 D. The audiologist or speech-language pathologist may apply for licensure in advance of a
29 change in primary state of residence.
30 E. A license shall not be issued by the new home state until the audiologist or speech-language
31 pathologist provides satisfactory evidence of a change in primary state of residence to the new home
32 state and satisfies all applicable requirements to obtain a license from the new home state.
33 F. If an audiologist or speech-language pathologist changes primary state of residence by
34 moving from a member state to a non-member state, the license issued by the prior home state shall
35 convert to a single-state license, valid only in the former home state.

1 G. The compact privilege is valid until the expiration date of the home state license. The
2 licensee must comply with the requirements of Section 4A to maintain the compact privilege in the
3 remote state.
4 H. A licensee providing audiology or speech-language pathology services in a remote state under
5 the compact privilege shall function within the laws and regulations of the remote state.
6 I. A licensee providing audiology or speech-language pathology services in a remote state is
7 subject to that state's regulatory authority. A remote state may, in accordance with due process and
8 that state's laws, remove a licensee's compact privilege in the remote state for a specific period of
9 time, impose fines, and/or take any other necessary actions to protect the health and safety of its
10 citizens.
11 J. If a home state license is encumbered, the licensee shall lose the compact privilege in any
12 remote state until the following occur:
13 1. The home state license is no longer encumbered; and
14 2. Two years have elapsed from the date of the adverse action.
15 K. Once an encumbered license in the home state is restored to good standing, the licensee must
16 meet the requirements of Section 4A to obtain a compact privilege in any remote state.
17 L. Once the requirements of Section 4J have been met, the licensee must meet the requirements
18 in Section 4A to obtain a compact privilege in a remote state.
19 SECTION 5. COMPACT PRIVILEGE TO PRACTICE TELEHEALTH
20 Member states shall recognize the right of an audiologist or speech-language pathologist, licensed by
21 a home state in accordance with Section 3 and under rules promulgated by the Commission, to
22 practice audiology or speech-language pathology in any member state via telehealth under a
23 privilege to practice as provided in the Compact and rules promulgated by the Commission.
24 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES
25 Active duty military personnel, or their spouse, shall designate a home state where the individual
26 has a current license in good standing. The individual may retain the home state designation during
27 the period the service member is on active duty. Subsequent to designating a home state, the
28 individual shall only change their home state through application for licensure in the new state.
29 SECTION 7. ADVERSE ACTIONS
30 A. In addition to the other powers conferred by state law, a remote state shall have the
31 authority, in accordance with existing state due process law, to:
32 1. Take adverse action against an audiologist's or speech-language pathologist's privilege to
33 practice within that member state.
34 2. Issue subpoenas for both hearings and investigations that require the attendance and
35 testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board
36 in a member state for the attendance and testimony of witnesses or the production of evidence from
37 another member state shall be enforced in the latter state by any court of competent jurisdiction,

1 according to the practice and procedure of that court applicable to subpoenas issued in proceedings
2 pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and
3 other fees required by the service statutes of the state in which the witnesses or evidence are
4 located.
5 3. Only the home state shall have the power to take adverse action against a audiologist's or
6 speech-language pathologist's license issued by the home state.
7 B. For purposes of taking adverse action, the home state shall give the same priority and effect
8 to reported conduct received from a member state as it would if the conduct had occurred within the
9 home state. In so doing, the home state shall apply its own state laws to determine appropriate
10 action.
11 C. The home state shall complete any pending investigations of an audiologist or speech-
12 language pathologist who changes primary state of residence during the course of the investigations.
13 The home state shall also have the authority to take appropriate action(s) and shall promptly report
14 the conclusions of the investigations to the administrator of the data system. The administrator of
15 the coordinated licensure information system shall promptly notify the new home state of any
16 adverse actions.
17 D. If otherwise permitted by state law, the member state may recover from the affected
18 audiologist or speech-language pathologist the costs of investigations and disposition of cases
19 resulting from any adverse action taken against that audiologist or speech-language pathologist.
20 E. The member state may take adverse action based on the factual findings of the remote state,
21 provided that the member state follows the member state's own procedures for taking the adverse
22 action.
23 F. Joint Investigations
24 1. In addition to the authority granted to a member state by its respective audiology or speech-
25 language pathology practice act or other applicable state law, any member state may participate
26 with other member states in joint investigations of licensees.
27 2. Member states shall share any investigative, litigation, or compliance materials in
28 furtherance of any joint or individual investigation initiated under the Compact.
29 G. If adverse action is taken by the home state against an audiologist's or speech language
30 pathologist's license, the audiologist's or speech-language pathologist's privilege to practice in all
31 other member states shall be deactivated until all encumbrances have been removed from the state
32 license. All home state disciplinary orders that impose adverse action against an audiologist's or
33 speech language pathologist's license shall include a statement that the audiologist's or speech-
34 language pathologist's privilege to practice is deactivated in all member states during the pendency
35 of the order.

1 H. If a member state takes adverse action, it shall promptly notify the administrator of the data
2 system. The administrator of the data system shall promptly notify the home state of any adverse
3 actions by remote states.
4 I. Nothing in this Compact shall override a member state's decision that participation in an
5 alternative program may be used in lieu of adverse action.
6 SECTION 8. ESTABLISHMENT OF THE AUDIOLOGY AND SPEECH-LANGUAGE
7 PATHOLOGY COMPACT COMMISSION
8 A. The Compact member states hereby create and establish a joint public agency known as the
9 Audiology and Speech-Language Pathology Compact Commission:
10 1. The Commission is an instrumentality of the Compact states.
11 2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely
12 and exclusively in a court of competent jurisdiction where the principal office of the Commission is
13 located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or
14 consents to participate in alternative dispute resolution proceedings.
15 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
16 B. Membership, Voting and Meetings
17 1. Each member state shall have two (2) delegates selected by that member state's licensing
18 board. The delegates shall be current members of the licensing board. One shall be an audiologist
19 and one shall be a speech-language pathologist.
20 2. An additional five (5) delegates, who are either a public member or board administrator from
21 a state licensing board, shall be chosen by the Executive Committee from a pool of nominees
22 provided by the Commission at Large.
23 3. Any delegate may be removed or suspended from office as provided by the law of the state
24 from which the delegate is appointed.
25 4. The member state board shall fill any vacancy occurring on the Commission, within 90 days.
26 5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and
27 creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs
28 of the Commission.
29 6. A delegate shall vote in person or by other means as provided in the bylaws. The bylaws may
30 provide for delegates' participation in meetings by telephone or other means of communication.
31 7. The Commission shall meet at least once during each calendar year. Additional meetings
32 shall be held as set forth in the bylaws.
33 C. The Commission shall have the following powers and duties:
34 1. Establish the fiscal year of the Commission;
35 2. Establish bylaws;
36 3. Establish a Code of Ethics;
37 4. Maintain its financial records in accordance with the bylaws;

1 5. Meet and take actions as are consistent with the provisions of this Compact and the bylaws;
2 6. Promulgate uniform rules to facilitate and coordinate implementation and administration of
3 this Compact. The rules shall have the force and effect of law and shall be binding in all member
4 states;
5 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided
6 that the standing of any state audiology or speech-language pathology licensing board to sue or be
7 sued under applicable law shall not be affected;
8 8. Purchase and maintain insurance and bonds;
9 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees
10 of a member state;
11 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant individuals
12 appropriate authority to carry out the purposes of the Compact, and to establish the Commission's
13 personnel policies and programs relating to conflicts of interest, qualifications of personnel, and
14 other related personnel matters;
15 11. Accept any and all appropriate donations and grants of money, equipment, supplies,
16 materials and services, and to receive, utilize and dispose of the same; provided that at all times the
17 Commission shall avoid any appearance of impropriety and/or conflict of interest;
18 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve
19 or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid
20 any appearance of impropriety;
21 13. Sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any
22 property real, personal, or mixed;
23 14. Establish a budget and make expenditures;
24 15. Borrow money;
25 16. Appoint committees, including standing committees composed of members, and other
26 interested persons as may be designated in this Compact and the bylaws;
27 17. Provide and receive information from, and cooperate with, law enforcement agencies;
28 18. Establish and elect an Executive Committee; and
29 19. Perform other functions as may be necessary or appropriate to achieve the purposes of this
30 Compact consistent with the state regulation of audiology and speech-language pathology licensure
31 and practice.
32 D. The Executive Committee
33 The Executive Committee shall have the power to act on behalf of the Commission according to the
34 terms of this Compact:
35 1. The Executive Committee shall be composed of ten (10) members:
36 a. Seven (7) voting members who are elected by the Commission from the current membership
37 of the Commission;

1 b. Two (2) ex-officios, consisting of one nonvoting member from a recognized national audiology
2 professional association and one nonvoting member from a recognized national speech-language
3 pathology association; and
4 c. One (1) ex-officio, nonvoting member from the recognized membership organization of the
5 audiology and speech-language pathology licensing boards.
6 E. The ex-officio members shall be selected by their respective organizations.
7 1. The Commission may remove any member of the Executive Committee as provided in bylaws.
8 2. The Executive Committee shall meet at least annually.
9 3. The Executive Committee shall have the following duties and responsibilities:
10 a. Recommend to the entire Commission changes to the rules or bylaws, changes to this
11 Compact legislation, fees paid by Compact member states such as annual dues, and any commission
12 Compact fee charged to licensees for the compact privilege;
13 b. Ensure Compact administration services are appropriately provided, contractual or
14 otherwise;
15 c. Prepare and recommend the budget;
16 d. Maintain financial records on behalf of the Commission;
17 e. Monitor Compact compliance of member states and provide compliance reports to the
18 Commission;
19 f. Establish additional committees as necessary; and
20 g. Other duties as provided in rules or bylaws.
21 4. Meetings of the Commission
22 All meetings shall be open to the public, and public notice of meetings shall be given in the same
23 manner as required under the rulemaking provisions in Section 10.
24 5. The Commission or the Executive Committee or other committees of the Commission may
25 convene in a closed, non-public meeting if the Commission or Executive Committee or other
26 committees of the Commission must discuss:
27 a. Non-compliance of a member state with its obligations under the
28 Compact;
29 b. The employment, compensation, discipline or other matters, practices or procedures related to
30 specific employees or other matters related to the Commission's internal personnel practices and
31 procedures;
32 c. Current, threatened, or reasonably anticipated litigation;
33 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;
34 e. Accusing any person of a crime or formally censuring any person;
35 f. Disclosure of trade secrets or commercial or financial information that is privileged or
36 confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigative records compiled for law enforcement purposes;

i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision.

7. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

8. Financing of the Commission

a. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

b. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

c. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

9. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

10. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

F. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 9. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Adverse actions against a license or compact privilege;
4. Non-confidential information related to alternative program participation;
5. Any denial of application for licensure, and the reason(s) for denial; and
6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

1 C. Investigative information pertaining to a licensee in any member state shall only be available
2 to other member states.
3 D. The Commission shall promptly notify all member states of any adverse action taken against
4 a licensee or an individual applying for a license. Adverse action information pertaining to a licensee
5 in any member state shall be available to any other member state.
6 E. Member states contributing information to the data system may designate information that
7 may not be shared with the public without the express permission of the contributing state.
8 F. Any information submitted to the data system that is subsequently required to be expunged
9 by the laws of the member state contributing the information shall be removed from the data
10 system.
11 SECTION 10. RULEMAKING
12 A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in
13 this Section and the rules adopted thereunder. Rules and amendments shall become binding as of
14 the date specified in each rule or amendment.
15 B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute
16 or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
17 the rule, the rule shall have no further force and effect in any member state.
18 C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the
19 Commission.
20 D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least
21 thirty (30) days in advance of the meeting at which the rule shall be considered and voted upon, the
22 Commission shall file a Notice of Proposed Rulemaking:
23 1. On the website of the Commission or other publicly accessible platform; and
24 2. On the website of each member state audiology or speech-language pathology licensing board
25 or other publicly accessible platform or the publication in which each state would otherwise publish
26 proposed rules.
27 E. The Notice of Proposed Rulemaking shall include:
28 1. The proposed time, date, and location of the meeting in which the rule shall be considered and
29 voted upon;
30 2. The text of the proposed rule or amendment and the reason for the proposed rule;
31 3. A request for comments on the proposed rule from any interested person; and
32 4. The manner in which interested persons may submit notice to the Commission of their
33 intention to attend the public hearing and any written comments.
34 F. Prior to the adoption of a proposed rule, the Commission shall allow persons to submit
35 written data, facts, opinions and arguments, which shall be made available to the public.
36 G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or
37 amendment if a hearing is requested by:

1. At least twenty-five (25) persons;

2. A state or federal governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings shall be recorded. A copy of the recording shall be made available on request.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

K. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds; or

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the

1 revision results in a material change to a rule. A challenge shall be made in writing and delivered to
2 the chair of the Commission prior to the end of the notice period. If no challenge is made, the
3 revision shall take effect without further action. If the revision is challenged, the revision may not
4 take effect without the approval of the Commission.
5 SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT
6 A. Dispute Resolution
7 1. Upon request by a member state, the Commission shall attempt to resolve disputes related to
8 the Compact that arise among member states and between member and non-member states.
9 2. The Commission shall promulgate a rule providing for both mediation and binding dispute
10 resolution for disputes as appropriate.
11 B. Enforcement
12 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
13 rules of this Compact.
14 2. By majority vote, the Commission may initiate legal action in the United States District
15 Court for the District of Columbia or the federal district where the Commission has its principal
16 offices against a member state in default to enforce compliance with the provisions of the Compact
17 and its promulgated rules and bylaws. The relief sought may include both injunctive relief and
18 damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all
19 costs of litigation, including reasonable attorney's fees.
20 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
21 may pursue any other remedies available under federal or state law.
22 SECTION 12. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR
23 AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY PRACTICE AND ASSOCIATED RULES,
24 WITHDRAWAL, AND AMENDMENT
25 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
26 law in the 10th member state. The provisions, which become effective at that time, shall be limited
27 to the powers granted to the Commission relating to assembly and the promulgation of rules.
28 Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the
29 implementation and administration of the Compact.
30 B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules
31 shall be subject to the rules as they exist on the date on which the Compact becomes law in that
32 state. Any rule that has been previously adopted by the Commission shall have the full force and
33 effect of law on the day the Compact becomes law in that state.
34 C. Any member state may withdraw from this Compact by enacting a statute repealing the
35 same.
36 1. A member state's withdrawal shall not take effect until six (6) months after enactment of the
37 repealing statute.

1 2. Withdrawal shall not affect the continuing requirement of the withdrawing state's audiology
2 or speech-language pathology licensing board to comply with the investigative and adverse action
3 reporting requirements of this act prior to the effective date of withdrawal.
4 D. Nothing contained in this Compact shall be construed to invalidate or prevent any audiology
5 or speech-language pathology licensure agreement or other cooperative arrangement between a
6 member state and a non-member state that does not conflict with the provisions of this Compact.
7 E. This Compact may be amended by the member states. No amendment to this Compact shall
8 become effective and binding upon any member state until it is enacted into the laws of all member
9 states.
10 SECTION 13. CONSTRUCTION AND SEVERABILITY
11 This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of
12 this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is
13 declared to be contrary to the constitution of any member state or of the United States or the
14 applicability thereof to any government, agency, person or circumstance is held invalid, the validity
15 of the remainder of this Compact and the applicability thereof to any government, agency, person or
16 circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution
17 of any member state, the Compact shall remain in full force and effect as to the remaining member
18 states and in full force and effect as to the member state affected as to all severable matters.
19 SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS
20 A. Nothing herein prevents the enforcement of any other law of a member state that is not
21 inconsistent with the Compact.
22 B. All laws in a member state in conflict with the Compact are superseded to the extent of the
23 conflict.
24 C. All lawful actions of the Commission, including all rules and bylaws promulgated by the
25 Commission, are binding upon the member states.
26 D. All agreements between the Commission and the member states are binding in accordance
27 with their terms.
28 E. In the event any provision of the Compact exceeds the constitutional limits imposed on the
29 legislature of any member state, the provision shall be ineffective to the extent of the conflict with
30 the constitutional provision in question in that member state.
31 3 New Section; Occupational Therapists; Occupational Therapy Licensure Compact. Amend
32 RSA 326-C by inserting after section 8 the following new section:
33 326-C:9 Occupational Therapy Licensure Compact. The state of New Hampshire hereby adopts
34 the provisions of the Occupational Therapy Licensure Compact as follows:
35 SECTION 1. PURPOSE
36 The purpose of this Compact is to facilitate interstate practice of occupational therapy with the goal
37 of improving public access to occupational therapy services. The Practice of occupational therapy

1 occurs in the state where the patient/client is located at the time of the patient/client encounter. The
2 Compact preserves the regulatory authority of states to protect public health and safety through the
3 current system of state licensure.
4 This Compact is designed to achieve the following objectives:
5 A. Increase public access to occupational therapy services by providing for the mutual
6 recognition of other member state licenses;
7 B. Enhance the states' ability to protect the public's health and safety;
8 C. Encourage the cooperation of member states in regulating multi-state occupational therapy
9 practice;
10 D. Support spouses of relocating military members;
11 E. Enhance the exchange of licensure, investigative, and disciplinary information between
12 Member states;
13 F. Allow a remote state to hold a provider of services with a Compact privilege in that state
14 accountable to that state's practice standards; and
15 G. Facilitate the use of telehealth technology in order to increase access to occupational therapy
16 services.
17 SECTION 2. DEFINITIONS
18 As used in this Compact, and except as otherwise provided, the following definitions shall apply:
19 A. "Active Duty Military" means full-time duty status in the active uniformed service of the
20 United States, including members of the National Guard and Reserve on active duty orders
21 pursuant to 10 U.S.C. Chapter 1209 and Section 1211.
22 B. "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a
23 state's laws which is imposed by a licensing board or other authority against an occupational
24 therapist or occupational therapy assistant, including actions against an individual's license or
25 Compact privilege such as censure, revocation, suspension, probation, monitoring of the licensee, or
26 restriction on the licensee's practice.
27 C. "Alternative Program" means a non-disciplinary monitoring process approved by an
28 occupational therapy licensing board.
29 D. "Compact privilege" means the authorization, which is equivalent to a license, granted by a
30 remote state to allow a licensee from another member state to practice as an occupational therapist
31 or practice as an occupational therapy assistant in the remote state under its laws and rules. The
32 practice of occupational therapy occurs in the member state where the patient/client is located at the
33 time of the patient/client encounter.
34 E. "Continuing Competence/Education" means a requirement, as a condition of license renewal,
35 to provide evidence of participation in, and/or completion of, educational and professional activities
36 relevant to practice or area of work.

1 F. "Current significant investigative information" means investigative information that a
2 licensing board, after an inquiry or investigation that includes notification and an opportunity for
3 the occupational therapist or occupational therapy assistant to respond, if required by state law, has
4 reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.
5 G. "Data system" means a repository of information about licensees, including but not limited to
6 license status, investigative information, Compact privileges, and adverse actions.
7 H. "Encumbered license" means a license in which an adverse action restricts the practice of
8 occupational therapy by the licensee or said adverse action has been reported to the National
9 Practitioners Data Bank (NPDB).
10 I. "Executive Committee" means a group of directors elected or appointed to act on behalf of, and
11 within the powers granted to them by, the Commission.
12 J. "Home state" means the member state that is the licensee's Primary state of residence.
13 K. "Impaired practitioner" means individuals whose professional practice is adversely affected
14 by substance abuse, addiction, or other health-related conditions.
15 L. "Investigative Information" means information, records, and/or documents received or
16 generated by an occupational therapy licensing board pursuant to an investigation.
17 M. "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws
18 and rules governing the practice of occupational therapy in a state.
19 N. "Licensee" means an individual who currently holds an authorization from the state to
20 practice as an occupational therapist or as an occupational therapy assistant.
21 O. "Member state" means a state that has enacted the Compact.
22 P. "Occupational therapist" means an individual who is licensed by a state to practice
23 occupational therapy.
24 Q. "Occupational therapy assistant" means an individual who is licensed by a state to assist in
25 the practice of occupational therapy.
26 R. "Occupational therapy," "occupational therapy practice," and the "practice of occupational
27 therapy" mean the care and services provided by an occupational therapist or an occupational
28 therapy assistant as set forth in the member state's statutes and regulations.
29 S. "Occupational therapy Compact Commission" or "Commission" means the national
30 administrative body whose membership consists of all states that have enacted the Compact.
31 T. "Occupational therapy licensing board" or "licensing board" means the agency of a state that
32 is authorized to license and regulate occupational therapists and occupational therapy assistants.
33 U. "Primary state of residence" means the state (also known as the home state) in which an
34 occupational therapist or occupational therapy assistant who is not Active Duty Military declares a
35 primary residence for legal purposes as verified by: driver's license, federal income tax return, lease,
36 deed, mortgage or voter registration or other verifying documentation as further defined by
37 Commission rules.

1 V. "Remote state" means a member state other than the home state, where a licensee is
2 exercising or seeking to exercise the Compact privilege.
3 W. "Rule" means a regulation promulgated by the Commission that has the force of law.
4 X. "State" means any state, commonwealth, district, or territory of the United States of America
5 that regulates the practice of occupational therapy.
6 Y. "Single-state license" means an occupational therapist or occupational therapy assistant
7 license issued by a member state that authorizes practice only within the issuing state and does not
8 include a Compact privilege in any other member state.
9 Z. "Telehealth" means the application of telecommunication technology to deliver occupational
10 therapy services for assessment, intervention and/or consultation.
11 SECTION 3. STATE PARTICIPATION IN THE COMPACT
12 A. To participate in the Compact, a member state shall:
13 1. License occupational therapists and occupational therapy assistants;
14 2. Participate fully in the Commission's data system, including but not limited to using the
15 Commission's unique identifier as defined in rules of the Commission;
16 3. Have a mechanism in place for receiving and investigating complaints about licensees;
17 4. Notify the Commission, in compliance with the terms of the Compact and rules, of any
18 adverse action or the availability of investigative information regarding a licensee;
19 5. Implement or utilize procedures for considering the criminal history records of applicants for
20 an initial Compact privilege. These procedures shall include the submission of fingerprints or other
21 biometric-based information by applicants for the purpose of obtaining an applicant's criminal
22 history record information from the Federal Bureau of Investigation and the agency responsible for
23 retaining that state's criminal records;
24 a. A member state shall, within a time frame established by the Commission, require a criminal
25 background check for a licensee seeking/applying for a Compact privilege whose Primary state of
26 residence is that member state, by receiving the results of the Federal Bureau of Investigation
27 criminal record search, and shall use the results in making licensure decisions.
28 b. Communication between a member state, the Commission and among member states
29 regarding the verification of eligibility for licensure through the Compact shall not include any
30 information received from the Federal Bureau of Investigation relating to a federal criminal records
31 check performed by a member state under Public Law 92-544.
32 6. Comply with the rules of the Commission;
33 7. Utilize only a recognized national examination as a requirement for licensure pursuant to the
34 rules of the Commission; and
35 8. Have Continuing Competence/Education requirements as a condition for license renewal.
36 B. A member state shall grant the Compact privilege to a licensee holding a valid unencumbered
37 license in another member state in accordance with the terms of the Compact and rules.

1 C. Member states may charge a fee for granting a Compact privilege.
2 D. A member state shall provide for the state's delegate to attend all occupational therapy
3 Compact Commission meetings.
4 E. Individuals not residing in a member state shall continue to be able to apply for a member
5 state's Single-state license as provided under the laws of each member state. However, the Single-
6 state license granted to these individuals shall not be recognized as granting the Compact privilege
7 in any other member state.
8 F. Nothing in this Compact shall affect the requirements established by a member state for the
9 issuance of a Single-state license.
10 SECTION 4. COMPACT PRIVILEGE
11 A. To exercise the Compact privilege under the terms and provisions of the Compact, the
12 licensee shall:
13 1. Hold a license in the home state;
14 2. Have a valid United States Social Security Number or National Practitioner Identification
15 number;
16 3. Have no encumbrance on any state license;
17 4. Be eligible for a Compact privilege in any member state in accordance with Section 4D, F, G,
18 and H;
19 5. Have paid all fines and completed all requirements resulting from any adverse action against
20 any license or Compact privilege, and two years have elapsed from the date of such completion;
21 6. Notify the Commission that the licensee is seeking the Compact privilege within a remote
22 state(s);
23 7. Pay any applicable fees, including any state fee, for the Compact privilege;
24 8. Complete a criminal background check in accordance with Section 3A(5);
25 a. The licensee shall be responsible for the payment of any fee associated with the completion of
26 a criminal background check.
27 9. Meet any jurisprudence requirements established by the remote state(s) in which the licensee
28 is seeking a Compact privilege; and
29 10. Report to the Commission adverse action taken by any non-member state within 30 days
30 from the date the adverse action is taken.
31 B. The Compact privilege is valid until the expiration date of the home state license. The
32 licensee must comply with the requirements of Section 4A to maintain the Compact privilege in the
33 remote state.
34 C. A licensee providing occupational therapy in a remote state under the Compact privilege
35 shall function within the laws and regulations of the remote state.
36 D. Occupational therapy assistants practicing in a remote state shall be supervised by an
37 occupational therapist licensed or holding a Compact privilege in that remote state.

1 E. A licensee providing occupational therapy in a remote state is subject to that state's
2 regulatory authority. A remote state may, in accordance with due process and that state's laws,
3 remove a licensee's Compact privilege in the remote state for a specific period of time, impose fines,
4 and/or take any other necessary actions to protect the health and safety of its citizens. The licensee
5 may be ineligible for a Compact privilege in any state until the specific time for removal has passed
6 and all fines are paid.
7 F. If a home state license is encumbered, the licensee shall lose the Compact privilege in any
8 remote state until the following occur:
9 1. The home state license is no longer encumbered; and
10 2. Two years have elapsed from the date on which the home state license is no longer
11 encumbered in accordance with Section 4(F)(1).
12 G. Once an Encumbered license in the home state is restored to good standing, the licensee must
13 meet the requirements of Section 4A to obtain a Compact privilege in any remote state.
14 H. If a licensee's Compact privilege in any remote state is removed, the individual may lose the
15 Compact privilege in any other remote state until the following occur:
16 1. The specific period of time for which the Compact privilege was removed has ended;
17 2. All fines have been paid and all conditions have been met;
18 3. Two years have elapsed from the date of completing requirements for 4(H)(1) and (2); and
19 4. The Compact privileges are reinstated by the Commission, and the compact data system is
20 updated to reflect reinstatement.
21 I. If a licensee's Compact privilege in any remote state is removed due to an erroneous charge,
22 privileges shall be restored through the compact data system.
23 J. Once the requirements of Section 4H have been met, the license must meet the requirements
24 in Section 4A to obtain a Compact privilege in a remote state.
25 SECTION 5: OBTAINING A NEW HOME STATE LICENSE BY VIRTUE OF COMPACT
26 PRIVILEGE
27 A. An occupational therapist or occupational therapy assistant may hold a home state license,
28 which allows for Compact privileges in member states, in only one member state at a time.
29 B. If an occupational therapist or occupational therapy assistant changes primary state of
30 residence by moving between two member states:
31 1. The occupational therapist or occupational therapy assistant shall file an application for
32 obtaining a new home state license by virtue of a Compact privilege, pay all applicable fees, and
33 notify the current and new home state in accordance with applicable rules adopted by the
34 Commission.
35 2. Upon receipt of an application for obtaining a new home state license by virtue of compact
36 privilege, the new home state shall verify that the occupational therapist or occupational therapy

1 assistant meets the pertinent criteria outlined in Section 4 via the data system, without need for
2 primary source verification except for:
3 a. An FBI fingerprint based criminal background check if not previously performed or updated
4 pursuant to applicable rules adopted by the Commission in accordance with Public Law 92-544;
5 b. Other criminal background check as required by the new home state; and
6 c. Submission of any requisite jurisprudence requirements of the new home state.
7 3. The former home state shall convert the former home state license into a Compact privilege
8 once the new home state has activated the new home state license in accordance with applicable
9 rules adopted by the Commission.
10 4. Notwithstanding any other provision of this Compact, if the occupational therapist or
11 occupational therapy assistant cannot meet the criteria in Section 4, the new home state shall apply
12 its requirements for issuing a new Single-state license.
13 5. The occupational therapist or the occupational therapy assistant shall pay all applicable fees
14 to the new home state in order to be issued a new home state license.
15 C. If an occupational therapist or occupational therapy assistant changes primary state of
16 residence by moving from a member state to a non-member state, or from a non-member state to a
17 member state, the state criteria shall apply for issuance of a Single-state license in the new state.
18 D. Nothing in this compact shall interfere with a licensee's ability to hold a Single-state license
19 in multiple states; however, for the purposes of this compact, a licensee shall have only one home
20 state license.
21 E. Nothing in this Compact shall affect the requirements established by a member state for the
22 issuance of a Single-state license.
23 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES
24 A. Active Duty Military personnel, or their spouses, shall designate a home state where the
25 individual has a current license in good standing. The individual may retain the home state
26 designation during the period the service member is on active duty. Subsequent to designating a
27 home state, the individual shall only change their home state through application for licensure in the
28 new state or through the process described in Section 5.
29 SECTION 7. ADVERSE ACTIONS
30 A. A home state shall have exclusive power to impose adverse action against an occupational
31 therapist's or occupational therapy assistant's license issued by the home state.
32 B. In addition to the other powers conferred by state law, a remote state shall have the
33 authority, in accordance with existing state due process law, to:
34 1. Take adverse action against an occupational therapist's or occupational therapy assistant's
35 Compact privilege within that member state.
36 2. Issue subpoenas for both hearings and investigations that require the attendance and
37 testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board

in a member state for the attendance and testimony of witnesses or the production of evidence from another member state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.

C. For purposes of taking adverse action, the home state shall give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

D. The home state shall complete any pending investigations of an occupational therapist or occupational therapy assistant who changes primary state of residence during the course of the investigations. The home state, where the investigations were initiated, shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of the investigations to the OT Compact Commission data system. The occupational therapy Compact Commission data system administrator shall promptly notify the new home state of any adverse actions.

E. A member state, if otherwise permitted by state law, may recover from the affected occupational therapist or occupational therapy assistant the costs of investigations and disposition of cases resulting from any adverse action taken against that occupational therapist or occupational therapy assistant.

F. A member state may take adverse action based on the factual findings of the remote state, provided that the member state follows its own procedures for taking the adverse action.

G. Joint Investigations

1. In addition to the authority granted to a member state by its respective state occupational therapy laws and regulations or other applicable state law, any member state may participate with other member states in joint investigations of licensees.

2. Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

H. If an adverse action is taken by the home state against an occupational therapist's or occupational therapy assistant's license, the occupational therapist's or occupational therapy assistant's Compact privilege in all other member states shall be deactivated until all encumbrances have been removed from the state license. All home state disciplinary orders that impose adverse action against an occupational therapist's or occupational therapy assistant's license shall include a statement that the occupational therapist's or occupational therapy assistant's Compact privilege is deactivated in all member states during the pendency of the order.

1 I. If a member state takes adverse action, it shall promptly notify the administrator of the data
2 system. The administrator of the data system shall promptly notify the home state of any adverse
3 actions by remote states.
4 J. Nothing in this Compact shall override a member state's decision that participation in an
5 Alternative Program may be used in lieu of adverse action.
6 SECTION 8. ESTABLISHMENT OF THE OCCUPATIONAL THERAPY COMPACT
7 COMMISSION.
8 A. The Compact member states hereby create and establish a joint public agency known as the
9 occupational therapy Compact Commission:
10 1. The Commission is an instrumentality of the Compact states.
11 2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely
12 and exclusively in a court of competent jurisdiction where the principal office of the Commission is
13 located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or
14 consents to participate in alternative dispute resolution proceedings.
15 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
16 B. Membership, Voting, and Meetings
17 1. Each member state shall have and be limited to one (1) delegate selected by that member
18 state's licensing board.
19 2. The delegate shall be either:
20 a. A current member of the licensing board, who is an occupational therapist, occupational
21 therapy assistant, or public member; or
22 b. An administrator of the licensing board.
23 3. Any delegate may be removed or suspended from office as provided by the law of the state
24 from which the delegate is appointed.
25 4. The member state board shall fill any vacancy occurring in the Commission within 90 days.
26 5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and
27 creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs
28 of the Commission. A delegate shall vote in person or by such other means as provided in the
29 bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other
30 means of communication.
31 6. The Commission shall meet at least once during each calendar year. Additional meetings
32 shall be held as set forth in the bylaws.
33 7. The Commission shall establish by rule a term of office for delegates.
34 C. The Commission shall have the following powers and duties:
35 1. Establish a Code of Ethics for the Commission;
36 2. Establish the fiscal year of the Commission;
37 3. Establish bylaws;

1 4. Maintain its financial records in accordance with the bylaws;
2 5. Meet and take such actions as are consistent with the provisions of this Compact and the
3 bylaws;
4 6. Promulgate uniform rules to facilitate and coordinate implementation and administration of
5 this Compact. The rules shall have the force and effect of law and shall be binding in all member
6 states;
7 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided
8 that the standing of any state occupational therapy licensing board to sue or be sued under
9 applicable law shall not be affected;
10 8. Purchase and maintain insurance and bonds;
11 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees
12 of a member state;
13 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant such
14 individuals appropriate authority to carry out the purposes of the Compact, and establish the
15 Commission's personnel policies and programs relating to conflicts of interest, qualifications of
16 personnel, and other related personnel matters;
17 11. Accept any and all appropriate donations and grants of money, equipment, supplies,
18 materials and services, and receive, utilize and dispose of the same; provided that at all times the
19 Commission shall avoid any appearance of impropriety and/or conflict of interest;
20 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or
21 use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any
22 appearance of impropriety;
23 13. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any
24 property real, personal, or mixed;
25 14. Establish a budget and make expenditures;
26 15. Borrow money;
27 16. Appoint committees, including standing committees composed of members, state regulators,
28 state legislators or their representatives, and consumer representatives, and such other interested
29 persons as may be designated in this Compact and the bylaws;
30 17. Provide and receive information from, and cooperate with, law enforcement agencies;
31 18. Establish and elect an Executive Committee; and
32 19. Perform such other functions as may be necessary or appropriate to achieve the purposes of
33 this Compact consistent with the state regulation of occupational therapy licensure and practice.
34 D. The Executive Committee. The Executive Committee shall have the power to act on behalf of
35 the Commission according to the terms of this Compact.
36 1. The Executive Committee shall be composed of nine members:

1 a. Seven voting members who are elected by the Commission from the current membership of
2 the Commission;
3 b. One ex-officio, nonvoting member from a recognized national occupational therapy
4 professional association; and
5 c. One ex-officio, nonvoting member from a recognized national occupational therapy
6 certification organization.
7 2. The ex-officio members will be selected by their respective organizations.
8 3. The Commission may remove any member of the Executive Committee as provided in bylaws.
9 4. The Executive Committee shall meet at least annually.
10 5. The Executive Committee shall have the following duties and responsibilities:
11 a. Recommend to the entire Commission changes to the rules or bylaws, changes to this
12 Compact legislation, fees paid by Compact member states such as annual dues, and any Commission
13 Compact fee charged to licensees for the Compact privilege;
14 b. Ensure Compact administration services are appropriately provided, contractual or
15 otherwise;
16 c. Prepare and recommend the budget;
17 d. Maintain financial records on behalf of the Commission;
18 e. Monitor Compact compliance of member states and provide compliance reports to the
19 Commission;
20 f. Establish additional committees as necessary; and
21 g. Perform other duties as provided in rules or bylaws.
22 E. Meetings of the Commission
23 1. All meetings shall be open to the public, and public notice of meetings shall be given in the
24 same manner as required under the rulemaking provisions in Section 10.
25 2. The Commission or the Executive Committee or other committees of the Commission may
26 convene in a closed, non-public meeting if the Commission or Executive Committee or other
27 committees of the Commission must discuss:
28 a. Non-compliance of a member state with its obligations under the Compact;
29 b. The employment, compensation, discipline or other matters, practices or procedures related to
30 specific employees or other matters related to the Commission's internal personnel practices and
31 procedures;
32 c. Current, threatened, or reasonably anticipated litigation;
33 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;
34 e. Accusing any person of a crime or formally censuring any person;
35 f. Disclosure of trade secrets or commercial or financial information that is privileged or
36 confidential;

1 g. Disclosure of information of a personal nature where disclosure would constitute a clearly
2 unwarranted invasion of personal privacy;
3 h. Disclosure of investigative records compiled for law enforcement purposes;
4 i. Disclosure of information related to any investigative reports prepared by or on behalf of or for
5 use of the Commission or other committee charged with responsibility of investigation or
6 determination of compliance issues pursuant to the Compact; or
7 j. Matters specifically exempted from disclosure by federal or member state statute.
8 3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's
9 legal counsel or designee shall certify that the meeting may be closed and shall reference each
10 relevant exempting provision.
11 4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a
12 meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore,
13 including a description of the views expressed. All documents considered in connection with an
14 action shall be identified in such minutes. All minutes and documents of a closed meeting shall
15 remain under seal, subject to release by a majority vote of the Commission or order of a court of
16 competent jurisdiction.
17 F. Financing of the Commission
18 1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
19 establishment, organization, and ongoing activities.
20 2. The Commission may accept any and all appropriate revenue sources, donations, and grants
21 of money, equipment, supplies, materials, and services.
22 3. The Commission may levy on and collect an annual assessment from each member state or
23 impose fees on other parties to cover the cost of the operations and activities of the Commission and
24 its staff, which must be in a total amount sufficient to cover its annual budget as approved by the
25 Commission each year for which revenue is not provided by other sources. The aggregate annual
26 assessment amount shall be allocated based upon a formula to be determined by the Commission,
27 which shall promulgate a rule binding upon all member states.
28 4. The Commission shall not incur obligations of any kind prior to securing the funds adequate
29 to meet the same; nor shall the Commission pledge the credit of any of the member states, except by
30 and with the authority of the member state.
31 5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts
32 and disbursements of the Commission shall be subject to the audit and accounting procedures
33 established under its bylaws. However, all receipts and disbursements of funds handled by the
34 Commission shall be audited yearly by a certified or licensed public accountant, and the report of the
35 audit shall be included in and become part of the annual report of the Commission.
36 G. Qualified Immunity, Defense, and Indemnification

1 1. The members, officers, executive director, employees and representatives of the Commission
2 shall be immune from suit and liability, either personally or in their official capacity, for any claim
3 for damage to or loss of property or personal injury or other civil liability caused by or arising out of
4 any actual or alleged act, error or omission that occurred, or that the person against whom the claim
5 is made had a reasonable basis for believing occurred within the scope of Commission employment,
6 duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any
7 such person from suit and/or liability for any damage, loss, injury, or liability caused by the
8 intentional or willful or wanton misconduct of that person.
9 2. The Commission shall defend any member, officer, executive director, employee, or
10 representative of the Commission in any civil action seeking to impose liability arising out of any
11 actual or alleged act, error, or omission that occurred within the scope of Commission employment,
12 duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis
13 for believing occurred within the scope of Commission employment, duties, or responsibilities;
14 provided that nothing herein shall be construed to prohibit that person from retaining his or her own
15 counsel; and provided further, that the actual or alleged act, error, or omission did not result from
16 that person's intentional or willful or wanton misconduct.
17 3. The Commission shall indemnify and hold harmless any member, officer, executive director,
18 employee, or representative of the Commission for the amount of any settlement or judgment
19 obtained against that person arising out of any actual or alleged act, error or omission that occurred
20 within the scope of Commission employment, duties, or responsibilities, or that such person had a
21 reasonable basis for believing occurred within the scope of Commission employment, duties, or
22 responsibilities, provided that the actual or alleged act, error, or omission did not result from the
23 intentional or willful or wanton misconduct of that person.
24 SECTION 9. DATA SYSTEM
25 A. The Commission shall provide for the development, maintenance, and utilization of a
26 coordinated database and reporting system containing licensure, adverse action, and investigative
27 information on all licensed individuals in member states.
28 B. A member state shall submit a uniform data set to the data system on all individuals to
29 whom this Compact is applicable (utilizing a unique identifier) as required by the rules of the
30 Commission, including:
31 1. Identifying information;
32 2. Licensure data;
33 3. Adverse actions against a license or Compact privilege;
34 4. Non-confidential information related to Alternative Program participation;
35 5. Any denial of application for licensure, and the reason(s) for such denial;
36 6. Other information that may facilitate the administration of this Compact, as determined by
37 the rules of the Commission; and

1 7. Current significant investigative information.
2 C. Current significant investigative information and other investigative information pertaining
3 to a licensee in any member state will only be available to other member states.
4 D. The Commission shall promptly notify all member states of any adverse action taken against
5 a licensee or an individual applying for a license. Adverse action information pertaining to a licensee
6 in any member state will be available to any other member state.
7 E. Member states contributing information to the data system may designate information that
8 may not be shared with the public without the express permission of the contributing state.
9 F. Any information submitted to the data system that is subsequently required to be expunged
10 by the laws of the member state contributing the information shall be removed from the data
11 system.
12 SECTION 10. RULEMAKING
13 A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in
14 this Section and the rules adopted thereunder. Rules and amendments shall become binding as of
15 the date specified in each rule or amendment.
16 B. The Commission shall promulgate reasonable rules in order to effectively and efficiently
17 achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Commission
18 exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the
19 Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid
20 and have no force and effect.
21 C. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute
22 or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
23 the rule, then such rule shall have no further force and effect in any member state.
24 D. Rules or amendments to the rules shall be adopted at a regular or special meeting of the
25 Commission.
26 E. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least
27 thirty (30) days in advance of the meeting at which the rule will be considered and voted upon, the
28 Commission shall file a notice of proposed rulemaking:
29 1. On the website of the Commission or other publicly accessible platform; and
30 2. On the website of each member state occupational therapy licensing board or other publicly
31 accessible platform or the publication in which each state would otherwise publish proposed rules.
32 F. The notice of proposed rulemaking shall include:
33 1. The proposed time, date, and location of the meeting in which the rule will be considered and
34 voted upon;
35 2. The text of the proposed rule or amendment and the reason for the proposed rule;
36 3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

G. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

H. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least twenty five (25) persons;

2. A state or federal governmental subdivision or agency; or

3. An association or organization having at least twenty five (25) members.

I. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording will be made available on request.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

J. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

M. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds;

1 3. Meet a deadline for the promulgation of an administrative rule that is established by federal
2 law or rule; or
3 4. Protect public health and safety.
4 N. The Commission or an authorized committee of the Commission may direct revisions to a
5 previously adopted rule or amendment for purposes of correcting typographical errors, errors in
6 format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted
7 on the website of the Commission. The revision shall be subject to challenge by any person for a
8 period of thirty (30) days after posting. The revision may be challenged only on grounds that the
9 revision results in a material change to a rule. A challenge shall be made in writing and delivered to
10 the chair of the Commission prior to the end of the notice period. If no challenge is made, the
11 revision will take effect without further action. If the revision is challenged, the revision may not
12 take effect without the approval of the Commission.
13 SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT
14 A. Oversight
15 1. The executive, legislative, and judicial branches of state government in each member state
16 shall enforce this Compact and take all actions necessary and appropriate to effectuate the
17 Compact's purposes and intent. The provisions of this Compact and the rules promulgated
18 hereunder shall have standing as statutory law.
19 2. All courts shall take judicial notice of the Compact and the rules in any judicial or
20 administrative proceeding in a member state pertaining to the subject matter of this Compact which
21 may affect the powers, responsibilities, or actions of the Commission.
22 3. The Commission shall be entitled to receive service of process in any such proceeding, and
23 shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of
24 process to the Commission shall render a judgment or order void as to the Commission, this
25 Compact, or promulgated rules.
26 B. Default, Technical Assistance, and Termination
27 1. If the Commission determines that a member state has defaulted in the performance of its
28 obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:
29 a. Provide written notice to the defaulting state and other member states of the nature of the
30 default, the proposed means of curing the default and/or any other action to be taken by the
31 Commission; and
32 b. Provide remedial training and specific technical assistance regarding the default.
33 2. If a state in default fails to cure the default, the defaulting state may be terminated from the
34 Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and
35 benefits conferred by this Compact may be terminated on the effective date of termination. A cure of
36 the default does not relieve the offending state of obligations or liabilities incurred during the period
37 of default.

1 3. Termination of membership in the Compact shall be imposed only after all other means of
2 securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by
3 the Commission to the governor, the majority and minority leaders of the defaulting state's
4 legislature, and each of the member states.
5 4. A state that has been terminated is responsible for all assessments, obligations, and liabilities
6 incurred through the effective date of termination, including obligations that extend beyond the
7 effective date of termination.
8 5. The Commission shall not bear any costs related to a state that is found to be in default or
9 that has been terminated from the Compact, unless agreed upon in writing between the Commission
10 and the defaulting state.
11 6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District
12 Court for the District of Columbia or the federal district where the Commission has its principal
13 offices. The prevailing member shall be awarded all costs of such litigation, including reasonable
14 attorney's fees.
15 C. Dispute Resolution
16 1. Upon request by a member state, the Commission shall attempt to resolve disputes related to
17 the Compact that arise among member states and between member and non-member states.
18 2. The Commission shall promulgate a rule providing for both mediation and binding dispute
19 resolution for disputes as appropriate.
20 D. Enforcement
21 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
22 rules of this Compact.
23 2. By majority vote, the Commission may initiate legal action in the United States District
24 Court for the District of Columbia or the federal district where the Commission has its principal
25 offices against a member state in default to enforce compliance with the provisions of the Compact
26 and its promulgated rules and bylaws. The relief sought may include both injunctive relief and
27 damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all
28 costs of such litigation, including reasonable attorney's fees.
29 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
30 may pursue any other remedies available under federal or state law.
31 SECTION 12. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR
32 OCCUPATIONAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND
33 AMENDMENT
34 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
35 law in the tenth member state. The provisions, which become effective at that time, shall be limited
36 to the powers granted to the Commission relating to assembly and the promulgation of rules.

1 Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the
2 implementation and administration of the Compact.
3 B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules
4 shall be subject to the rules as they exist on the date on which the Compact becomes law in that
5 state. Any rule that has been previously adopted by the Commission shall have the full force and
6 effect of law on the day the Compact becomes law in that state.
7 C. Any member state may withdraw from this Compact by enacting a statute repealing the
8 same.
9 1. A member state's withdrawal shall not take effect until six (6) months after enactment of the
10 repealing statute.
11 2. Withdrawal shall not affect the continuing requirement of the withdrawing state's
12 occupational therapy licensing board to comply with the investigative and adverse action reporting
13 requirements of this act prior to the effective date of withdrawal.
14 D. Nothing contained in this Compact shall be construed to invalidate or prevent any
15 occupational therapy licensure agreement or other cooperative arrangement between a member state
16 and a non-member state that does not conflict with the provisions of this Compact.
17 E. This Compact may be amended by the member states. No amendment to this Compact shall
18 become effective and binding upon any member state until it is enacted into the laws of all member
19 states.
20 SECTION 13. CONSTRUCTION AND SEVERABILITY
21 This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of
22 this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is
23 declared to be contrary to the constitution of any member state or of the United States or the
24 applicability thereof to any government, agency, person, or circumstance is held invalid, the validity
25 of the remainder of this Compact and the applicability thereof to any government, agency, person, or
26 circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution
27 of any member state, the Compact shall remain in full force and effect as to the remaining member
28 states and in full force and effect as to the member state affected as to all severable matters.
29 SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS
30 A. A licensee providing occupational therapy in a remote state under the Compact privilege
31 shall function within the laws and regulations of the remote state.
32 B. Nothing herein prevents the enforcement of any other law of a member state that is not
33 inconsistent with the Compact.
34 C. Any laws in a member state in conflict with the Compact are superseded to the extent of the
35 conflict.
36 D. Any lawful actions of the Commission, including all rules and bylaws promulgated by the
37 Commission, are binding upon the member states.

1 E. All agreements between the Commission and the member states are binding in accordance
2 with their terms.
3 F. In the event any provision of the Compact exceeds the constitutional limits imposed on the
4 legislature of any member state, the provision shall be ineffective to the extent of the conflict with
5 the constitutional provision in question in that member state.
6 4 Effective Date. Part IV of this act shall take effect July 1, 2021.
7
8 PART V
9 Relative to the authority of the office of professional licensure and certification for administration,
10 rulemaking, and enforcement of investigations, hearings, and appeals.
11 1 Office of Professional Licensure and Certification; Administration; Rulemaking. Amend RSA
12 310-A:1-d, II(h)(2) to read as follows:
13 (2) Such organizational and procedural rules necessary to administer the boards,
14 commissions, and councils in the office of professional licensure and certification, including rules
15 governing the administration of complaints and investigations, ***hearings, disciplinary***
16 ***proceedings,*** payment processing procedures, and application procedures; and
17 2 New Paragraph; Office of Professional Licensure and Certification; Administration; Standing
18 Orders. Amend RSA 310-A:1-d by inserting after paragraph III the following new paragraph:
19 IV. All boards, councils, and commissions may issue standing orders delegating non-
20 discretionary tasks to staff of the office of professional licensure and certification.
21 3 New Sections; Office of Professional Licensure and Certification; Investigations; Hearings;
22 Penalties; Appeals. Amend RSA 310-A by inserting after section 1-g the following new sections:
23 310-A:1-h Investigations.
24 I. Boards, which shall include all boards, councils, and commissions within the office of
25 professional licensure and certification, may authorize an investigation of allegations of misconduct
26 by licensees (a) upon their own initiative or (b) upon written complaint of any person that charges
27 that a person licensed by the board has committed misconduct. When requested by the board, the
28 office shall assign an investigator, who may assist in the investigation.
29 II. The procedures set forth in RSA 310-A:1-h through RSA 310-A:1-l are supplementary and
30 shall not supplant or supersede any procedures expressly set forth in any board's individual practice
31 act.
32 III. The following information obtained during investigations shall be held confidential and
33 shall be exempt from the disclosure requirements of RSA 91-A:
34 (a) Complaints received by the office.
35 (b) Information and records acquired by the office during the investigation.
36 (c) Reports and records made by the office as a result of its investigation.
37 IV. For the purpose of carrying out investigations, the executive director is authorized to:

1 (a) Retain qualified experts.
2 (b) Conduct inspections of places of business of licensees or certificate holders.
3 (c) Retain legal counsel when authorized to do so by the attorney general.
4 (d) Issue subpoenas for persons, relevant documents and relevant things in accordance
5 with the following conditions:
6 (1) Subpoenas for persons shall not require compliance in less than 48 hours after
7 receipt of service.
8 (2) Subpoenas for documents and things shall not require compliance in fewer than
9 15 days after receipt of service.
10 (3) Service shall be made on licensees and certified individuals by certified mail to
11 the address on file with the office or by hand and shall not entitle them to witness or mileage fees.
12 (4) Service shall be made on persons who are not licensees or certified individuals in
13 accordance with the procedures and fee schedules of the superior court, and the subpoenas served on
14 them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure
15 and Certification."
16 V. The office or the boards, councils, and commissions within the office may disclose
17 information acquired in an investigation to law enforcement, if it involves suspected criminal
18 activity, to health licensing agencies in this state or any other jurisdiction, or in response to specific
19 statutory requirements or court orders.
20 VI. Allegations of professional misconduct shall be brought within 5 years from the time the
21 office reasonably could have discovered the act, omission or failure complained of, except that
22 conduct which resulted in a criminal conviction or in a disciplinary action by a relevant licensing
23 authority in another jurisdiction may be considered by the board without time limitation in making
24 licensing or disciplinary decisions if the conduct would otherwise be a ground for discipline. The
25 board may also consider licensee conduct without time limitation when the ultimate issue before the
26 board involves a pattern of conduct or the cumulative effect of conduct which becomes apparent as a
27 result of conduct which has occurred within the 5-year limitation period prescribed by this
28 paragraph.
29 VII. Each board, council, or commission may dismiss a complaint if the allegations do not
30 state a claim of professional misconduct.
31 310-A:1-i Disciplinary Proceedings; Remedial Proceedings.
32 I. Boards, which shall include all boards, councils, and commissions within the office of
33 professional licensure and certification, are authorized to conduct disciplinary proceedings in
34 accordance with procedural rules adopted by the executive director.
35 II. For the purpose of carrying out disciplinary proceedings, each board, council, or
36 commission is authorized to issue subpoenas for persons, relevant documents and relevant things in
37 accordance with the following conditions:

1 (a) Subpoenas for persons shall not require compliance in less than 48 hours after
2 receipt of service.
3 (b) Subpoenas for documents and things shall not require compliance in fewer than 15
4 days after receipt of service.
5 (c) Service shall be made on licensees and certified individuals by certified mail to the
6 address on file with the office or by hand and shall not entitle them to witness or mileage fees.
7 (d) Service shall be made on persons who are not licensees or certified individuals in
8 accordance with the procedures and fee schedules of the superior court, and the subpoenas served on
9 them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure
10 and Certification."
11 III. At any time before or during disciplinary proceedings, complaints may be dismissed or
12 disposed of, in whole or in part, by written settlement agreement approved by the board and the
13 licensees or certified individuals involved, provided that any complainant shall have the opportunity,
14 before the settlement agreement has been executed, to comment on the terms of the proposed
15 settlement. The board, council, or commission may hold a settlement agreement hearing prior to its
16 approval of the settlement agreement.
17 IV. Final board actions having the effect of terminating disciplinary proceedings, whether
18 taken before, during or after the completion of the proceedings, shall be set forth in a written record
19 that shall be available to the public after service upon the licensees or certified individuals involved.
20 V. In carrying out disciplinary or licensing proceedings, each board shall have the authority
21 to:
22 (a) Hold pre-hearing conferences exempt from the provisions of RSA 91-A.
23 (b) Appoint a board member or other qualified person as presiding officer.
24 (c) Administer, and authorize an appointed presiding officer to administer, oaths and
25 affirmations.
26 VI. Neither the office nor the boards, councils, and commissions shall have an obligation or
27 authority to appoint or pay the fees of attorneys representing licensees, certified individuals, or
28 witnesses during investigations or adjudicatory proceedings.
29 VII. Boards, councils, and commissions may take non-disciplinary remedial action against
30 any person licensed by it upon finding that the person is afflicted with physical or mental disability,
31 disease, disorder, or condition deemed dangerous to the public health. Upon making an affirmative
32 finding after notice and an opportunity for a hearing, the board, council, or commission may take
33 non-disciplinary remedial action:
34 (a) By suspension, limitation, or restriction of a license for a period of time as
35 determined reasonable by the board.
36 (b) By revocation of license.

1 (c) By requiring the person to submit to the care, treatment, or observation of a
2 physician, counseling service, health care facility, professional assistance program, or any
3 combination thereof which is acceptable to the board.
4 VIII. All proceedings for non-disciplinary remedial action shall be exempt from the
5 provisions of RSA 91-A, except that the board may disclose any final remedial action that affects the
6 status of a license, including any non-disciplinary restrictions imposed.
7 310-A:1-j Hearings, Decisions and Appeals.
8 I. Disciplinary proceedings shall be open to the public, except upon order by the board,
9 council, or commission upon good cause shown. The public docket file for each such proceeding shall
10 be retained in accordance with the retention policy established by the office of professional licensure
11 and certification.
12 II. Notwithstanding any other provision of law, allegations of misconduct or lack of
13 professional qualifications that are not settled shall be heard by the board, council, or commission, or
14 a panel of the board, council, or commission with a minimum of 3 members appointed by the chair of
15 the board or other designee. Any member of the board, or other person qualified to act as presiding
16 officer and duly designated by the board, shall have the authority to preside at such hearing and to
17 issue oaths or affirmations to witnesses, rule on evidentiary and other procedural matters, and
18 prepare a recommended decision. In the case of a hearing before a panel, the presiding officer shall
19 prepare a recommended decision for the board, council, or commission, which shall determine
20 sanctions.
21 III. Except as otherwise provided by RSA 541-A:30, the board, council, or commission shall
22 furnish the respondent and the complainant, if any, at least 15 days' written notice of the date, time
23 and place of a hearing. Such notice shall include an itemization of the issues to be heard, and, in the
24 case of a disciplinary hearing, a statement as to whether the action has been initiated by a written
25 complaint or upon the board's own motion, or both. If a written complaint is involved, the notice
26 shall provide the complainant with a reasonable opportunity to intervene as a party.
27 IV. In disciplinary and licensing proceedings, the presiding officer may hold prehearing
28 conferences that are closed to the public and exempt from the provisions of RSA 91-A until such time
29 as a public evidentiary hearing is convened. In all instances, settlement discussions engaged in by
30 the parties at prehearing conferences may be conducted off the record.
31 V. The board, council, or commission may dispose of issues or allegations at any time during
32 an investigation or disciplinary proceeding by approving a settlement agreement or issuing a consent
33 order or an order of dismissal for default or failure to state a proper basis for disciplinary action.
34 Disciplinary action taken by the board at any stage of a proceeding, and any dispositive action taken
35 after the issuance of a public hearing notice, shall be reduced to writing and made available to the
36 public. Such decisions shall not be public until they are served upon the parties.

1 VI. No civil action shall be maintained against the board or any member of the board or its
2 agents or employees, against any organization or its members, or against any other person for or by
3 reason of any statement, report, communication, or testimony to the board or determination by the
4 board in relation to proceedings under this chapter.
5 310-A:1-k Penalties.
6 I. Upon making an affirmative finding that a licensee or certificate holder has committed
7 professional misconduct, boards, which shall include all boards, councils, and commissions within
8 the office of professional licensure and certification, may take disciplinary action in any one or more
9 of the following ways:
10 (a) By reprimand.
11 (b) By suspension of a license or certificate for a period of time as determined reasonable
12 by the board.
13 (c) By revocation of license.
14 (d) By placing the licensee or certificate holder on probationary status. The board may
15 require the person to submit to any of the following:
16 (1) Regular reporting to the board concerning the matters which are the basis of the
17 probation.
18 (2) Continuing professional education until a satisfactory degree of skill has been
19 achieved in those areas which are the basis of probation.
20 (3) Submitting to the care, counseling, or treatment of a physician, counseling
21 service, health care facility, professional assistance program, or any comparable person or facility
22 approved by the board.
23 (4) Practicing under the direct supervision of another licensee for a period of time
24 specified by the board.
25 (e) By assessing administrative fines in amounts established by the board which shall
26 not exceed $3,000 per offense, or, in the case of continuing offenses, $300 for each day that the
27 violation continues, whichever is greater.
28 II. The board may issue a non-disciplinary confidential letter of concern to a licensee
29 advising that while there is insufficient evidence to support disciplinary action, the board believes
30 the licensee or certificate holder should modify or eliminate certain practices, and that continuation
31 of the activities which led to the information being submitted to the board may result in action
32 against the licensee's license. This letter shall not be released to the public or any other licensing
33 authority, except that the letter may be used as evidence in subsequent adjudicatory proceedings by
34 the board.
35 III. In the case of sanctions for discipline in another jurisdiction, the decision of the other
36 jurisdiction's disciplinary authority may not be collaterally attacked and the board may impose any

1 of the sanctions set forth in this chapter, but shall provide notice and an opportunity to be heard
2 prior to imposing any sanctions.
3 IV. In cases involving imminent danger to life or health, a board may order suspension of a
4 license or certification pending hearing for a period of no more than 10 business days, unless the
5 licensee or certified individual agrees in writing to a longer period. In such cases, the board shall
6 comply with RSA 541-A:30.
7 V. Any person whose license has been suspended or revoked by the board may apply to the
8 board, in writing, to request a hearing for reinstatement. Upon a hearing, the board may issue a
9 new license or modify the suspension or revocation of the license.
10 VI. For any order issued in resolution of an disciplinary proceeding by the board, where the
11 board has found misconduct sufficient to support disciplinary action, the board may require the
12 licensee or certificate holder who is the subject of such finding to pay the office a sum not to exceed
13 the reasonable cost of investigation and prosecution of the proceeding. This sum shall not exceed
14 $10,000. This sum may be imposed in addition to any otherwise authorized administrative fines
15 levied by the board as part of the penalty. The investigative and prosecution costs shall be assessed
16 by the board and any sums recovered shall be credited to the office's fund and disbursed by the office
17 for any future investigations of complaints and activities that violate this chapter or rules adopted
18 under this chapter.
19 VII. When an investigation of a complaint is determined to be unfounded, the board shall
20 dismiss the complaint and explain in writing to the complainant and the licensee or certificate
21 holder its reason for dismissing the complaint. After six years, the board may destroy all
22 information concerning the investigation, retaining only a record noting that an investigation was
23 conducted and that the board determined the complaint to be unfounded. For the purpose of this
24 paragraph, a complaint shall be deemed to be unfounded if it does not fall within the jurisdiction of
25 the board, does not relate to the actions of the licensee or certificate holder, or is determined by the
26 board to be frivolous.
27 VIII. Whoever, not being licensed or otherwise authorized to practice according to the laws
28 of this state, shall advertise oneself as engaging in a profession licensed or certified by the office of
29 professional licensure and certification, shall engage in activity requiring professional licensure, or
30 in any way hold oneself out as qualified to do so, or call oneself a licensed professional, or whoever
31 does such acts after receiving notice that such person's license to practice has been suspended or
32 revoked, is engaged in unlawful practice. After hearing and upon making an affirmative finding of
33 unlawful practice, the board, council, or commission may take action in any one of the following
34 ways:
35 (a) Issue a cease and desist order against any person or entity engaged in unlawful,
36 which shall be enforceable in superior court.

1 (b) Impose a fine not to exceed the amount of any gain or economic benefit that the
2 person derived from the violation or $10,000 for each offense, whichever amount is greater. Each
3 violation of unlicensed or unlawful practice shall be deemed a separate offense.
4 (c) The attorney general, board, council, or commission, or prosecuting attorney of any
5 county or municipality where the act to unlawful practice takes place may maintain an action to
6 enjoin any person or entity from continuing to do acts of unlawful practice. The action to enjoin shall
7 not replace any other civil, criminal, or regulatory remedy. An injunction without bond is available
8 to any board, council, or commission.
9 310-A:1-l Rehearing; Appeals.
10 I. Any person who has been refused a license or certification by the board, which shall
11 include all boards, councils, and commissions within the office of professional licensure and
12 certification, or has been disciplined by the board shall have the right to petition for a rehearing
13 within 30 days after the original final decision.
14 II. Appeals from a decision on rehearing shall be by appeal to the supreme court pursuant to
15 RSA 541.
16 III. No sanction shall be stayed by the board during an appeal.
17 3 Effective Date. Part V of this act shall take effect January 1, 2022.
18
19 PART VI
20 Relative to temporary licensure of certain licensed nursing assistants.
21 1 Statement of Purpose. The general court acknowledges the critical importance of ensuring the
22 quality, accessibility, and sustainability of Medicaid services provided in nursing homes, and
23 recognizes the critical shortage of licensed nursing assistants throughout the state. The purpose of
24 this act is to strengthen the frontline staffing in nursing homes. The general court finds that during
25 the COVID-19 pandemic federal regulatory and statutory provisions were waived to facilitate the
26 hiring of nurse aides by nursing homes. Under state emergency order, these individuals were
27 allowed to work in nursing homes as temporary health partners following no less than 8 hours of
28 training provided either by a national association or a New Hampshire educational program. As a
29 matter of public policy, the general court finds that these workers were indispensable as facilities
30 struggled with staffing issues, particularly during outbreaks of the COVID-19 virus. Accordingly,
31 this act shall provide the board of nursing with the additional authority to expand the workforce of
32 licensed nursing assistants by recognizing the service of temporary health partners during the
33 COVID-19 pandemic.
34 2 Special Licensure as a Licensed Nursing Assistant; Applicants Who Served as Temporary
35 Health Partners.
36 I. Persons who have worked no fewer than 100 hours as temporary health partners in a
37 licensed nursing home and have demonstrated, through their work experience during a national and

state public health emergency, the competency to transition to status as a licensed nursing assistant, shall be deemed to have taken a board-approved nursing assistant course and may apply for a license as a licensed nursing assistant in New Hampshire.

II. Notwithstanding any provision of law to the contrary, the state-approved training program for licensed nursing assistants shall take into account the training and experience acquired during the COVID-19 pandemic to transition these individuals to placement on the state's licensed nursing assistant registry pursuant to RSA 326-B:26. Such individuals shall be subject to all continuing education requirements under RSA 326-B:31.

III. For purposes of this act:

(a) “COVID-19” means the novel coronavirus first identified in 2019, or SARS-CoV-2.

(b) “Temporary health partner” means anyone authorized to work in a nursing home by Emergency Order 42 issued by the governor on May 11, 2020, and required to complete training of no less than eight hours and work under the supervision of an RN, APRN, or LPN, as is required of LNAs under RSA 326-B:14.

3 Effective Date. Part VI of this act shall take effect upon its passage.

PART VII

Relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

1 Emergency Medical and Trauma Services; Revocation of License. Amend the introductory paragraph of RSA 153-A:13, I to read as follows:

I. The commissioner [~~shall~~] ***may*** deny an application for issuance or renewal of a license, or ***issue a letter of concern,*** suspend***,*** or revoke a license, when the commissioner finds that the applicant is guilty of any of the following acts or offenses:

2 Effective Date. Part VII of this act shall take effect 60 days after its passage.

PART VIII

Relative to schools for barbering, cosmetology, and esthetics.

1 Barbering, Cosmetology, and Esthetics; Definition; School. Amend RSA 313-A:1, XIII to read as follows:

XIII. "School" means a school or other institution***, or a dedicated program within such school or institution,*** conducted for the purpose of teaching cosmetology, manicuring, barbering, or esthetics.

2 Duties of the Board; Schools; Manicuring, Cosmetology, Barbering, Esthetics. RSA 313-A:7, II is repealed and reenacted to read as follows:

II. The board may license a school to operate either:

(a) Dedicated programs within secondary schools, the purpose of which is to teach cosmetology, manicuring, barbering, or esthetics; or

(b) Postsecondary programs conducted for the purpose of teaching cosmetology, manicuring, barbering, or esthetics, including postsecondary programs leading to a certificate in manicuring, barbering, cosmetology, or esthetics.

3 Barbering, Cosmetology, Esthetics, Manicuring; Apprenticeship Certificates. Amend RSA 313-A:24 to read as follows:

313-A:24 Apprentice Registration and [~~Licensure~~] ***Certificates***.

I. No person shall enter an apprenticeship or enroll in a school under this chapter unless such person has registered with the board as an apprentice and been issued an apprentice [~~license~~] ***certificate***. The board shall have sole authority to regulate apprentices and apprenticeship under this chapter. The board shall issue an apprentice [~~license~~] ***certificate*** to any student receiving instruction within a licensed school [~~or~~] ***and/or*** shop to learn barbering, cosmetology, esthetics, or manicuring.

II. A person applying for [~~a license~~] ***an apprentice certificate*** under this section shall be granted such [~~license~~] ***certificate*** upon:

(a) Submitting proof sufficient to the board to show that such person is at least 16 years of age;

(b) Paying a fee established by the [~~board~~] ***office of professional licensure and certification***; and

(c) Being deemed by the board to be of good professional character.

III. No salon or barbershop shall at any one time have more than one apprentice per licensed professional, except as follows:

(a) Each licensed barber may have up to 2 apprentices for barbering.

(b) Each licensed master barber may have up to 2 apprentices for barbering, or one apprentice master barber and one apprentice barber.

IV. Upon completing the number of hours specified in the board's apprentice rules, an apprentice shall be eligible to apply to the board for [~~licensure~~] ***certification***.

V. Notwithstanding RSA 161-B:11, VI-a, an applicant for an apprentice certificate shall not be required to provide a social security number as a prerequisite for obtaining a certificate.

4 Expiration and Renewal of Licenses and Certificates. Amend RSA 313-A:20 to read as follows:

313-A:20 Expiration and Renewal of Licenses ***and Certificates***. Each barber, master barber, barber instructor, [~~apprentice,~~] barbershop, barber school, esthetician, esthetics instructor, esthetics school, esthetics salon, manicurist, [~~apprentice,~~] beauty salon, or manicuring salon license issued under this chapter***, and any apprentice certificate issued under RSA 313-A:24,*** shall expire on the last day of the birth month of the licensee ***or certificate holder*** in the odd year next succeeding

its date of issuance. Each cosmetologist, cosmetology instructor, or cosmetology school license issued under this chapter shall expire on the last day of the birth month of the licensee in the even year next succeeding its date of issuance. Any personal license ***or apprentice certificate*** which has expired may be renewed within 6 months by payment of the renewal fee and a late fee established by the board. After 6 months and within 5 years, a personal license ***or apprentice certificate*** may be renewed by paying the renewal fee and a late fee established by the board. Any school or shop license which has expired may be renewed upon payment of the renewal fee plus a late fee established by the board.

5 Effective Date. Part VIII of this act shall take effect 60 days after its passage.

PART IX

Relative to telemedicine provided by out-of-state psychologists.

1 Psychologists; Electronic Practice of Psychology. RSA 329-B:16 is repealed and reenacted to read as follows:

329-B:16 Electronic Practice of Psychology, Telehealth, Telemedicine.

I. Telepsychology, telehealth, and telemedicine services, as provided by psychologists, include those psychology services that utilize electronic means, including audio, video, or other electronic media, to engage in visual or virtual presence in contemporaneous time. A New Hampshire tele-pass license shall be required for provision of such care to people in New Hampshire. Contacts that are exempt from this requirement are:

(a) Persons exempted by 329-B:28.

(b) Screenings for inclusion in voluntary research projects that have been properly approved by a New Hampshire based institutional review board.

(c) Psychologists licensed by the board, who may provide tele-psychology services to a person within the state of New Hampshire without acquiring a tele-pass psychology license.

(d) Persons exempted by RSA 329-D.

II. A doctoral level psychologist who is not licensed in New Hampshire shall be eligible to provide telepsychology services to a person in New Hampshire pursuant to RSA 329-D, or providing that the psychologist:

(a) Is licensed in one of the jurisdictions in the United States or Canada;

(b) Is in good standing in all license jurisdictions in the United States and Canada;

(c) Has satisfied conditions determined in rules adopted by the board;

and

(d) Has applied for and obtained a valid New Hampshire tele-pass psychology license in accordance with board rules and payment of license fees with effective dates that cover the dates of services provided.

1 III. The tele-pass psychology licensee shall agree to conditions including, but not limited to,
2 conditions stipulated by the board that the licensee shall:
3 (a) Conform to all New Hampshire statutes and rules.
4 (b) Agree that electronic attendance for appearances shall be deemed adequate for
5 regulatory enforcement purposes and that in-person appearances by the licensee are optional and
6 such associated costs for in-person attendance are the full responsibility of the tele-pass psychology
7 licensee.
8 (c) Understand that false statements or failure to comply with official requests and
9 official orders shall constitute sufficient cause for revocation of the tele-pass psychology license.
10 (d) Understand that all conditions of tele-pass psychology license to practice and
11 enforcement shall be pursuant to New Hampshire law.
12 (e) Grant the New Hampshire board of psychologists and its investigators authority to
13 disclose to law enforcement and related regulatory authorities, at their discretion, information
14 including but not limited to status of application, actions and information pertinent to investigations
15 and enforcement of the laws and rules pertaining to the licensee's conduct.
16 (f) Not conduct face-to-face in-person psychological services in New Hampshire.
17 IV. The board shall adopt rules pursuant to RSA 541-A for:
18 (a) The application procedure for a New Hampshire tele-pass psychology license;
19 (b) Additional requirements for a psychologist licensed in another state of Canada to
20 acquire a tele-pass psychology license, including attestations;
21 (c) The standards of care for telemedicine practice of psychology and their enforcement;
22 and
23 (d) Procedures for investigation and discipline pursuant to all means authorized in this
24 chapter, including but not limited to suspension or revocation of a tele-pass psychology license.
25 V. Persons who have been granted emergency licenses to practice psychology under the
26 Covid 19 emergency pursuant to the Governor’s Emergency Order #29 shall be granted a tele-pass
27 license upon application to the board.
28 2 Effective Date. Part IX of this act shall take effect upon its passage.
29
30 PART X
31 Relative to certified food protection managers.
32 1 New Section; Food Service Licensure; Certified Food Protection Manager. Amend RSA 143-A
33 by inserting after RSA 143-A:11 the following new section:
34 143-A:11-a Certified Food Protection Manager.
35 I.(a) Each food service establishment licensed by the state under RSA 143-A:6 shall have a
36 person in charge and present during all hours of operation trained as a certified food protection

1 manager by a program approved by the Conference for Food Protection or other equivalent industry
2 standards program.
3 (b) The requirement in subparagraph (a) shall not apply under these conditions:
4 (1) Food establishments having at least one certified food protection manager on
5 staff shall not be required to have the certified food protection manager present when no food
6 preparation is taking place;
7 (2) Food establishments having at least one certified food protection manager on
8 staff shall not be required to have the certified food protection manager present when food
9 preparation is limited to reheating commercially prepared food or ready to eat food; or
10 (3) Food establishments having 5 food employees or less on duty are required to have
11 only one certified food protection manager on staff who is available, although not required to be
12 present, during all hours of operation.
13 II. This section shall not apply to any food service establishment exempt from licensure or
14 inspection under RSA 143-A:5.
15 III. This section shall not apply to food establishments licensed under RSA 143-A:6 as food
16 processing plants, cold storage or refrigerating warehouses; retail stores with no food preparation or
17 limited to self service foods, servicing areas, bed and breakfasts, lodging facilities serving continental
18 breakfasts, home delivery services of packaged frozen food; pushcarts and other mobile food units,
19 those serving packaged food and non-potentially hazardous unwrapped foods only;
20 wholesalers/distributors; on-site vending machines, bars/lounges without a food preparation area;
21 arena/theater concessions serving non-potentially hazardous; sellers of pre-packaged frozen meat or
22 poultry that is processed in a USDA-inspected plant; homestead food operations.
23 2 Effective Date. Part X of this act shall take effect upon its passage.
24
25 PART XI
26 Establishing minimum qualifications for certification as a child care associate teacher.
27 1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education
28 Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after
29 subparagraph (m) the following new subparagraph:
30 (n) The following qualification for certification as an associate teacher: a minimum of
31 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of
32 training in child growth and development, the latter of which may be documented life experience.
33 Documented life experience in lieu of training in child growth and development shall include
34 experience with the same age children the associate teacher supervises, such as a family child care
35 provider; service as a foster parent; work as a school teacher; work as a camp counselor; and
36 experience as a group leader for children in sports or other activities, such as scouts or little league,
37 or closely related experience.

1 2 Effective Date. Part XI of this act shall take effect 60 days after its passage.

2021-1579h

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Licensing places of assembly.

II. Repealing the emergency medical services personnel licensure interstate compact.

III. Hearings at the board of nursing.

IV. Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

V. The authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

VI. Temporary licensure of certain licensed nursing assistants.

VII. The revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

VIII. Schools for barbering, cosmetology, and esthetics.

IX. Telemedicine provided by out-of-state psychologists.

X. Sanitary production and distribution of food.

XI. Minimum qualifications for certification as a child care associate teacher.

Voting Sheets

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

EXECUTIVE SESSION on SB 133-FN

BILL TITLE: adopting omnibus legislation relative to occupational licensure.

DATE: May 25, 2021

LOB ROOM: Remote / Hybrid

MOTIONS: **OUGHT TO PASS WITH AMENDMENT**

Moved by Rep. McGuire   Seconded by Rep. S. Pearson   AM Vote: 19-0

Amendment # 2021-1579h

Moved by Rep. McGuire   Seconded by Rep. Goley   Vote: 19-0

CONSENT CALENDAR: YES

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep John Sytek, Clerk

HOUSE COMMITTEE ON ED+A

EXECUTIVE SESSION ON ~~HB~~ SB 133

BILL TITLE:

DATE: 5-25-21

LOB ROOM: 306-308

MOTION: (Please check one box)

☐ OTP ☐ ITL ☐ Retain (1st year) ☐ Interim Study (2nd year) ☐ Adoption of Amendment # 1579H *(if offered)*

Moved by Rep. McGuire Seconded by Rep. S. Pearson Vote: 19-0

MOTION: (Please check one box)

☐ OTP ☒ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Interim Study (2nd year) ☐ Adoption of Amendment # ___ *(if offered)*

Moved by Rep. McGuire Seconded by Rep. Goley Vote: 19-0

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Interim Study (2nd year) ☐ Adoption of Amendment # ___ *(if offered)*

Moved by Rep. ___ Seconded by Rep. ___ Vote: ___

MOTION: (Please check one box)

☐ OTP ☐ OTP/A ☐ ITL ☐ Retain (1st year) ☐ Interim Study (2nd year) ☐ Adoption of Amendment # ___ *(if offered)*

Moved by Rep. ___ Seconded by Rep. ___ Vote: ___

CONSENT CALENDAR? X **Yes** ___ **No**

Minority Report? ___ Yes ___ No If yes, author, Rep.: ___ Motion: ___

Respectfully submitted, Rep. [signature], **Clerk**

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ADOPT AMEND **AM #:** 1579H **Exec Session Date:** 5-25-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP/A **AM #:** 1579H **Exec Session Date:** 5-25-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

House Executive Departments and Administration
May 19, 2021
2021-1579h
05/04

Amendment to SB 133-FN

1 Amend the bill by replacing all after the enacting clause with the following:

2

3 1 Sponsorship. This act consists of the following proposed legislation:

4 Part I: LSR 21-0964, relative to the definition of "licensing agency" for purposes of licensing
5 places of assembly, sponsored by Sen. Carson, Prime/Dist 14.

6 Part II: LSR 21-0506, repealing the emergency medical services personnel licensure
7 interstate compact, sponsored by Sen. Rosenwald, Prime/Dist 13, Sen. Cavanaugh, Dist 16; Sen.
8 Carson, Dist 14; Rep. Goley, Hills. 8; Rep. Milz, Rock. 6; Rep. O'Brien, Hills. 36; Rep. S. Pearson,
9 Rock. 6.

10 Part III: LSR 21-0207, relative to hearings of the New Hampshire board of nursing,
11 sponsored by Sen. Ward, Prime/Dist 8.

12 Part IV: LSR 21-0846, adopting the Audiology and Speech-Language Pathology Compact
13 and the Occupational Therapy Licensure Compact, sponsored by Sen. Sherman, Prime/Dist 24; Sen.
14 Soucy, Dist 18; Sen. Carson, Dist 14; Rep. March, Carr. 8.

15 Part V: LSR 21-0899, relative to the authority of the office of professional licensure and
16 certification for administration, rulemaking, and enforcement of investigations, hearings, and
17 appeals, sponsored by Sen. Reagan, Prime/ Dist 17, Sen. Carson, Dist 14; Sen. French, Dist 7; Sen.
18 Kahn, Dist 10; Sen. Prentiss, Dist 5; Sen. Rosenwald, Dist 13; Sen. Bradley, Dist 3; Sen.
19 D'Allesandro, Dist 20; Sen. Ward, Dist 8; Sen. Soucy, Dist 18; Sen. Giuda, Dist 2; Rep. Spillane,
20 Rock. 2; Rep. McGuire, Merr. 29; Rep. Seaworth, Merr. 20.

21 Part VI: LSR 21-0973, relative to temporary licensure of certain licensed nursing assistants,
22 sponsored by Sen. Hennessey, Dist 1; Sen. Rosenwald, Dist 13; Rep. Dostie, Coos 1; Rep. Thompson,
23 Coos 1.

24 Part VII: LSR 21-1011, relative to the revocation of licensure for licensed emergency medical
25 service units and emergency medical service vehicles, sponsored by Sen. Prentiss, Prime/Dist 5; Rep.
26 Merchant, Sull. 4; Rep. Goley, Hills. 8; Rep. McGuire, Merr. 29.

27 Part VIII: LSR 21-1050, relative to schools for barbering, cosmetology, and esthetics,
28 sponsored by Sen. Reagan, Prime/Dist 17; Sen. Rosenwald, Dist 13; Sen. Prentiss, Dist 5; Sen.
29 Carson, Dist 14; Sen. Bradley, Dist 3; Sen. D'Allesandro, Dist 20; Sen. Gannon, Dist 23; Rep.
30 McGuire, Merr. 29; Rep. Roy, Rock. 32; Rep. Harrington, Straf. 3.

31 Part IX: LSR 21-0277, relative to telemedicine provided by out-of-state psychologists,
32 sponsored by Sen. Reagan, Prime/Dist 17; Sen. Carson, Dist 14; Sen. Bradley, Dist 3; Sen. Prentiss,

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1 Dist 5; Sen. French, Dist 7; Sen. Giuda, Dist 2; Sen. Hennessey, Dist 1; Sen. D'Allesandro, Dist 20;
2 Rep. Spillane, Rock. 2; Rep. Tudor, Rock. 1.
3 Part X: LSR 21-1049, establishing program rules within the department of health and
4 human services for sanitary production and distribution of food, sponsored by Sen. Giuda,
5 Prime/Dist 2; Sen. Gannon, Dist 23.
6 Part XI: relative to minimum qualifications for certification as a child care associate teacher.
7 2 Legislation Enacted. The general court hereby enacts the following legislation:
8
9 PART I
10 Relative to the definition of "licensing agency" for purposes of licensing places of assembly.
11 1 Places of Assembly; Definition of Licensing Agency. Amend RSA 155:17, II to read as follows:
12 II. "Licensing agency" shall mean the chief of the fire department, the firewards or
13 engineers, if any, otherwise the selectmen of the town or the commissioners of village district as the
14 case may be***, or the state fire marshal, as he or she deems necessary, in consultation with the***
15 ***local licensing agency, if any***.
16 2 Places of Assembly; License Required. Amend RSA 155:18 to read as follows:
17 155:18 License Required. No person shall own or operate a place of assembly within this state
18 unless licensed so to do by the licensing agency of the ***state,*** city, town, or village district where said
19 place of assembly is located, including assemblies occurring on state waters or ice formed on state
20 waters, in accordance with the regulations herein promulgated. In the application of this act to
21 existing places of assembly the licensing agency may modify such of its provisions as would require
22 structural changes if in his or her opinion adequate safety may be obtained otherwise and provided
23 that a permanent record is kept of such modifications and the reasons therefor.
24 3 Effective Date. Part I of this act shall take effect 60 days after its passage.
25
26 PART II
27 Repealing the emergency medical services personnel licensure interstate compact.
28 1 Repeal. The following are repealed:
29 I. RSA 153-A:36 and the subdivision heading preceding RSA 153-A:36, relative to the
30 emergency medical services personnel licensure interstate compact.
31 II. RSA 153-A:20, XXIV, relative to rulemaking by the department of safety regarding
32 implementation of the compact.
33 2 Effective Date. Part II of this act shall take effect 60 days after its passage.
34
35 PART III
36 Relative to hearings of the New Hampshire board of nursing.
37 1 Board of Nursing; Adjudicative Hearings. Amend 326-B:38, VIII to read as follows:

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VIII. The board may hold adjudicative hearings concerning allegations of misconduct or other matters within the scope of this chapter. Such hearings shall be public proceedings. Any member of the board [~~other than the public members~~], or any other qualified person appointed by the board, shall have authority to preside at such a hearing and to issue oaths or affirmations to witnesses.

2 Effective Date. Part III of this act shall take effect upon its passage.

PART IV

Adopting the Audiology and Speech-Language Pathology Compact
and the Occupational Therapy Licensure Compact.

1 New Paragraph; Office of Professional Licensure and Certification; Fees; Financing of Interstate Compacts. Amend RSA 310-A:1-e by inserting after paragraph II the following new paragraph:

III. The office of professional licensure and certification shall be responsible for the financing of any interstate compact joined by the state that affects a profession governed by a board listed in 310-A:1-a. Such financing shall be from money deposited in the office of professional licensure and certification fund.

2 New Section; Speech-Language Pathology Practice; Audiology and Speech-Language Pathology Compact. Amend RSA 326-F by inserting after section 8 the following new section:

326-F:9 Interstate Compact Adopted. The state of New Hampshire hereby adopts the provisions of the Audiology and Speech-Language Pathology Compact as follows:

SECTION 1: PURPOSE

The purpose of this Compact is to facilitate interstate practice of audiology and speech-language pathology with the goal of improving public access to audiology and speech-language pathology services. The practice of audiology and speech-language pathology occurs in the state where the patient/client/student is located at the time of the patient/client/student encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other member state licenses;

2. Enhance the states' ability to protect the public's health and safety;

3. Encourage the cooperation of member states in regulating multistate audiology and speech-language pathology practice;

4. Support spouses of relocating active duty military personnel;

5. Enhance the exchange of licensure, investigative and disciplinary information between member states;

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1 6. Allow a remote state to hold a provider of services with a compact privilege in that state
2 accountable to that state's practice standards; and
3 7. Allow for the use of telehealth technology to facilitate increased access to audiology and
4 speech-language pathology services.
5 SECTION 2. DEFINITIONS
6 As used in this Compact, and except as otherwise provided, the following definitions shall apply:
7 A. "Active duty military" means full-time duty status in the active uniformed service of the
8 United States, including members of the National Guard and Reserve on active duty orders
9 pursuant to 10 U.S.C. Chapter 1209 and 10 U.S.C Chapter 1211.
10 B. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a
11 state's laws which is imposed by a licensing board or other authority against an audiologist or
12 speech-language pathologist, including actions against an individual's license or privilege to practice
13 such as revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee's
14 practice.
15 C. "Alternative program" means a non-disciplinary monitoring process approved by an audiology
16 or speech-language pathology licensing board to address impaired practitioners.
17 D. "Audiologist" means an individual who is licensed by a state to practice audiology.
18 E. "Audiology" means the care and services provided by a licensed audiologist as set forth in the
19 member state's statutes and rules.
20 F. "Audiology and Speech-Language Pathology Compact Commission" or "Commission" means
21 the national administrative body whose membership consists of all states that have enacted the
22 Compact.
23 G. "Audiology and speech-language pathology licensing board," "audiology licensing board,"
24 "speech-language pathology licensing board," or "licensing board" means the agency of a state that is
25 responsible for the licensing and regulation of audiologists and/or speech-language pathologists.
26 H. "Compact privilege" means the authorization granted by a remote state to allow a licensee
27 from another member state to practice as an audiologist or speech-language pathologist in the
28 remote state under its laws and rules. The practice of audiology or speech-language pathology
29 occurs in the member state where the patient/client/student is located at the time of the
30 patient/client/student encounter.
31 I. "Current significant investigative information" means investigative information that a
32 licensing board, after an inquiry or investigation that includes notification and an opportunity for
33 the audiologist or speech-language pathologist to respond, if required by state law, has reason to
34 believe is not groundless and, if proved true, would indicate more than a minor infraction.
35 J. "Data system" means a repository of information about licensees, including, but not limited
36 to, continuing education, examination, licensure, investigative, compact privilege and adverse action.

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1 K. "Encumbered license" means a license in which an adverse action restricts the practice of
2 audiology or speech-language pathology by the licensee and said adverse action has been reported to
3 the National Practitioners Data Bank (NPDB).
4 L. "Executive committee" means a group of directors elected or appointed to act on behalf of, and
5 within the powers granted to them by, the Commission.
6 M. "Home state" means the member state that is the licensee's primary state of residence.
7 N. "Impaired practitioner" means individuals whose professional practice is adversely affected
8 by substance abuse, addiction, or other health-related conditions.
9 O. "Licensee" means an individual who currently holds an authorization from the state licensing
10 board to practice as an audiologist or speech-language pathologist.
11 P. "Member state" means a state that has enacted the Compact.
12 Q. "Privilege to practice" means a legal authorization permitting the practice of audiology or
13 speech-language pathology in a remote state.
14 R. "Remote state" means a member state other than the home state where a licensee is
15 exercising or seeking to exercise the compact privilege.
16 S. "Rule" means a regulation, principle or directive promulgated by the Commission that has the
17 force of law.
18 T. "Single-state license" means an audiology or speech-language pathology license issued by a
19 member state that authorizes practice only within the issuing state and does not include a privilege
20 to practice in any other member state.
21 U. "Speech-language pathologist" means an individual who is licensed by a state to practice
22 speech-language pathology.
23 V. "Speech-language pathology means the care and services provided by a licensed speech-
24 language pathologist as set forth in the member state's statutes and rules.
25 W. "State" means any state, commonwealth, district or territory of the United States of America
26 that regulates the practice of audiology and speech-language pathology.
27 X. "State practice laws" means a member state's laws, rules and regulations that govern the
28 practice of audiology or speech-language pathology, define the scope of audiology or speech-language
29 pathology practice, and create the methods and grounds for imposing discipline.
30 Y. "Telehealth" means the application of telecommunication technology to deliver audiology or
31 speech-language pathology services at a distance for assessment, intervention and/or consultation.
32 SECTION 3. STATE PARTICIPATION IN THE COMPACT
33 A. A license issued to an audiologist or speech-language pathologist by a home state to a
34 resident in that state shall be recognized by each member state as authorizing an audiologist or
35 speech-language pathologist to practice audiology or speech-language pathology, under a privilege to
36 practice, in each member state.

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1 B. A state must implement or utilize procedures for considering the criminal history records of
2 applicants for initial privilege to practice. These procedures shall include the submission of
3 fingerprints or other biometric-based information by applicants for the purpose of obtaining an
4 applicant's criminal history record information from the Federal Bureau of Investigation and the
5 agency responsible for retaining that state's criminal records
6 1. A member state must fully implement a criminal background check requirement, within a
7 time frame established by rule, by receiving the results of the Federal Bureau of Investigation record
8 search on criminal background checks and use the results in making licensure decisions.
9 2. Communication between a member state, the Commission and among member states
10 regarding the verification of eligibility for licensure through the Compact shall not include any
11 information received from the Federal Bureau of Investigation relating to a federal criminal records
12 check performed by a member state under Public Law 92-544.
13 C. Upon application for a privilege to practice, the licensing board in the issuing remote state
14 shall ascertain, through the data system, whether the applicant has ever held, or is the holder of, a
15 license issued by any other state, whether there are any encumbrances on any license or privilege to
16 practice held by the applicant, whether any adverse action has been taken against any license or
17 privilege to practice held by the applicant.
18 D. Each member state shall require an applicant to obtain or retain a license in the home state
19 and meet the home state's qualifications for licensure or renewal of licensure, as well as, all other
20 applicable state laws.
21 E. For an audiologist:
22 1. Must meet one of the following educational requirements:
23 a. On or before, Dec. 31, 2007, has graduated with a master's degree or doctorate in audiology,
24 or equivalent degree regardless of degree name, from a program that is accredited by an accrediting
25 agency recognized by the Council for Higher Education Accreditation, or its successor, or by the
26 United States Department of Education and operated by a college or university accredited by a
27 regional or national accrediting organization recognized by the board; or
28 b. On or after, Jan. 1, 2008, has graduated with a Doctoral degree in audiology, or equivalent
29 degree, regardless of degree name, from a program that is accredited by an accrediting agency
30 recognized by the Council for Higher Education Accreditation, or its successor, or by the United
31 States Department of Education and operated by a college or university accredited by a regional or
32 national accrediting organization recognized by the board; or
33 c. Has graduated from an audiology program that is housed in an institution of higher education
34 outside of the United States (a) for which the program and institution have been approved by the
35 authorized accrediting body in the applicable country and (b) the degree program has been verified
36 by an independent credentials review agency to be comparable to a state licensing board-approved
37 program.

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1 2. Has completed a supervised clinical practicum experience from an accredited educational
2 institution or its cooperating programs as required by the commission;
3 3. Has successfully passed a national examination approved by the Commission;
4 4. Holds an active, unencumbered license;
5 5. Has not been convicted or found guilty, and has not entered into an agreed disposition, of a
6 felony related to the practice of audiology, under applicable state or federal criminal law;
7 6. Has a valid United States Social Security or National Practitioner Identification number.
8 F. For a speech-language pathologist:
9 1. Must meet one of the following educational requirements:
10 a. Has graduated with a master's degree from a speech-language pathology program that is
11 accredited by an organization recognized by the United States Department of Education and
12 operated by a college or university accredited by a regional or national accrediting organization
13 recognized by the board; or
14 b. Has graduated from a speech-language pathology program that is housed in an institution of
15 higher education outside of the United States (a) for which the program and institution have been
16 approved by the authorized accrediting body in the applicable country and (b) the degree program
17 has been verified by an independent credentials review agency to be comparable to a state licensing
18 board-approved program.
19 2. Has completed a supervised clinical practicum experience from an educational institution or
20 its cooperating programs as required by the Commission;
21 3. Has completed a supervised postgraduate professional experience as required by the
22 Commission
23 4. Has successfully passed a national examination approved by the Commission;
24 5. Holds an active, unencumbered license;
25 6. Has not been convicted or found guilty, and has not entered into an agreed disposition, of a
26 felony related to the practice of speech-language pathology, under applicable state or federal
27 criminal law;
28 7. Has a valid United States Social Security or National Practitioner Identification number.
29 G. The privilege to practice is derived from the home state license.
30 H. An audiologist or speech-language pathologist practicing in a member state must comply
31 with the state practice laws of the state in which the client is located at the time service is provided.
32 The practice of audiology and speech-language pathology shall include all audiology and speech-
33 language pathology practice as defined by the state practice laws of the member state in which the
34 client is located. The practice of audiology and speech-language pathology in a member state under
35 a privilege to practice shall subject an audiologist or speech-language pathologist to the jurisdiction
36 of the licensing board, the courts and the laws of the member state in which the client is located at
37 the time service is provided.

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1 I. Individuals not residing in a member state shall continue to be able to apply for a member
2 state's single-state license as provided under the laws of each member state. However, the single-
3 state license granted to these individuals shall not be recognized as granting the privilege to practice
4 audiology or speech-language pathology in any other member state. Nothing in this Compact shall
5 affect the requirements established by a member state for the issuance of a single-state license.
6 J. Member states may charge a fee for granting a compact privilege.
7 K. Member states must comply with the bylaws and rules and regulations of the Commission.
8 SECTION 4. COMPACT PRIVILEGE
9 A. To exercise the compact privilege under the terms and provisions of the Compact, the
10 audiologist or speech-language pathologist shall:
11 1. Hold an active license in the home state;
12 2. Have no encumbrance on any state license;
13 3. Be eligible for a compact privilege in any member state in accordance with Section 3;
14 4. Have not had any adverse action against any license or compact privilege within the previous
15 2 years from date of application;
16 5. Notify the Commission that the licensee is seeking the compact privilege within a remote
17 state(s);
18 6. Pay any applicable fees, including any state fee, for the compact privilege;
19 7. Report to the Commission adverse action taken by any non-member state within 30 days from
20 the date the adverse action is taken.
21 B. For the purposes of the compact privilege, an audiologist or speech-language pathologist shall
22 only hold one home state license at a time.
23 C. Except as provided in Section 6, if an audiologist or speech-language pathologist changes
24 primary state of residence by moving between two-member states, the audiologist or speech-
25 language pathologist must apply for licensure in the new home state, and the license issued by the
26 prior home state shall be deactivated in accordance with applicable rules adopted by the
27 Commission.
28 D. The audiologist or speech-language pathologist may apply for licensure in advance of a
29 change in primary state of residence.
30 E. A license shall not be issued by the new home state until the audiologist or speech-language
31 pathologist provides satisfactory evidence of a change in primary state of residence to the new home
32 state and satisfies all applicable requirements to obtain a license from the new home state.
33 F. If an audiologist or speech-language pathologist changes primary state of residence by
34 moving from a member state to a non-member state, the license issued by the prior home state shall
35 convert to a single-state license, valid only in the former home state.

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1 G. The compact privilege is valid until the expiration date of the home state license. The
2 licensee must comply with the requirements of Section 4A to maintain the compact privilege in the
3 remote state.
4 H. A licensee providing audiology or speech-language pathology services in a remote state under
5 the compact privilege shall function within the laws and regulations of the remote state.
6 I. A licensee providing audiology or speech-language pathology services in a remote state is
7 subject to that state's regulatory authority. A remote state may, in accordance with due process and
8 that state's laws, remove a licensee's compact privilege in the remote state for a specific period of
9 time, impose fines, and/or take any other necessary actions to protect the health and safety of its
10 citizens.
11 J. If a home state license is encumbered, the licensee shall lose the compact privilege in any
12 remote state until the following occur:
13 1. The home state license is no longer encumbered; and
14 2. Two years have elapsed from the date of the adverse action.
15 K. Once an encumbered license in the home state is restored to good standing, the licensee must
16 meet the requirements of Section 4A to obtain a compact privilege in any remote state.
17 L. Once the requirements of Section 4J have been met, the licensee must meet the requirements
18 in Section 4A to obtain a compact privilege in a remote state.
19 SECTION 5. COMPACT PRIVILEGE TO PRACTICE TELEHEALTH
20 Member states shall recognize the right of an audiologist or speech-language pathologist, licensed by
21 a home state in accordance with Section 3 and under rules promulgated by the Commission, to
22 practice audiology or speech-language pathology in any member state via telehealth under a
23 privilege to practice as provided in the Compact and rules promulgated by the Commission.
24 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES
25 Active duty military personnel, or their spouse, shall designate a home state where the individual
26 has a current license in good standing. The individual may retain the home state designation during
27 the period the service member is on active duty. Subsequent to designating a home state, the
28 individual shall only change their home state through application for licensure in the new state.
29 SECTION 7. ADVERSE ACTIONS
30 A. In addition to the other powers conferred by state law, a remote state shall have the
31 authority, in accordance with existing state due process law, to:
32 1. Take adverse action against an audiologist's or speech-language pathologist's privilege to
33 practice within that member state.
34 2. Issue subpoenas for both hearings and investigations that require the attendance and
35 testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board
36 in a member state for the attendance and testimony of witnesses or the production of evidence from
37 another member state shall be enforced in the latter state by any court of competent jurisdiction,

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according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.

3. Only the home state shall have the power to take adverse action against a audiologist's or speech-language pathologist's license issued by the home state.

B. For purposes of taking adverse action, the home state shall give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

C. The home state shall complete any pending investigations of an audiologist or speech-language pathologist who changes primary state of residence during the course of the investigations. The home state shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of the investigations to the administrator of the data system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any adverse actions.

D. If otherwise permitted by state law, the member state may recover from the affected audiologist or speech-language pathologist the costs of investigations and disposition of cases resulting from any adverse action taken against that audiologist or speech-language pathologist.

E. The member state may take adverse action based on the factual findings of the remote state, provided that the member state follows the member state's own procedures for taking the adverse action.

F. Joint Investigations

1. In addition to the authority granted to a member state by its respective audiology or speech-language pathology practice act or other applicable state law, any member state may participate with other member states in joint investigations of licensees.

2. Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

G. If adverse action is taken by the home state against an audiologist's or speech language pathologist's license, the audiologist's or speech-language pathologist's privilege to practice in all other member states shall be deactivated until all encumbrances have been removed from the state license. All home state disciplinary orders that impose adverse action against an audiologist's or speech language pathologist's license shall include a statement that the audiologist's or speech-language pathologist's privilege to practice is deactivated in all member states during the pendency of the order.

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1 H. If a member state takes adverse action, it shall promptly notify the administrator of the data
2 system. The administrator of the data system shall promptly notify the home state of any adverse
3 actions by remote states.
4 I. Nothing in this Compact shall override a member state's decision that participation in an
5 alternative program may be used in lieu of adverse action.
6 SECTION 8. ESTABLISHMENT OF THE AUDIOLOGY AND SPEECH-LANGUAGE
7 PATHOLOGY COMPACT COMMISSION
8 A. The Compact member states hereby create and establish a joint public agency known as the
9 Audiology and Speech-Language Pathology Compact Commission:
10 1. The Commission is an instrumentality of the Compact states.
11 2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely
12 and exclusively in a court of competent jurisdiction where the principal office of the Commission is
13 located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or
14 consents to participate in alternative dispute resolution proceedings.
15 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
16 B. Membership, Voting and Meetings
17 1. Each member state shall have two (2) delegates selected by that member state's licensing
18 board. The delegates shall be current members of the licensing board. One shall be an audiologist
19 and one shall be a speech-language pathologist.
20 2. An additional five (5) delegates, who are either a public member or board administrator from
21 a state licensing board, shall be chosen by the Executive Committee from a pool of nominees
22 provided by the Commission at Large.
23 3. Any delegate may be removed or suspended from office as provided by the law of the state
24 from which the delegate is appointed.
25 4. The member state board shall fill any vacancy occurring on the Commission, within 90 days.
26 5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and
27 creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs
28 of the Commission.
29 6. A delegate shall vote in person or by other means as provided in the bylaws. The bylaws may
30 provide for delegates' participation in meetings by telephone or other means of communication.
31 7. The Commission shall meet at least once during each calendar year. Additional meetings
32 shall be held as set forth in the bylaws.
33 C. The Commission shall have the following powers and duties:
34 1. Establish the fiscal year of the Commission;
35 2. Establish bylaws;
36 3. Establish a Code of Ethics;
37 4. Maintain its financial records in accordance with the bylaws;

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1 5. Meet and take actions as are consistent with the provisions of this Compact and the bylaws;
2 6. Promulgate uniform rules to facilitate and coordinate implementation and administration of
3 this Compact. The rules shall have the force and effect of law and shall be binding in all member
4 states;
5 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided
6 that the standing of any state audiology or speech-language pathology licensing board to sue or be
7 sued under applicable law shall not be affected;
8 8. Purchase and maintain insurance and bonds;
9 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees
10 of a member state;
11 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant individuals
12 appropriate authority to carry out the purposes of the Compact, and to establish the Commission's
13 personnel policies and programs relating to conflicts of interest, qualifications of personnel, and
14 other related personnel matters;
15 11. Accept any and all appropriate donations and grants of money, equipment, supplies,
16 materials and services, and to receive, utilize and dispose of the same; provided that at all times the
17 Commission shall avoid any appearance of impropriety and/or conflict of interest;
18 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve
19 or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid
20 any appearance of impropriety;
21 13. Sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any
22 property real, personal, or mixed;
23 14. Establish a budget and make expenditures;
24 15. Borrow money;
25 16. Appoint committees, including standing committees composed of members, and other
26 interested persons as may be designated in this Compact and the bylaws;
27 17. Provide and receive information from, and cooperate with, law enforcement agencies;
28 18. Establish and elect an Executive Committee; and
29 19. Perform other functions as may be necessary or appropriate to achieve the purposes of this
30 Compact consistent with the state regulation of audiology and speech-language pathology licensure
31 and practice.
32 D. The Executive Committee
33 The Executive Committee shall have the power to act on behalf of the Commission according to the
34 terms of this Compact:
35 1. The Executive Committee shall be composed of ten (10) members:
36 a. Seven (7) voting members who are elected by the Commission from the current membership
37 of the Commission;

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1 b. Two (2) ex-officios, consisting of one nonvoting member from a recognized national audiology
2 professional association and one nonvoting member from a recognized national speech-language
3 pathology association; and
4 c. One (1) ex-officio, nonvoting member from the recognized membership organization of the
5 audiology and speech-language pathology licensing boards.
6 E. The ex-officio members shall be selected by their respective organizations.
7 1. The Commission may remove any member of the Executive Committee as provided in bylaws.
8 2. The Executive Committee shall meet at least annually.
9 3. The Executive Committee shall have the following duties and responsibilities:
10 a. Recommend to the entire Commission changes to the rules or bylaws, changes to this
11 Compact legislation, fees paid by Compact member states such as annual dues, and any commission
12 Compact fee charged to licensees for the compact privilege;
13 b. Ensure Compact administration services are appropriately provided, contractual or
14 otherwise;
15 c. Prepare and recommend the budget;
16 d. Maintain financial records on behalf of the Commission;
17 e. Monitor Compact compliance of member states and provide compliance reports to the
18 Commission;
19 f. Establish additional committees as necessary; and
20 g. Other duties as provided in rules or bylaws.
21 4. Meetings of the Commission
22 All meetings shall be open to the public, and public notice of meetings shall be given in the same
23 manner as required under the rulemaking provisions in Section 10.
24 5. The Commission or the Executive Committee or other committees of the Commission may
25 convene in a closed, non-public meeting if the Commission or Executive Committee or other
26 committees of the Commission must discuss:
27 a. Non-compliance of a member state with its obligations under the
28 Compact;
29 b. The employment, compensation, discipline or other matters, practices or procedures related to
30 specific employees or other matters related to the Commission's internal personnel practices and
31 procedures;
32 c. Current, threatened, or reasonably anticipated litigation;
33 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;
34 e. Accusing any person of a crime or formally censuring any person;
35 f. Disclosure of trade secrets or commercial or financial information that is privileged or
36 confidential;

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1 g. Disclosure of information of a personal nature where disclosure would constitute a clearly
2 unwarranted invasion of personal privacy;
3 h. Disclosure of investigative records compiled for law enforcement purposes;
4 i. Disclosure of information related to any investigative reports prepared by or on behalf of or for
5 use of the Commission or other committee charged with responsibility of investigation or
6 determination of compliance issues pursuant to the Compact; or
7 j. Matters specifically exempted from disclosure by federal or member state statute.
8 6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's
9 legal counsel or designee shall certify that the meeting may be closed and shall reference each
10 relevant exempting provision.
11 7. The Commission shall keep minutes that fully and clearly describe all matters discussed in a
12 meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore,
13 including a description of the views expressed. All documents considered in connection with an
14 action shall be identified in minutes. All minutes and documents of a closed meeting shall remain
15 under seal, subject to release by a majority vote of the Commission or order of a court of competent
16 jurisdiction.
17 8. Financing of the Commission
18 a. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
19 establishment, organization, and ongoing activities.
20 b. The Commission may accept any and all appropriate revenue sources, donations, and grants
21 of money, equipment, supplies, materials, and services.
22 c. The Commission may levy on and collect an annual assessment from each member state or
23 impose fees on other parties to cover the cost of the operations and activities of the Commission and
24 its staff, which must be in a total amount sufficient to cover its annual budget as approved each year
25 for which revenue is not provided by other sources. The aggregate annual assessment amount shall
26 be allocated based upon a formula to be determined by the Commission, which shall promulgate a
27 rule binding upon all member states.
28 9. The Commission shall not incur obligations of any kind prior to securing the funds adequate
29 to meet the same; nor shall the Commission pledge the credit of any of the member states, except by
30 and with the authority of the member state.
31 10. The Commission shall keep accurate accounts of all receipts and disbursements. The
32 receipts and disbursements of the Commission shall be subject to the audit and accounting
33 procedures established under its bylaws. However, all receipts and disbursements of funds handled
34 by the Commission shall be audited yearly by a certified or licensed public accountant, and the
35 report of the audit shall be included in and become part of the annual report of the Commission.
36 F. Qualified Immunity, Defense, and Indemnification

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1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 9. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Adverse actions against a license or compact privilege;
4. Non-confidential information related to alternative program participation;
5. Any denial of application for licensure, and the reason(s) for denial; and
6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

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1 C. Investigative information pertaining to a licensee in any member state shall only be available
2 to other member states.
3 D. The Commission shall promptly notify all member states of any adverse action taken against
4 a licensee or an individual applying for a license. Adverse action information pertaining to a licensee
5 in any member state shall be available to any other member state.
6 E. Member states contributing information to the data system may designate information that
7 may not be shared with the public without the express permission of the contributing state.
8 F. Any information submitted to the data system that is subsequently required to be expunged
9 by the laws of the member state contributing the information shall be removed from the data
10 system.
11 SECTION 10. RULEMAKING
12 A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in
13 this Section and the rules adopted thereunder. Rules and amendments shall become binding as of
14 the date specified in each rule or amendment.
15 B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute
16 or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
17 the rule, the rule shall have no further force and effect in any member state.
18 C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the
19 Commission.
20 D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least
21 thirty (30) days in advance of the meeting at which the rule shall be considered and voted upon, the
22 Commission shall file a Notice of Proposed Rulemaking:
23 1. On the website of the Commission or other publicly accessible platform; and
24 2. On the website of each member state audiology or speech-language pathology licensing board
25 or other publicly accessible platform or the publication in which each state would otherwise publish
26 proposed rules.
27 E. The Notice of Proposed Rulemaking shall include:
28 1. The proposed time, date, and location of the meeting in which the rule shall be considered and
29 voted upon;
30 2. The text of the proposed rule or amendment and the reason for the proposed rule;
31 3. A request for comments on the proposed rule from any interested person; and
32 4. The manner in which interested persons may submit notice to the Commission of their
33 intention to attend the public hearing and any written comments.
34 F. Prior to the adoption of a proposed rule, the Commission shall allow persons to submit
35 written data, facts, opinions and arguments, which shall be made available to the public.
36 G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or
37 amendment if a hearing is requested by:

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1. At least twenty-five (25) persons;

2. A state or federal governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings shall be recorded. A copy of the recording shall be made available on request.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

K. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds; or

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the

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1 revision results in a material change to a rule. A challenge shall be made in writing and delivered to
2 the chair of the Commission prior to the end of the notice period. If no challenge is made, the
3 revision shall take effect without further action. If the revision is challenged, the revision may not
4 take effect without the approval of the Commission.
5 SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT
6 A. Dispute Resolution
7 1. Upon request by a member state, the Commission shall attempt to resolve disputes related to
8 the Compact that arise among member states and between member and non-member states.
9 2. The Commission shall promulgate a rule providing for both mediation and binding dispute
10 resolution for disputes as appropriate.
11 B. Enforcement
12 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
13 rules of this Compact.
14 2. By majority vote, the Commission may initiate legal action in the United States District
15 Court for the District of Columbia or the federal district where the Commission has its principal
16 offices against a member state in default to enforce compliance with the provisions of the Compact
17 and its promulgated rules and bylaws. The relief sought may include both injunctive relief and
18 damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all
19 costs of litigation, including reasonable attorney's fees.
20 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
21 may pursue any other remedies available under federal or state law.
22 SECTION 12. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR
23 AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY PRACTICE AND ASSOCIATED RULES,
24 WITHDRAWAL, AND AMENDMENT
25 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
26 law in the 10th member state. The provisions, which become effective at that time, shall be limited
27 to the powers granted to the Commission relating to assembly and the promulgation of rules.
28 Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the
29 implementation and administration of the Compact.
30 B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules
31 shall be subject to the rules as they exist on the date on which the Compact becomes law in that
32 state. Any rule that has been previously adopted by the Commission shall have the full force and
33 effect of law on the day the Compact becomes law in that state.
34 C. Any member state may withdraw from this Compact by enacting a statute repealing the
35 same.
36 1. A member state's withdrawal shall not take effect until six (6) months after enactment of the
37 repealing statute.

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1 2. Withdrawal shall not affect the continuing requirement of the withdrawing state's audiology
2 or speech-language pathology licensing board to comply with the investigative and adverse action
3 reporting requirements of this act prior to the effective date of withdrawal.
4 D. Nothing contained in this Compact shall be construed to invalidate or prevent any audiology
5 or speech-language pathology licensure agreement or other cooperative arrangement between a
6 member state and a non-member state that does not conflict with the provisions of this Compact.
7 E. This Compact may be amended by the member states. No amendment to this Compact shall
8 become effective and binding upon any member state until it is enacted into the laws of all member
9 states.
10 SECTION 13. CONSTRUCTION AND SEVERABILITY
11 This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of
12 this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is
13 declared to be contrary to the constitution of any member state or of the United States or the
14 applicability thereof to any government, agency, person or circumstance is held invalid, the validity
15 of the remainder of this Compact and the applicability thereof to any government, agency, person or
16 circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution
17 of any member state, the Compact shall remain in full force and effect as to the remaining member
18 states and in full force and effect as to the member state affected as to all severable matters.
19 SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS
20 A. Nothing herein prevents the enforcement of any other law of a member state that is not
21 inconsistent with the Compact.
22 B. All laws in a member state in conflict with the Compact are superseded to the extent of the
23 conflict.
24 C. All lawful actions of the Commission, including all rules and bylaws promulgated by the
25 Commission, are binding upon the member states.
26 D. All agreements between the Commission and the member states are binding in accordance
27 with their terms.
28 E. In the event any provision of the Compact exceeds the constitutional limits imposed on the
29 legislature of any member state, the provision shall be ineffective to the extent of the conflict with
30 the constitutional provision in question in that member state.
31 3 New Section; Occupational Therapists; Occupational Therapy Licensure Compact. Amend
32 RSA 326-C by inserting after section 8 the following new section:
33 326-C:9 Occupational Therapy Licensure Compact. The state of New Hampshire hereby adopts
34 the provisions of the Occupational Therapy Licensure Compact as follows:
35 SECTION 1. PURPOSE
36 The purpose of this Compact is to facilitate interstate practice of occupational therapy with the goal
37 of improving public access to occupational therapy services. The Practice of occupational therapy

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1 occurs in the state where the patient/client is located at the time of the patient/client encounter. The
2 Compact preserves the regulatory authority of states to protect public health and safety through the
3 current system of state licensure.
4 This Compact is designed to achieve the following objectives:
5 A. Increase public access to occupational therapy services by providing for the mutual
6 recognition of other member state licenses;
7 B. Enhance the states' ability to protect the public's health and safety;
8 C. Encourage the cooperation of member states in regulating multi-state occupational therapy
9 practice;
10 D. Support spouses of relocating military members;
11 E. Enhance the exchange of licensure, investigative, and disciplinary information between
12 Member states;
13 F. Allow a remote state to hold a provider of services with a Compact privilege in that state
14 accountable to that state's practice standards; and
15 G. Facilitate the use of telehealth technology in order to increase access to occupational therapy
16 services.
17 SECTION 2. DEFINITIONS
18 As used in this Compact, and except as otherwise provided, the following definitions shall apply:
19 A. "Active Duty Military" means full-time duty status in the active uniformed service of the
20 United States, including members of the National Guard and Reserve on active duty orders
21 pursuant to 10 U.S.C. Chapter 1209 and Section 1211.
22 B. "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a
23 state's laws which is imposed by a licensing board or other authority against an occupational
24 therapist or occupational therapy assistant, including actions against an individual's license or
25 Compact privilege such as censure, revocation, suspension, probation, monitoring of the licensee, or
26 restriction on the licensee's practice.
27 C. "Alternative Program" means a non-disciplinary monitoring process approved by an
28 occupational therapy licensing board.
29 D. "Compact privilege" means the authorization, which is equivalent to a license, granted by a
30 remote state to allow a licensee from another member state to practice as an occupational therapist
31 or practice as an occupational therapy assistant in the remote state under its laws and rules. The
32 practice of occupational therapy occurs in the member state where the patient/client is located at the
33 time of the patient/client encounter.
34 E. "Continuing Competence/Education" means a requirement, as a condition of license renewal,
35 to provide evidence of participation in, and/or completion of, educational and professional activities
36 relevant to practice or area of work.

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1 F. "Current significant investigative information" means investigative information that a
2 licensing board, after an inquiry or investigation that includes notification and an opportunity for
3 the occupational therapist or occupational therapy assistant to respond, if required by state law, has
4 reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.
5 G. "Data system" means a repository of information about licensees, including but not limited to
6 license status, investigative information, Compact privileges, and adverse actions.
7 H. "Encumbered license" means a license in which an adverse action restricts the practice of
8 occupational therapy by the licensee or said adverse action has been reported to the National
9 Practitioners Data Bank (NPDB).
10 I. "Executive Committee" means a group of directors elected or appointed to act on behalf of, and
11 within the powers granted to them by, the Commission.
12 J. "Home state" means the member state that is the licensee's Primary state of residence.
13 K. "Impaired practitioner" means individuals whose professional practice is adversely affected
14 by substance abuse, addiction, or other health-related conditions.
15 L. "Investigative Information" means information, records, and/or documents received or
16 generated by an occupational therapy licensing board pursuant to an investigation.
17 M. "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws
18 and rules governing the practice of occupational therapy in a state.
19 N. "Licensee" means an individual who currently holds an authorization from the state to
20 practice as an occupational therapist or as an occupational therapy assistant.
21 O. "Member state" means a state that has enacted the Compact.
22 P. "Occupational therapist" means an individual who is licensed by a state to practice
23 occupational therapy.
24 Q. "Occupational therapy assistant" means an individual who is licensed by a state to assist in
25 the practice of occupational therapy.
26 R. "Occupational therapy," "occupational therapy practice," and the "practice of occupational
27 therapy" mean the care and services provided by an occupational therapist or an occupational
28 therapy assistant as set forth in the member state's statutes and regulations.
29 S. "Occupational therapy Compact Commission" or "Commission" means the national
30 administrative body whose membership consists of all states that have enacted the Compact.
31 T. "Occupational therapy licensing board" or "licensing board" means the agency of a state that
32 is authorized to license and regulate occupational therapists and occupational therapy assistants.
33 U. "Primary state of residence" means the state (also known as the home state) in which an
34 occupational therapist or occupational therapy assistant who is not Active Duty Military declares a
35 primary residence for legal purposes as verified by: driver's license, federal income tax return, lease,
36 deed, mortgage or voter registration or other verifying documentation as further defined by
37 Commission rules.

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1 V. "Remote state" means a member state other than the home state, where a licensee is
2 exercising or seeking to exercise the Compact privilege.
3 W. "Rule" means a regulation promulgated by the Commission that has the force of law.
4 X. "State" means any state, commonwealth, district, or territory of the United States of America
5 that regulates the practice of occupational therapy.
6 Y. "Single-state license" means an occupational therapist or occupational therapy assistant
7 license issued by a member state that authorizes practice only within the issuing state and does not
8 include a Compact privilege in any other member state.
9 Z. "Telehealth" means the application of telecommunication technology to deliver occupational
10 therapy services for assessment, intervention and/or consultation.
11 SECTION 3. STATE PARTICIPATION IN THE COMPACT
12 A. To participate in the Compact, a member state shall:
13 1. License occupational therapists and occupational therapy assistants;
14 2. Participate fully in the Commission's data system, including but not limited to using the
15 Commission's unique identifier as defined in rules of the Commission;
16 3. Have a mechanism in place for receiving and investigating complaints about licensees;
17 4. Notify the Commission, in compliance with the terms of the Compact and rules, of any
18 adverse action or the availability of investigative information regarding a licensee;
19 5. Implement or utilize procedures for considering the criminal history records of applicants for
20 an initial Compact privilege. These procedures shall include the submission of fingerprints or other
21 biometric-based information by applicants for the purpose of obtaining an applicant's criminal
22 history record information from the Federal Bureau of Investigation and the agency responsible for
23 retaining that state's criminal records;
24 a. A member state shall, within a time frame established by the Commission, require a criminal
25 background check for a licensee seeking/applying for a Compact privilege whose Primary state of
26 residence is that member state, by receiving the results of the Federal Bureau of Investigation
27 criminal record search, and shall use the results in making licensure decisions.
28 b. Communication between a member state, the Commission and among member states
29 regarding the verification of eligibility for licensure through the Compact shall not include any
30 information received from the Federal Bureau of Investigation relating to a federal criminal records
31 check performed by a member state under Public Law 92-544.
32 6. Comply with the rules of the Commission;
33 7. Utilize only a recognized national examination as a requirement for licensure pursuant to the
34 rules of the Commission; and
35 8. Have Continuing Competence/Education requirements as a condition for license renewal.
36 B. A member state shall grant the Compact privilege to a licensee holding a valid unencumbered
37 license in another member state in accordance with the terms of the Compact and rules.

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1 C. Member states may charge a fee for granting a Compact privilege.
2 D. A member state shall provide for the state's delegate to attend all occupational therapy
3 Compact Commission meetings.
4 E. Individuals not residing in a member state shall continue to be able to apply for a member
5 state's Single-state license as provided under the laws of each member state. However, the Single-
6 state license granted to these individuals shall not be recognized as granting the Compact privilege
7 in any other member state.
8 F. Nothing in this Compact shall affect the requirements established by a member state for the
9 issuance of a Single-state license.
10 SECTION 4. COMPACT PRIVILEGE
11 A. To exercise the Compact privilege under the terms and provisions of the Compact, the
12 licensee shall:
13 1. Hold a license in the home state;
14 2. Have a valid United States Social Security Number or National Practitioner Identification
15 number;
16 3. Have no encumbrance on any state license;
17 4. Be eligible for a Compact privilege in any member state in accordance with Section 4D, F, G,
18 and H;
19 5. Have paid all fines and completed all requirements resulting from any adverse action against
20 any license or Compact privilege, and two years have elapsed from the date of such completion;
21 6. Notify the Commission that the licensee is seeking the Compact privilege within a remote
22 state(s);
23 7. Pay any applicable fees, including any state fee, for the Compact privilege;
24 8. Complete a criminal background check in accordance with Section 3A(5);
25 a. The licensee shall be responsible for the payment of any fee associated with the completion of
26 a criminal background check.
27 9. Meet any jurisprudence requirements established by the remote state(s) in which the licensee
28 is seeking a Compact privilege; and
29 10. Report to the Commission adverse action taken by any non-member state within 30 days
30 from the date the adverse action is taken.
31 B. The Compact privilege is valid until the expiration date of the home state license. The
32 licensee must comply with the requirements of Section 4A to maintain the Compact privilege in the
33 remote state.
34 C. A licensee providing occupational therapy in a remote state under the Compact privilege
35 shall function within the laws and regulations of the remote state.
36 D. Occupational therapy assistants practicing in a remote state shall be supervised by an
37 occupational therapist licensed or holding a Compact privilege in that remote state.

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E. A licensee providing occupational therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's Compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee may be ineligible for a Compact privilege in any state until the specific time for removal has passed and all fines are paid.

F. If a home state license is encumbered, the licensee shall lose the Compact privilege in any remote state until the following occur:

1. The home state license is no longer encumbered; and

2. Two years have elapsed from the date on which the home state license is no longer encumbered in accordance with Section 4(F)(1).

G. Once an Encumbered license in the home state is restored to good standing, the licensee must meet the requirements of Section 4A to obtain a Compact privilege in any remote state.

H. If a licensee's Compact privilege in any remote state is removed, the individual may lose the Compact privilege in any other remote state until the following occur:

1. The specific period of time for which the Compact privilege was removed has ended;

2. All fines have been paid and all conditions have been met;

3. Two years have elapsed from the date of completing requirements for 4(H)(1) and (2); and

4. The Compact privileges are reinstated by the Commission, and the compact data system is updated to reflect reinstatement.

I. If a licensee's Compact privilege in any remote state is removed due to an erroneous charge, privileges shall be restored through the compact data system.

J. Once the requirements of Section 4H have been met, the license must meet the requirements in Section 4A to obtain a Compact privilege in a remote state.

SECTION 5: OBTAINING A NEW HOME STATE LICENSE BY VIRTUE OF COMPACT PRIVILEGE

A. An occupational therapist or occupational therapy assistant may hold a home state license, which allows for Compact privileges in member states, in only one member state at a time.

B. If an occupational therapist or occupational therapy assistant changes primary state of residence by moving between two member states:

1. The occupational therapist or occupational therapy assistant shall file an application for obtaining a new home state license by virtue of a Compact privilege, pay all applicable fees, and notify the current and new home state in accordance with applicable rules adopted by the Commission.

2. Upon receipt of an application for obtaining a new home state license by virtue of compact privilege, the new home state shall verify that the occupational therapist or occupational therapy

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1 assistant meets the pertinent criteria outlined in Section 4 via the data system, without need for
2 primary source verification except for:
3 a. An FBI fingerprint based criminal background check if not previously performed or updated
4 pursuant to applicable rules adopted by the Commission in accordance with Public Law 92-544;
5 b. Other criminal background check as required by the new home state; and
6 c. Submission of any requisite jurisprudence requirements of the new home state.
7 3. The former home state shall convert the former home state license into a Compact privilege
8 once the new home state has activated the new home state license in accordance with applicable
9 rules adopted by the Commission.
10 4. Notwithstanding any other provision of this Compact, if the occupational therapist or
11 occupational therapy assistant cannot meet the criteria in Section 4, the new home state shall apply
12 its requirements for issuing a new Single-state license.
13 5. The occupational therapist or the occupational therapy assistant shall pay all applicable fees
14 to the new home state in order to be issued a new home state license.
15 C. If an occupational therapist or occupational therapy assistant changes primary state of
16 residence by moving from a member state to a non-member state, or from a non-member state to a
17 member state, the state criteria shall apply for issuance of a Single-state license in the new state.
18 D. Nothing in this compact shall interfere with a licensee's ability to hold a Single-state license
19 in multiple states; however, for the purposes of this compact, a licensee shall have only one home
20 state license.
21 E. Nothing in this Compact shall affect the requirements established by a member state for the
22 issuance of a Single-state license.
23 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES
24 A. Active Duty Military personnel, or their spouses, shall designate a home state where the
25 individual has a current license in good standing. The individual may retain the home state
26 designation during the period the service member is on active duty. Subsequent to designating a
27 home state, the individual shall only change their home state through application for licensure in the
28 new state or through the process described in Section 5.
29 SECTION 7. ADVERSE ACTIONS
30 A. A home state shall have exclusive power to impose adverse action against an occupational
31 therapist's or occupational therapy assistant's license issued by the home state.
32 B. In addition to the other powers conferred by state law, a remote state shall have the
33 authority, in accordance with existing state due process law, to:
34 1. Take adverse action against an occupational therapist's or occupational therapy assistant's
35 Compact privilege within that member state.
36 2. Issue subpoenas for both hearings and investigations that require the attendance and
37 testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board

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1 in a member state for the attendance and testimony of witnesses or the production of evidence from
2 another member state shall be enforced in the latter state by any court of competent jurisdiction,
3 according to the practice and procedure of that court applicable to subpoenas issued in proceedings
4 pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and
5 other fees required by the service statutes of the state in which the witnesses or evidence are
6 located.
7 C. For purposes of taking adverse action, the home state shall give the same priority and effect
8 to reported conduct received from a member state as it would if the conduct had occurred within the
9 home state. In so doing, the home state shall apply its own state laws to determine appropriate
10 action.
11 D. The home state shall complete any pending investigations of an occupational therapist or
12 occupational therapy assistant who changes primary state of residence during the course of the
13 investigations. The home state, where the investigations were initiated, shall also have the
14 authority to take appropriate action(s) and shall promptly report the conclusions of the
15 investigations to the OT Compact Commission data system. The occupational therapy Compact
16 Commission data system administrator shall promptly notify the new home state of any adverse
17 actions.
18 E. A member state, if otherwise permitted by state law, may recover from the affected
19 occupational therapist or occupational therapy assistant the costs of investigations and disposition of
20 cases resulting from any adverse action taken against that occupational therapist or occupational
21 therapy assistant.
22 F. A member state may take adverse action based on the factual findings of the remote state,
23 provided that the member state follows its own procedures for taking the adverse action.
24 G. Joint Investigations
25 1. In addition to the authority granted to a member state by its respective state occupational
26 therapy laws and regulations or other applicable state law, any member state may participate with
27 other member states in joint investigations of licensees.
28 2. Member states shall share any investigative, litigation, or compliance materials in
29 furtherance of any joint or individual investigation initiated under the Compact.
30 H. If an adverse action is taken by the home state against an occupational therapist's or
31 occupational therapy assistant's license, the occupational therapist's or occupational therapy
32 assistant's Compact privilege in all other member states shall be deactivated until all encumbrances
33 have been removed from the state license. All home state disciplinary orders that impose adverse
34 action against an occupational therapist's or occupational therapy assistant's license shall include a
35 statement that the occupational therapist's or occupational therapy assistant's Compact privilege is
36 deactivated in all member states during the pendency of the order.

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1 I. If a member state takes adverse action, it shall promptly notify the administrator of the data
2 system. The administrator of the data system shall promptly notify the home state of any adverse
3 actions by remote states.
4 J. Nothing in this Compact shall override a member state's decision that participation in an
5 Alternative Program may be used in lieu of adverse action.
6 SECTION 8. ESTABLISHMENT OF THE OCCUPATIONAL THERAPY COMPACT
7 COMMISSION.
8 A. The Compact member states hereby create and establish a joint public agency known as the
9 occupational therapy Compact Commission:
10 1. The Commission is an instrumentality of the Compact states.
11 2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely
12 and exclusively in a court of competent jurisdiction where the principal office of the Commission is
13 located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or
14 consents to participate in alternative dispute resolution proceedings.
15 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
16 B. Membership, Voting, and Meetings
17 1. Each member state shall have and be limited to one (1) delegate selected by that member
18 state's licensing board.
19 2. The delegate shall be either:
20 a. A current member of the licensing board, who is an occupational therapist, occupational
21 therapy assistant, or public member; or
22 b. An administrator of the licensing board.
23 3. Any delegate may be removed or suspended from office as provided by the law of the state
24 from which the delegate is appointed.
25 4. The member state board shall fill any vacancy occurring in the Commission within 90 days.
26 5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and
27 creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs
28 of the Commission. A delegate shall vote in person or by such other means as provided in the
29 bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other
30 means of communication.
31 6. The Commission shall meet at least once during each calendar year. Additional meetings
32 shall be held as set forth in the bylaws.
33 7. The Commission shall establish by rule a term of office for delegates.
34 C. The Commission shall have the following powers and duties:
35 1. Establish a Code of Ethics for the Commission;
36 2. Establish the fiscal year of the Commission;
37 3. Establish bylaws;

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1 4. Maintain its financial records in accordance with the bylaws;
2 5. Meet and take such actions as are consistent with the provisions of this Compact and the
3 bylaws;
4 6. Promulgate uniform rules to facilitate and coordinate implementation and administration of
5 this Compact. The rules shall have the force and effect of law and shall be binding in all member
6 states;
7 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided
8 that the standing of any state occupational therapy licensing board to sue or be sued under
9 applicable law shall not be affected;
10 8. Purchase and maintain insurance and bonds;
11 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees
12 of a member state;
13 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant such
14 individuals appropriate authority to carry out the purposes of the Compact, and establish the
15 Commission's personnel policies and programs relating to conflicts of interest, qualifications of
16 personnel, and other related personnel matters;
17 11. Accept any and all appropriate donations and grants of money, equipment, supplies,
18 materials and services, and receive, utilize and dispose of the same; provided that at all times the
19 Commission shall avoid any appearance of impropriety and/or conflict of interest;
20 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or
21 use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any
22 appearance of impropriety;
23 13. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any
24 property real, personal, or mixed;
25 14. Establish a budget and make expenditures;
26 15. Borrow money;
27 16. Appoint committees, including standing committees composed of members, state regulators,
28 state legislators or their representatives, and consumer representatives, and such other interested
29 persons as may be designated in this Compact and the bylaws;
30 17. Provide and receive information from, and cooperate with, law enforcement agencies;
31 18. Establish and elect an Executive Committee; and
32 19. Perform such other functions as may be necessary or appropriate to achieve the purposes of
33 this Compact consistent with the state regulation of occupational therapy licensure and practice.
34 D. The Executive Committee. The Executive Committee shall have the power to act on behalf of
35 the Commission according to the terms of this Compact.
36 1. The Executive Committee shall be composed of nine members:

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1 a. Seven voting members who are elected by the Commission from the current membership of
2 the Commission;
3 b. One ex-officio, nonvoting member from a recognized national occupational therapy
4 professional association; and
5 c. One ex-officio, nonvoting member from a recognized national occupational therapy
6 certification organization.
7 2. The ex-officio members will be selected by their respective organizations.
8 3. The Commission may remove any member of the Executive Committee as provided in bylaws.
9 4. The Executive Committee shall meet at least annually.
10 5. The Executive Committee shall have the following duties and responsibilities:
11 a. Recommend to the entire Commission changes to the rules or bylaws, changes to this
12 Compact legislation, fees paid by Compact member states such as annual dues, and any Commission
13 Compact fee charged to licensees for the Compact privilege;
14 b. Ensure Compact administration services are appropriately provided, contractual or
15 otherwise;
16 c. Prepare and recommend the budget;
17 d. Maintain financial records on behalf of the Commission;
18 e. Monitor Compact compliance of member states and provide compliance reports to the
19 Commission;
20 f. Establish additional committees as necessary; and
21 g. Perform other duties as provided in rules or bylaws.
22 E. Meetings of the Commission
23 1. All meetings shall be open to the public, and public notice of meetings shall be given in the
24 same manner as required under the rulemaking provisions in Section 10.
25 2. The Commission or the Executive Committee or other committees of the Commission may
26 convene in a closed, non-public meeting if the Commission or Executive Committee or other
27 committees of the Commission must discuss:
28 a. Non-compliance of a member state with its obligations under the Compact;
29 b. The employment, compensation, discipline or other matters, practices or procedures related to
30 specific employees or other matters related to the Commission's internal personnel practices and
31 procedures;
32 c. Current, threatened, or reasonably anticipated litigation;
33 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;
34 e. Accusing any person of a crime or formally censuring any person;
35 f. Disclosure of trade secrets or commercial or financial information that is privileged or
36 confidential;

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1 g. Disclosure of information of a personal nature where disclosure would constitute a clearly
2 unwarranted invasion of personal privacy;
3 h. Disclosure of investigative records compiled for law enforcement purposes;
4 i. Disclosure of information related to any investigative reports prepared by or on behalf of or for
5 use of the Commission or other committee charged with responsibility of investigation or
6 determination of compliance issues pursuant to the Compact; or
7 j. Matters specifically exempted from disclosure by federal or member state statute.
8 3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's
9 legal counsel or designee shall certify that the meeting may be closed and shall reference each
10 relevant exempting provision.
11 4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a
12 meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore,
13 including a description of the views expressed. All documents considered in connection with an
14 action shall be identified in such minutes. All minutes and documents of a closed meeting shall
15 remain under seal, subject to release by a majority vote of the Commission or order of a court of
16 competent jurisdiction.
17 F. Financing of the Commission
18 1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
19 establishment, organization, and ongoing activities.
20 2. The Commission may accept any and all appropriate revenue sources, donations, and grants
21 of money, equipment, supplies, materials, and services.
22 3. The Commission may levy on and collect an annual assessment from each member state or
23 impose fees on other parties to cover the cost of the operations and activities of the Commission and
24 its staff, which must be in a total amount sufficient to cover its annual budget as approved by the
25 Commission each year for which revenue is not provided by other sources. The aggregate annual
26 assessment amount shall be allocated based upon a formula to be determined by the Commission,
27 which shall promulgate a rule binding upon all member states.
28 4. The Commission shall not incur obligations of any kind prior to securing the funds adequate
29 to meet the same; nor shall the Commission pledge the credit of any of the member states, except by
30 and with the authority of the member state.
31 5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts
32 and disbursements of the Commission shall be subject to the audit and accounting procedures
33 established under its bylaws. However, all receipts and disbursements of funds handled by the
34 Commission shall be audited yearly by a certified or licensed public accountant, and the report of the
35 audit shall be included in and become part of the annual report of the Commission.
36 G. Qualified Immunity, Defense, and Indemnification

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1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 9. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. A member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable (utilizing a unique identifier) as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Adverse actions against a license or Compact privilege;
4. Non-confidential information related to Alternative Program participation;
5. Any denial of application for licensure, and the reason(s) for such denial;
6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission; and

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1 7. Current significant investigative information.
2 C. Current significant investigative information and other investigative information pertaining
3 to a licensee in any member state will only be available to other member states.
4 D. The Commission shall promptly notify all member states of any adverse action taken against
5 a licensee or an individual applying for a license. Adverse action information pertaining to a licensee
6 in any member state will be available to any other member state.
7 E. Member states contributing information to the data system may designate information that
8 may not be shared with the public without the express permission of the contributing state.
9 F. Any information submitted to the data system that is subsequently required to be expunged
10 by the laws of the member state contributing the information shall be removed from the data
11 system.
12 SECTION 10. RULEMAKING
13 A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in
14 this Section and the rules adopted thereunder. Rules and amendments shall become binding as of
15 the date specified in each rule or amendment.
16 B. The Commission shall promulgate reasonable rules in order to effectively and efficiently
17 achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Commission
18 exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the
19 Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid
20 and have no force and effect.
21 C. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute
22 or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
23 the rule, then such rule shall have no further force and effect in any member state.
24 D. Rules or amendments to the rules shall be adopted at a regular or special meeting of the
25 Commission.
26 E. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least
27 thirty (30) days in advance of the meeting at which the rule will be considered and voted upon, the
28 Commission shall file a notice of proposed rulemaking:
29 1. On the website of the Commission or other publicly accessible platform; and
30 2. On the website of each member state occupational therapy licensing board or other publicly
31 accessible platform or the publication in which each state would otherwise publish proposed rules.
32 F. The notice of proposed rulemaking shall include:
33 1. The proposed time, date, and location of the meeting in which the rule will be considered and
34 voted upon;
35 2. The text of the proposed rule or amendment and the reason for the proposed rule;
36 3. A request for comments on the proposed rule from any interested person; and

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1 4. The manner in which interested persons may submit notice to the Commission of their
2 intention to attend the public hearing and any written comments.
3 G. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written
4 data, facts, opinions, and arguments, which shall be made available to the public.
5 H. The Commission shall grant an opportunity for a public hearing before it adopts a rule or
6 amendment if a hearing is requested by:
7 1. At least twenty five (25) persons;
8 2. A state or federal governmental subdivision or agency; or
9 3. An association or organization having at least twenty five (25) members.
10 I. If a hearing is held on the proposed rule or amendment, the Commission shall publish the
11 place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the
12 Commission shall publish the mechanism for access to the electronic hearing.
13 1. All persons wishing to be heard at the hearing shall notify the executive director of the
14 Commission or other designated member in writing of their desire to appear and testify at the
15 hearing not less than five (5) business days before the scheduled date of the hearing.
16 2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair
17 and reasonable opportunity to comment orally or in writing.
18 3. All hearings will be recorded. A copy of the recording will be made available on request.
19 4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules
20 may be grouped for the convenience of the Commission at hearings required by this section.
21 J. Following the scheduled hearing date, or by the close of business on the scheduled hearing
22 date if the hearing was not held, the Commission shall consider all written and oral comments
23 received.
24 K. If no written notice of intent to attend the public hearing by interested parties is received, the
25 Commission may proceed with promulgation of the proposed rule without a public hearing.
26 L. The Commission shall, by majority vote of all members, take final action on the proposed rule
27 and shall determine the effective date of the rule, if any, based on the rulemaking record and the full
28 text of the rule.
29 M. Upon determination that an emergency exists, the Commission may consider and adopt an
30 emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual
31 rulemaking procedures provided in the Compact and in this section shall be retroactively applied to
32 the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective
33 date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted
34 immediately in order to:
35 1. Meet an imminent threat to public health, safety, or welfare;
36 2. Prevent a loss of Commission or member state funds;

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3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

N. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

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1 3. Termination of membership in the Compact shall be imposed only after all other means of
2 securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by
3 the Commission to the governor, the majority and minority leaders of the defaulting state's
4 legislature, and each of the member states.
5 4. A state that has been terminated is responsible for all assessments, obligations, and liabilities
6 incurred through the effective date of termination, including obligations that extend beyond the
7 effective date of termination.
8 5. The Commission shall not bear any costs related to a state that is found to be in default or
9 that has been terminated from the Compact, unless agreed upon in writing between the Commission
10 and the defaulting state.
11 6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District
12 Court for the District of Columbia or the federal district where the Commission has its principal
13 offices. The prevailing member shall be awarded all costs of such litigation, including reasonable
14 attorney's fees.
15 C. Dispute Resolution
16 1. Upon request by a member state, the Commission shall attempt to resolve disputes related to
17 the Compact that arise among member states and between member and non-member states.
18 2. The Commission shall promulgate a rule providing for both mediation and binding dispute
19 resolution for disputes as appropriate.
20 D. Enforcement
21 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
22 rules of this Compact.
23 2. By majority vote, the Commission may initiate legal action in the United States District
24 Court for the District of Columbia or the federal district where the Commission has its principal
25 offices against a member state in default to enforce compliance with the provisions of the Compact
26 and its promulgated rules and bylaws. The relief sought may include both injunctive relief and
27 damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all
28 costs of such litigation, including reasonable attorney's fees.
29 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
30 may pursue any other remedies available under federal or state law.
31 SECTION 12. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR
32 OCCUPATIONAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND
33 AMENDMENT
34 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
35 law in the tenth member state. The provisions, which become effective at that time, shall be limited
36 to the powers granted to the Commission relating to assembly and the promulgation of rules.

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1 Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the
2 implementation and administration of the Compact.
3 B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules
4 shall be subject to the rules as they exist on the date on which the Compact becomes law in that
5 state. Any rule that has been previously adopted by the Commission shall have the full force and
6 effect of law on the day the Compact becomes law in that state.
7 C. Any member state may withdraw from this Compact by enacting a statute repealing the
8 same.
9 1. A member state's withdrawal shall not take effect until six (6) months after enactment of the
10 repealing statute.
11 2. Withdrawal shall not affect the continuing requirement of the withdrawing state's
12 occupational therapy licensing board to comply with the investigative and adverse action reporting
13 requirements of this act prior to the effective date of withdrawal.
14 D. Nothing contained in this Compact shall be construed to invalidate or prevent any
15 occupational therapy licensure agreement or other cooperative arrangement between a member state
16 and a non-member state that does not conflict with the provisions of this Compact.
17 E. This Compact may be amended by the member states. No amendment to this Compact shall
18 become effective and binding upon any member state until it is enacted into the laws of all member
19 states.
20 SECTION 13. CONSTRUCTION AND SEVERABILITY
21 This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of
22 this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is
23 declared to be contrary to the constitution of any member state or of the United States or the
24 applicability thereof to any government, agency, person, or circumstance is held invalid, the validity
25 of the remainder of this Compact and the applicability thereof to any government, agency, person, or
26 circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution
27 of any member state, the Compact shall remain in full force and effect as to the remaining member
28 states and in full force and effect as to the member state affected as to all severable matters.
29 SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS
30 A. A licensee providing occupational therapy in a remote state under the Compact privilege
31 shall function within the laws and regulations of the remote state.
32 B. Nothing herein prevents the enforcement of any other law of a member state that is not
33 inconsistent with the Compact.
34 C. Any laws in a member state in conflict with the Compact are superseded to the extent of the
35 conflict.
36 D. Any lawful actions of the Commission, including all rules and bylaws promulgated by the
37 Commission, are binding upon the member states.

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1 E. All agreements between the Commission and the member states are binding in accordance
2 with their terms.
3 F. In the event any provision of the Compact exceeds the constitutional limits imposed on the
4 legislature of any member state, the provision shall be ineffective to the extent of the conflict with
5 the constitutional provision in question in that member state.
6 4 Effective Date. Part IV of this act shall take effect July 1, 2021.
7
8 PART V
9 Relative to the authority of the office of professional licensure and certification for administration,
10 rulemaking, and enforcement of investigations, hearings, and appeals.
11 1 Office of Professional Licensure and Certification; Administration; Rulemaking. Amend RSA
12 310-A:1-d, II(h)(2) to read as follows:
13 (2) Such organizational and procedural rules necessary to administer the boards,
14 commissions, and councils in the office of professional licensure and certification, including rules
15 governing the administration of complaints and investigations, ***hearings, disciplinary***
16 ***proceedings,*** payment processing procedures, and application procedures; and
17 2 New Paragraph; Office of Professional Licensure and Certification; Administration; Standing
18 Orders. Amend RSA 310-A:1-d by inserting after paragraph III the following new paragraph:
19 IV. All boards, councils, and commissions may issue standing orders delegating non-
20 discretionary tasks to staff of the office of professional licensure and certification.
21 3 New Sections; Office of Professional Licensure and Certification; Investigations; Hearings;
22 Penalties; Appeals. Amend RSA 310-A by inserting after section 1-g the following new sections:
23 310-A:1-h Investigations.
24 I. Boards, which shall include all boards, councils, and commissions within the office of
25 professional licensure and certification, may authorize an investigation of allegations of misconduct
26 by licensees (a) upon their own initiative or (b) upon written complaint of any person that charges
27 that a person licensed by the board has committed misconduct. When requested by the board, the
28 office shall assign an investigator, who may assist in the investigation.
29 II. The procedures set forth in RSA 310-A:1-h through RSA 310-A:1-l are supplementary and
30 shall not supplant or supersede any procedures expressly set forth in any board's individual practice
31 act.
32 III. The following information obtained during investigations shall be held confidential and
33 shall be exempt from the disclosure requirements of RSA 91-A:
34 (a) Complaints received by the office.
35 (b) Information and records acquired by the office during the investigation.
36 (c) Reports and records made by the office as a result of its investigation.
37 IV. For the purpose of carrying out investigations, the executive director is authorized to:

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1 (a) Retain qualified experts.
2 (b) Conduct inspections of places of business of licensees or certificate holders.
3 (c) Retain legal counsel when authorized to do so by the attorney general.
4 (d) Issue subpoenas for persons, relevant documents and relevant things in accordance
5 with the following conditions:
6 (1) Subpoenas for persons shall not require compliance in less than 48 hours after
7 receipt of service.
8 (2) Subpoenas for documents and things shall not require compliance in fewer than
9 15 days after receipt of service.
10 (3) Service shall be made on licensees and certified individuals by certified mail to
11 the address on file with the office or by hand and shall not entitle them to witness or mileage fees.
12 (4) Service shall be made on persons who are not licensees or certified individuals in
13 accordance with the procedures and fee schedules of the superior court, and the subpoenas served on
14 them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure
15 and Certification."
16 V. The office or the boards, councils, and commissions within the office may disclose
17 information acquired in an investigation to law enforcement, if it involves suspected criminal
18 activity, to health licensing agencies in this state or any other jurisdiction, or in response to specific
19 statutory requirements or court orders.
20 VI. Allegations of professional misconduct shall be brought within 5 years from the time the
21 office reasonably could have discovered the act, omission or failure complained of, except that
22 conduct which resulted in a criminal conviction or in a disciplinary action by a relevant licensing
23 authority in another jurisdiction may be considered by the board without time limitation in making
24 licensing or disciplinary decisions if the conduct would otherwise be a ground for discipline. The
25 board may also consider licensee conduct without time limitation when the ultimate issue before the
26 board involves a pattern of conduct or the cumulative effect of conduct which becomes apparent as a
27 result of conduct which has occurred within the 5-year limitation period prescribed by this
28 paragraph.
29 VII. Each board, council, or commission may dismiss a complaint if the allegations do not
30 state a claim of professional misconduct.
31 310-A:1-i Disciplinary Proceedings; Remedial Proceedings.
32 I. Boards, which shall include all boards, councils, and commissions within the office of
33 professional licensure and certification, are authorized to conduct disciplinary proceedings in
34 accordance with procedural rules adopted by the executive director.
35 II. For the purpose of carrying out disciplinary proceedings, each board, council, or
36 commission is authorized to issue subpoenas for persons, relevant documents and relevant things in
37 accordance with the following conditions:

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1 (a) Subpoenas for persons shall not require compliance in less than 48 hours after
2 receipt of service.
3 (b) Subpoenas for documents and things shall not require compliance in fewer than 15
4 days after receipt of service.
5 (c) Service shall be made on licensees and certified individuals by certified mail to the
6 address on file with the office or by hand and shall not entitle them to witness or mileage fees.
7 (d) Service shall be made on persons who are not licensees or certified individuals in
8 accordance with the procedures and fee schedules of the superior court, and the subpoenas served on
9 them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure
10 and Certification."
11 III. At any time before or during disciplinary proceedings, complaints may be dismissed or
12 disposed of, in whole or in part, by written settlement agreement approved by the board and the
13 licensees or certified individuals involved, provided that any complainant shall have the opportunity,
14 before the settlement agreement has been executed, to comment on the terms of the proposed
15 settlement. The board, council, or commission may hold a settlement agreement hearing prior to its
16 approval of the settlement agreement.
17 IV. Final board actions having the effect of terminating disciplinary proceedings, whether
18 taken before, during or after the completion of the proceedings, shall be set forth in a written record
19 that shall be available to the public after service upon the licensees or certified individuals involved.
20 V. In carrying out disciplinary or licensing proceedings, each board shall have the authority
21 to:
22 (a) Hold pre-hearing conferences exempt from the provisions of RSA 91-A.
23 (b) Appoint a board member or other qualified person as presiding officer.
24 (c) Administer, and authorize an appointed presiding officer to administer, oaths and
25 affirmations.
26 VI. Neither the office nor the boards, councils, and commissions shall have an obligation or
27 authority to appoint or pay the fees of attorneys representing licensees, certified individuals, or
28 witnesses during investigations or adjudicatory proceedings.
29 VII. Boards, councils, and commissions may take non-disciplinary remedial action against
30 any person licensed by it upon finding that the person is afflicted with physical or mental disability,
31 disease, disorder, or condition deemed dangerous to the public health. Upon making an affirmative
32 finding after notice and an opportunity for a hearing, the board, council, or commission may take
33 non-disciplinary remedial action:
34 (a) By suspension, limitation, or restriction of a license for a period of time as
35 determined reasonable by the board.
36 (b) By revocation of license.

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1 (c) By requiring the person to submit to the care, treatment, or observation of a
2 physician, counseling service, health care facility, professional assistance program, or any
3 combination thereof which is acceptable to the board.
4 VIII. All proceedings for non-disciplinary remedial action shall be exempt from the
5 provisions of RSA 91-A, except that the board may disclose any final remedial action that affects the
6 status of a license, including any non-disciplinary restrictions imposed.
7 310-A:1-j Hearings, Decisions and Appeals.
8 I. Disciplinary proceedings shall be open to the public, except upon order by the board,
9 council, or commission upon good cause shown. The public docket file for each such proceeding shall
10 be retained in accordance with the retention policy established by the office of professional licensure
11 and certification.
12 II. Notwithstanding any other provision of law, allegations of misconduct or lack of
13 professional qualifications that are not settled shall be heard by the board, council, or commission, or
14 a panel of the board, council, or commission with a minimum of 3 members appointed by the chair of
15 the board or other designee. Any member of the board, or other person qualified to act as presiding
16 officer and duly designated by the board, shall have the authority to preside at such hearing and to
17 issue oaths or affirmations to witnesses, rule on evidentiary and other procedural matters, and
18 prepare a recommended decision. In the case of a hearing before a panel, the presiding officer shall
19 prepare a recommended decision for the board, council, or commission, which shall determine
20 sanctions.
21 III. Except as otherwise provided by RSA 541-A:30, the board, council, or commission shall
22 furnish the respondent and the complainant, if any, at least 15 days' written notice of the date, time
23 and place of a hearing. Such notice shall include an itemization of the issues to be heard, and, in the
24 case of a disciplinary hearing, a statement as to whether the action has been initiated by a written
25 complaint or upon the board's own motion, or both. If a written complaint is involved, the notice
26 shall provide the complainant with a reasonable opportunity to intervene as a party.
27 IV. In disciplinary and licensing proceedings, the presiding officer may hold prehearing
28 conferences that are closed to the public and exempt from the provisions of RSA 91-A until such time
29 as a public evidentiary hearing is convened. In all instances, settlement discussions engaged in by
30 the parties at prehearing conferences may be conducted off the record.
31 V. The board, council, or commission may dispose of issues or allegations at any time during
32 an investigation or disciplinary proceeding by approving a settlement agreement or issuing a consent
33 order or an order of dismissal for default or failure to state a proper basis for disciplinary action.
34 Disciplinary action taken by the board at any stage of a proceeding, and any dispositive action taken
35 after the issuance of a public hearing notice, shall be reduced to writing and made available to the
36 public. Such decisions shall not be public until they are served upon the parties.

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1 VI. No civil action shall be maintained against the board or any member of the board or its
2 agents or employees, against any organization or its members, or against any other person for or by
3 reason of any statement, report, communication, or testimony to the board or determination by the
4 board in relation to proceedings under this chapter.
5 310-A:1-k Penalties.
6 I. Upon making an affirmative finding that a licensee or certificate holder has committed
7 professional misconduct, boards, which shall include all boards, councils, and commissions within
8 the office of professional licensure and certification, may take disciplinary action in any one or more
9 of the following ways:
10 (a) By reprimand.
11 (b) By suspension of a license or certificate for a period of time as determined reasonable
12 by the board.
13 (c) By revocation of license.
14 (d) By placing the licensee or certificate holder on probationary status. The board may
15 require the person to submit to any of the following:
16 (1) Regular reporting to the board concerning the matters which are the basis of the
17 probation.
18 (2) Continuing professional education until a satisfactory degree of skill has been
19 achieved in those areas which are the basis of probation.
20 (3) Submitting to the care, counseling, or treatment of a physician, counseling
21 service, health care facility, professional assistance program, or any comparable person or facility
22 approved by the board.
23 (4) Practicing under the direct supervision of another licensee for a period of time
24 specified by the board.
25 (e) By assessing administrative fines in amounts established by the board which shall
26 not exceed $3,000 per offense, or, in the case of continuing offenses, $300 for each day that the
27 violation continues, whichever is greater.
28 II. The board may issue a non-disciplinary confidential letter of concern to a licensee
29 advising that while there is insufficient evidence to support disciplinary action, the board believes
30 the licensee or certificate holder should modify or eliminate certain practices, and that continuation
31 of the activities which led to the information being submitted to the board may result in action
32 against the licensee's license. This letter shall not be released to the public or any other licensing
33 authority, except that the letter may be used as evidence in subsequent adjudicatory proceedings by
34 the board.
35 III. In the case of sanctions for discipline in another jurisdiction, the decision of the other
36 jurisdiction's disciplinary authority may not be collaterally attacked and the board may impose any

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of the sanctions set forth in this chapter, but shall provide notice and an opportunity to be heard prior to imposing any sanctions.

IV. In cases involving imminent danger to life or health, a board may order suspension of a license or certification pending hearing for a period of no more than 10 business days, unless the licensee or certified individual agrees in writing to a longer period. In such cases, the board shall comply with RSA 541-A:30.

V. Any person whose license has been suspended or revoked by the board may apply to the board, in writing, to request a hearing for reinstatement. Upon a hearing, the board may issue a new license or modify the suspension or revocation of the license.

VI. For any order issued in resolution of an disciplinary proceeding by the board, where the board has found misconduct sufficient to support disciplinary action, the board may require the licensee or certificate holder who is the subject of such finding to pay the office a sum not to exceed the reasonable cost of investigation and prosecution of the proceeding. This sum shall not exceed $10,000. This sum may be imposed in addition to any otherwise authorized administrative fines levied by the board as part of the penalty. The investigative and prosecution costs shall be assessed by the board and any sums recovered shall be credited to the office's fund and disbursed by the office for any future investigations of complaints and activities that violate this chapter or rules adopted under this chapter.

VII. When an investigation of a complaint is determined to be unfounded, the board shall dismiss the complaint and explain in writing to the complainant and the licensee or certificate holder its reason for dismissing the complaint. After six years, the board may destroy all information concerning the investigation, retaining only a record noting that an investigation was conducted and that the board determined the complaint to be unfounded. For the purpose of this paragraph, a complaint shall be deemed to be unfounded if it does not fall within the jurisdiction of the board, does not relate to the actions of the licensee or certificate holder, or is determined by the board to be frivolous.

VIII. Whoever, not being licensed or otherwise authorized to practice according to the laws of this state, shall advertise oneself as engaging in a profession licensed or certified by the office of professional licensure and certification, shall engage in activity requiring professional licensure, or in any way hold oneself out as qualified to do so, or call oneself a licensed professional, or whoever does such acts after receiving notice that such person's license to practice has been suspended or revoked, is engaged in unlawful practice. After hearing and upon making an affirmative finding of unlawful practice, the board, council, or commission may take action in any one of the following ways:

(a) Issue a cease and desist order against any person or entity engaged in unlawful, which shall be enforceable in superior court.

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1 (b) Impose a fine not to exceed the amount of any gain or economic benefit that the
2 person derived from the violation or $10,000 for each offense, whichever amount is greater. Each
3 violation of unlicensed or unlawful practice shall be deemed a separate offense.
4 (c) The attorney general, board, council, or commission, or prosecuting attorney of any
5 county or municipality where the act to unlawful practice takes place may maintain an action to
6 enjoin any person or entity from continuing to do acts of unlawful practice. The action to enjoin shall
7 not replace any other civil, criminal, or regulatory remedy. An injunction without bond is available
8 to any board, council, or commission.
9 310-A:1-l Rehearing; Appeals.
10 I. Any person who has been refused a license or certification by the board, which shall
11 include all boards, councils, and commissions within the office of professional licensure and
12 certification, or has been disciplined by the board shall have the right to petition for a rehearing
13 within 30 days after the original final decision.
14 II. Appeals from a decision on rehearing shall be by appeal to the supreme court pursuant to
15 RSA 541.
16 III. No sanction shall be stayed by the board during an appeal.
17 3 Effective Date. Part V of this act shall take effect January 1, 2022.
18
19 PART VI
20 Relative to temporary licensure of certain licensed nursing assistants.
21 1 Statement of Purpose. The general court acknowledges the critical importance of ensuring the
22 quality, accessibility, and sustainability of Medicaid services provided in nursing homes, and
23 recognizes the critical shortage of licensed nursing assistants throughout the state. The purpose of
24 this act is to strengthen the frontline staffing in nursing homes. The general court finds that during
25 the COVID-19 pandemic federal regulatory and statutory provisions were waived to facilitate the
26 hiring of nurse aides by nursing homes. Under state emergency order, these individuals were
27 allowed to work in nursing homes as temporary health partners following no less than 8 hours of
28 training provided either by a national association or a New Hampshire educational program. As a
29 matter of public policy, the general court finds that these workers were indispensable as facilities
30 struggled with staffing issues, particularly during outbreaks of the COVID-19 virus. Accordingly,
31 this act shall provide the board of nursing with the additional authority to expand the workforce of
32 licensed nursing assistants by recognizing the service of temporary health partners during the
33 COVID-19 pandemic.
34 2 Special Licensure as a Licensed Nursing Assistant; Applicants Who Served as Temporary
35 Health Partners.
36 I. Persons who have worked no fewer than 100 hours as temporary health partners in a
37 licensed nursing home and have demonstrated, through their work experience during a national and

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1 state public health emergency, the competency to transition to status as a licensed nursing assistant,
2 shall be deemed to have taken a board-approved nursing assistant course and may apply for a
3 license as a licensed nursing assistant in New Hampshire.
4 II. Notwithstanding any provision of law to the contrary, the state-approved training
5 program for licensed nursing assistants shall take into account the training and experience acquired
6 during the COVID-19 pandemic to transition these individuals to placement on the state's licensed
7 nursing assistant registry pursuant to RSA 326-B:26. Such individuals shall be subject to all
8 continuing education requirements under RSA 326-B:31.
9 III. For purposes of this act:
10 (a) “COVID-19” means the novel coronavirus first identified in 2019, or SARS-CoV-2.
11 (b) “Temporary health partner” means anyone authorized to work in a nursing home by
12 Emergency Order 42 issued by the governor on May 11, 2020, and required to complete training of
13 no less than eight hours and work under the supervision of an RN, APRN, or LPN, as is required of
14 LNAs under RSA 326-B:14.
15 3 Effective Date. Part VI of this act shall take effect upon its passage.
16
17 PART VII
18 Relative to the revocation of licensure for licensed emergency medical service units
19 and emergency medical service vehicles.
20 1 Emergency Medical and Trauma Services; Revocation of License. Amend the introductory
21 paragraph of RSA 153-A:13, I to read as follows:
22 I. The commissioner [~~shall~~] ***may*** deny an application for issuance or renewal of a license, or
23 ***issue a letter of concern,*** suspend***,*** or revoke a license, when the commissioner finds that the
24 applicant is guilty of any of the following acts or offenses:
25 2 Effective Date. Part VII of this act shall take effect 60 days after its passage.
26
27 PART VIII
28 Relative to schools for barbering, cosmetology, and esthetics.
29 1 Barbering, Cosmetology, and Esthetics; Definition; School. Amend RSA 313-A:1, XIII to read
30 as follows:
31 XIII. "School" means a school or other institution***, or a dedicated program within such***
32 ***school or institution,*** conducted for the purpose of teaching cosmetology, manicuring, barbering, or
33 esthetics.
34 2 Duties of the Board; Schools; Manicuring, Cosmetology, Barbering, Esthetics. RSA 313-A:7, II
35 is repealed and reenacted to read as follows:
36 II. The board may license a school to operate either:

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(a) Dedicated programs within secondary schools, the purpose of which is to teach cosmetology, manicuring, barbering, or esthetics; or

(b) Postsecondary programs conducted for the purpose of teaching cosmetology, manicuring, barbering, or esthetics, including postsecondary programs leading to a certificate in manicuring, barbering, cosmetology, or esthetics.

3 Barbering, Cosmetology, Esthetics, Manicuring; Apprenticeship Certificates. Amend RSA 313-A:24 to read as follows:

313-A:24 Apprentice Registration and [~~Licensure~~] ***Certificates***.

I. No person shall enter an apprenticeship or enroll in a school under this chapter unless such person has registered with the board as an apprentice and been issued an apprentice [~~license~~] ***certificate***. The board shall have sole authority to regulate apprentices and apprenticeship under this chapter. The board shall issue an apprentice [~~license~~] ***certificate*** to any student receiving instruction within a licensed school [~~or~~] ***and/or*** shop to learn barbering, cosmetology, esthetics, or manicuring.

II. A person applying for [~~a license~~] ***an apprentice certificate*** under this section shall be granted such [~~license~~] ***certificate*** upon:

(a) Submitting proof sufficient to the board to show that such person is at least 16 years of age;

(b) Paying a fee established by the [~~board~~] ***office of professional licensure and certification***; and

(c) Being deemed by the board to be of good professional character.

III. No salon or barbershop shall at any one time have more than one apprentice per licensed professional, except as follows:

(a) Each licensed barber may have up to 2 apprentices for barbering.

(b) Each licensed master barber may have up to 2 apprentices for barbering, or one apprentice master barber and one apprentice barber.

IV. Upon completing the number of hours specified in the board's apprentice rules, an apprentice shall be eligible to apply to the board for [~~licensure~~] ***certification***.

V. Notwithstanding RSA 161-B:11, VI-a, an applicant for an apprentice certificate shall not be required to provide a social security number as a prerequisite for obtaining a certificate.

4 Expiration and Renewal of Licenses and Certificates. Amend RSA 313-A:20 to read as follows:

313-A:20 Expiration and Renewal of Licenses ***and Certificates***. Each barber, master barber, barber instructor, [~~apprentice,~~] barbershop, barber school, esthetician, esthetics instructor, esthetics school, esthetics salon, manicurist, [~~apprentice,~~] beauty salon, or manicuring salon license issued under this chapter***, and any apprentice certificate issued under RSA 313-A:24,*** shall expire on the last day of the birth month of the licensee ***or certificate holder*** in the odd year next succeeding

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1 its date of issuance. Each cosmetologist, cosmetology instructor, or cosmetology school license issued
2 under this chapter shall expire on the last day of the birth month of the licensee in the even year
3 next succeeding its date of issuance. Any personal license ***or apprentice certificate*** which has
4 expired may be renewed within 6 months by payment of the renewal fee and a late fee established by
5 the board. After 6 months and within 5 years, a personal license ***or apprentice certificate*** may be
6 renewed by paying the renewal fee and a late fee established by the board. Any school or shop
7 license which has expired may be renewed upon payment of the renewal fee plus a late fee
8 established by the board.
9 5 Effective Date. Part VIII of this act shall take effect 60 days after its passage.
10
11 PART IX
12 Relative to telemedicine provided by out-of-state psychologists.
13 1 Psychologists; Electronic Practice of Psychology. RSA 329-B:16 is repealed and reenacted to
14 read as follows:
15 329-B:16 Electronic Practice of Psychology, Telehealth, Telemedicine.
16 I. Telepsychology, telehealth, and telemedicine services, as provided by psychologists,
17 include those psychology services that utilize electronic means, including audio, video, or other
18 electronic media, to engage in visual or virtual presence in contemporaneous time. A New
19 Hampshire tele-pass license shall be required for provision of such care to people in New Hampshire.
20 Contacts that are exempt from this requirement are:
21 (a) Persons exempted by 329-B:28.
22 (b) Screenings for inclusion in voluntary research projects that have been properly
23 approved by a New Hampshire based institutional review board.
24 (c) Psychologists licensed by the board, who may provide tele-psychology services to a
25 person within the state of New Hampshire without acquiring a tele-pass psychology license.
26 (d) Persons exempted by RSA 329-D.
27 II. A doctoral level psychologist who is not licensed in New Hampshire shall be eligible to
28 provide telepsychology services to a person in New Hampshire pursuant to RSA 329-D, or providing
29 that the psychologist:
30 (a) Is licensed in one of the jurisdictions in the United States or Canada;
31 (b) Is in good standing in all license jurisdictions in the United States and Canada;
32 (c) Has satisfied conditions determined in rules adopted by the board;
33 and
34 (d) Has applied for and obtained a valid New Hampshire tele-pass psychology license in
35 accordance with board rules and payment of license fees with effective dates that cover the dates of
36 services provided.

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1 III. The tele-pass psychology licensee shall agree to conditions including, but not limited to,
2 conditions stipulated by the board that the licensee shall:
3 (a) Conform to all New Hampshire statutes and rules.
4 (b) Agree that electronic attendance for appearances shall be deemed adequate for
5 regulatory enforcement purposes and that in-person appearances by the licensee are optional and
6 such associated costs for in-person attendance are the full responsibility of the tele-pass psychology
7 licensee.
8 (c) Understand that false statements or failure to comply with official requests and
9 official orders shall constitute sufficient cause for revocation of the tele-pass psychology license.
10 (d) Understand that all conditions of tele-pass psychology license to practice and
11 enforcement shall be pursuant to New Hampshire law.
12 (e) Grant the New Hampshire board of psychologists and its investigators authority to
13 disclose to law enforcement and related regulatory authorities, at their discretion, information
14 including but not limited to status of application, actions and information pertinent to investigations
15 and enforcement of the laws and rules pertaining to the licensee's conduct.
16 (f) Not conduct face-to-face in-person psychological services in New Hampshire.
17 IV. The board shall adopt rules pursuant to RSA 541-A for:
18 (a) The application procedure for a New Hampshire tele-pass psychology license;
19 (b) Additional requirements for a psychologist licensed in another state of Canada to
20 acquire a tele-pass psychology license, including attestations;
21 (c) The standards of care for telemedicine practice of psychology and their enforcement;
22 and
23 (d) Procedures for investigation and discipline pursuant to all means authorized in this
24 chapter, including but not limited to suspension or revocation of a tele-pass psychology license.
25 V. Persons who have been granted emergency licenses to practice psychology under the
26 Covid 19 emergency pursuant to the Governor's Emergency Order #29 shall be granted a tele-pass
27 license upon application to the board.
28 2 Effective Date. Part IX of this act shall take effect upon its passage.
29
30 PART X
31 Relative to certified food protection managers.
32 1 New Section; Food Service Licensure; Certified Food Protection Manager. Amend RSA 143-A
33 by inserting after RSA 143-A:11 the following new section:
34 143-A:11-a Certified Food Protection Manager.
35 I.(a) Each food service establishment licensed by the state under RSA 143-A:6 shall have a
36 person in charge and present during all hours of operation trained as a certified food protection

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1 manager by a program approved by the Conference for Food Protection or other equivalent industry
2 standards program.
3 (b) The requirement in subparagraph (a) shall not apply under these conditions:
4 (1) Food establishments having at least one certified food protection manager on
5 staff shall not be required to have the certified food protection manager present when no food
6 preparation is taking place;
7 (2) Food establishments having at least one certified food protection manager on
8 staff shall not be required to have the certified food protection manager present when food
9 preparation is limited to reheating commercially prepared food or ready to eat food; or
10 (3) Food establishments having 5 food employees or less on duty are required to have
11 only one certified food protection manager on staff who is available, although not required to be
12 present, during all hours of operation.
13 II. This section shall not apply to any food service establishment exempt from licensure or
14 inspection under RSA 143-A:5.
15 III. This section shall not apply to food establishments licensed under RSA 143-A:6 as food
16 processing plants, cold storage or refrigerating warehouses; retail stores with no food preparation or
17 limited to self service foods, servicing areas, bed and breakfasts, lodging facilities serving continental
18 breakfasts, home delivery services of packaged frozen food; pushcarts and other mobile food units,
19 those serving packaged food and non-potentially hazardous unwrapped foods only;
20 wholesalers/distributors; on-site vending machines, bars/lounges without a food preparation area;
21 arena/theater concessions serving non-potentially hazardous; sellers of pre-packaged frozen meat or
22 poultry that is processed in a USDA-inspected plant; homestead food operations.
23 2 Effective Date. Part X of this act shall take effect upon its passage.
24
25 PART XI
26 Establishing minimum qualifications for certification as a child care associate teacher.
27 1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education
28 Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after
29 subparagraph (m) the following new subparagraph:
30 (n) The following qualification for certification as an associate teacher: a minimum of
31 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of
32 training in child growth and development, the latter of which may be documented life experience.
33 Documented life experience in lieu of training in child growth and development shall include
34 experience with the same age children the associate teacher supervises, such as a family child care
35 provider; service as a foster parent; work as a school teacher; work as a camp counselor; and
36 experience as a group leader for children in sports or other activities, such as scouts or little league,
37 or closely related experience.

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1 2 Effective Date. Part XI of this act shall take effect 60 days after its passage.

2021-1579h

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Licensing places of assembly.

II. Repealing the emergency medical services personnel licensure interstate compact.

III. Hearings at the board of nursing.

IV. Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

V. The authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

VI. Temporary licensure of certain licensed nursing assistants.

VII. The revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

VIII. Schools for barbering, cosmetology, and esthetics.

IX. Telemedicine provided by out-of-state psychologists.

X. Sanitary production and distribution of food.

XI. Minimum qualifications for certification as a child care associate teacher.

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FULL COMMITTEE EXECUTIVE Work Session

-on omnibus bill sections-

EDA – May 4th, 2021

EXECUTIVE – Work Session and discussions on SB 133

Discussion of motions and amendments –

Work Session votes on consensus for actions to bring forward to Executive Session next week.

EDA FULL COMMITTEE – EXEC WORK SESSION May 4th

- **Work session motions on Parts of SB 133 Omnibus bill.**

PART I	Motion OTP Yakubovich / Santonastaso	Vote 16-0
PART II	Motion OTP Pearson / Goley	Vote 11-8
	Motion ITL Yakubovich / Roy	Vote 8-10
PART III	Motion OTP Yakubovich / Fellows	Vote 16-0
PART IV	Motion ITL Yakubovich/ Alliegro	Vote 11-7
PART V*	Motion Adopt AM Roy/ Schultz	Vote 19-0
	Motion OTP/ AM Roy/ Schmidt	Vote 12-6
PART VI		
PART VII*	Motion Adopt AM McGuire /Goley	18-0
	Motion OTP/ AM McGuire/ Goley	18-0
PART VIII		
PART IX *	Motion Adopt AM Yakubovich/ Pearson	17-2
2 changes*	Motion Adopt *further AM Yakubovich / Pearson	19-0
	Motion OTP/Am Yakubovich /Bailey	16-2
PART X	Motion OTP Yakubovich/ Pearson	19-0
PART XI *	Motion Adopt AM #1260h Lekas/McGuire	19-0
	Motion OTP/AM Lekas/ McGuire	19-0
PART XII		
PART XIII	Motion OTP Yakubovich / McGuire	18-1

Re: Summary of SB 133 Exec Work session

Carol McGuire <mcguire4house@gmail.com>
To Miriam Simmons
Cc Pam Smarling

11:26 AM

Follow up. Start by Wednesday, May 5, 2021. Due by Wednesday, May 5, 2021.
You replied to this message on 5/5/2021 11:27 AM.
This message is part of a tracked conversation. Click here to find all related messages or to open the original flagged message.

thanks, Miriam. I'm keeping track of the ideas for each section's amendment, but I'm relying on Pam to get the final words.

FYI, my hope is to delete section VI (music therapists), adopt section 14 (non-germane amendment), either kill or amend section 12(psychologists) , and probably ITL section 8 (skilled medical personnel). No guarantees!

Carol

On Wed, May 5, 2021 at 11:19 AM Miriam Simmons <miriam.simmons@leg.state.nh.us> wrote:

> The attached worksheet is a summary of the Roll call sheets from yesterday's Exec Work Session on SB 133 Omnibus bill.

RE: Summary of SB 133 Exec Work session

PS

Pam Smarling
To Miriam Simmons; Carol McGuire

11:22 AM

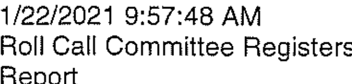
You replied to this message on 5/5/2021 11:25 AM.
This message is part of a tracked conversation. Click here to find all related messages or to open the original flagged message.

Yes. I have the draft amendment for the entire bill in good shape. Once the committee works out a consensus for the remaining 4 sections, I'll send it to OLS for the formal draft.

Pam

Pam Smarling, Senior Committee Researcher
House Committee Research, Room 409, LOB
33 N. State St., Concord, NH 03301
(603) 271-3387

WORK SESSION



1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

MOVED YAKUBOVICH – SANTONASTASO

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP SECTION 1 **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.			
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.			
O'Brien, Michael B.	X		
TOTAL VOTE:			

16-0

WORK SESSION POLL

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

PEARSON - GOLEY

2021 SESSION

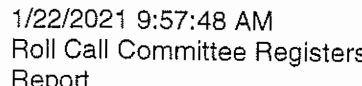
Executive Departments and Administration

Bill #: SB 133 **Motion:** ~~OTP~~ OTP SECTION 2 **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman		X	
Roy, Terry Vice Chairman		X	
Sytek, John Clerk		X	
Pearson, Stephen C.	X		
Yakubovich, Michael		X	
Lekas, Tony		X	
Alliegro, Mark C.	X		
Bailey, Glenn		X	
Lanzara, Tom E.	X		
Santonastaso, Matthew		X	
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.		X	
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

11-8

Work Session


1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

Yakubovich - Roy

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ITL Section 2 **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.		X	
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.		X	
Bailey, Glenn	X		
Lanzara, Tom E.		X	
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.		X	
Jeudy, Jean L.		X	
Schmidt, Peter B.	X		
Schultz, Kristina M.		X	
Fellows, Sallie D.		X	
Fontneau, Timothy J.		X	
Grote, Jaci L.			
O'Brien, Michael B.		X	
TOTAL VOTE:	8	10	

Work session

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

YAKUBOVICH — FELLOWS

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP SECTION 3 **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.			
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.			
O'Brien, Michael B.	X		
TOTAL VOTE:			

16-0

WORK SESSION POLL

OFFICE OF THE HOUSE CLERK

YAKUBOVICH - ALLIEGRO

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ITL SECTION 4 **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.		X	
Jeudy, Jean L.		X	
Schmidt, Peter B.		X	
Schultz, Kristina M.		X	
Fellows, Sallie D.	X	[crossed out]	
Fontneau, Timothy J.		X	
Grote, Jaci L.			
O'Brien, Michael B.		X	
TOTAL VOTE:			

11 - 7

WORK SESSION ROLL

UFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

ROY - SCHMIDT

ROY - SCHM **2021 SESSION**

Executive Departments and Administration

Bill #: SB 133 **Motion:** SECT 5 OTP/A **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.		X	
Jeudy, Jean L.		X	
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.		X	
O'Brien, Michael B.		X	
TOTAL VOTE:			

12 - 6

WORK SESSION ROLL

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

ROY - SCHULTZ

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** ~~OTP~~ ADOPT AMENDMENT SECTION 5 **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

Work Session Poll

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

McGuire - Goley

2021 SESSION

Executive Departments and Administration Mc - Gol

Bill #: SB 133 **Motion:** OTP/A VII **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

18-0

WORK SESSION POLL

OFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration McGUIRE ^ GOLEY

Bill #: SB 133 **Motion:** Section 7 ADOPT AMENDMENT **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

18-0

WORK SESSION ROLL

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

2021 SESSION YAKUBOVICH-BAILEY

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP/A SECTION IX **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman			
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

16-2

WORK SESSION POLL

OFFICE OF THE HOUSE CLERK

PEARSON
YAKUBOVICH - [illegible]
YAK - [illegible]

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

FURTHER AMENDMENT
• Change effect date to upon passage.
• Remove April 1 - anniversary

Bill #: SB 133 **Motion:** SECTION IV **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

WORK SESSION POLL

OFFICE OF THE HOUSE CLERK

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Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration YAKUBOVICH / PEARSON

Bill #: SB 133 **Motion:** ADOPT IX AMENDMENT **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

17-2

WORK SESSION ROLL

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Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration YAKUBOVICH - PEARSON

Bill #: SB 133 **Motion:** OTP X **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

WORK SESSION ROLL

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration LEKAS-MCGUIRE

Bill #: SB 133 **Motion:** OTP/A SECTION XI **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

WORK SESSION POLL

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Roll Call Committee Registers Report

LEKAS - McGUIRE

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ADOPT AMEND 1260H SECTION IV **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

WORK SESSION POLL

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

YAKUBOVICH-McGUIRE

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP SECTION XIII **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.			
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

18-1

EXECUTIVE Work Session – “straw votes”

May 11th 2021

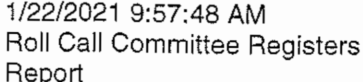
Full Committee – ED&A

Executive Session – working discussion on sections of bill.

SB 133

Section VI (6)	ITL – music therapists Yakubovich/ Alliegro	10-9
Section VIII (8)	ITL McGuire/Fellows	19-0
Section XII (12)	OPLC Amendment Yakubovich/ McGuire	18-1
Section XIV (14)	Adopt Section XIV Grote/Lekas	19-0

COMMITTEE WORK SESSION


1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

YAKUBOVICH - ALLIEGRO

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ITL SECTION VI **AM #:** ____ **Exec Session Date:** 5-11-21

6 MUSIC THERAPISTS

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, ~~Stephen C.~~ MARK	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.		X	
Jeudy, Jean L.		X	
Schmidt, Peter B.		X	
Schultz, Kristina M.		X	
Fellows, Sallie D.		X	
Fontneau, Timothy J.		X	
Grote, Jaci L.		X	
O'Brien, Michael B.		X	
TOTAL VOTE:			

10-9

COMMITTEE WORK SESSION

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

McGUIRE – FELLOWS

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ADOPT ~~BELOW~~ VIII (ITL) 8 **AM #:** **Exec Session Date:** 5-11-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, ~~Stephen C.~~ MARK	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

COMMITTEE WORK SESSION

OFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

YAKUBOVICH-McGUIRE ("OPLC AMENDMENT")

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** SECTION XII (12) **AM #:** **Exec Session Date:** 5-11-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, ~~Stephen C.~~ MARK	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

18-1

COMMITTEE WORK ~~SECTION~~ SESSION

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

GROTE/LEKAS

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ADOPT SECTION ~~XIV~~ 14 **AM #:** **Exec Session Date:** 5-11-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, ~~Stephen C.~~ MARK	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

EXECUTIVE Work Session- straw votes

May 18th 2021

Full Committee – ED&A

Executive Session – working discussion on sections of bill.

SB 133

Adopt Am proposed by Dr. Warner, Approved by OPLC **to Replace Section XII**	Adopt Am proposed by Dr. Warner, Approved by OPLC to Replace Section XII Schmidt/ Schultz	17-2
Section XII	To Reconsider Section XII Schmidt / Schultz	16-1

STRAW POLL OF ED+A

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

ADOPT AMENDMENT PROPOSED BY DR. WARNER APPROVED BY OPLC TO REPLACE SECTION XII

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION SCHMIDT-SCHULTZ

Executive Departments and Administration

Bill #: SB 133 **Motion:** ↑ **AM #:** ______ **Exec Session Date:** 5-18-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman		X	
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony		X	
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
~~Fontneau, Timothy J.~~ PIMENTEL	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

17-2

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

SCHMIDT-SCHULTZ

Bill #: SB 133 **Motion:** RECONSIDER SECTION XII **AM #:** **Exec Session Date:** 5-18-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman		X	
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.			
Schmidt, Peter B.	X		
Schultz, Kristina M. NO ANSWER	[crossed out]		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

16-1

Sub-Committee Minutes

Archived: Tuesday, May 18, 2021 9:12:04 AM
From: Pam Smarling
Sent: Tuesday, May 18, 2021 9:07:45 AM
To: ~House Executive Departments and Administration
Cc: Rod Pimentel
Subject: subcommittee draft for SB 133 and New Warner proposals for XII
Response requested: Yes
Importance: Normal
Attachments:
Draft Committee Amendment to SB 133.docx NEW 2021 05 14 p OPLC confer - Sug amendment for SB133 Part XII Tele-Pass license by Dr Deborah Warner +.doc

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TO: All Members of he House ED&A Committee,

I have not yet received the OLS amendment to SB 133. Attached is the language that I sent to them with the request for an amendment. Also attached is a proposal sent by Dr. Warner this morning for Part XII. Copies of both of these documents are in the committee room.

Pam

Pam Smarling, Senior Committee Researcher
House Committee Research, Room 409, LOB
33 N. State St., Concord, NH 03301
(603) 271-3387

Archived: Tuesday, May 11, 2021 8:41:31 AM
From: Pam Smarling
Sent: Monday, May 10, 2021 3:45:33 PM
To: ~House Executive Departments and Administration
Cc: Mark Pearson
Subject: SB 133 proposed revision for discussion tomorrow
Response requested: No
Importance: Normal

TO: All members of the House ED&A Committee,

As you know, the subcommittee on SB 155 will be meeting at 10:00 am tomorrow. The full committee will be discussing SB 133 at 1:00 p.m. The Zoom link that was sent out last Friday will be sent again tomorrow morning. **The same link should be used for both meetings.**

One of the Parts of SB 133 that the committee will discuss in exec session tomorrow is Part XIV.

The subcommittee has adopted a revision to this part. Rep. McGuire asked me to distribute a further revision proposed by Melissa Clement, Chief of the Child Care Licensing Unit.

Subcommittee Proposal, Part XIV, Establishing minimum qualifications for certification as a child care associate teacher.

1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after subparagraph (m) the following new subparagraph:

(n) The following qualification for certification as an associate teacher: a minimum of 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of training in child growth and development, the latter of which may be documented life experience. *Documented life experience shall include work for a family child care provider; service as a foster parent; work as a school teacher; work as a camp counselor; and experience as a group leader for children in sports or other activities, such as scouts, little league , or closely related activity.*

2 Effective Date. This act shall take effect 60 days after its passage.

Department Proposal; revision to final sentence

Documented life experience in lieu of training in child growth and development shall include experience with the same age children the associate teacher supervises, such as a family child care provider; service as a foster parent; work as a school teacher; work as a camp counselor; and experience as a group leader for children in sports or other activities, such as scouts or little league, or closely related experience.

I'll see you in the morning.

Pam
Pam Smarling, Senior Committee Researcher
House Committee Research, Room 409, LOB
33 N. State St., Concord, NH 03301
(603) 271-3387

Amendment for Psychology Tele-Pass license, Part XII of SB133, May 14, 2021, by Board of Psych Dr Warner following conference with OPLC Executive Director and input from Committee work session, NHPA request and other updates from recent statutes passed and refinements for the language of the bill.

PART XII Relative to telemedicine provided by out of state psychologists.

1 Psychologists; Electronic Practice of Psychology. RSA 329-B:16 is repealed and reenacted to read as follows:

329-B:16 Electronic Practice of Psychology, Telehealth, Telemedicine.

I. Telepsychology, telehealth, and telemedicine services, as provided by psychologists, include those psychology services that utilize electronic means including audio, video, or other electronic media to engage in visual or virtual presence in contemporaneous time. A New Hampshire tele-pass license shall be required for provision of such care to people in New Hampshire. Contacts that are exempt from this requirement are:

(a) Persons exempted by 329-B:28.

(b) Screenings for inclusion in voluntary research projects that have been properly approved by a New Hampshire based institutional review board.

(c) Psychologists licensed by the board, who may provide tele-psychology services to a person within the state of New Hampshire without acquiring a tele-pass psychology license.

(d) Persons exempted by RSA 329-D.

II. A doctoral level psychologist who is not licensed in New Hampshire shall be eligible to provide telepsychology services to a person in New Hampshire pursuant to RSA 329-D, or providing that the psychologist:

(a) Is licensed in one of the jurisdictions in the United States or Canada;

(b) Is in good standing in all license jurisdictions in the United States and Canada;

(c) Has satisfied conditions determined in rules adopted by the board; and

(d) Has applied for and obtained a valid New Hampshire tele-pass psychology license in accordance with board rules and payment of license fees with effective dates that cover the dates of services provided.

(e)

III. The tele-pass psychology licensee shall agree to conditions including, but not limited to, conditions stipulated by the board that the licensee shall:

(a) Conform to all New Hampshire statutes and rules.

(b) Agree that electronic attendance for appearances shall be deemed adequate for regulatory enforcement purposes and that in-person appearances by the licensee are optional and such associated costs for in-person attendance are the full responsibility of the tele-pass psychology licensee.

(c) Understand that false statements or failure to comply with official requests and official orders shall constitute sufficient cause for revocation of the tele-pass psychology license.

(d) Understand that all conditions of tele-pass psychology license to practice and enforcement shall be pursuant to New Hampshire law.

(e) Grant the New Hampshire board of psychologists and its investigators authority to disclose to law enforcement and related regulatory authorities, at their discretion, information including but not limited to status of application, actions and information pertinent to investigations and enforcement of the laws and rules pertaining to the licensee's conduct.

(f) Not conduct face-to-face in-person psychological services in NH.

IV. The board shall adopt rules pursuant to RSA 541-A for:

(a) The application procedure for a New Hampshire tele-pass psychology license;

(b) Additional requirements for a psychologist licensed in another state of Canada to acquire a tele-pass psychology license, including attestations;

(c)

The standards of care for telemedicine practice of psychology and their enforcement; and

(d) Procedures for the investigation and discipline pursuant to all means authorized in this chapter including but not limited to suspension or revocation of a tele-pass psychology license.

V. Persons who have been granted Emergency Licenses to practice Psychology under the Covid 19 emergency pursuant to the Governor's Emergency Order #29 shall be granted a Tele-Pass license.

VI. Effective date. This Part shall become effective upon passage of the bill.

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PART# ____ SB 133; Part 5

DATE: APRIL 22nd, 2021

Subcommittee Members: Chairman- Representative Roy;
Members; Reps – Lekas, Lanzara, Grote, Schultz

MINUTES

Comments and Recommendations: (or include minutes on separate sheets)

-The meeting opened at about 1:00 pm on 04/22/2021 -Rep Roy read the EO script

- -Rep Schultz had informed Chair Roy that she would be unable to attend and asked that Rep Schmidt replace her
- Rep Schimdt was not in attendance at the beginning of the meeting and Chair Roy asked Rep Goley to replace Rep Schultz. Rep Goley agreed.
- -Rep Schmidt did join later.

-Attending at various points in the meeting were:

- Reps Roy, Lekas Goley, Lanzara, Grote, Schuett, Schmidt
- Senator Sherman
- Tom Broderick
- Tina Kelley
- Susan Adams - ASHA
- Dan Logsdon - Director, National Center for Interstate Compacts at The Council of State
- Governments
- Pam Smarling

-Questions were asked about the development of the language in this section.

Tina Kelley said that the Council of State Governments developed it and that NH was already a member of other similar compacts. In particular the PT compact that NH has been a member of for about 4 years.

-**Questions were asked** about the number of States already in these compacts.
Pam Smarling later sent an email with this information.

-**Rep Grote offered to send** us information presented during the Senate hearing on this bill. Chair Roy asked her to do so.

-**Rep Goley asked** if this was originally or mainly intended to assist military families. Mr Broderick and/or Ms Adams answered that they did not know if that was the initial reason but that the compact applied more generally.

Discussion Followed

- -There was extensive discussion about how misconduct was handled under the compact and what the authority of OPLC and the NH boards would be.

- -There was extensive discussion of fees that could be charged for out of state participants operating in NH and how they would be set.

- -There was discussion of how the compact would handle practitioners moving. The conclusion was that if someone moved to NH they must get a NH license.

- -There was a very extensive discussion of the fees the compact could charge NH, what control NH would have over those fees, and where the money would come from. There were concerns about providing the compact with a blank check.

Mr Broderick and perhaps others indicated that for the current compacts under OPLC the fees were either zero or in the case of the Nursing Compact they were $6,000/year.

-**Chair Roy expressed concern** about many people practicing in NH, generating work for OPLC and the boards, and costing them money. Rep. Goley concurred. OPLC indicated that their would be a fee for out of state practitioners to recoup lost licensing fees.

-**Rep Schmidt made extensive remarks** concerning peoples' rights to move in the US including some of his history of coming to NH and the value of having people come to NH especially given the shortage of practitioners in various areas. He also expressed concern about remarks made about people flooding into NH.

-**Rep Goley responded** that his remarks were not intended to object to people coming to NH.

-**Rep Lekas indicated general support** for the compact and making it easier for people to move and work where they wanted but he indicated that it was our responsibility to do our due diligence.

Subcommittee concensus

-The language in the bill permits out of state members of the compact who practice in NH to be charged a fee and that fee could be used to cover all costs related to the compact.
-There was a consensus of the Sub Committee members that the bill should be amended to specify that any costs be paid for by OPLC.

-**Mr Broderick was asked to propose language** for such an amendment. He agreed to speak with the director about this but he did not expect any objection. He agreed to propose the language.

-Chair Roy said that he would schedule another meeting sometime next week to finalize the Sub Committee's business.

-The Sub Committee was adjourned at approximately 2:45 PM.

Minutes respectfully submitted by, Terry W. Roy
Subcommittee Chair / Clerk

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PART# SB 133; Part 7

DATE: APRIL 22nd, 2021

Subcommittee Members: Reps. McGuire, Roy, Sytek, S. Pearson, Yakubovich, T. Lekas, Alliegro, Bailey, Lanzara, Santonastaso, Goley, Schuett, Jeudy, P. Schmidt, Schultz, Fellows, Fontneau, Grote and O'Brien

MINUTES

Comments and Recommendations: (or include minutes on separate sheets)

THE SUBCOMMITTEE REVIEWED THE SECTION (PART 7) WITH OPLC ATTORNEYS AND WITH OTHER INTEREST PARTICIPANTS. SEVERAL ISSUES WERE IDENTIFIED AND RESOLVED. OPLC VOLUNTEERED TO DRAFT LANGUAGE TO REFLECT THE RESOLUTION OF THE IDENTIFIED ISSUES.

Minutes respectfully submitted by, [signature: Sytek]

Subcommittee Chair / Clerk

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

2021 SESSION YEAR

1/21/2021 4:03:18 PM
Committee Attendance Registers - All Report

For: 4 / 22 / 21

Executive Departments and Administration			
Employee No.	**Name**	**Div-Seat**	**Signature** EDA MEMBERS
408987	Alliegro, Mark C.	3-028	OBSERVING
409046	Bailey, Glenn	3-044	ZOOM
408836	Fellows, Sallie D.	4-018	
408625	Fontneau, Timothy J.	4-087	
376227	Goley, Jeffrey P.	4-091	Zoom
408923	Grote, Jaci L.	4-061	
376657	Jeudy, Jean L.	5-023	Zoom
409012	Lanzara, Tom E.	2-088	Zoom
408881	Lekas, Tony	3-036	
376841	McGuire, Carol M.	2-090	Carol McGuire
376720	O'Brien, Michael B.	4-098	Zoom
408906	Pearson, Stephen C.	1-008	Zoom
408925	Roy, Terry	2-089	ZOOM
409052	Santonastaso, Matthew	2-087	
376521	Schmidt, Peter B.	4-096	ZOOM
376862	Schuett, Dianne E.	4-009	
408808	Schultz, Kristina M.	4-095	
375692	Sytek, John	2-007	J Sytek
408896	Yakubovich, Michael	3-063	

Total Committee Members: 19

Speaker's Authorization **Date Keyed:** **Received by Legislative Accounting**

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PART# SB 133; Part 7

DATE: APRIL 29, 2021

Subcommittee Members: Sytek, O'Brien, Fontneau, Jeudy, McGuire

MINUTES

Comments and Recommendations: (or include minutes on separate sheets)

THE SUBCOMMITTEE REVIEWED THE CHANGES WHICH IT HAD REQUESTED AT ITS PREVIOUS MEETING (THE FIRST MTG) THESE CHANGES WERE MADE BY OPLC. OPLC ALSO SUGGESTED OTHER CHANGES. THESE INVOLVED ELIMINATING REDUNDANCIES AND MOVING ONE SECTION TO MAKE CLEAR ITS GENERAL APPLICABILITY. THE SUBCOMMITTEE ALSO MADE ONE SLIGHT WORDING CHANGE. THERE WERE NO VOTES TAKEN BUT THERE WAS CONSENSUS TO ASK OPLC TO MAKE A FINAL VERSION OF PART VII.

THERE WAS CONSENSUS THAT AN ADDITIONAL MEETING OF THE SUBCOMMITTEE COULD BE INCORPORATED INTO A FULL ED+A COMMITTEE INASMUCH AS THE CHANGES WERE ALL AGREED ON.

Minutes respectfully submitted by, [signature]

Subcommittee Chair / Clerk

Subcommittee Work Session

April 29th 2021

Subcommittee Chair Yakubovich;

Clerk Bailey, Member Reps – Roy, Goley, Fellows

SB 133

PART I – 1	Motion OTP Bailey/ Yakubovich	Vote 5-0
PART II 2	Motion ITL Roy / Yakubovich	Vote 3-2
PART III -	Motion OTP Fellows / Roy	Vote 5-0
PART IV	Motion OTP Fellows/ Goley	Vote Failed 2-3
PART IV	Motion ITL Bailey / Yakubovich	Vote 3-2 Passed
PART VI	Motion ITL Bailey/ Yakubovich	Vote 3-2
PART VIII	Motion ITL Fellows/ Golly	Vote 5-0
PART IX	Motion OTP/**Am#** Yakubovich/ Goley	Vote 5-0 with Amendment
PART X	Motion OTP Yakubovich/ Roy	Vote 5-0
PART XI	Motion OTP/ **AM#** Yakubovich/ Roy	Vote 5-0 with Amendment
PART XII	Motion OTP/ AM# Yakubovich /Roy	Vote 3-2 with Amendment
PART XIII	Motion OTP Yakubovich / Roy	Vote 4-1

Part I – Subcommittee Clerk's Minutes – Rep Bailey

Part II - Subcommittee Clerk's Minutes – Rep Bailey

Roy spoke opposed; Goley spoke in favor, Schmidt ? ____; O'Brien in favor.
Dan Mann, Compact & Commission for Replica, spoke, opposed; Goley rebuttle; Roy questioned scope & protocols, Mann respond; Chief Justin Romanello answered; Dan Mann answered; Roy sought example of compact in use; Mann verified; Goley asked about temp. licensure vs compact. Romanello replied compact quicker, Goley follow-up; which protocol in effect? Romanello : NH protocol. Goley follow-up: any exam on NH protocol? Romanello: They must "satisfy" NH protocol prior to working (2 hour process); Roy access to co-ordinated database? Mann emergency orders allow for less access; Chris Stawasz (Medical Response Solution) spoke opposed; Christoper Arnold (Dept of Defense – state liaison office) spoke opposed; Eric Schelberg (NH paramedic) spoke opposed; Rep Schmidt asked for more; Schelberg deferred to Mann & Romanello; Rep Schultz for Arnold – have you worked in states writing legislation for military spouse w/o compact? Arnold seeks 30 day turnaround on licensure.
Arnold: compact most effective option but DOD works with other approaches. Brian Ryll professional firefighters of NH, compact is for day to day use, what he has heard is sometimes contradictory. We have not used replica model in ~~con~~ current emergency. Compact solution to problem we do not have. Supports repeal.
Roy motion for ITL, withdrawn.

Dough Wolfberg comment, Roy motion ITL, spoke to compact not having had a chance as yet. Goley to vote against ITL, mentioned boiler plate language, source of money, costs, qualified immunity, military language could be put in NH statutes.

PART III - Subcommittee Clerk's Minutes – Rep Bailey

PART IV - Subcommittee Clerk's Minutes – Rep Bailey

Fellows spoke in favor; Yakubovich opposed.

PART VI – Subcommittee Clerk's Minutes – Rep Bailey

Judy Simpson spoke in favor, Nicole O'Malley Gov Rep of NE Music Therapists in favor' Rep Schmidt asked O'Malley if satisfied with amendment; O'Malley – Yes. Susan Adams of ASHA in favor with amendment; Rep Bailey asked Adams about border. Adams said Yes.

PART VIII – Subcommittee Clerk's Minutes – Rep Bailey

Rep Fellows spoke against; Rep Goley against. Schmidt wanted advice from other committee. McGuire spoke to having taken advise from HHS, who sought removal.

PART XIII

Advanced to accommodate Rep Fellows who had an 3:00 appointment. Fellows' research reveal exceptions, including grocery and convenience stores. She is concerned with restaurants. She is opposed because there is already a process. Sen Guida, Sponsor, thought Fellows in error on several points. He mentioned labor shortages, high turnover, etc, This would save $300 per training which would be a burden, HHS backs this section, Berry put in statute because HHS does not want to deal with it. Rep Goley asks if Coleen Smith available. Roy ask Guida if Aroma Joe's comes under HHS or has received waiver. Guida says it would cost tens of thousands for a small business. Fellows asked should business with 5 employees that sell raw oyster should be exempt? Guida this does not reduce safety, nor does having such a mgr guarantee safety. Roy observed. Colleen Smith of HHS. Goley what is defin of 5 food emp? Smith gave devin which excludes wait staff. Is there a waiver process? Smith – Yes.

definition definition employees

Goley – rule making? Smith, we craft rules to fit statute. Mike Sillen of Aroma Joe's . Every city does not have health inspectors. They use HHS. Those cities with health inspectors need their own variance. This would be statewide. Roy for Smith – Are the variances only good for a year. They grant about 20 per year. Roy: How about this instance? New requirement and with Covid there have been few. Sillen: self-inspecting cities look to state. Fellows asks Smith if she is comfortable with statute permitting raw seafood exception? Smith – those would be a Food Production mgr somewhere on staff, and they do have other oversight and enforcement measures. Guida: B&B exempt from day one. This exempts small businesses from site-by-site requirement. Restaurant Assn supports this bill. Schuett ask if have business es not covered presently? Sillen: In the towns in which I operate some localities require variance, others do not. Schmidt, Is something missing from statute that this bill supplies? Smith – No. We grant exceptions, and this allows for more. Fellows isn't it the nature of food rather than size of staff? Smith: This exempts from "all hours of operation". Fellows: How often does wait-staff Food Production Mgr have to visit? Smith – no set schedule. Guida concerned with apparent inability to understand nature of business. Who is most qualified? Fellows: current once-a-year not enough. She was served

under-cooked mussels. Guida – requirement remain in place. Less than 500 incidents from 8000 plus restaurants. Not reducing safety measures, only costs.

PART IX - Subcommittee Clerk's Minutes – Rep Bailey

Tom Broderick of OPLC has concern about need for LNA requirement section. Fellows: paragraph II notwithstanding... training for LNAs... training programs in nursing board rules are one option. Lindsay Courtney: attending approved program at 100 hours has to do with LTC reimbursement. She feels there should be further clarification. Goley : there are issues. Fellows: State should pay for them to move up. Bailey: spoke to it being a battlefield promotion. Fellows: Medicaid reimbursement problem. Courtney – that is no longer a problem through grants and such. Goley: take effect upon passage. Yakubovich: He'd like that too. Roy: What is cost of reimbursement. Courtney: reimbursement from DHHS as part of CSS, not General Fund or agency. Yakubovich: He would remove end date or extend ___ to end of emergency in full committee.

Part X – Subcommittee Clerk's Minutes – Rep Bailey

Fellows: term "letter of concern" in statutes. Chief Romanello: Yes. Roy: difference between "shall" and "may" issues. Romanello: trying to bring this in line with existing rules.

Part XI - Subcommittee Clerk's Minutes – Rep Bailey

Rep McGuire: checked as requested against bill just passed. We should amend "or" to "and/or" to bring them into alignment.

Part XII – Subcommittee Clerk's Minutes – Rep Bailey

John DeJoie NH Psychology Assn. We would remind you of RSA 329:D. We request that you add 329D language as an amendment. Tom Broderick., legal counsel of OPLC, does not necessarily think this is necessary as it seems duplicative.
Rep Goley concurs that it might be duplicative. Also do out of staters pay additional fee? Borderick- they would pay a fee, but not have to get a license. Rep Goley – the fee would somewhat alleviate his concern. Broderick – fee would be charged ($90) but not the license fee ($300). Lindsay Courtney opposed- have board amend rules.
Rep Schmidt – does board have statutory authority already? Courtney- Yes. Rep Ry. [Roy] He has noticed there are a lot of "Apps" online, how does NH handle that? Courtney – If we got word of that, we would report it. Yakubovich, in favor, would aid patients and doctors traveling. Goley – thinks not yet ready for prime time.

OFFICE OF THE HOUSE CLERK

Committee Attendance Registers - All Report

2021 SESSION YEAR

For: 4 / 29 / 21

Yakubovich Subcommittee

Executive Departments and Administration			
Employee No.	**Name**	**Div-Seat**	**Signature**
408987	Alliegro, Mark C.	3-028	
409046	Bailey, Glenn	3-044	Glenn Bailey
408836	Fellows, Sallie D.	4-018	Zoom
408625	Fontneau, Timothy J.	4-087	
376227	Goley, Jeffrey P.	4-091	Zoom
408923	Grote, Jaci L.	4-061	
376657	Jeudy, Jean L.	5-023	
409012	Lanzara, Tom E.	2-088	
408881	Lekas, Tony	3-036	
376841	McGuire, Carol M.	2-090	
376720	O'Brien, Michael B.	4-098	Present not on Sub. (Zoom
408906	Pearson, Stephen C.	1-008	
408925	Roy, Terry	2-089	Zoom
409052	Santonastaso, Matthew	2-087	
376521	Schmidt, Peter B.	4-096	Present not on Sub. (Zoom
376862	Schuett, Dianne E.	4-009	
408808	Schultz, Kristina M.	4-095	Present not on Sub. (Zo
375692	Sytek, John	2-007	
408896	Yakubovich, Michael	3-063	[illegible signature]

Total Committee Members: 19

Speaker's Authorization **Date Keyed:** **Received by Legislative Accounting**

Minutes

Roy

Clerk

Goley

Fellows

chair

I OTP, unanimous vote

II Roy spoke opposed; Goley spoke ~~opposed~~ in favor;
Schmidt ? ; O'Brien in favor

Dan Mann, ~~[illegible]~~, compact & commission for REPLICA
spoke opposed; Goley rebutted; Roy questioned Mann res scope
& protocols; Chief Justin Romanello answered; Dan
Mann answered; Roy ~~questioned~~ sought example of
compact in use, Mann replied; Goley asked about
temp. licensure vs. compact. Romanello replied compact quicker;
Goley followup: which protocol in effect? Romanello: NH protocol
Goley followups any exam on NH protocol? Romanello: They must
'satisfy' NH protocol prior to working (2-hr process); Roy access
to co-ordinated database? Mann emergency orders allow for
less access; Chris Stawasz (Medical Response Solution)
spoke opposed; Christopher Arnold (Dept. of Def. State Liason office) spoke
opposed; Eric Schelberg NH paramedic spoke opposed; Schmidt asked
for more; Schelberg deferred to Mann & Romanello; Schultz
for Arnold: have you worked w states writing leg for mil. spouse w/o
compact? Arnold seeks 30-day turnaround on licensure

(2.)

Roy, Clerk, Goley, Fellows, Chair

Minutes

II continued, Arnold compact most effective option but DOD works w/ other approaches Brian Ryll, professional firefighters of NH, compact is for day-to-day use, what he has heard is somewhat contradictory. We have not used Replica model in current emergency. Compact a solution to problem we do not have. Supports repeal. Roy motion for ITL, withdrawn. Doug Wolfberg comment, Roy motion ITL, spoke to compact not having had a chance as yet. Goley to vote against ITL mentioned boiler plate language, source of money, costs, qualified immunity, military language could be put in NH statutes, ~~Schmidt~~

III

IV Fellows spoke in favor; Yakubovich opposed

VI Judy Simpson spoke in favor, Nicole O'Malley Govt rep. of NE Music Therapists in favor, Schmidt asked if O'Malley ~~satisfied~~ w amendment, O'Malley yes. Susan Adams of ASHA in favor w/ amendment; Bailey asked Adams ~~about~~ border. Adams said yes

(3)

minutes

SEC VIII Fellows spoke against; Goley against.

~~McGuire~~ Schmitt wanted advice from other committee

McGuire spoke to having taken advice from HHS, who sought removal.

SEC. XIII Advanced to accomodate Rep. ~~[illegible]~~ Fellows, who had a 3:00 blood donation appointment, Fellows' research reveal exceptions, including grocery & convenience stores. She is concerned w restaurants. She is opposed b/c there is already a process. Sen. Gurda, sponsor, thought Fellows in error on several points. He mentioned labor shortages, high turnover, etc. This would save $300 per training, which would be a burden. HHS backs this section, Barry put in statute b/c HHS does not want to deal with it. Goley asks if Coleen Smith available. Roy ask Gurda if Aroma Joe's comes under HHS or has received waiver. Gurda says it would cost tens of thousands for a small business. Fellows should business w 5 emp that sell raw oyster should be exempt? Gurda this does not reduce safety, nor does having such a mgr. guarantee safety. Roy ~~questioned~~ observed. Coleen Smith of HHS. Goley what is def. of 5 food emp? Smith gave def., which excludes waitstaff. Is there a waiver process? Smith yes

(4)

Sec. XIII cont, Boley rulemaking? Smith we craft rules to fit statute. Mike Sillen of Amatoe's. Every city does not have health inspectors. They use HHS. Those cities w health inspectors need their own variance. This would be statewide. Roy for Smith. Are the variances only good for a year. They grant about 20 per year. Roy: How about this instance & New requirement and w Covid there have been few. Sillen: self-inspecting cities look to state. Fellows ask Smith if she is comfortable w statute permitting raw seafood exception? Smith there would be a fl mgr somewhere on staff, and they do have other oversight and enforcement measures. Gurda: B&B exempt from day one. This exempts small businesses from site-by-site requirement. Restaurant Assn supports this bill. Schmidt ask if there businesses not covered presently? Sillen: In the towns in which I operate some localities require variance others do not. Schmidt, Is something missing from statute that this bill supplies? Smith. No. ~~This~~ we grant exceptions, and this allows for more. Fellows. Isn't it the nature of food rather than size of staff? Smith: This exempts from "all hours of operation". Fellows: How often does on-staff fl mgr have to visit? Smith. No set schedule. ~~...~~ Gurda concerned with apparent inability to understand nature of business. Who is most qualified? Fellows: current once-a-year not enough. She was served under-cooked mussels. Gurda, Requirement remain in place. Less than 500 incidents from 8000 plus restaurants. Not reducing safety measures, only costs.

minutes

See: IX. Tom Broderick of OPLC has concern about need for ~~NLA~~ LNA requirement section, Fellows: paragraph II notwithstanding ... training for LNAs... training programs in Nursing board rules are one option Lindsay Courtney: Attending approved program at 100 hours has to do with LTC reimbursement, she feels there should be further clarification Foley: There issues. Fellows state should pay for them to move up. Bailey: spoke to it being a battlefield promotion. Fellows. Medicaid reimbursement problem. Conway that is no longer a problem through grants & such. Foley: take effect upon passage, Yakubovich: He'd like that too, Roy: what is cost of reimbursement, Courtney: reimbursement from DHHS as part of CSS, not general fund or agency, Yakubovich. He would remove end date to end of emergency or extend in full committee

See X, Fellows: term "letter of concern" in statutes Chief Romanello: yes Roy: difference between shall and may issue, Romanello: Trying to bring this in line w existing rules.

4/29/21 (6)

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PARTs - SB 133; Parts I, II, III, IV, --, VI, --, VIII, IX, X, XI, XII, XIII

DATE: APRIL 29, 2021

Subcommittee Chair: Rep Yakubovich
Subcommittee members: REPS -Bailey, Goley, Fellows, Roy

MINUTES
Comments and Recommendations: (or include minutes on separate sheets)

SB133, Sec. XI.
Rep. McGuire: checked as requested against bill just passed. We should amend "or" to "and/or" to bring them into alignment.

SB133, Sec. XII John DeJore NH Psychology Assn. We would remind you of RSA 329:D. We request that you add 329D language as an amendment. Tom Broderick legal counsel of OPLC, does not necessarily think this is necessary as it seems duplicative.
Rep. Goley concurs that it might be duplicative. Also do out of staters pay additional fee? Broderick: they would pay a fee but not have to get a license. Rep. Goley the fee would somewhat alleviate his concern. Broderick, fee would be charged ($90) but not the license fee ($300). Lindsay Courtney opposed, have board amend rules.

Minutes respectfully submitted by, Glenn Bailey
Subcommittee Chair / ~~Clerk~~

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION **on bill # SB 133**

BILL Title / PARTs - SB 133; Parts I, II, III, IV, --, VI, --, VIII, IX, X, XI, XII, XIII

DATE: APRIL 29, 2021

Subcommittee Chair: Rep Yakubovich
Subcommittee members: REPS -Bailey, Goley, Fellows, Roy

MINUTES

Comments and Recommendations: (or include minutes on separate sheets)

SB 133, Sec. XII Rep Schmidt does board have statutory authority already? Courtney: Yes. ~~Rep. Schmidt~~: Rep. Roy: He has notice there are a lot of "apps" online, how does NH handle that? Courtney. If we got wind of that, we would report it. Yakubovich, in favor, would add patients and doctors traveling. Goley, thinks not yet ready for prime time.

Minutes respectfully submitted by, ______________________

Subcommittee Chair / Clerk

Subcommittee Work Session

April 29th 2021

Subcommittee Chair Yakubovich;

Clerk Bailey, Member Reps – Roy, Goley, Fellows

SB 133

PART I	Motion OTP Bailey/ Yakubovich	Vote 5-0
PART II	Motion ITL Roy / Yakubovich	Vote 3-2
PART III -	Motion OTP Fellows / Roy	Vote 5-0
PART IV	Motion OTP Fellows/ Goley	Vote Failed 2-3
PART IV	Motion ITL Bailey / Yakubovich	Vote 3-2 Passed
PART VI	Motion ITL Bailey/ Yakubovich	Vote 3-2
PART VIII	Motion ITL Fellows/ Golly	Vote 5-0
PART IX	Motion OTP/**Am#** Yakubovich/ Goley	Vote 5-0 with Amendment
PART X	Motion OTP Yakubovich/ Roy	Vote 5-0
PART XI	Motion OTP/ **AM#** Yakubovich/ Roy	Vote 5-0 with Amendment
PART XII	Motion OTP/ AM# Yakubovich /Roy	Vote 3-2 with Amendment
PART XIII	Motion OTP Yakubovich / Roy	Vote 4-1

Part I – Subcommittee Clerk's Minutes – Rep Bailey

Part II - Subcommittee Clerk's Minutes – Rep Bailey

Rep Roy spoke opposed; Rep Goley spoke in favor, Rep Schmidt; Rep O'Brien in favor.
Dan Mann, Compact & Commission for Replica, spoke, opposed;

Rep Goley rebuttal; Rep Roy questioned scope & protocols, Mann respond; Chief Justin Romanello answered; Dan Mann answered;
Rep Roy sought example of compact in use; Mann verified;
Rep Goley asked about temp. licensure vs compact.
Romanello replied compact quicker, Rep Goley follow-up; which protocol in effect?
Romanello : NH protocol. Goley follow-up: any exam on NH protocol? Romanello: They must "satisfy" NH protocol prior to working (2 hour process);
Rep Roy access to coordinated database?

Mann emergency orders allow for less access;
Chris Stawasz (Medical Response Solution) spoke opposed;
Christohper Arnold (Dept of Defense – state liaison office) spoke opposed;

Eric Schelberg (NH paramedic) spoke opposed;
Rep Schmidt asked for more;
Schelberg deferred to Mann & Romanello;

Rep Schultz for Arnold – have you worked in states writing legislation for military spouse w/o compact? Arnold seeks 30 day turnaround on licensure.
Arnold compact most effective option but DOD works with other approaches.
Brian Ryll professional firefighters of NH, compact is for day to day use, what he has heard is sometimes contradictory. We have not used replica model in current emergency. Compact solution to problem we do not have. Supports repeal.

Roy motion for ITL, withdrawn.

Dough Wolfberg comment,
Rep Roy motion ITL, spoke to compact not having had a chance as yet.
Rep Goley to vote against ITL, mentioned boiler plate language, source of money, costs, qualified immunity, military language could be put in NH statutes.

PART III - Subcommittee Clerk's Minutes – Rep Bailey

PART IV - Subcommittee Clerk's Minutes – Rep Bailey
Fellows spoke in favor; Yakubovich opposed.

PART VI – Subcommittee Clerk's Minutes – Rep Bailey
Judy Simpson spoke in favor, Nicole O'Malley Gov Rep of NE Music Therapists in favor' Rep Schmidt asked O'Malley if satisfied with amendment; O'Malley – Yes. Susan Adams of ASHA in favor with amendment; Rep Bailey asked Adams about border. Adams said Yes.

PART VIII – Subcommittee Clerk's Minutes – Rep Bailey
Rep Fellows spoke against; Rep Goley against. Schmidt wanted advice from other committee. Rep McGuire spoke to having taken advise from HHS, who sought removal.

PART XIII – Subcommittee Clerk's Minutes – Rep Bailey
Advanced to accommodate Rep Fellows who had an 3:00 appointment.

Rep Fellows' research reveal exceptions, including grocery and convenience stores. She is concerned with restaurants. She is opposed because there is already a process.
Sen Guida, Sponsor, thought Fellows in error on several points. He mentioned labor shortages, high turnover, etc, This would save $300 per training, which would be a burden HHS backs this section, Berry put in statute because HHS does not want to deal with it.
Rep Goley asks if Coleen Smith available.
Rep Roy ask Guida if Aroma Joe's comes under HHS or has received waiver.
Sen Guida says it would cost tens of thousands for a small business.
Rep Fellows asked should business with 5 employees that sell raw oyster be exempt?
Sen Guida this does not reduce safety, nor does having such a manager guarantee safety.
Rep Roy observed. Colleen Smith of HHS.
Rep Goley; what is definition of 5 food employees?
Rep Smith gave definition, which excludes wait staff. Is there a waiver process?
Rep Smith – Yes.

Rep Goley – rule making?
Rep Smith, we craft rules to fit statute.
Mike Sillen of Aroma Joe's . Every city does not have health inspectors. They use HHS. Those cities with health inspectors need their own variance. This would be statewide.
Rep Roy for Smith – Are the variances only good for a year. They grant about 20 per year.

Rep Roy: How about this instance? New requirement and with Covid there have been few.
Sillen: self-inspecting cities look to state.
Rep Fellows asks Smith if she is comfortable with statute permitting raw seafood exception?
Rep Smith – those would be a Food Producers/ Mgr somewhere on staff, and they do have other oversight and enforcement measures.
Rep Guida: B&B exempt from day one. This exempts small businesses from site-by-site requirement. Restaurant Assn supports this bill.
Rep Schuett ask if have businesses not covered presently?
Sillen: In the towns in which I operate some localities require variance, others do not. Rep Schmidt, Isn't something missing from statute that this bill supplies?
Rep Smith – No. We grant exceptions, and this allows for more.
Rep Fellows – Isn't the nature of food rather than size of staff?
Rep Smith: This exempts from "all hours of operation".
Rep Fellows: How often does wait-staff Food Producer / Mgr have to visit?
Rep Smith – no set schedule.
Sen Guida concerned with apparent inability to understand nature of business. Who is most qualified?
Rep Fellows: current once-a-year not enough. She was served under-cooked mussels.
Sen Guida – requirement remain in place. Less than 500 incidents from 8000 plus restaurants. Not reducing safety measures, only costs.

PART IX - Subcommittee Clerk's Minutes – Rep Bailey

Tom Broderick of OPLC has concern about need for LNA requirement section.
Rep Fellows: paragraph II notwithstanding… training for LNAs… training programs in nursing board rules are one option.
Lindsay Courtney: attending approved program at 100 hours has to do with LTC reimbursement. She feels there should be further clarification.
Rep Goley : there are issues.
Rep Fellows: State should pay for them to move up.
REp Bailey: spoke to it being a battlefield promotion. Rep
Fellows: Medicaid reimbursement problem.
Courtney – that is no longer a problem through grants and such.
Rep Goley: take effect upon passage.
Rep Yakubovich: He'd like that too.
Rep Roy: What is cost of reimbursement.
Courtney: reimbursement from DHHS as part of CSS, not General Fund or agency.
Yakubovich: He would remove end date or extend -- to end of emergency in full committee.

Part X – Subcommittee Clerk's Minutes – Rep Bailey

Fellows: term "letter of concern" in statutes. Chief Romanello: Yes. Roy: difference between "shall" and "may" issues. Romanello: trying to bring this in line with existing rules.

Part XI - Subcommittee Clerk's Minutes – Rep Bailey

Rep McGuire**:** checked as requested against bill just passed. We should amend "or" to "and/or" to bring them into alignment.

Part XII – Subcommittee Clerk's Minutes – Rep Bailey

John DeJoie NH Psychology Assn. We would remind you of RSA 329:D. We request that you add 329D language as an amendment.
Tom Broderick., legal counsel of OPLC, does not necessarily think this is necessary as it seems duplicative.
Rep Goley concurs that it might be duplicative. Also do out of staters pay additional fee?

Atty Broderick;- they would pay a fee, but not have to get a license.
Rep Goley – the fee would somewhat alleviate his concern.
Broderick – fee would be charged ($90) but not the license fee ($300).
Lindsay Courtney opposed- have board amend rules.
Rep Schmidt – does board have statutory authority already? Courtney- Yes.
Rep Roy- He has noticed there are a lot of "Apps" online, how does NH handle that? Courtney – If we got word of that, we would report it.
Rep Yakubovich, in favor, would aid patients and doctors traveling.
Rep Goley – thinks not yet ready for prime time.

Respectfully submitted by,
Rep Glenn Bailey
Committee Clerk

HOUSE SCHEDULING NOTICE

Executive Departments and Administration

SUBCOMMITTEE WORK SESSION

*Work Session ONLY on Part V of SB 133

Tuesday, 5/4/21

REMOTE 000

Subcommittee Chairman Rep Roy
Subcommittee Members: Reps - Lekas, Lanzara, Grote, Schultz

9:30 a.m.	SB 133-FN	adopting omnibus legislation relative to occupational licensure.
		Work Session ONLY on Part V of SB 133

Committee members will receive secure Zoom invitations via email.

Members of the public may attend using the following links:

1. To join the webinar: https://zoom.us/j/91038843098
2. Or Telephone: 1-929-205-6099
3. Webinar ID: 910 3884 3098

The following email will be monitored throughout the meeting by someone who can assist with and alert the committee to any technical issues: hcs@leg.state.nh.us or call (603-271-3600).

Sponsors: SB 133; Part V
BILL SPONSORSHIP - Part V: LSR 21-0846, adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact, sponsored by Sen. Sherman, Prime/Dist 24; Sen. Soucy, Dist 18; Sen. Carson, Dist 14; Rep. March, Carr. 8

Committee Asst: Miriam Simmons — Carol M. McGuire, Chairman
Scheduled By: Miriam Simmons - 271-3600
Created: April 26, 2021 2:48 p.m.

Sub-Committee Actions

Subcommittee Work Session

April 29th 2021

Subcommittee Chair Yakubovich;

Clerk Bailey, Member Reps – Roy, Goley, Fellows

SB 133

PART I – 1	Motion OTP Bailey/ Yakubovich	Vote 5-0
PART II 2	Motion ITL Roy / Yakubovich	Vote 3-2
PART III -	Motion OTP Fellows / Roy	Vote 5-0
PART IV	Motion OTP Fellows/ Goley	Vote Failed 2-3
PART IV	Motion ITL Bailey / Yakubovich	Vote 3-2 Passed
PART VI	Motion ITL Bailey/ Yakubovich	Vote 3-2
PART VIII	Motion ITL Fellows/ Golly	Vote 5-0
PART IX	Motion OTP/**Am#** Yakubovich/ Goley	Vote 5-0 with Amendment
PART X	Motion OTP Yakubovich/ Roy	Vote 5-0
PART XI	Motion OTP/ **AM#** Yakubovich/ Roy	Vote 5-0 with Amendment
PART XII	Motion OTP/ AM# Yakubovich /Roy	Vote 3-2 with Amendment
PART XIII	Motion OTP Yakubovich / Roy	Vote 4-1

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PARTs - SB 133; Parts I, II, III, IV, --, VI, --, VIII, IX, X, XI, XII, XIII

DATE: APRIL 29, 2021

Subcommittee Chair: Rep Yakubovich
Subcommittee members: REPS -Bailey, Goley, Fellows, Roy

Section I of SB133-FN

MOTIONS: (OTP), OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment 5-0

(Please circle one motion)

Moved by Rep. Bailey Seconded by Rep. Yakubovich AM Vote: ______

Adoption of Amendment # ____________

Moved by Rep. ____________ Seconded by Rep. ____________ Vote: OTP Y N

______ Amendment Adopted ______ Amendment Failed IIIII 0

Section II of SB133-FN

MOTIONS: OTP, OTP/A, (ITL), Retained (1st Yr), Interim Study (2nd Yr), Amendment ITL 3-2

(Please circle one motion)

Moved by Rep. Roy Seconded by Rep. Yakubovich AM Vote: ______

Adoption of Amendment # ____________

Moved by Rep. ____________ Seconded by Rep. ____________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Respectfully submitted,

Rep. ____________________
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PARTs - SB 133; Parts I, II, III, IV, --, VI, --, VIII, IX, X, XI, XII, XIII

DATE: APRIL 29, 2021

Subcommittee Chair: Rep Yakubovich
Subcommittee members: REPS -Bailey, Goley, Fellows, Roy

Section III of SB133-FN

MOTIONS: (OTP) OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

Moved by Rep. Fellows Seconded by Rep. Roy AM Vote: OTP 5-0

Adoption of Amendment # ______

Moved by Rep. ______ Seconded by Rep. ______ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Section IV of SB133-FN

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

OTP Moved by Rep. Fellows Seconded by Rep. Goley AM Vote: Failed 2-3

Adoption of Amendment # ______

ITL Moved by Rep. Bailey Seconded by Rep. Yakubovich Vote: Passed 3-2

______ Amendment Adopted ______ Amendment Failed

Respectfully submitted,

Rep. ______
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PARTs - SB 133; Parts I, II, III, IV, --, VI, --, VIII, IX, X, XI, XII, XIII

DATE: APRIL 29, 2021

Subcommittee Chair: Rep Yakubovich
Subcommittee members: REPS -Bailey, Goley, Fellows, Roy

sec VII of SB 133

MOTIONS: OTP, OTP/A, (ITL) Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

Moved by Rep. Bailey Seconded by Rep. Yakubovich AM Vote: ITL 3-2

Adoption of Amendment # ____________

Moved by Rep. ____________ Seconded by Rep. ____________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Sec VIII of SB 133

MOTIONS: OTP, OTP/A, (ITL) Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

Moved by Rep. Fellows Seconded by Rep. Goley AM Vote: ITL 5-0

Adoption of Amendment # ____________

Moved by Rep. ____________ Seconded by Rep. ____________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Respectfully submitted,

Rep. ____________________
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PARTs - SB 133; Parts I, II, III, IV, --, VI, --, VIII, IX, X, XI, XII, XIII

DATE: APRIL 29, 2021

Subcommittee Chair: Rep Yakubovich
Subcommittee members: REPS -Bailey, Goley, Fellows, Roy

Sec. XIII of SB133

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion) OTP 4-1

Moved by Rep. Yakubovich Seconded by Rep. Roy ~~AM Vote:~~ ______

Adoption of Amendment # ____________

Moved by Rep. ____________ Seconded by Rep. ____________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Sec IX of SB133

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion) OTPA 5-0

Moved by Rep. Yakubovich Seconded by Rep. Goley AM Vote: ______

Adoption of Amendment # ____________

Moved by Rep. ____________ Seconded by Rep. ____________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Respectfully submitted,

Rep. ____________
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PARTs - SB 133; Parts I, II, III, IV, --, VI, --, VIII, IX, X, XI, XII, XIII

DATE: APRIL 29, 2021

Subcommittee Chair: Rep Yakubovich
Subcommittee members: REPS -Bailey, Goley, Fellows, Roy

SB 133 Sec X

MOTIONS: (OTP) OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

OTP 5-0

Moved by Rep. Yakubovich Seconded by Rep. Roy AM Vote: ______

Adoption of Amendment # ______________________

Moved by Rep. ____________________ Seconded by Rep. __________________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

SB 133 Sec, XI

MOTIONS: ~~OTP~~, (OTP/A), ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

OTPA 5-0

Moved by Rep. Yakubovich Seconded by Rep. Roy AM Vote: ______

Adoption of Amendment # ______________________

Moved by Rep. ____________________ Seconded by Rep. __________________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Respectfully submitted,

Rep. ____________________________
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133

BILL Title / PARTs - SB 133; Parts I, II, III, IV, --, VI, --, VIII, IX, X, XI, XII, XIII

DATE: APRIL 29, 2021

Subcommittee Chair: Rep Yakubovich
Subcommittee members: REPS -Bailey, Goley, Fellows, Roy

SB 133, Sec XII

MOTIONS: OTP, (OTP/A), ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion) OTPA 3-2.

Moved by Rep. Yakubovich Seconded by Rep. Roy AM Vote: ______

Adoption of Amendment # ____________________

Moved by Rep. ________________ Seconded by Rep. ________________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

Moved by Rep. ________________ Seconded by Rep. ________________ AM Vote: ______

Adoption of Amendment # ____________________

Moved by Rep. ________________ Seconded by Rep. ________________ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Respectfully submitted,

Rep. ______________________
Subcommittee Chairman/Clerk

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

Definition of 'licensing agency' in licensing places of assembly

2021 SESSION

Executive Departments and Administration

Bill #: SB 133-FN **Motion:** Sec. 1 OTP **AM #:** **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	✓		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	✓		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	✓		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.	✓		
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.	✓		
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

OTP
Passed
5-0

OFFICE OF THE HOUSE CLERK

Repealing EMS interstate compact

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

Bill #: SB 133-FN **Motion:** Sec. II ITL **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.		N	
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.		N	
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

ITL passed 3-2

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** Sec 3 OTP **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.	Y		
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.	Y		
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

OTP Passed
5-0

OFFICE OF THE HOUSE CLERK

(4)

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** Sec IV **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman		N	
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	~~Y~~	N	
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn		N	
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.	Y		
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.	Y		
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

OTP FAILED
3-2

OFFICE OF THE HOUSE CLERK

(5)

ITL
2 of 2

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** Sec. W **AM #:** ____ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.		N	
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.		N	
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

ITL Passed
3-2

OFFICE OF THE HOUSE CLERK

(6)

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** See, VI **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.		N	
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.		N	
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

ITL Passed
3-2

(7)

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** Sec VIII ITL **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.	Y		
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.	Y		
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

5-0
ITL

(8)

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** SEC. XIII **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.	Y		
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.		N	
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

OTP
Passed 4-1

(9)

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** See IX **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.	Y		
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.	Y		
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

5-0 OTPA

(10)

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Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** See X **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.	Y		
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.	Y		
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

OTP
5-0

(11)

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Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** See. X1 **AM #:** ______ **Exec Session Date:** 4/29/21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.	Y		
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.	Y		
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

(12)

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** See, XII **AM #:** ______ **Exec Session Date:** ______

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	Y		
Sytek, John Clerk			
Pearson, Stephen C.			
Yakubovich, Michael	Y		
Lekas, Tony			
Alliegro, Mark C.			
Bailey, Glenn	Y		
Lanzara, Tom E.			
Santonastaso, Matthew			
Goley, Jeffrey P.		N	
Schuett, Dianne E.			
Jeudy, Jean L.			
Schmidt, Peter B.			
Schultz, Kristina M.			
Fellows, Sallie D.		N	
Fontneau, Timothy J.			
Grote, Jaci L.			
O'Brien, Michael B.			
TOTAL VOTE:			

OTPA
Passed 3-2

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

SUBCOMMITTEE WORK SESSION on bill # SB 133 Non-Germ AMD

BILL Title / PART# 14 **SB 133; Non-germane amendment 2021-1162h**

DATE: MAY 4, 2021

Subcommittee Members: CHAIR Sytek REPS: O'Brien, Fontneau, Jeudy, McGuire (ALL PRESENT)

MOTIONS: OTP, OTP/A (circled; ADOPT AMENDMENT), ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

Moved by Rep. McGUIRE Seconded by Rep. SYTEK AM Vote: 4-0

Adoption of Amendment # NO NUMBER YET - AGREED ON LANGUAGE TO BE DRAFTED INTO THE OVERALL AMENDMENT TO SB 133

Moved by Rep. ______ Seconded by Rep. ______ Vote: ______

______ Amendment Adopted ______ Amendment Failed

MOTIONS: OTP, OTP/A, ITL, Retained (1st Yr), Interim Study (2nd Yr), Amendment ______

(Please circle one motion)

Moved by Rep. ______ Seconded by Rep. ______ AM Vote: ______

Adoption of Amendment # ______

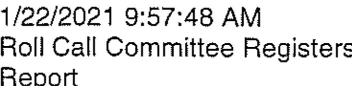
Moved by Rep. ______ Seconded by Rep. ______ Vote: ______

______ Amendment Adopted ______ Amendment Failed

Respectfully submitted,

Rep. [signature]
Subcommittee Chairman/Clerk

WORK SESSION



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Roll Call Committee Registers
Report

MOVED YAKUBOVICH – SANTONASTASO

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP SECTION 1 **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.			
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.			
O'Brien, Michael B.	X		
TOTAL VOTE:			

16-0

Work Session Poll

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Roll Call Committee Registers Report

Pearson- Goley

2021 SESSION

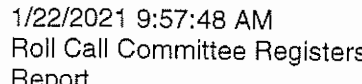
Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP OTP Section 2 **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman		X	
Roy, Terry Vice Chairman		X	
Sytek, John Clerk		X	
Pearson, Stephen C.	X		
Yakubovich, Michael		X	
Lekas, Tony		X	
Alliegro, Mark C.	X		
Bailey, Glenn		X	
Lanzara, Tom E.	X		
Santonastaso, Matthew		X	
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.		X	
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

11-8

WORK SESSION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Roll Call Committee Registers Report

YAKUBOVICH - ROY

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ITL Section 2 **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.		X	
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.		X	
Bailey, Glenn	X		
Lanzara, Tom E.		X	
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.		X	
Jeudy, Jean L.		X	
Schmidt, Peter B.	X		
Schultz, Kristina M.		X	
Fellows, Sallie D.		X	
Fontneau, Timothy J.		X	
Grote, Jaci L.			
O'Brien, Michael B.		X	
TOTAL VOTE:	8	10	

WORK SESSION

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Roll Call Committee Registers
Report

YAKUBOVICH — FELLOWS

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP SECTION 3 **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.			
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.			
O'Brien, Michael B.	X		
TOTAL VOTE:			

16-0

WORK SESSION POLL

OFFICE OF THE HOUSE CLERK

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Roll Call Committee Registers
Report

YAKUBOVICH - ALLIEGRO

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** ITL SECTION 4 **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.		X	
Jeudy, Jean L.		X	
Schmidt, Peter B.		X	
Schultz, Kristina M.		X	
Fellows, Sallie D.	X		
Fontneau, Timothy J.		X	
Grote, Jaci L.			
O'Brien, Michael B.		X	
TOTAL VOTE:			

11 - 7

WORK SESSION ROLL

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Roll Call Committee Registers
Report

ROY - SCHMIDT

ROY - SCHM

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** SECT 5 OTP/A **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
	X		
McGuire, Carol M. Chairman			
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.		X	
Jeudy, Jean L.		X	
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.		X	
O'Brien, Michael B.		X	
TOTAL VOTE:			

12 - 6

Work session roll

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

ROY-SCHULTZ

2021 SESSION

Executive Departments and Administration

Bill #: SB133 **Motion:** ~~OTP~~ ADOPT AMENDMENT SECTION 5 **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

WORK SESSION POLL

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

McGUIRE - GOLEY

2021 SESSION

Executive Departments and Administration Mc - GOL

Bill #: SB 133 **Motion:** OTP/A VII **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

18-0

WORK SESSION POLL

OFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers Report

2021 SESSION

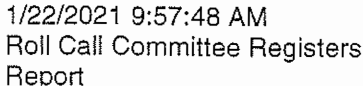
Executive Departments and Administration McGUIRE ^ GOLEY

Bill #: SB 133 **Motion:** SECTION 7 ADOPT AMENDMENT **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.			
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

18-0

WORK SESSION ROLL



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Roll Call Committee Registers Report

2021 SESSION Y.AKUBOVICH-BAILEY

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP/A SECTION IX **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman			
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

16-2

WORK SESSION POLL

OFFICE OF THE HOUSE CLERK

PEARSON
YAKUBOVICH - [illegible]
YAK - [illegible]

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Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration

FURTHER AMENDMENT
• Change effect date to upon passage.
• Remove April 1 - anniversary

Bill #: SB 133 **Motion:** SECTION [illegible] **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

WORK SESSION POLL

OFFICE OF THE HOUSE CLERK

1/22/2021 9:57:48 AM
Roll Call Committee Registers
Report

2021 SESSION

Executive Departments and Administration YAKUBOVICH / PEARSON

Bill #: SB 133 **Motion:** ADOPT IX AMENDMENT **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.		X	
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

17-2

WORK SESSION ROLL

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Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration YAKUBOVICH - PEARSON

Bill #: SB 133 **Motion:** OTP X **AM #:** **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

WORK SESSION ROLL

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Roll Call Committee Registers Report

2021 SESSION

Executive Departments and Administration LEKAS-MCGUIRE

Bill #: SB 133 **Motion:** OTP/A Sections XI **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:	19-0		

WORK SESSION POLL

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Roll Call Committee Registers Report

LEKAS - McGUIRE

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 Motion: ADOPT AMEND 1260H SECTION II AM #: Exec Session Date: 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.	X		
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.	X		
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:			

19-0

WORK SESSION POLL

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Roll Call Committee Registers Report

YAKUBOVICH-McGUIRE

2021 SESSION

Executive Departments and Administration

Bill #: SB 133 **Motion:** OTP SECTION XIII **AM #:** ______ **Exec Session Date:** 5-4-21

Members	YEAS	Nays	NV
McGuire, Carol M. Chairman	X		
Roy, Terry Vice Chairman	X		
Sytek, John Clerk	X		
Pearson, Stephen C.	X		
Yakubovich, Michael	X		
Lekas, Tony	X		
Alliegro, Mark C.	X		
Bailey, Glenn	X		
Lanzara, Tom E.	X		
Santonastaso, Matthew	X		
Goley, Jeffrey P.	X		
Schuett, Dianne E.			
Jeudy, Jean L.	X		
Schmidt, Peter B.	X		
Schultz, Kristina M.	X		
Fellows, Sallie D.		X	
Fontneau, Timothy J.	X		
Grote, Jaci L.	X		
O'Brien, Michael B.	X		
TOTAL VOTE:		18-1	

Sub-Committee

work on

Proposed Amendments

-on Omnibus Bill Sections

Amendment for Psychology Tele-Pass license, Part XII of SB133, May 14, 2021, by Board of Psych Dr Warner following conference with OPLC Executive Director and input from Committee work session, NHPA request and other updates from recent statutes passed and refinements for the language of the bill.

PART XII Relative to telemedicine provided by out of state psychologists.

1 Psychologists; Electronic Practice of Psychology. RSA 329-B:16 is repealed and reenacted to read as follows:

329-B:16 Electronic Practice of Psychology, Telehealth, Telemedicine.

I. Telepsychology, telehealth, and telemedicine services, as provided by psychologists, include those psychology services that utilize electronic means including audio, video, or other electronic media to engage in visual or virtual presence in contemporaneous time. A New Hampshire tele-pass license shall be required for provision of such care to people in New Hampshire. Contacts that are exempt from this requirement are:

(a) Persons exempted by 329-B:28.

(b) Screenings for inclusion in voluntary research projects that have been properly approved by a New Hampshire based institutional review board.

(c) Psychologists licensed by the board, who may provide tele-psychology services to a person within the state of New Hampshire without acquiring a tele-pass psychology license.

(d) Persons exempted by RSA 329-D.

II. A doctoral level psychologist who is not licensed in New Hampshire shall be eligible to provide telepsychology services to a person in New Hampshire pursuant to RSA 329-D, or providing that the psychologist:

(a) Is licensed in one of the jurisdictions in the United States or Canada;

(b) Is in good standing in all license jurisdictions in the United States and Canada;

(c) Has satisfied conditions determined in rules adopted by the board; and

(d) Has applied for and obtained a valid New Hampshire tele-pass psychology license in accordance with board rules and payment of license fees with effective dates that cover the dates of services provided.

(e)

III. The tele-pass psychology licensee shall agree to conditions including, but not limited to, conditions stipulated by the board that the licensee shall:

(a) Conform to all New Hampshire statutes and rules.

(b) Agree that electronic attendance for appearances shall be deemed adequate for regulatory enforcement purposes and that in-person appearances by the licensee are optional and such associated costs for in-person attendance are the full responsibility of the tele-pass psychology licensee.

(c) Understand that false statements or failure to comply with official requests and official orders shall constitute sufficient cause for revocation of the tele-pass psychology license.

(d) Understand that all conditions of tele-pass psychology license to practice and enforcement shall be pursuant to New Hampshire law.

(e) Grant the New Hampshire board of psychologists and its investigators authority to disclose to law enforcement and related regulatory authorities, at their discretion, information including but not limited to status of application, actions and information pertinent to investigations and enforcement of the laws and rules pertaining to the licensee's conduct.

(f) Not conduct face-to-face in-person psychological services in NH.

IV. The board shall adopt rules pursuant to RSA 541-A for:

(a) The application procedure for a New Hampshire tele-pass psychology license;

(b) Additional requirements for a psychologist licensed in another state of Canada to acquire a tele-pass psychology license, including attestations;

(c)

The standards of care for telemedicine practice of psychology and their enforcement; and

(d) Procedures for the investigation and discipline pursuant to all means authorized in this chapter including but not limited to suspension or revocation of a tele-pass psychology license.

V. Persons who have been granted Emergency Licenses to practice Psychology under the Covid 19 emergency pursuant to the Governor's Emergency Order #29 shall be granted a Tele-Pass license.

VI. Effective date. This Part shall become effective upon passage of the bill.

OPLC Draft Legislation 4-28-21 (LBC)

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

Amendment to SB 133

Amend the bill to include the following:

Section 328-F:18

328-F:18 Allied Health Professionals; Issuance of Licenses; Conditional Licenses. –
I. Each governing board shall issue initial licenses and license renewals to applicants who have completed the required application procedures and have met the eligibility requirements established by the practice act and the rules of the governing board. If a governing board is authorized by its practice act to issue provisional licenses, it shall issue such licenses to applicants who have completed the required application procedures and have met the eligibility requirements for provisional licensure established by the practice act and the rules of the governing board.
II. The governing boards shall take no action on an application for any type of license, or reinstate any lapsed or suspended license, until the applicant has completed the application procedures required by the practice acts and the rules of the governing boards.
III. To insure the competency of licensees, the governing boards are authorized to issue initial licenses, license renewals, and reinstatements of licensure after lapse or suspension for disciplinary reasons that are conditional in nature. Such conditional licenses may include the following conditions on the licensee's authorization to practice:
(a) A limit on the duration of the license.
(b) A requirement that specified education, clinical experience, or training is completed by the licensee before removal of the condition.
(c) A requirement that the conditional licensee be supervised in his or her practice.
(d) A limitation on the scope of the practice of the conditional licensee.
IV. Initial licenses, including conditional licenses that are the first license issued to the individual, and provisional licenses shall be:
~~(a) Signed and dated by the chairperson of the governing board issuing them~~.
(b) Numbered consecutively and recorded.
V. Nothing in this chapter or in the practice acts of the governing boards shall be construed to restrict persons licensed under any other law of this state from engaging in a profession or practice for which they are licensed.
VI. Occupational therapists, occupational therapist assistants, recreational therapists, speech pathologists, respiratory care practitioners, physical therapists, and physical therapist assistants from the states of Connecticut, Rhode Island, Massachusetts, Maine, New York, and Vermont, who are currently licensed, shall be eligible for temporary licensure for 120 days while the person makes application for licensure to the respective governing board under this chapter. An applicant for temporary licensure to practice, who is currently licensed or certified in Connecticut, Rhode Island, Massachusetts, Maine, New York, or Vermont, shall:

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(a) Hold an active unencumbered license; and
(b) Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction, or, if such acts have been committed, would be grounds for disciplinary action.

Section 317-A:10

317-A:10 License. – ~~All licenses issued by the board shall be signed by all the members thereof and attested by its president and vice-president~~.

Section 325:20

325:20 Licensure. – The board shall issue to each applicant successfully passing the examination, where an examination is required, and who otherwise satisfies the board of his qualifications, a license~~, signed by all the members of the board,~~ entitling him to practice or engage in the business in this state as a funeral director, embalmer, or both, as the case may be.

Section 329:14

329:14 Action on License Applications. –
I. The board shall make no final decision concerning the qualifications of a new or reinstatement applicant until it has received the results of all required examinations, criminal history record checks, and all third-party certifications required to be submitted with the license application, and the time periods specified by RSA 541-A:29 shall be calculated from the date the last of the required documents is received by the board.
II. No application shall be granted unless the board finds that the applicant possesses the necessary educational, character and other professional qualifications to practice medicine, and that no circumstances exist which would be grounds for disciplinary action against a licensed physician pursuant to RSA 329:17, I.
III. The board shall grant an unrestricted permanent license to persons it finds to have the necessary professional qualifications. The board may also, by consent or after notice and the opportunity to be heard, resolve issues concerning professional qualifications or circumstances that would be grounds for non-disciplinary remedial action against a licensed physician by granting a temporary license, or a temporary or permanent license with restrictions.
IV. Licenses shall ~~be signed and dated by the president of the board,~~ stating~~e~~ that the licensee is authorized to engage in the practice of medicine, be numbered consecutively, and be recorded.
V. (a) The board shall issue special training licenses to persons of good professional character who are enrolled in a regular residency or graduate fellowship training program accredited by the Council on Graduate Medical Education, and who possess such further education and training as the board may require by rule.
(b) Persons holding training licenses shall be subject to the disciplinary provisions of RSA 329:17 and such additional professional character and competency requirements as the board may require by rule.
(c) Training licenses shall be confined to activities performed in the course of the qualifying residency or graduate fellowship training program, shall expire automatically upon the licensee's separation from the residency or graduate fellowship training program for any reason, and may be issued on a restricted or conditional basis.

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VI. The board may issue special licenses containing conditions, limitations, or restrictions, including licenses limited to specific periods of time in accordance with rules adopted under RSA 329:9, VIII.
VII. The board may issue courtesy licenses authorizing the practice of medicine under limited conditions as defined by the board by rule. Courtesy licenses shall not exceed 100 days and shall be limited in location. All applicants shall hold an active, unrestricted license in another state and meet the same character qualifications as other licensees.
VIII. The board may issue licenses authorizing the practice of medicine limited to administrative medicine for physicians whose practice does not include the provision of clinical services to patients.

Section 151-A:7

151-A:7 Licenses. –
I. An applicant for a license as a nursing home administrator who has:
(a) Successfully complied with the requirements of RSA 151-A:5 and the standards provided for therein; and
(b) Passed the examination provided for in RSA 151-A:6 shall be issued a license on a form provided for that purpose by the board, certifying that such applicant has met the requirements of the laws and rules entitling the applicant to serve, act, practice and otherwise hold such applicant out as a duly licensed nursing home administrator.
II. Under emergency conditions the secretary of the board in the secretary's discretion subject to the confirmation of the board may issue a non-renewable temporary emergency permit to a person of good character and suitability to act in the capacity of an administrator under the supervision of a licensed administrator pending action by the board until the next examination or not to exceed 6 months.
II-a. If the board is satisfied that a candidate for licensure under the reciprocity provisions of RSA 151-A:9 meets all the requirements and needs only sit for the state examination, the board may, if an urgent need is demonstrated, provide the candidate with a temporary permit to work as an administrator in a nursing home within the state of New Hampshire. This temporary permit shall only be valid for a period of 6 months and shall not be renewable or reissued to the same candidate.
~~III. Any license issued by the board under or pursuant to the provisions of this section shall be under the hand and seal of the secretary of the board~~.
IV. If the board finds that programs of training and instruction conducted within the state are not sufficient in number or content to enable nursing home administrators to meet requirements established pursuant to this chapter, the board may request the department of health and human services to institute and conduct or arrange with others to conduct one or more such programs, and shall make provision for their accessibility to residents of this state. The department of health and human services may approve programs conducted within and without this state as sufficient to meet education and training requirements established pursuant to this chapter. For purposes of this paragraph, the department of health and human services shall have the authority to receive and disburse state funds allocated for this purpose and federal funds received pursuant to section 1908(e)(1) of the Social Security Act. .

Section 310-A:18

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310-A:18 Certificates; Seals. – The board shall issue a license, upon payment of the registration fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed professional engineer while the license remains valid. Each licensee shall upon licensure obtain a seal of the design authorized by the board, bearing the registrant's name and the legend, "Licensed Professional Engineer." All papers or documents involving the practice of engineering under this subdivision, when issued or filed for public record, shall be dated and bear the signature and seal of the licensed professional engineer who prepared or had responsibility for and approved them. It shall be a class B misdemeanor for the licensee to stamp or seal any documents with such seal after the license of the licensee has expired or has been revoked, unless such license shall have been renewed or reissued.

Section 310-A:44

310-A:44 Certificates; Seals. – The board shall issue a license upon payment of the registration fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed architect while the license remains valid. Each licensee shall upon licensure obtain a seal of the design authorized by the board, bearing the registrant's name and the legend, "Licensed Architect." All papers or documents involving the practice of a profession under this subdivision, when issued or filed for public record, shall be dated and bear the signature and seal of the licensed professional who prepared or had responsibility for and approved them. It shall be a class B misdemeanor for the licensee to stamp or seal any documents with such seal after the license of the licensee has expired or has been revoked, unless such license shall have been renewed, reinstated, or reissued.

Section 310-A:87

310-A:87 Certificates. – Certificates shall show the full name of the certified soil scientist, apprentice soil scientist, certified wetland scientist, or apprentice wetland scientist~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. Each certified soil scientist or certified wetland scientist shall obtain a seal of the design authorized by the board bearing the name of the certified individual, the legend "Certified Soil Scientist" or "Certified Wetland Scientist," as appropriate, and a place for the certified individual's signature. Plans and reports prepared by a certified individual shall be stamped with the seal and signed by the certified individual during the life of the certificate.

Section 310-A:107

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310-A:107 Issuance of License; Endorsement of Documents. – The board shall issue a license upon payment of the fee as provided in this subdivision to any applicant, who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be evidence that the person named in the license is entitled to all rights and privileges of a licensed forester while such license remains unrevoked or unexpired. Plans, maps, and reports issued by the licensee shall be endorsed with the licensee's name and license number during the life of the license. It shall be a class B misdemeanor for anyone to endorse any document with such name and license number after the license of the named licensee has expired or has been revoked, unless said license has been renewed or reissued. It shall be a class B misdemeanor for any licensed forester to endorse any plan, map or report unless the licensed forester shall have actually prepared such plan, map or report, or shall have been in the actual charge of the preparation of the same.

Section 310-A:130

310-A:130 Certificates; Seals. – The board shall issue a license, upon payment of the licensing fee established by the board, to any applicant who has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed professional geologist while the license remains valid. Each licensee shall upon licensure obtain a seal of the design authorized by the board, bearing the registrant's name and the legend, "Licensed Professional Geologist." All papers or documents involving the practice of geology affecting public health, safety, and welfare, under this subdivision, when issued or filed for public record, shall be dated and bear the signature and seal of the licensed professional geologist who prepared or had responsibility for and approved them.

Section 310-A:152

310-A:152 Certificates; Seals. – The board shall issue a license upon payment of the license fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed landscape architect while the license remains valid. Each licensee shall upon licensure obtain a seal of the design authorized by the board, bearing the registrant's name and the legend, "licensed landscape architect." All papers or documents involving the practice of landscape architecture under this subdivision, when issued or filed for public record, shall be dated and bear the signature and seal of the licensed professional who prepared or had responsibility for and approved them. It shall be a class B misdemeanor for the licensee to stamp or seal any documents with such seal after the license of the licensee has expired or has been revoked, unless such license shall have been renewed, reinstated, or reissued.

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Section 310-A:193

310-A:193 Issuance of Licenses. – The board shall issue a license upon payment of the license fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board.~~ The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed home inspector while the license remains valid. It shall be a class B misdemeanor for the licensee to perform home inspections after the license of the licensee has expired or has been revoked, unless such license shall have been renewed, reinstated, or reissued.

Section 310-A:213

310-A:213 Issuance of Licenses. – The board shall issue a license upon payment of the license fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a certified septic system evaluator while the license remains valid. It shall be a class B misdemeanor for the license holder to perform septic system evaluations after the license of the evaluator has expired or has been revoked, unless such license shall have been renewed, reinstated, or reissued.

Section 319-C:7

319-C:7 Licensing Requirements. –
I. [Repealed.]
II. After June 30, 1976, the board shall issue a license as a master or journeyman electrician to any person who files an application and meets the following qualifications:
(a) Completion of 8,000 hours of service as an apprentice electrician. The board may give credit toward such service for the satisfactory completion of a course of instruction in the field at a school recognized by the board; and
(b) Satisfactory passing of an examination conducted by said board as provided in RSA 319-C:8 to determine his fitness to receive such license.
II-a. The board shall issue a license as a high/medium voltage electrician to any person who files an application and meets the following qualifications:
(a) Shows proof of successfully completing a state, national, or employer certification program approved by the board or;
(b) Prior to January 1, 2003, shows proof of having been employed for a minimum of 5 years as a high/medium voltage electrician working for a company with an approved training program.
III. All persons licensed by the board shall receive a certificate ~~under the seal of the board and with the signature of the board chairman~~, which must be publicly displayed at the principal place of business of said electrician, or, if no such place of business, must be carried on his or her person and displayed at any time upon request to any electrical inspector appointed by the board

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under this chapter, as long as said person continues in the business as herein defined. The certificate shall specify the name of the person licensed who, in the case of a firm, shall be one of its members or employees and, in the case of a corporation, one of its officers or employees passing the examination. In the case of a firm or corporation, the license shall be void upon the death of or the severance from the company of said person.
IV. Apprentice electricians shall register with the board.

Section 310-B:16

310-B:16 License or Certificate. –
I. A license or certificate issued under authority of this chapter shall bear ~~the signature of the board chairperson or a designee who is a member of the board and~~ a license or certificate number assigned by the board.
II. Each licensed or certified real estate appraiser shall place such appraiser's license or certificate number adjacent to or immediately below the appraiser's signature whenever the appraiser's signature is used in an appraisal report or in a contract or other instrument used by the license or certificate holder in conducting real estate appraisal activities.

DRAFT

Rep. Wallner, Merr. 10
Rep. McWilliams, Merr. 27
April 19, 2021
2021-1162h
08/05

Amendment to SB 133-FN

1 Amend section 2 of the bill by inserting after Part XIII the following:
2
3 Part XIV
4 Establishing minimum qualifications for certification as a child care associate teacher.
5 1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education
6 Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after
7 subparagraph (m) the following new subparagraph:
8 (n) The following qualification for certification as an associate teacher: a minimum of
9 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of
10 training in child growth and development, the latter of which may be documented life experience.
11 2 Effective Date. This act shall take effect 60 days after its passage.

UNAPPROVED

2021-1162h

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Licensing places of assembly.

II. Repealing the emergency medical services personnel licensure interstate compact.

III. Hearings at the board of nursing.

IV. Membership of the professional standards board.

V. Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

VI. Licensure and regulation of music therapists.

VII. The authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

VIII. Skilled professional medical personnel.

IX. Temporary licensure of certain licensed nursing assistants.

X. The revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

XI. Schools for barbering, cosmetology, and esthetics.

XII. Telemedicine provided by out of state psychologists.

XIII. Sanitary production and distribution of food.

XIV. Establishes minimum qualifications for certification as a child care associate teacher.

UNAPPROVED

Rep. T. Lekas, Hills. 37
April 30, 2021
2021-1260h
05/10

Amendment to SB 133-FN

Amend RSA 313-A:24, I as inserted by Part XI, section 3 of the bill by replacing it with the following:

I. No person shall enter an apprenticeship or enroll in a school under this chapter unless such person has registered with the board as an apprentice and been issued an apprentice [~~license~~] ***certificate***. The board shall have sole authority to regulate apprentices and apprenticeship under this chapter. The board shall issue an apprentice [~~license~~] ***certificate*** to any student receiving instruction within a licensed school [~~or~~] ***and/or*** shop to learn barbering, cosmetology, esthetics, or manicuring.

Amend RSA 313-A:24, IV as inserted by Part XI, section 3 of the bill by replacing it with the following:

IV. Upon completing the number of hours specified in the board's apprentice rules, an apprentice shall be eligible to apply to the board for [~~licensure~~] ***certification***.

Amend Part XI of the bill by inserting after section 3 the following and renumbering the original section 4 to read as section 5:

4 Expiration and Renewal of Licenses and Certificates. Amend RSA 313-A:20 to read as follows:

313-A:20 Expiration and Renewal of Licenses ***and Certificates***. Each barber, master barber, barber instructor, [~~apprentice,~~] barbershop, barber school, esthetician, esthetics instructor, esthetics school, esthetics salon, manicurist, [~~apprentice,~~] beauty salon, or manicuring salon license issued under this chapter***, and any apprentice certificate issued under RSA 313-A:24,*** shall expire on the last day of the birth month of the licensee ***or certificate holder*** in the odd year next succeeding its date of issuance. Each cosmetologist, cosmetology instructor, or cosmetology school license issued under this chapter shall expire on the last day of the birth month of the licensee in the even year next succeeding its date of issuance. Any personal license ***or apprentice certificate*** which has expired may be renewed within 6 months by payment of the renewal fee and a late fee established by the board. After 6 months and within 5 years, a personal license ***or apprentice certificate*** may be renewed by paying the renewal fee and a late fee established by the board. Any school or shop license which has expired may be renewed upon payment of the renewal fee plus a late fee established by the board.

UNAPPROVED

Amendment to SB 133-FN

1 Amend the bill by replacing all after the enacting clause with the following:
2
3 1 Sponsorship. This act consists of the following proposed legislation:
4 Part I: LSR 21-0964, relative to the definition of "licensing agency" for purposes of licensing
5 places of assembly, sponsored by Sen. Carson, Prime/Dist 14.
6 Part II: LSR 21-0506, repealing the emergency medical services personnel licensure
7 interstate compact, sponsored by Sen. Rosenwald, Prime/Dist 13, Sen. Cavanaugh, Dist 16; Sen.
8 Carson, Dist 14; Rep. Goley, Hills. 8; Rep. Milz, Rock. 6; Rep. O'Brien, Hills. 36; Rep. S. Pearson,
9 Rock. 6.
10 Part III: LSR 21-0207, relative to hearings of the New Hampshire board of nursing,
11 sponsored by Sen. Ward, Prime/Dist 8.
12 Part IV: LSR 21-0846, adopting the Audiology and Speech-Language Pathology Compact
13 and the Occupational Therapy Licensure Compact, sponsored by Sen. Sherman, Prime/Dist 24; Sen.
14 Soucy, Dist 18; Sen. Carson, Dist 14; Rep. March, Carr. 8.
15 Part V: LSR 21-0899, relative to the authority of the office of professional licensure and
16 certification for administration, rulemaking, and enforcement of investigations, hearings, and
17 appeals, sponsored by Sen. Reagan, Prime/ Dist 17, Sen. Carson, Dist 14; Sen. French, Dist 7; Sen.
18 Kahn, Dist 10; Sen. Prentiss, Dist 5; Sen. Rosenwald, Dist 13; Sen. Bradley, Dist 3; Sen.
19 D'Allesandro, Dist 20; Sen. Ward, Dist 8; Sen. Soucy, Dist 18; Sen. Giuda, Dist 2; Rep. Spillane,
20 Rock. 2; Rep. McGuire, Merr. 29; Rep. Seaworth, Merr. 20.
21 Part VI: LSR 21-0973, relative to temporary licensure of certain licensed nursing assistants,
22 sponsored by Sen. Hennessey, Dist 1; Sen. Rosenwald, Dist 13; Rep. Dostie, Coos 1; Rep. Thompson,
23 Coos 1.
24 Part VII: LSR 21-1011, relative to the revocation of licensure for licensed emergency medical
25 service units and emergency medical service vehicles, sponsored by Sen. Prentiss, Prime/Dist 5; Rep.
26 Merchant, Sull. 4; Rep. Goley, Hills. 8; Rep. McGuire, Merr. 29.
27 Part VIII: LSR 21-1050, relative to schools for barbering, cosmetology, and esthetics,
28 sponsored by Sen. Reagan, Prime/Dist 17; Sen. Rosenwald, Dist 13; Sen. Prentiss, Dist 5; Sen.
29 Carson, Dist 14; Sen. Bradley, Dist 3; Sen. D'Allesandro, Dist 20; Sen. Gannon, Dist 23; Rep.
30 McGuire, Merr. 29; Rep. Roy, Rock. 32; Rep. Harrington, Straf. 3.
31 Part IX: LSR 21-0277, relative to telemedicine provided by out-of-state psychologists,
32 sponsored by Sen. Reagan, Prime/Dist 17; Sen. Carson, Dist 14; Sen. Bradley, Dist 3; Sen. Prentiss,

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1 Dist 5; Sen. French, Dist 7; Sen. Giuda, Dist 2; Sen. Hennessey, Dist 1; Sen. D'Allesandro, Dist 20;
2 Rep. Spillane, Rock. 2; Rep. Tudor, Rock. 1.
3 Part X: LSR 21-1049, establishing program rules within the department of health and
4 human services for sanitary production and distribution of food, sponsored by Sen. Giuda,
5 Prime/Dist 2; Sen. Gannon, Dist 23.
6 Part XI: relative to minimum qualifications for certification as a child care associate teacher.
7 2 Legislation Enacted. The general court hereby enacts the following legislation:
8
9 PART I
10 Relative to the definition of "licensing agency" for purposes of licensing places of assembly.
11 1 Places of Assembly; Definition of Licensing Agency. Amend RSA 155:17, II to read as follows:
12 II. "Licensing agency" shall mean the chief of the fire department, the firewards or
13 engineers, if any, otherwise the selectmen of the town or the commissioners of village district as the
14 case may be***, or the state fire marshal, as he or she deems necessary, in consultation with the***
15 ***local licensing agency, if any***.
16 2 Places of Assembly; License Required. Amend RSA 155:18 to read as follows:
17 155:18 License Required. No person shall own or operate a place of assembly within this state
18 unless licensed so to do by the licensing agency of the ***state,*** city, town, or village district where said
19 place of assembly is located, including assemblies occurring on state waters or ice formed on state
20 waters, in accordance with the regulations herein promulgated. In the application of this act to
21 existing places of assembly the licensing agency may modify such of its provisions as would require
22 structural changes if in his or her opinion adequate safety may be obtained otherwise and provided
23 that a permanent record is kept of such modifications and the reasons therefor.
24 3 Effective Date. Part I of this act shall take effect 60 days after its passage.
25
26 PART II
27 Repealing the emergency medical services personnel licensure interstate compact.
28 1 Repeal. The following are repealed:
29 I. RSA 153-A:36 and the subdivision heading preceding RSA 153-A:36, relative to the
30 emergency medical services personnel licensure interstate compact.
31 II. RSA 153-A:20, XXIV, relative to rulemaking by the department of safety regarding
32 implementation of the compact.
33 2 Effective Date. Part II of this act shall take effect 60 days after its passage.
34
35 PART III
36 Relative to hearings of the New Hampshire board of nursing.
37 1 Board of Nursing; Adjudicative Hearings. Amend 326-B:38, VIII to read as follows:

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1 VIII. The board may hold adjudicative hearings concerning allegations of misconduct or
2 other matters within the scope of this chapter. Such hearings shall be public proceedings. Any
3 member of the board [~~other than the public members~~], or any other qualified person appointed by the
4 board, shall have authority to preside at such a hearing and to issue oaths or affirmations to
5 witnesses.
6 2 Effective Date. Part III of this act shall take effect upon its passage.
7
8 PART IV
9 Adopting the Audiology and Speech-Language Pathology Compact
10 and the Occupational Therapy Licensure Compact.
11 1 New Paragraph; Office of Professional Licensure and Certification; Fees; Financing of
12 Interstate Compacts. Amend RSA 310-A:1-e by inserting after paragraph II the following new
13 paragraph:
14 III. The office of professional licensure and certification shall be responsible for the
15 financing of any interstate compact joined by the state that affects a profession governed by a board
16 listed in 310-A:1-a. Such financing shall be from money deposited in the office of professional
17 licensure and certification fund.
18 2 New Section; Speech-Language Pathology Practice; Audiology and Speech-Language
19 Pathology Compact. Amend RSA 326-F by inserting after section 8 the following new section:
20 326-F:9 Interstate Compact Adopted. The state of New Hampshire hereby adopts the provisions
21 of the Audiology and Speech-Language Pathology Compact as follows:
22 SECTION 1: PURPOSE
23 The purpose of this Compact is to facilitate interstate practice of audiology and speech-language
24 pathology with the goal of improving public access to audiology and speech-language pathology
25 services. The practice of audiology and speech-language pathology occurs in the state where the
26 patient/client/student is located at the time of the patient/client/student encounter. The Compact
27 preserves the regulatory authority of states to protect public health and safety through the current
28 system of state licensure.
29 This Compact is designed to achieve the following objectives:
30 1. Increase public access to audiology and speech-language pathology services by providing for
31 the mutual recognition of other member state licenses;
32 2. Enhance the states' ability to protect the public's health and safety;
33 3. Encourage the cooperation of member states in regulating multistate audiology and speech-
34 language pathology practice;
35 4. Support spouses of relocating active duty military personnel;
36 5. Enhance the exchange of licensure, investigative and disciplinary information between
37 member states;

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6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards; and

7. Allow for the use of telehealth technology to facilitate increased access to audiology and speech-language pathology services.

SECTION 2. DEFINITIONS

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

A. "Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Chapter 1209 and 10 U.S.C Chapter 1211.

B. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against an audiologist or speech-language pathologist, including actions against an individual's license or privilege to practice such as revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee's practice.

C. "Alternative program" means a non-disciplinary monitoring process approved by an audiology or speech-language pathology licensing board to address impaired practitioners.

D. "Audiologist" means an individual who is licensed by a state to practice audiology.

E. "Audiology" means the care and services provided by a licensed audiologist as set forth in the member state's statutes and rules.

F. "Audiology and Speech-Language Pathology Compact Commission" or "Commission" means the national administrative body whose membership consists of all states that have enacted the Compact.

G. "Audiology and speech-language pathology licensing board," "audiology licensing board," "speech-language pathology licensing board," or "licensing board" means the agency of a state that is responsible for the licensing and regulation of audiologists and/or speech-language pathologists.

H. "Compact privilege" means the authorization granted by a remote state to allow a licensee from another member state to practice as an audiologist or speech-language pathologist in the remote state under its laws and rules. The practice of audiology or speech-language pathology occurs in the member state where the patient/client/student is located at the time of the patient/client/student encounter.

I. "Current significant investigative information" means investigative information that a licensing board, after an inquiry or investigation that includes notification and an opportunity for the audiologist or speech-language pathologist to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.

J. "Data system" means a repository of information about licensees, including, but not limited to, continuing education, examination, licensure, investigative, compact privilege and adverse action.

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1 K. "Encumbered license" means a license in which an adverse action restricts the practice of
2 audiology or speech-language pathology by the licensee and said adverse action has been reported to
3 the National Practitioners Data Bank (NPDB).
4 L. "Executive committee" means a group of directors elected or appointed to act on behalf of, and
5 within the powers granted to them by, the Commission.
6 M. "Home state" means the member state that is the licensee's primary state of residence.
7 N. "Impaired practitioner" means individuals whose professional practice is adversely affected
8 by substance abuse, addiction, or other health-related conditions.
9 O. "Licensee" means an individual who currently holds an authorization from the state licensing
10 board to practice as an audiologist or speech-language pathologist.
11 P. "Member state" means a state that has enacted the Compact.
12 Q. "Privilege to practice" means a legal authorization permitting the practice of audiology or
13 speech-language pathology in a remote state.
14 R. "Remote state" means a member state other than the home state where a licensee is
15 exercising or seeking to exercise the compact privilege.
16 S. "Rule" means a regulation, principle or directive promulgated by the Commission that has the
17 force of law.
18 T. "Single-state license" means an audiology or speech-language pathology license issued by a
19 member state that authorizes practice only within the issuing state and does not include a privilege
20 to practice in any other member state.
21 U. "Speech-language pathologist" means an individual who is licensed by a state to practice
22 speech-language pathology.
23 V. "Speech-language pathology means the care and services provided by a licensed speech-
24 language pathologist as set forth in the member state's statutes and rules.
25 W. "State" means any state, commonwealth, district or territory of the United States of America
26 that regulates the practice of audiology and speech-language pathology.
27 X. "State practice laws" means a member state's laws, rules and regulations that govern the
28 practice of audiology or speech-language pathology, define the scope of audiology or speech-language
29 pathology practice, and create the methods and grounds for imposing discipline.
30 Y. "Telehealth" means the application of telecommunication technology to deliver audiology or
31 speech-language pathology services at a distance for assessment, intervention and/or consultation.
32 SECTION 3. STATE PARTICIPATION IN THE COMPACT
33 A. A license issued to an audiologist or speech-language pathologist by a home state to a
34 resident in that state shall be recognized by each member state as authorizing an audiologist or
35 speech-language pathologist to practice audiology or speech-language pathology, under a privilege to
36 practice, in each member state.

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1 B. A state must implement or utilize procedures for considering the criminal history records of
2 applicants for initial privilege to practice. These procedures shall include the submission of
3 fingerprints or other biometric-based information by applicants for the purpose of obtaining an
4 applicant's criminal history record information from the Federal Bureau of Investigation and the
5 agency responsible for retaining that state's criminal records
6 1. A member state must fully implement a criminal background check requirement, within a
7 time frame established by rule, by receiving the results of the Federal Bureau of Investigation record
8 search on criminal background checks and use the results in making licensure decisions.
9 2. Communication between a member state, the Commission and among member states
10 regarding the verification of eligibility for licensure through the Compact shall not include any
11 information received from the Federal Bureau of Investigation relating to a federal criminal records
12 check performed by a member state under Public Law 92-544.
13 C. Upon application for a privilege to practice, the licensing board in the issuing remote state
14 shall ascertain, through the data system, whether the applicant has ever held, or is the holder of, a
15 license issued by any other state, whether there are any encumbrances on any license or privilege to
16 practice held by the applicant, whether any adverse action has been taken against any license or
17 privilege to practice held by the applicant.
18 D. Each member state shall require an applicant to obtain or retain a license in the home state
19 and meet the home state's qualifications for licensure or renewal of licensure, as well as, all other
20 applicable state laws.
21 E. For an audiologist:
22 1. Must meet one of the following educational requirements:
23 a. On or before, Dec. 31, 2007, has graduated with a master's degree or doctorate in audiology,
24 or equivalent degree regardless of degree name, from a program that is accredited by an accrediting
25 agency recognized by the Council for Higher Education Accreditation, or its successor, or by the
26 United States Department of Education and operated by a college or university accredited by a
27 regional or national accrediting organization recognized by the board; or
28 b. On or after, Jan. 1, 2008, has graduated with a Doctoral degree in audiology, or equivalent
29 degree, regardless of degree name, from a program that is accredited by an accrediting agency
30 recognized by the Council for Higher Education Accreditation, or its successor, or by the United
31 States Department of Education and operated by a college or university accredited by a regional or
32 national accrediting organization recognized by the board; or
33 c. Has graduated from an audiology program that is housed in an institution of higher education
34 outside of the United States (a) for which the program and institution have been approved by the
35 authorized accrediting body in the applicable country and (b) the degree program has been verified
36 by an independent credentials review agency to be comparable to a state licensing board-approved
37 program.

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1 2. Has completed a supervised clinical practicum experience from an accredited educational
2 institution or its cooperating programs as required by the commission;
3 3. Has successfully passed a national examination approved by the Commission;
4 4. Holds an active, unencumbered license;
5 5. Has not been convicted or found guilty, and has not entered into an agreed disposition, of a
6 felony related to the practice of audiology, under applicable state or federal criminal law;
7 6. Has a valid United States Social Security or National Practitioner Identification number.
8 F. For a speech-language pathologist:
9 1. Must meet one of the following educational requirements:
10 a. Has graduated with a master's degree from a speech-language pathology program that is
11 accredited by an organization recognized by the United States Department of Education and
12 operated by a college or university accredited by a regional or national accrediting organization
13 recognized by the board; or
14 b. Has graduated from a speech-language pathology program that is housed in an institution of
15 higher education outside of the United States (a) for which the program and institution have been
16 approved by the authorized accrediting body in the applicable country and (b) the degree program
17 has been verified by an independent credentials review agency to be comparable to a state licensing
18 board-approved program.
19 2. Has completed a supervised clinical practicum experience from an educational institution or
20 its cooperating programs as required by the Commission;
21 3. Has completed a supervised postgraduate professional experience as required by the
22 Commission
23 4. Has successfully passed a national examination approved by the Commission;
24 5. Holds an active, unencumbered license;
25 6. Has not been convicted or found guilty, and has not entered into an agreed disposition, of a
26 felony related to the practice of speech-language pathology, under applicable state or federal
27 criminal law;
28 7. Has a valid United States Social Security or National Practitioner Identification number.
29 G. The privilege to practice is derived from the home state license.
30 H. An audiologist or speech-language pathologist practicing in a member state must comply
31 with the state practice laws of the state in which the client is located at the time service is provided.
32 The practice of audiology and speech-language pathology shall include all audiology and speech-
33 language pathology practice as defined by the state practice laws of the member state in which the
34 client is located. The practice of audiology and speech-language pathology in a member state under
35 a privilege to practice shall subject an audiologist or speech-language pathologist to the jurisdiction
36 of the licensing board, the courts and the laws of the member state in which the client is located at
37 the time service is provided.

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1 I. Individuals not residing in a member state shall continue to be able to apply for a member
2 state's single-state license as provided under the laws of each member state. However, the single-
3 state license granted to these individuals shall not be recognized as granting the privilege to practice
4 audiology or speech-language pathology in any other member state. Nothing in this Compact shall
5 affect the requirements established by a member state for the issuance of a single-state license.
6 J. Member states may charge a fee for granting a compact privilege.
7 K. Member states must comply with the bylaws and rules and regulations of the Commission.
8 SECTION 4. COMPACT PRIVILEGE
9 A. To exercise the compact privilege under the terms and provisions of the Compact, the
10 audiologist or speech-language pathologist shall:
11 1. Hold an active license in the home state;
12 2. Have no encumbrance on any state license;
13 3. Be eligible for a compact privilege in any member state in accordance with Section 3;
14 4. Have not had any adverse action against any license or compact privilege within the previous
15 2 years from date of application;
16 5. Notify the Commission that the licensee is seeking the compact privilege within a remote
17 state(s);
18 6. Pay any applicable fees, including any state fee, for the compact privilege;
19 7. Report to the Commission adverse action taken by any non-member state within 30 days from
20 the date the adverse action is taken.
21 B. For the purposes of the compact privilege, an audiologist or speech-language pathologist shall
22 only hold one home state license at a time.
23 C. Except as provided in Section 6, if an audiologist or speech-language pathologist changes
24 primary state of residence by moving between two-member states, the audiologist or speech-
25 language pathologist must apply for licensure in the new home state, and the license issued by the
26 prior home state shall be deactivated in accordance with applicable rules adopted by the
27 Commission.
28 D. The audiologist or speech-language pathologist may apply for licensure in advance of a
29 change in primary state of residence.
30 E. A license shall not be issued by the new home state until the audiologist or speech-language
31 pathologist provides satisfactory evidence of a change in primary state of residence to the new home
32 state and satisfies all applicable requirements to obtain a license from the new home state.
33 F. If an audiologist or speech-language pathologist changes primary state of residence by
34 moving from a member state to a non-member state, the license issued by the prior home state shall
35 convert to a single-state license, valid only in the former home state.

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1 G. The compact privilege is valid until the expiration date of the home state license. The
2 licensee must comply with the requirements of Section 4A to maintain the compact privilege in the
3 remote state.
4 H. A licensee providing audiology or speech-language pathology services in a remote state under
5 the compact privilege shall function within the laws and regulations of the remote state.
6 I. A licensee providing audiology or speech-language pathology services in a remote state is
7 subject to that state's regulatory authority. A remote state may, in accordance with due process and
8 that state's laws, remove a licensee's compact privilege in the remote state for a specific period of
9 time, impose fines, and/or take any other necessary actions to protect the health and safety of its
10 citizens.
11 J. If a home state license is encumbered, the licensee shall lose the compact privilege in any
12 remote state until the following occur:
13 1. The home state license is no longer encumbered; and
14 2. Two years have elapsed from the date of the adverse action.
15 K. Once an encumbered license in the home state is restored to good standing, the licensee must
16 meet the requirements of Section 4A to obtain a compact privilege in any remote state.
17 L. Once the requirements of Section 4J have been met, the licensee must meet the requirements
18 in Section 4A to obtain a compact privilege in a remote state.
19 SECTION 5. COMPACT PRIVILEGE TO PRACTICE TELEHEALTH
20 Member states shall recognize the right of an audiologist or speech-language pathologist, licensed by
21 a home state in accordance with Section 3 and under rules promulgated by the Commission, to
22 practice audiology or speech-language pathology in any member state via telehealth under a
23 privilege to practice as provided in the Compact and rules promulgated by the Commission.
24 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES
25 Active duty military personnel, or their spouse, shall designate a home state where the individual
26 has a current license in good standing. The individual may retain the home state designation during
27 the period the service member is on active duty. Subsequent to designating a home state, the
28 individual shall only change their home state through application for licensure in the new state.
29 SECTION 7. ADVERSE ACTIONS
30 A. In addition to the other powers conferred by state law, a remote state shall have the
31 authority, in accordance with existing state due process law, to:
32 1. Take adverse action against an audiologist's or speech-language pathologist's privilege to
33 practice within that member state.
34 2. Issue subpoenas for both hearings and investigations that require the attendance and
35 testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board
36 in a member state for the attendance and testimony of witnesses or the production of evidence from
37 another member state shall be enforced in the latter state by any court of competent jurisdiction,

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1 according to the practice and procedure of that court applicable to subpoenas issued in proceedings
2 pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and
3 other fees required by the service statutes of the state in which the witnesses or evidence are
4 located.
5 3. Only the home state shall have the power to take adverse action against a audiologist's or
6 speech-language pathologist's license issued by the home state.
7 B. For purposes of taking adverse action, the home state shall give the same priority and effect
8 to reported conduct received from a member state as it would if the conduct had occurred within the
9 home state. In so doing, the home state shall apply its own state laws to determine appropriate
10 action.
11 C. The home state shall complete any pending investigations of an audiologist or speech-
12 language pathologist who changes primary state of residence during the course of the investigations.
13 The home state shall also have the authority to take appropriate action(s) and shall promptly report
14 the conclusions of the investigations to the administrator of the data system. The administrator of
15 the coordinated licensure information system shall promptly notify the new home state of any
16 adverse actions.
17 D. If otherwise permitted by state law, the member state may recover from the affected
18 audiologist or speech-language pathologist the costs of investigations and disposition of cases
19 resulting from any adverse action taken against that audiologist or speech-language pathologist.
20 E. The member state may take adverse action based on the factual findings of the remote state,
21 provided that the member state follows the member state's own procedures for taking the adverse
22 action.
23 F. Joint Investigations
24 1. In addition to the authority granted to a member state by its respective audiology or speech-
25 language pathology practice act or other applicable state law, any member state may participate
26 with other member states in joint investigations of licensees.
27 2. Member states shall share any investigative, litigation, or compliance materials in
28 furtherance of any joint or individual investigation initiated under the Compact.
29 G. If adverse action is taken by the home state against an audiologist's or speech language
30 pathologist's license, the audiologist's or speech-language pathologist's privilege to practice in all
31 other member states shall be deactivated until all encumbrances have been removed from the state
32 license. All home state disciplinary orders that impose adverse action against an audiologist's or
33 speech language pathologist's license shall include a statement that the audiologist's or speech-
34 language pathologist's privilege to practice is deactivated in all member states during the pendency
35 of the order.

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1 H. If a member state takes adverse action, it shall promptly notify the administrator of the data
2 system. The administrator of the data system shall promptly notify the home state of any adverse
3 actions by remote states.
4 I. Nothing in this Compact shall override a member state's decision that participation in an
5 alternative program may be used in lieu of adverse action.
6 SECTION 8. ESTABLISHMENT OF THE AUDIOLOGY AND SPEECH-LANGUAGE
7 PATHOLOGY COMPACT COMMISSION
8 A. The Compact member states hereby create and establish a joint public agency known as the
9 Audiology and Speech-Language Pathology Compact Commission:
10 1. The Commission is an instrumentality of the Compact states.
11 2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely
12 and exclusively in a court of competent jurisdiction where the principal office of the Commission is
13 located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or
14 consents to participate in alternative dispute resolution proceedings.
15 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
16 B. Membership, Voting and Meetings
17 1. Each member state shall have two (2) delegates selected by that member state's licensing
18 board. The delegates shall be current members of the licensing board. One shall be an audiologist
19 and one shall be a speech-language pathologist.
20 2. An additional five (5) delegates, who are either a public member or board administrator from
21 a state licensing board, shall be chosen by the Executive Committee from a pool of nominees
22 provided by the Commission at Large.
23 3. Any delegate may be removed or suspended from office as provided by the law of the state
24 from which the delegate is appointed.
25 4. The member state board shall fill any vacancy occurring on the Commission, within 90 days.
26 5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and
27 creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs
28 of the Commission.
29 6. A delegate shall vote in person or by other means as provided in the bylaws. The bylaws may
30 provide for delegates' participation in meetings by telephone or other means of communication.
31 7. The Commission shall meet at least once during each calendar year. Additional meetings
32 shall be held as set forth in the bylaws.
33 C. The Commission shall have the following powers and duties:
34 1. Establish the fiscal year of the Commission;
35 2. Establish bylaws;
36 3. Establish a Code of Ethics;
37 4. Maintain its financial records in accordance with the bylaws;

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1 5. Meet and take actions as are consistent with the provisions of this Compact and the bylaws;
2 6. Promulgate uniform rules to facilitate and coordinate implementation and administration of
3 this Compact. The rules shall have the force and effect of law and shall be binding in all member
4 states;
5 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided
6 that the standing of any state audiology or speech-language pathology licensing board to sue or be
7 sued under applicable law shall not be affected;
8 8. Purchase and maintain insurance and bonds;
9 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees
10 of a member state;
11 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant individuals
12 appropriate authority to carry out the purposes of the Compact, and to establish the Commission's
13 personnel policies and programs relating to conflicts of interest, qualifications of personnel, and
14 other related personnel matters;
15 11. Accept any and all appropriate donations and grants of money, equipment, supplies,
16 materials and services, and to receive, utilize and dispose of the same; provided that at all times the
17 Commission shall avoid any appearance of impropriety and/or conflict of interest;
18 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve
19 or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid
20 any appearance of impropriety;
21 13. Sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any
22 property real, personal, or mixed;
23 14. Establish a budget and make expenditures;
24 15. Borrow money;
25 16. Appoint committees, including standing committees composed of members, and other
26 interested persons as may be designated in this Compact and the bylaws;
27 17. Provide and receive information from, and cooperate with, law enforcement agencies;
28 18. Establish and elect an Executive Committee; and
29 19. Perform other functions as may be necessary or appropriate to achieve the purposes of this
30 Compact consistent with the state regulation of audiology and speech-language pathology licensure
31 and practice.
32 D. The Executive Committee
33 The Executive Committee shall have the power to act on behalf of the Commission according to the
34 terms of this Compact:
35 1. The Executive Committee shall be composed of ten (10) members:
36 a. Seven (7) voting members who are elected by the Commission from the current membership
37 of the Commission;

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1 b. Two (2) ex-officios, consisting of one nonvoting member from a recognized national audiology
2 professional association and one nonvoting member from a recognized national speech-language
3 pathology association; and
4 c. One (1) ex-officio, nonvoting member from the recognized membership organization of the
5 audiology and speech-language pathology licensing boards.
6 E. The ex-officio members shall be selected by their respective organizations.
7 1. The Commission may remove any member of the Executive Committee as provided in bylaws.
8 2. The Executive Committee shall meet at least annually.
9 3. The Executive Committee shall have the following duties and responsibilities:
10 a. Recommend to the entire Commission changes to the rules or bylaws, changes to this
11 Compact legislation, fees paid by Compact member states such as annual dues, and any commission
12 Compact fee charged to licensees for the compact privilege;
13 b. Ensure Compact administration services are appropriately provided, contractual or
14 otherwise;
15 c. Prepare and recommend the budget;
16 d. Maintain financial records on behalf of the Commission;
17 e. Monitor Compact compliance of member states and provide compliance reports to the
18 Commission;
19 f. Establish additional committees as necessary; and
20 g. Other duties as provided in rules or bylaws.
21 4. Meetings of the Commission
22 All meetings shall be open to the public, and public notice of meetings shall be given in the same
23 manner as required under the rulemaking provisions in Section 10.
24 5. The Commission or the Executive Committee or other committees of the Commission may
25 convene in a closed, non-public meeting if the Commission or Executive Committee or other
26 committees of the Commission must discuss:
27 a. Non-compliance of a member state with its obligations under the
28 Compact;
29 b. The employment, compensation, discipline or other matters, practices or procedures related to
30 specific employees or other matters related to the Commission's internal personnel practices and
31 procedures;
32 c. Current, threatened, or reasonably anticipated litigation;
33 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;
34 e. Accusing any person of a crime or formally censuring any person;
35 f. Disclosure of trade secrets or commercial or financial information that is privileged or
36 confidential;

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1 g. Disclosure of information of a personal nature where disclosure would constitute a clearly
2 unwarranted invasion of personal privacy;
3 h. Disclosure of investigative records compiled for law enforcement purposes;
4 i. Disclosure of information related to any investigative reports prepared by or on behalf of or for
5 use of the Commission or other committee charged with responsibility of investigation or
6 determination of compliance issues pursuant to the Compact; or
7 j. Matters specifically exempted from disclosure by federal or member state statute.
8 6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's
9 legal counsel or designee shall certify that the meeting may be closed and shall reference each
10 relevant exempting provision.
11 7. The Commission shall keep minutes that fully and clearly describe all matters discussed in a
12 meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore,
13 including a description of the views expressed. All documents considered in connection with an
14 action shall be identified in minutes. All minutes and documents of a closed meeting shall remain
15 under seal, subject to release by a majority vote of the Commission or order of a court of competent
16 jurisdiction.
17 8. Financing of the Commission
18 a. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
19 establishment, organization, and ongoing activities.
20 b. The Commission may accept any and all appropriate revenue sources, donations, and grants
21 of money, equipment, supplies, materials, and services.
22 c. The Commission may levy on and collect an annual assessment from each member state or
23 impose fees on other parties to cover the cost of the operations and activities of the Commission and
24 its staff, which must be in a total amount sufficient to cover its annual budget as approved each year
25 for which revenue is not provided by other sources. The aggregate annual assessment amount shall
26 be allocated based upon a formula to be determined by the Commission, which shall promulgate a
27 rule binding upon all member states.
28 9. The Commission shall not incur obligations of any kind prior to securing the funds adequate
29 to meet the same; nor shall the Commission pledge the credit of any of the member states, except by
30 and with the authority of the member state.
31 10. The Commission shall keep accurate accounts of all receipts and disbursements. The
32 receipts and disbursements of the Commission shall be subject to the audit and accounting
33 procedures established under its bylaws. However, all receipts and disbursements of funds handled
34 by the Commission shall be audited yearly by a certified or licensed public accountant, and the
35 report of the audit shall be included in and become part of the annual report of the Commission.
36 F. Qualified Immunity, Defense, and Indemnification

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1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 9. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Adverse actions against a license or compact privilege;
4. Non-confidential information related to alternative program participation;
5. Any denial of application for licensure, and the reason(s) for denial; and
6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

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1 C. Investigative information pertaining to a licensee in any member state shall only be available
2 to other member states.
3 D. The Commission shall promptly notify all member states of any adverse action taken against
4 a licensee or an individual applying for a license. Adverse action information pertaining to a licensee
5 in any member state shall be available to any other member state.
6 E. Member states contributing information to the data system may designate information that
7 may not be shared with the public without the express permission of the contributing state.
8 F. Any information submitted to the data system that is subsequently required to be expunged
9 by the laws of the member state contributing the information shall be removed from the data
10 system.
11 SECTION 10. RULEMAKING
12 A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in
13 this Section and the rules adopted thereunder. Rules and amendments shall become binding as of
14 the date specified in each rule or amendment.
15 B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute
16 or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
17 the rule, the rule shall have no further force and effect in any member state.
18 C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the
19 Commission.
20 D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least
21 thirty (30) days in advance of the meeting at which the rule shall be considered and voted upon, the
22 Commission shall file a Notice of Proposed Rulemaking:
23 1. On the website of the Commission or other publicly accessible platform; and
24 2. On the website of each member state audiology or speech-language pathology licensing board
25 or other publicly accessible platform or the publication in which each state would otherwise publish
26 proposed rules.
27 E. The Notice of Proposed Rulemaking shall include:
28 1. The proposed time, date, and location of the meeting in which the rule shall be considered and
29 voted upon;
30 2. The text of the proposed rule or amendment and the reason for the proposed rule;
31 3. A request for comments on the proposed rule from any interested person; and
32 4. The manner in which interested persons may submit notice to the Commission of their
33 intention to attend the public hearing and any written comments.
34 F. Prior to the adoption of a proposed rule, the Commission shall allow persons to submit
35 written data, facts, opinions and arguments, which shall be made available to the public.
36 G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or
37 amendment if a hearing is requested by:

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1. At least twenty-five (25) persons;
2. A state or federal governmental subdivision or agency; or
3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.
2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.
3. All hearings shall be recorded. A copy of the recording shall be made available on request.
4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

K. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;
2. Prevent a loss of Commission or member state funds; or
3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the

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1 revision results in a material change to a rule. A challenge shall be made in writing and delivered to
2 the chair of the Commission prior to the end of the notice period. If no challenge is made, the
3 revision shall take effect without further action. If the revision is challenged, the revision may not
4 take effect without the approval of the Commission.
5 SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT
6 A. Dispute Resolution
7 1. Upon request by a member state, the Commission shall attempt to resolve disputes related to
8 the Compact that arise among member states and between member and non-member states.
9 2. The Commission shall promulgate a rule providing for both mediation and binding dispute
10 resolution for disputes as appropriate.
11 B. Enforcement
12 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
13 rules of this Compact.
14 2. By majority vote, the Commission may initiate legal action in the United States District
15 Court for the District of Columbia or the federal district where the Commission has its principal
16 offices against a member state in default to enforce compliance with the provisions of the Compact
17 and its promulgated rules and bylaws. The relief sought may include both injunctive relief and
18 damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all
19 costs of litigation, including reasonable attorney's fees.
20 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
21 may pursue any other remedies available under federal or state law.
22 SECTION 12. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR
23 AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY PRACTICE AND ASSOCIATED RULES,
24 WITHDRAWAL, AND AMENDMENT
25 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
26 law in the 10th member state. The provisions, which become effective at that time, shall be limited
27 to the powers granted to the Commission relating to assembly and the promulgation of rules.
28 Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the
29 implementation and administration of the Compact.
30 B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules
31 shall be subject to the rules as they exist on the date on which the Compact becomes law in that
32 state. Any rule that has been previously adopted by the Commission shall have the full force and
33 effect of law on the day the Compact becomes law in that state.
34 C. Any member state may withdraw from this Compact by enacting a statute repealing the
35 same.
36 1. A member state's withdrawal shall not take effect until six (6) months after enactment of the
37 repealing statute.

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1 2. Withdrawal shall not affect the continuing requirement of the withdrawing state's audiology
2 or speech-language pathology licensing board to comply with the investigative and adverse action
3 reporting requirements of this act prior to the effective date of withdrawal.
4 D. Nothing contained in this Compact shall be construed to invalidate or prevent any audiology
5 or speech-language pathology licensure agreement or other cooperative arrangement between a
6 member state and a non-member state that does not conflict with the provisions of this Compact.
7 E. This Compact may be amended by the member states. No amendment to this Compact shall
8 become effective and binding upon any member state until it is enacted into the laws of all member
9 states.
10 SECTION 13. CONSTRUCTION AND SEVERABILITY
11 This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of
12 this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is
13 declared to be contrary to the constitution of any member state or of the United States or the
14 applicability thereof to any government, agency, person or circumstance is held invalid, the validity
15 of the remainder of this Compact and the applicability thereof to any government, agency, person or
16 circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution
17 of any member state, the Compact shall remain in full force and effect as to the remaining member
18 states and in full force and effect as to the member state affected as to all severable matters.
19 SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS
20 A. Nothing herein prevents the enforcement of any other law of a member state that is not
21 inconsistent with the Compact.
22 B. All laws in a member state in conflict with the Compact are superseded to the extent of the
23 conflict.
24 C. All lawful actions of the Commission, including all rules and bylaws promulgated by the
25 Commission, are binding upon the member states.
26 D. All agreements between the Commission and the member states are binding in accordance
27 with their terms.
28 E. In the event any provision of the Compact exceeds the constitutional limits imposed on the
29 legislature of any member state, the provision shall be ineffective to the extent of the conflict with
30 the constitutional provision in question in that member state.
31 3 New Section; Occupational Therapists; Occupational Therapy Licensure Compact. Amend
32 RSA 326-C by inserting after section 8 the following new section:
33 326-C:9 Occupational Therapy Licensure Compact. The state of New Hampshire hereby adopts
34 the provisions of the Occupational Therapy Licensure Compact as follows:
35 SECTION 1. PURPOSE
36 The purpose of this Compact is to facilitate interstate practice of occupational therapy with the goal
37 of improving public access to occupational therapy services. The Practice of occupational therapy

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occurs in the state where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

A. Increase public access to occupational therapy services by providing for the mutual recognition of other member state licenses;

B. Enhance the states' ability to protect the public's health and safety;

C. Encourage the cooperation of member states in regulating multi-state occupational therapy practice;

D. Support spouses of relocating military members;

E. Enhance the exchange of licensure, investigative, and disciplinary information between Member states;

F. Allow a remote state to hold a provider of services with a Compact privilege in that state accountable to that state's practice standards; and

G. Facilitate the use of telehealth technology in order to increase access to occupational therapy services.

SECTION 2. DEFINITIONS

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

A. "Active Duty Military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Chapter 1209 and Section 1211.

B. "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against an occupational therapist or occupational therapy assistant, including actions against an individual's license or Compact privilege such as censure, revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee's practice.

C. "Alternative Program" means a non-disciplinary monitoring process approved by an occupational therapy licensing board.

D. "Compact privilege" means the authorization, which is equivalent to a license, granted by a remote state to allow a licensee from another member state to practice as an occupational therapist or practice as an occupational therapy assistant in the remote state under its laws and rules. The practice of occupational therapy occurs in the member state where the patient/client is located at the time of the patient/client encounter.

E. "Continuing Competence/Education" means a requirement, as a condition of license renewal, to provide evidence of participation in, and/or completion of, educational and professional activities relevant to practice or area of work.

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1 F. “Current significant investigative information” means investigative information that a
2 licensing board, after an inquiry or investigation that includes notification and an opportunity for
3 the occupational therapist or occupational therapy assistant to respond, if required by state law, has
4 reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.
5 G. “Data system” means a repository of information about licensees, including but not limited to
6 license status, investigative information, Compact privileges, and adverse actions.
7 H. “Encumbered license” means a license in which an adverse action restricts the practice of
8 occupational therapy by the licensee or said adverse action has been reported to the National
9 Practitioners Data Bank (NPDB).
10 I. “Executive Committee” means a group of directors elected or appointed to act on behalf of, and
11 within the powers granted to them by, the Commission.
12 J. “Home state” means the member state that is the licensee’s Primary state of residence.
13 K. “Impaired practitioner” means individuals whose professional practice is adversely affected
14 by substance abuse, addiction, or other health-related conditions.
15 L. “Investigative Information” means information, records, and/or documents received or
16 generated by an occupational therapy licensing board pursuant to an investigation.
17 M. “Jurisprudence requirement” means the assessment of an individual’s knowledge of the laws
18 and rules governing the practice of occupational therapy in a state.
19 N. “Licensee” means an individual who currently holds an authorization from the state to
20 practice as an occupational therapist or as an occupational therapy assistant.
21 O. “Member state” means a state that has enacted the Compact.
22 P. “Occupational therapist” means an individual who is licensed by a state to practice
23 occupational therapy.
24 Q. “Occupational therapy assistant” means an individual who is licensed by a state to assist in
25 the practice of occupational therapy.
26 R. “Occupational therapy,” “occupational therapy practice,” and the “practice of occupational
27 therapy” mean the care and services provided by an occupational therapist or an occupational
28 therapy assistant as set forth in the member state’s statutes and regulations.
29 S. “Occupational therapy Compact Commission” or “Commission” means the national
30 administrative body whose membership consists of all states that have enacted the Compact.
31 T. “Occupational therapy licensing board” or “licensing board” means the agency of a state that
32 is authorized to license and regulate occupational therapists and occupational therapy assistants.
33 U. “Primary state of residence” means the state (also known as the home state) in which an
34 occupational therapist or occupational therapy assistant who is not Active Duty Military declares a
35 primary residence for legal purposes as verified by: driver’s license, federal income tax return, lease,
36 deed, mortgage or voter registration or other verifying documentation as further defined by
37 Commission rules.

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1 V. "Remote state" means a member state other than the home state, where a licensee is
2 exercising or seeking to exercise the Compact privilege.
3 W. "Rule" means a regulation promulgated by the Commission that has the force of law.
4 X. "State" means any state, commonwealth, district, or territory of the United States of America
5 that regulates the practice of occupational therapy.
6 Y. "Single-state license" means an occupational therapist or occupational therapy assistant
7 license issued by a member state that authorizes practice only within the issuing state and does not
8 include a Compact privilege in any other member state.
9 Z. "Telehealth" means the application of telecommunication technology to deliver occupational
10 therapy services for assessment, intervention and/or consultation.
11 SECTION 3. STATE PARTICIPATION IN THE COMPACT
12 A. To participate in the Compact, a member state shall:
13 1. License occupational therapists and occupational therapy assistants;
14 2. Participate fully in the Commission's data system, including but not limited to using the
15 Commission's unique identifier as defined in rules of the Commission;
16 3. Have a mechanism in place for receiving and investigating complaints about licensees;
17 4. Notify the Commission, in compliance with the terms of the Compact and rules, of any
18 adverse action or the availability of investigative information regarding a licensee;
19 5. Implement or utilize procedures for considering the criminal history records of applicants for
20 an initial Compact privilege. These procedures shall include the submission of fingerprints or other
21 biometric-based information by applicants for the purpose of obtaining an applicant's criminal
22 history record information from the Federal Bureau of Investigation and the agency responsible for
23 retaining that state's criminal records;
24 a. A member state shall, within a time frame established by the Commission, require a criminal
25 background check for a licensee seeking/applying for a Compact privilege whose Primary state of
26 residence is that member state, by receiving the results of the Federal Bureau of Investigation
27 criminal record search, and shall use the results in making licensure decisions.
28 b. Communication between a member state, the Commission and among member states
29 regarding the verification of eligibility for licensure through the Compact shall not include any
30 information received from the Federal Bureau of Investigation relating to a federal criminal records
31 check performed by a member state under Public Law 92-544.
32 6. Comply with the rules of the Commission;
33 7. Utilize only a recognized national examination as a requirement for licensure pursuant to the
34 rules of the Commission; and
35 8. Have Continuing Competence/Education requirements as a condition for license renewal.
36 B. A member state shall grant the Compact privilege to a licensee holding a valid unencumbered
37 license in another member state in accordance with the terms of the Compact and rules.

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1 C. Member states may charge a fee for granting a Compact privilege.
2 D. A member state shall provide for the state's delegate to attend all occupational therapy
3 Compact Commission meetings.
4 E. Individuals not residing in a member state shall continue to be able to apply for a member
5 state's Single-state license as provided under the laws of each member state. However, the Single-
6 state license granted to these individuals shall not be recognized as granting the Compact privilege
7 in any other member state.
8 F. Nothing in this Compact shall affect the requirements established by a member state for the
9 issuance of a Single-state license.
10 SECTION 4. COMPACT PRIVILEGE
11 A. To exercise the Compact privilege under the terms and provisions of the Compact, the
12 licensee shall:
13 1. Hold a license in the home state;
14 2. Have a valid United States Social Security Number or National Practitioner Identification
15 number;
16 3. Have no encumbrance on any state license;
17 4. Be eligible for a Compact privilege in any member state in accordance with Section 4D, F, G,
18 and H;
19 5. Have paid all fines and completed all requirements resulting from any adverse action against
20 any license or Compact privilege, and two years have elapsed from the date of such completion;
21 6. Notify the Commission that the licensee is seeking the Compact privilege within a remote
22 state(s);
23 7. Pay any applicable fees, including any state fee, for the Compact privilege;
24 8. Complete a criminal background check in accordance with Section 3A(5);
25 a. The licensee shall be responsible for the payment of any fee associated with the completion of
26 a criminal background check.
27 9. Meet any jurisprudence requirements established by the remote state(s) in which the licensee
28 is seeking a Compact privilege; and
29 10. Report to the Commission adverse action taken by any non-member state within 30 days
30 from the date the adverse action is taken.
31 B. The Compact privilege is valid until the expiration date of the home state license. The
32 licensee must comply with the requirements of Section 4A to maintain the Compact privilege in the
33 remote state.
34 C. A licensee providing occupational therapy in a remote state under the Compact privilege
35 shall function within the laws and regulations of the remote state.
36 D. Occupational therapy assistants practicing in a remote state shall be supervised by an
37 occupational therapist licensed or holding a Compact privilege in that remote state.

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E. A licensee providing occupational therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's Compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee may be ineligible for a Compact privilege in any state until the specific time for removal has passed and all fines are paid.

F. If a home state license is encumbered, the licensee shall lose the Compact privilege in any remote state until the following occur:

1. The home state license is no longer encumbered; and

2. Two years have elapsed from the date on which the home state license is no longer encumbered in accordance with Section 4(F)(1).

G. Once an Encumbered license in the home state is restored to good standing, the licensee must meet the requirements of Section 4A to obtain a Compact privilege in any remote state.

H. If a licensee's Compact privilege in any remote state is removed, the individual may lose the Compact privilege in any other remote state until the following occur:

1. The specific period of time for which the Compact privilege was removed has ended;

2. All fines have been paid and all conditions have been met;

3. Two years have elapsed from the date of completing requirements for 4(H)(1) and (2); and

4. The Compact privileges are reinstated by the Commission, and the compact data system is updated to reflect reinstatement.

I. If a licensee's Compact privilege in any remote state is removed due to an erroneous charge, privileges shall be restored through the compact data system.

J. Once the requirements of Section 4H have been met, the license must meet the requirements in Section 4A to obtain a Compact privilege in a remote state.

SECTION 5: OBTAINING A NEW HOME STATE LICENSE BY VIRTUE OF COMPACT PRIVILEGE

A. An occupational therapist or occupational therapy assistant may hold a home state license, which allows for Compact privileges in member states, in only one member state at a time.

B. If an occupational therapist or occupational therapy assistant changes primary state of residence by moving between two member states:

1. The occupational therapist or occupational therapy assistant shall file an application for obtaining a new home state license by virtue of a Compact privilege, pay all applicable fees, and notify the current and new home state in accordance with applicable rules adopted by the Commission.

2. Upon receipt of an application for obtaining a new home state license by virtue of compact privilege, the new home state shall verify that the occupational therapist or occupational therapy

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1 assistant meets the pertinent criteria outlined in Section 4 via the data system, without need for
2 primary source verification except for:
3 a. An FBI fingerprint based criminal background check if not previously performed or updated
4 pursuant to applicable rules adopted by the Commission in accordance with Public Law 92-544;
5 b. Other criminal background check as required by the new home state; and
6 c. Submission of any requisite jurisprudence requirements of the new home state.
7 3. The former home state shall convert the former home state license into a Compact privilege
8 once the new home state has activated the new home state license in accordance with applicable
9 rules adopted by the Commission.
10 4. Notwithstanding any other provision of this Compact, if the occupational therapist or
11 occupational therapy assistant cannot meet the criteria in Section 4, the new home state shall apply
12 its requirements for issuing a new Single-state license.
13 5. The occupational therapist or the occupational therapy assistant shall pay all applicable fees
14 to the new home state in order to be issued a new home state license.
15 C. If an occupational therapist or occupational therapy assistant changes primary state of
16 residence by moving from a member state to a non-member state, or from a non-member state to a
17 member state, the state criteria shall apply for issuance of a Single-state license in the new state.
18 D. Nothing in this compact shall interfere with a licensee's ability to hold a Single-state license
19 in multiple states; however, for the purposes of this compact, a licensee shall have only one home
20 state license.
21 E. Nothing in this Compact shall affect the requirements established by a member state for the
22 issuance of a Single-state license.
23 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES
24 A. Active Duty Military personnel, or their spouses, shall designate a home state where the
25 individual has a current license in good standing. The individual may retain the home state
26 designation during the period the service member is on active duty. Subsequent to designating a
27 home state, the individual shall only change their home state through application for licensure in the
28 new state or through the process described in Section 5.
29 SECTION 7. ADVERSE ACTIONS
30 A. A home state shall have exclusive power to impose adverse action against an occupational
31 therapist's or occupational therapy assistant's license issued by the home state.
32 B. In addition to the other powers conferred by state law, a remote state shall have the
33 authority, in accordance with existing state due process law, to:
34 1. Take adverse action against an occupational therapist's or occupational therapy assistant's
35 Compact privilege within that member state.
36 2. Issue subpoenas for both hearings and investigations that require the attendance and
37 testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board

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1 in a member state for the attendance and testimony of witnesses or the production of evidence from
2 another member state shall be enforced in the latter state by any court of competent jurisdiction,
3 according to the practice and procedure of that court applicable to subpoenas issued in proceedings
4 pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and
5 other fees required by the service statutes of the state in which the witnesses or evidence are
6 located.
7 C. For purposes of taking adverse action, the home state shall give the same priority and effect
8 to reported conduct received from a member state as it would if the conduct had occurred within the
9 home state. In so doing, the home state shall apply its own state laws to determine appropriate
10 action.
11 D. The home state shall complete any pending investigations of an occupational therapist or
12 occupational therapy assistant who changes primary state of residence during the course of the
13 investigations. The home state, where the investigations were initiated, shall also have the
14 authority to take appropriate action(s) and shall promptly report the conclusions of the
15 investigations to the OT Compact Commission data system. The occupational therapy Compact
16 Commission data system administrator shall promptly notify the new home state of any adverse
17 actions.
18 E. A member state, if otherwise permitted by state law, may recover from the affected
19 occupational therapist or occupational therapy assistant the costs of investigations and disposition of
20 cases resulting from any adverse action taken against that occupational therapist or occupational
21 therapy assistant.
22 F. A member state may take adverse action based on the factual findings of the remote state,
23 provided that the member state follows its own procedures for taking the adverse action.
24 G. Joint Investigations
25 1. In addition to the authority granted to a member state by its respective state occupational
26 therapy laws and regulations or other applicable state law, any member state may participate with
27 other member states in joint investigations of licensees.
28 2. Member states shall share any investigative, litigation, or compliance materials in
29 furtherance of any joint or individual investigation initiated under the Compact.
30 H. If an adverse action is taken by the home state against an occupational therapist's or
31 occupational therapy assistant's license, the occupational therapist's or occupational therapy
32 assistant's Compact privilege in all other member states shall be deactivated until all encumbrances
33 have been removed from the state license. All home state disciplinary orders that impose adverse
34 action against an occupational therapist's or occupational therapy assistant's license shall include a
35 statement that the occupational therapist's or occupational therapy assistant's Compact privilege is
36 deactivated in all member states during the pendency of the order.

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1 I. If a member state takes adverse action, it shall promptly notify the administrator of the data
2 system. The administrator of the data system shall promptly notify the home state of any adverse
3 actions by remote states.
4 J. Nothing in this Compact shall override a member state's decision that participation in an
5 Alternative Program may be used in lieu of adverse action.
6 SECTION 8. ESTABLISHMENT OF THE OCCUPATIONAL THERAPY COMPACT
7 COMMISSION.
8 A. The Compact member states hereby create and establish a joint public agency known as the
9 occupational therapy Compact Commission:
10 1. The Commission is an instrumentality of the Compact states.
11 2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely
12 and exclusively in a court of competent jurisdiction where the principal office of the Commission is
13 located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or
14 consents to participate in alternative dispute resolution proceedings.
15 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
16 B. Membership, Voting, and Meetings
17 1. Each member state shall have and be limited to one (1) delegate selected by that member
18 state's licensing board.
19 2. The delegate shall be either:
20 a. A current member of the licensing board, who is an occupational therapist, occupational
21 therapy assistant, or public member; or
22 b. An administrator of the licensing board.
23 3. Any delegate may be removed or suspended from office as provided by the law of the state
24 from which the delegate is appointed.
25 4. The member state board shall fill any vacancy occurring in the Commission within 90 days.
26 5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and
27 creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs
28 of the Commission. A delegate shall vote in person or by such other means as provided in the
29 bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other
30 means of communication.
31 6. The Commission shall meet at least once during each calendar year. Additional meetings
32 shall be held as set forth in the bylaws.
33 7. The Commission shall establish by rule a term of office for delegates.
34 C. The Commission shall have the following powers and duties:
35 1. Establish a Code of Ethics for the Commission;
36 2. Establish the fiscal year of the Commission;
37 3. Establish bylaws;

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1 4. Maintain its financial records in accordance with the bylaws;
2 5. Meet and take such actions as are consistent with the provisions of this Compact and the
3 bylaws;
4 6. Promulgate uniform rules to facilitate and coordinate implementation and administration of
5 this Compact. The rules shall have the force and effect of law and shall be binding in all member
6 states;
7 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided
8 that the standing of any state occupational therapy licensing board to sue or be sued under
9 applicable law shall not be affected;
10 8. Purchase and maintain insurance and bonds;
11 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees
12 of a member state;
13 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant such
14 individuals appropriate authority to carry out the purposes of the Compact, and establish the
15 Commission's personnel policies and programs relating to conflicts of interest, qualifications of
16 personnel, and other related personnel matters;
17 11. Accept any and all appropriate donations and grants of money, equipment, supplies,
18 materials and services, and receive, utilize and dispose of the same; provided that at all times the
19 Commission shall avoid any appearance of impropriety and/or conflict of interest;
20 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or
21 use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any
22 appearance of impropriety;
23 13. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any
24 property real, personal, or mixed;
25 14. Establish a budget and make expenditures;
26 15. Borrow money;
27 16. Appoint committees, including standing committees composed of members, state regulators,
28 state legislators or their representatives, and consumer representatives, and such other interested
29 persons as may be designated in this Compact and the bylaws;
30 17. Provide and receive information from, and cooperate with, law enforcement agencies;
31 18. Establish and elect an Executive Committee; and
32 19. Perform such other functions as may be necessary or appropriate to achieve the purposes of
33 this Compact consistent with the state regulation of occupational therapy licensure and practice.
34 D. The Executive Committee. The Executive Committee shall have the power to act on behalf of
35 the Commission according to the terms of this Compact.
36 1. The Executive Committee shall be composed of nine members:

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1 a. Seven voting members who are elected by the Commission from the current membership of
2 the Commission;
3 b. One ex-officio, nonvoting member from a recognized national occupational therapy
4 professional association; and
5 c. One ex-officio, nonvoting member from a recognized national occupational therapy
6 certification organization.
7 2. The ex-officio members will be selected by their respective organizations.
8 3. The Commission may remove any member of the Executive Committee as provided in bylaws.
9 4. The Executive Committee shall meet at least annually.
10 5. The Executive Committee shall have the following duties and responsibilities:
11 a. Recommend to the entire Commission changes to the rules or bylaws, changes to this
12 Compact legislation, fees paid by Compact member states such as annual dues, and any Commission
13 Compact fee charged to licensees for the Compact privilege;
14 b. Ensure Compact administration services are appropriately provided, contractual or
15 otherwise;
16 c. Prepare and recommend the budget;
17 d. Maintain financial records on behalf of the Commission;
18 e. Monitor Compact compliance of member states and provide compliance reports to the
19 Commission;
20 f. Establish additional committees as necessary; and
21 g. Perform other duties as provided in rules or bylaws.
22 E. Meetings of the Commission
23 1. All meetings shall be open to the public, and public notice of meetings shall be given in the
24 same manner as required under the rulemaking provisions in Section 10.
25 2. The Commission or the Executive Committee or other committees of the Commission may
26 convene in a closed, non-public meeting if the Commission or Executive Committee or other
27 committees of the Commission must discuss:
28 a. Non-compliance of a member state with its obligations under the Compact;
29 b. The employment, compensation, discipline or other matters, practices or procedures related to
30 specific employees or other matters related to the Commission's internal personnel practices and
31 procedures;
32 c. Current, threatened, or reasonably anticipated litigation;
33 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;
34 e. Accusing any person of a crime or formally censuring any person;
35 f. Disclosure of trade secrets or commercial or financial information that is privileged or
36 confidential;

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1 g. Disclosure of information of a personal nature where disclosure would constitute a clearly
2 unwarranted invasion of personal privacy;
3 h. Disclosure of investigative records compiled for law enforcement purposes;
4 i. Disclosure of information related to any investigative reports prepared by or on behalf of or for
5 use of the Commission or other committee charged with responsibility of investigation or
6 determination of compliance issues pursuant to the Compact; or
7 j. Matters specifically exempted from disclosure by federal or member state statute.
8 3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's
9 legal counsel or designee shall certify that the meeting may be closed and shall reference each
10 relevant exempting provision.
11 4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a
12 meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore,
13 including a description of the views expressed. All documents considered in connection with an
14 action shall be identified in such minutes. All minutes and documents of a closed meeting shall
15 remain under seal, subject to release by a majority vote of the Commission or order of a court of
16 competent jurisdiction.
17 F. Financing of the Commission
18 1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
19 establishment, organization, and ongoing activities.
20 2. The Commission may accept any and all appropriate revenue sources, donations, and grants
21 of money, equipment, supplies, materials, and services.
22 3. The Commission may levy on and collect an annual assessment from each member state or
23 impose fees on other parties to cover the cost of the operations and activities of the Commission and
24 its staff, which must be in a total amount sufficient to cover its annual budget as approved by the
25 Commission each year for which revenue is not provided by other sources. The aggregate annual
26 assessment amount shall be allocated based upon a formula to be determined by the Commission,
27 which shall promulgate a rule binding upon all member states.
28 4. The Commission shall not incur obligations of any kind prior to securing the funds adequate
29 to meet the same; nor shall the Commission pledge the credit of any of the member states, except by
30 and with the authority of the member state.
31 5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts
32 and disbursements of the Commission shall be subject to the audit and accounting procedures
33 established under its bylaws. However, all receipts and disbursements of funds handled by the
34 Commission shall be audited yearly by a certified or licensed public accountant, and the report of the
35 audit shall be included in and become part of the annual report of the Commission.
36 G. Qualified Immunity, Defense, and Indemnification

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1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 9. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. A member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable (utilizing a unique identifier) as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Adverse actions against a license or Compact privilege;
4. Non-confidential information related to Alternative Program participation;
5. Any denial of application for licensure, and the reason(s) for such denial;
6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission; and

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1 7. Current significant investigative information.
2 C. Current significant investigative information and other investigative information pertaining
3 to a licensee in any member state will only be available to other member states.
4 D. The Commission shall promptly notify all member states of any adverse action taken against
5 a licensee or an individual applying for a license. Adverse action information pertaining to a licensee
6 in any member state will be available to any other member state.
7 E. Member states contributing information to the data system may designate information that
8 may not be shared with the public without the express permission of the contributing state.
9 F. Any information submitted to the data system that is subsequently required to be expunged
10 by the laws of the member state contributing the information shall be removed from the data
11 system.
12 SECTION 10. RULEMAKING
13 A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in
14 this Section and the rules adopted thereunder. Rules and amendments shall become binding as of
15 the date specified in each rule or amendment.
16 B. The Commission shall promulgate reasonable rules in order to effectively and efficiently
17 achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Commission
18 exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the
19 Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid
20 and have no force and effect.
21 C. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute
22 or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
23 the rule, then such rule shall have no further force and effect in any member state.
24 D. Rules or amendments to the rules shall be adopted at a regular or special meeting of the
25 Commission.
26 E. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least
27 thirty (30) days in advance of the meeting at which the rule will be considered and voted upon, the
28 Commission shall file a notice of proposed rulemaking:
29 1. On the website of the Commission or other publicly accessible platform; and
30 2. On the website of each member state occupational therapy licensing board or other publicly
31 accessible platform or the publication in which each state would otherwise publish proposed rules.
32 F. The notice of proposed rulemaking shall include:
33 1. The proposed time, date, and location of the meeting in which the rule will be considered and
34 voted upon;
35 2. The text of the proposed rule or amendment and the reason for the proposed rule;
36 3. A request for comments on the proposed rule from any interested person; and

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1 4. The manner in which interested persons may submit notice to the Commission of their
2 intention to attend the public hearing and any written comments.
3 G. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written
4 data, facts, opinions, and arguments, which shall be made available to the public.
5 H. The Commission shall grant an opportunity for a public hearing before it adopts a rule or
6 amendment if a hearing is requested by:
7 1. At least twenty five (25) persons;
8 2. A state or federal governmental subdivision or agency; or
9 3. An association or organization having at least twenty five (25) members.
10 I. If a hearing is held on the proposed rule or amendment, the Commission shall publish the
11 place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the
12 Commission shall publish the mechanism for access to the electronic hearing.
13 1. All persons wishing to be heard at the hearing shall notify the executive director of the
14 Commission or other designated member in writing of their desire to appear and testify at the
15 hearing not less than five (5) business days before the scheduled date of the hearing.
16 2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair
17 and reasonable opportunity to comment orally or in writing.
18 3. All hearings will be recorded. A copy of the recording will be made available on request.
19 4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules
20 may be grouped for the convenience of the Commission at hearings required by this section.
21 J. Following the scheduled hearing date, or by the close of business on the scheduled hearing
22 date if the hearing was not held, the Commission shall consider all written and oral comments
23 received.
24 K. If no written notice of intent to attend the public hearing by interested parties is received, the
25 Commission may proceed with promulgation of the proposed rule without a public hearing.
26 L. The Commission shall, by majority vote of all members, take final action on the proposed rule
27 and shall determine the effective date of the rule, if any, based on the rulemaking record and the full
28 text of the rule.
29 M. Upon determination that an emergency exists, the Commission may consider and adopt an
30 emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual
31 rulemaking procedures provided in the Compact and in this section shall be retroactively applied to
32 the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective
33 date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted
34 immediately in order to:
35 1. Meet an imminent threat to public health, safety, or welfare;
36 2. Prevent a loss of Commission or member state funds;

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1 3. Meet a deadline for the promulgation of an administrative rule that is established by federal
2 law or rule; or
3 4. Protect public health and safety.
4 N. The Commission or an authorized committee of the Commission may direct revisions to a
5 previously adopted rule or amendment for purposes of correcting typographical errors, errors in
6 format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted
7 on the website of the Commission. The revision shall be subject to challenge by any person for a
8 period of thirty (30) days after posting. The revision may be challenged only on grounds that the
9 revision results in a material change to a rule. A challenge shall be made in writing and delivered to
10 the chair of the Commission prior to the end of the notice period. If no challenge is made, the
11 revision will take effect without further action. If the revision is challenged, the revision may not
12 take effect without the approval of the Commission.
13 SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT
14 A. Oversight
15 1. The executive, legislative, and judicial branches of state government in each member state
16 shall enforce this Compact and take all actions necessary and appropriate to effectuate the
17 Compact's purposes and intent. The provisions of this Compact and the rules promulgated
18 hereunder shall have standing as statutory law.
19 2. All courts shall take judicial notice of the Compact and the rules in any judicial or
20 administrative proceeding in a member state pertaining to the subject matter of this Compact which
21 may affect the powers, responsibilities, or actions of the Commission.
22 3. The Commission shall be entitled to receive service of process in any such proceeding, and
23 shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of
24 process to the Commission shall render a judgment or order void as to the Commission, this
25 Compact, or promulgated rules.
26 B. Default, Technical Assistance, and Termination
27 1. If the Commission determines that a member state has defaulted in the performance of its
28 obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:
29 a. Provide written notice to the defaulting state and other member states of the nature of the
30 default, the proposed means of curing the default and/or any other action to be taken by the
31 Commission; and
32 b. Provide remedial training and specific technical assistance regarding the default.
33 2. If a state in default fails to cure the default, the defaulting state may be terminated from the
34 Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and
35 benefits conferred by this Compact may be terminated on the effective date of termination. A cure of
36 the default does not relieve the offending state of obligations or liabilities incurred during the period
37 of default.

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1 3. Termination of membership in the Compact shall be imposed only after all other means of
2 securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by
3 the Commission to the governor, the majority and minority leaders of the defaulting state's
4 legislature, and each of the member states.
5 4. A state that has been terminated is responsible for all assessments, obligations, and liabilities
6 incurred through the effective date of termination, including obligations that extend beyond the
7 effective date of termination.
8 5. The Commission shall not bear any costs related to a state that is found to be in default or
9 that has been terminated from the Compact, unless agreed upon in writing between the Commission
10 and the defaulting state.
11 6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District
12 Court for the District of Columbia or the federal district where the Commission has its principal
13 offices. The prevailing member shall be awarded all costs of such litigation, including reasonable
14 attorney's fees.
15 C. Dispute Resolution
16 1. Upon request by a member state, the Commission shall attempt to resolve disputes related to
17 the Compact that arise among member states and between member and non-member states.
18 2. The Commission shall promulgate a rule providing for both mediation and binding dispute
19 resolution for disputes as appropriate.
20 D. Enforcement
21 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
22 rules of this Compact.
23 2. By majority vote, the Commission may initiate legal action in the United States District
24 Court for the District of Columbia or the federal district where the Commission has its principal
25 offices against a member state in default to enforce compliance with the provisions of the Compact
26 and its promulgated rules and bylaws. The relief sought may include both injunctive relief and
27 damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all
28 costs of such litigation, including reasonable attorney's fees.
29 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
30 may pursue any other remedies available under federal or state law.
31 SECTION 12. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR
32 OCCUPATIONAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND
33 AMENDMENT
34 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
35 law in the tenth member state. The provisions, which become effective at that time, shall be limited
36 to the powers granted to the Commission relating to assembly and the promulgation of rules.

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Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any member state may withdraw from this Compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's occupational therapy licensing board to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any occupational therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 13. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person, or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any member state, the Compact shall remain in full force and effect as to the remaining member states and in full force and effect as to the member state affected as to all severable matters.

SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS

A. A licensee providing occupational therapy in a remote state under the Compact privilege shall function within the laws and regulations of the remote state.

B. Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the Compact.

C. Any laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

D. Any lawful actions of the Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

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1 E. All agreements between the Commission and the member states are binding in accordance
2 with their terms.
3 F. In the event any provision of the Compact exceeds the constitutional limits imposed on the
4 legislature of any member state, the provision shall be ineffective to the extent of the conflict with
5 the constitutional provision in question in that member state.
6 4 Effective Date. Part IV of this act shall take effect July 1, 2021.
7
8 PART V
9 Relative to the authority of the office of professional licensure and certification for administration,
10 rulemaking, and enforcement of investigations, hearings, and appeals.
11 1 Office of Professional Licensure and Certification; Administration; Rulemaking. Amend RSA
12 310-A:1-d, II(h)(2) to read as follows:
13 (2) Such organizational and procedural rules necessary to administer the boards,
14 commissions, and councils in the office of professional licensure and certification, including rules
15 governing the administration of complaints and investigations, ***hearings, disciplinary***
16 ***proceedings,*** payment processing procedures, and application procedures; and
17 2 New Paragraph; Office of Professional Licensure and Certification; Administration; Standing
18 Orders. Amend RSA 310-A:1-d by inserting after paragraph III the following new paragraph:
19 IV. All boards, councils, and commissions may issue standing orders delegating non-
20 discretionary tasks to staff of the office of professional licensure and certification.
21 3 New Sections; Office of Professional Licensure and Certification; Investigations; Hearings;
22 Penalties; Appeals. Amend RSA 310-A by inserting after section 1-g the following new sections:
23 310-A:1-h Investigations.
24 I. Boards, which shall include all boards, councils, and commissions within the office of
25 professional licensure and certification, may authorize an investigation of allegations of misconduct
26 by licensees (a) upon their own initiative or (b) upon written complaint of any person that charges
27 that a person licensed by the board has committed misconduct. When requested by the board, the
28 office shall assign an investigator, who may assist in the investigation.
29 II. The procedures set forth in RSA 310-A:1-h through RSA 310-A:1-l are supplementary and
30 shall not supplant or supersede any procedures expressly set forth in any board's individual practice
31 act.
32 III. The following information obtained during investigations shall be held confidential and
33 shall be exempt from the disclosure requirements of RSA 91-A:
34 (a) Complaints received by the office.
35 (b) Information and records acquired by the office during the investigation.
36 (c) Reports and records made by the office as a result of its investigation.
37 IV. For the purpose of carrying out investigations, the executive director is authorized to:

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1 (a) Retain qualified experts.
2 (b) Conduct inspections of places of business of licensees or certificate holders.
3 (c) Retain legal counsel when authorized to do so by the attorney general.
4 (d) Issue subpoenas for persons, relevant documents and relevant things in accordance
5 with the following conditions:
6 (1) Subpoenas for persons shall not require compliance in less than 48 hours after
7 receipt of service.
8 (2) Subpoenas for documents and things shall not require compliance in fewer than
9 15 days after receipt of service.
10 (3) Service shall be made on licensees and certified individuals by certified mail to
11 the address on file with the office or by hand and shall not entitle them to witness or mileage fees.
12 (4) Service shall be made on persons who are not licensees or certified individuals in
13 accordance with the procedures and fee schedules of the superior court, and the subpoenas served on
14 them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure
15 and Certification."
16 V. The office or the boards, councils, and commissions within the office may disclose
17 information acquired in an investigation to law enforcement, if it involves suspected criminal
18 activity, to health licensing agencies in this state or any other jurisdiction, or in response to specific
19 statutory requirements or court orders.
20 VI. Allegations of professional misconduct shall be brought within 5 years from the time the
21 office reasonably could have discovered the act, omission or failure complained of, except that
22 conduct which resulted in a criminal conviction or in a disciplinary action by a relevant licensing
23 authority in another jurisdiction may be considered by the board without time limitation in making
24 licensing or disciplinary decisions if the conduct would otherwise be a ground for discipline. The
25 board may also consider licensee conduct without time limitation when the ultimate issue before the
26 board involves a pattern of conduct or the cumulative effect of conduct which becomes apparent as a
27 result of conduct which has occurred within the 5-year limitation period prescribed by this
28 paragraph.
29 VII. Each board, council, or commission may dismiss a complaint if the allegations do not
30 state a claim of professional misconduct.
31 310-A:1-i Disciplinary Proceedings; Remedial Proceedings.
32 I. Boards, which shall include all boards, councils, and commissions within the office of
33 professional licensure and certification, are authorized to conduct disciplinary proceedings in
34 accordance with procedural rules adopted by the executive director.
35 II. For the purpose of carrying out disciplinary proceedings, each board, council, or
36 commission is authorized to issue subpoenas for persons, relevant documents and relevant things in
37 accordance with the following conditions:

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1 (a) Subpoenas for persons shall not require compliance in less than 48 hours after
2 receipt of service.
3 (b) Subpoenas for documents and things shall not require compliance in fewer than 15
4 days after receipt of service.
5 (c) Service shall be made on licensees and certified individuals by certified mail to the
6 address on file with the office or by hand and shall not entitle them to witness or mileage fees.
7 (d) Service shall be made on persons who are not licensees or certified individuals in
8 accordance with the procedures and fee schedules of the superior court, and the subpoenas served on
9 them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure
10 and Certification."
11 III. At any time before or during disciplinary proceedings, complaints may be dismissed or
12 disposed of, in whole or in part, by written settlement agreement approved by the board and the
13 licensees or certified individuals involved, provided that any complainant shall have the opportunity,
14 before the settlement agreement has been executed, to comment on the terms of the proposed
15 settlement. The board, council, or commission may hold a settlement agreement hearing prior to its
16 approval of the settlement agreement.
17 IV. Final board actions having the effect of terminating disciplinary proceedings, whether
18 taken before, during or after the completion of the proceedings, shall be set forth in a written record
19 that shall be available to the public after service upon the licensees or certified individuals involved.
20 V. In carrying out disciplinary or licensing proceedings, each board shall have the authority
21 to:
22 (a) Hold pre-hearing conferences exempt from the provisions of RSA 91-A.
23 (b) Appoint a board member or other qualified person as presiding officer.
24 (c) Administer, and authorize an appointed presiding officer to administer, oaths and
25 affirmations.
26 VI. Neither the office nor the boards, councils, and commissions shall have an obligation or
27 authority to appoint or pay the fees of attorneys representing licensees, certified individuals, or
28 witnesses during investigations or adjudicatory proceedings.
29 VII. Boards, councils, and commissions may take non-disciplinary remedial action against
30 any person licensed by it upon finding that the person is afflicted with physical or mental disability,
31 disease, disorder, or condition deemed dangerous to the public health. Upon making an affirmative
32 finding after notice and an opportunity for a hearing, the board, council, or commission may take
33 non-disciplinary remedial action:
34 (a) By suspension, limitation, or restriction of a license for a period of time as
35 determined reasonable by the board.
36 (b) By revocation of license.

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1 (c) By requiring the person to submit to the care, treatment, or observation of a
2 physician, counseling service, health care facility, professional assistance program, or any
3 combination thereof which is acceptable to the board.
4 VIII. All proceedings for non-disciplinary remedial action shall be exempt from the
5 provisions of RSA 91-A, except that the board may disclose any final remedial action that affects the
6 status of a license, including any non-disciplinary restrictions imposed.
7 310-A:1-j Hearings, Decisions and Appeals.
8 I. Disciplinary proceedings shall be open to the public, except upon order by the board,
9 council, or commission upon good cause shown. The public docket file for each such proceeding shall
10 be retained in accordance with the retention policy established by the office of professional licensure
11 and certification.
12 II. Notwithstanding any other provision of law, allegations of misconduct or lack of
13 professional qualifications that are not settled shall be heard by the board, council, or commission, or
14 a panel of the board, council, or commission with a minimum of 3 members appointed by the chair of
15 the board or other designee. Any member of the board, or other person qualified to act as presiding
16 officer and duly designated by the board, shall have the authority to preside at such hearing and to
17 issue oaths or affirmations to witnesses, rule on evidentiary and other procedural matters, and
18 prepare a recommended decision. In the case of a hearing before a panel, the presiding officer shall
19 prepare a recommended decision for the board, council, or commission, which shall determine
20 sanctions.
21 III. Except as otherwise provided by RSA 541-A:30, the board, council, or commission shall
22 furnish the respondent and the complainant, if any, at least 15 days' written notice of the date, time
23 and place of a hearing. Such notice shall include an itemization of the issues to be heard, and, in the
24 case of a disciplinary hearing, a statement as to whether the action has been initiated by a written
25 complaint or upon the board's own motion, or both. If a written complaint is involved, the notice
26 shall provide the complainant with a reasonable opportunity to intervene as a party.
27 IV. In disciplinary and licensing proceedings, the presiding officer may hold prehearing
28 conferences that are closed to the public and exempt from the provisions of RSA 91-A until such time
29 as a public evidentiary hearing is convened. In all instances, settlement discussions engaged in by
30 the parties at prehearing conferences may be conducted off the record.
31 V. The board, council, or commission may dispose of issues or allegations at any time during
32 an investigation or disciplinary proceeding by approving a settlement agreement or issuing a consent
33 order or an order of dismissal for default or failure to state a proper basis for disciplinary action.
34 Disciplinary action taken by the board at any stage of a proceeding, and any dispositive action taken
35 after the issuance of a public hearing notice, shall be reduced to writing and made available to the
36 public. Such decisions shall not be public until they are served upon the parties.

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1 VI. No civil action shall be maintained against the board or any member of the board or its
2 agents or employees, against any organization or its members, or against any other person for or by
3 reason of any statement, report, communication, or testimony to the board or determination by the
4 board in relation to proceedings under this chapter.
5 310-A:1-k Penalties.
6 I. Upon making an affirmative finding that a licensee or certificate holder has committed
7 professional misconduct, boards, which shall include all boards, councils, and commissions within
8 the office of professional licensure and certification, may take disciplinary action in any one or more
9 of the following ways:
10 (a) By reprimand.
11 (b) By suspension of a license or certificate for a period of time as determined reasonable
12 by the board.
13 (c) By revocation of license.
14 (d) By placing the licensee or certificate holder on probationary status. The board may
15 require the person to submit to any of the following:
16 (1) Regular reporting to the board concerning the matters which are the basis of the
17 probation.
18 (2) Continuing professional education until a satisfactory degree of skill has been
19 achieved in those areas which are the basis of probation.
20 (3) Submitting to the care, counseling, or treatment of a physician, counseling
21 service, health care facility, professional assistance program, or any comparable person or facility
22 approved by the board.
23 (4) Practicing under the direct supervision of another licensee for a period of time
24 specified by the board.
25 (e) By assessing administrative fines in amounts established by the board which shall
26 not exceed $3,000 per offense, or, in the case of continuing offenses, $300 for each day that the
27 violation continues, whichever is greater.
28 II. The board may issue a non-disciplinary confidential letter of concern to a licensee
29 advising that while there is insufficient evidence to support disciplinary action, the board believes
30 the licensee or certificate holder should modify or eliminate certain practices, and that continuation
31 of the activities which led to the information being submitted to the board may result in action
32 against the licensee's license. This letter shall not be released to the public or any other licensing
33 authority, except that the letter may be used as evidence in subsequent adjudicatory proceedings by
34 the board.
35 III. In the case of sanctions for discipline in another jurisdiction, the decision of the other
36 jurisdiction's disciplinary authority may not be collaterally attacked and the board may impose any

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of the sanctions set forth in this chapter, but shall provide notice and an opportunity to be heard prior to imposing any sanctions.

IV. In cases involving imminent danger to life or health, a board may order suspension of a license or certification pending hearing for a period of no more than 10 business days, unless the licensee or certified individual agrees in writing to a longer period. In such cases, the board shall comply with RSA 541-A:30.

V. Any person whose license has been suspended or revoked by the board may apply to the board, in writing, to request a hearing for reinstatement. Upon a hearing, the board may issue a new license or modify the suspension or revocation of the license.

VI. For any order issued in resolution of an disciplinary proceeding by the board, where the board has found misconduct sufficient to support disciplinary action, the board may require the licensee or certificate holder who is the subject of such finding to pay the office a sum not to exceed the reasonable cost of investigation and prosecution of the proceeding. This sum shall not exceed $10,000. This sum may be imposed in addition to any otherwise authorized administrative fines levied by the board as part of the penalty. The investigative and prosecution costs shall be assessed by the board and any sums recovered shall be credited to the office's fund and disbursed by the office for any future investigations of complaints and activities that violate this chapter or rules adopted under this chapter.

VII. When an investigation of a complaint is determined to be unfounded, the board shall dismiss the complaint and explain in writing to the complainant and the licensee or certificate holder its reason for dismissing the complaint. After six years, the board may destroy all information concerning the investigation, retaining only a record noting that an investigation was conducted and that the board determined the complaint to be unfounded. For the purpose of this paragraph, a complaint shall be deemed to be unfounded if it does not fall within the jurisdiction of the board, does not relate to the actions of the licensee or certificate holder, or is determined by the board to be frivolous.

VIII. Whoever, not being licensed or otherwise authorized to practice according to the laws of this state, shall advertise oneself as engaging in a profession licensed or certified by the office of professional licensure and certification, shall engage in activity requiring professional licensure, or in any way hold oneself out as qualified to do so, or call oneself a licensed professional, or whoever does such acts after receiving notice that such person's license to practice has been suspended or revoked, is engaged in unlawful practice. After hearing and upon making an affirmative finding of unlawful practice, the board, council, or commission may take action in any one of the following ways:

(a) Issue a cease and desist order against any person or entity engaged in unlawful, which shall be enforceable in superior court.

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1 (b) Impose a fine not to exceed the amount of any gain or economic benefit that the
2 person derived from the violation or $10,000 for each offense, whichever amount is greater. Each
3 violation of unlicensed or unlawful practice shall be deemed a separate offense.
4 (c) The attorney general, board, council, or commission, or prosecuting attorney of any
5 county or municipality where the act to unlawful practice takes place may maintain an action to
6 enjoin any person or entity from continuing to do acts of unlawful practice. The action to enjoin shall
7 not replace any other civil, criminal, or regulatory remedy. An injunction without bond is available
8 to any board, council, or commission.
9 310-A:1-l Rehearing; Appeals.
10 I. Any person who has been refused a license or certification by the board, which shall
11 include all boards, councils, and commissions within the office of professional licensure and
12 certification, or has been disciplined by the board shall have the right to petition for a rehearing
13 within 30 days after the original final decision.
14 II. Appeals from a decision on rehearing shall be by appeal to the supreme court pursuant to
15 RSA 541.
16 III. No sanction shall be stayed by the board during an appeal.
17 3 Effective Date. Part V of this act shall take effect January 1, 2022.
18
19 PART VI
20 Relative to temporary licensure of certain licensed nursing assistants.
21 1 Statement of Purpose. The general court acknowledges the critical importance of ensuring the
22 quality, accessibility, and sustainability of Medicaid services provided in nursing homes, and
23 recognizes the critical shortage of licensed nursing assistants throughout the state. The purpose of
24 this act is to strengthen the frontline staffing in nursing homes. The general court finds that during
25 the COVID-19 pandemic federal regulatory and statutory provisions were waived to facilitate the
26 hiring of nurse aides by nursing homes. Under state emergency order, these individuals were
27 allowed to work in nursing homes as temporary health partners following no less than 8 hours of
28 training provided either by a national association or a New Hampshire educational program. As a
29 matter of public policy, the general court finds that these workers were indispensable as facilities
30 struggled with staffing issues, particularly during outbreaks of the COVID-19 virus. Accordingly,
31 this act shall provide the board of nursing with the additional authority to expand the workforce of
32 licensed nursing assistants by recognizing the service of temporary health partners during the
33 COVID-19 pandemic.
34 2 Special Licensure as a Licensed Nursing Assistant; Applicants Who Served as Temporary
35 Health Partners.
36 I. Persons who have worked no fewer than 100 hours as temporary health partners in a
37 licensed nursing home and have demonstrated, through their work experience during a national and

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1 state public health emergency, the competency to transition to status as a licensed nursing assistant,
2 shall be deemed to have taken a board-approved nursing assistant course and may apply for a
3 license as a licensed nursing assistant in New Hampshire.
4 II. Notwithstanding any provision of law to the contrary, the state-approved training
5 program for licensed nursing assistants shall take into account the training and experience acquired
6 during the COVID-19 pandemic to transition these individuals to placement on the state's licensed
7 nursing assistant registry pursuant to RSA 326-B:26. Such individuals shall be subject to all
8 continuing education requirements under RSA 326-B:31.
9 III. For purposes of this act:
10 (a) "COVID-19" means the novel coronavirus first identified in 2019, or SARS-CoV-2.
11 (b) "Temporary health partner" means anyone authorized to work in a nursing home by
12 Emergency Order 42 issued by the governor on May 11, 2020, and required to complete training of
13 no less than eight hours and work under the supervision of an RN, APRN, or LPN, as is required of
14 LNAs under RSA 326-B:14.
15 3 Effective Date. Part VI of this act shall take effect upon its passage.
16
17 PART VII
18 Relative to the revocation of licensure for licensed emergency medical service units
19 and emergency medical service vehicles.
20 1 Emergency Medical and Trauma Services; Revocation of License. Amend the introductory
21 paragraph of RSA 153-A:13, I to read as follows:
22 I. The commissioner [~~shall~~] ***may*** deny an application for issuance or renewal of a license, or
23 ***issue a letter of concern,*** suspend***,*** or revoke a license, when the commissioner finds that the
24 applicant is guilty of any of the following acts or offenses:
25 2 Effective Date. Part VII of this act shall take effect 60 days after its passage.
26
27 PART VIII
28 Relative to schools for barbering, cosmetology, and esthetics.
29 1 Barbering, Cosmetology, and Esthetics; Definition; School. Amend RSA 313-A:1, XIII to read
30 as follows:
31 XIII. "School" means a school or other institution***, or a dedicated program within such***
32 ***school or institution,*** conducted for the purpose of teaching cosmetology, manicuring, barbering, or
33 esthetics.
34 2 Duties of the Board; Schools; Manicuring, Cosmetology, Barbering, Esthetics. RSA 313-A:7, II
35 is repealed and reenacted to read as follows:
36 II. The board may license a school to operate either:

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(a) Dedicated programs within secondary schools, the purpose of which is to teach cosmetology, manicuring, barbering, or esthetics; or

(b) Postsecondary programs conducted for the purpose of teaching cosmetology, manicuring, barbering, or esthetics, including postsecondary programs leading to a certificate in manicuring, barbering, cosmetology, or esthetics.

3 Barbering, Cosmetology, Esthetics, Manicuring; Apprenticeship Certificates. Amend RSA 313-A:24 to read as follows:

313-A:24 Apprentice Registration and [~~Licensure~~] ***Certificates***.

I. No person shall enter an apprenticeship or enroll in a school under this chapter unless such person has registered with the board as an apprentice and been issued an apprentice [~~license~~] ***certificate***. The board shall have sole authority to regulate apprentices and apprenticeship under this chapter. The board shall issue an apprentice [~~license~~] ***certificate*** to any student receiving instruction within a licensed school [~~or~~] ***and/or*** shop to learn barbering, cosmetology, esthetics, or manicuring.

II. A person applying for [~~a license~~] ***an apprentice certificate*** under this section shall be granted such [~~license~~] ***certificate*** upon:

(a) Submitting proof sufficient to the board to show that such person is at least 16 years of age;

(b) Paying a fee established by the [~~board~~] ***office of professional licensure and certification***; and

(c) Being deemed by the board to be of good professional character.

III. No salon or barbershop shall at any one time have more than one apprentice per licensed professional, except as follows:

(a) Each licensed barber may have up to 2 apprentices for barbering.

(b) Each licensed master barber may have up to 2 apprentices for barbering, or one apprentice master barber and one apprentice barber.

IV. Upon completing the number of hours specified in the board's apprentice rules, an apprentice shall be eligible to apply to the board for [~~licensure~~] ***certification***.

V. Notwithstanding RSA 161-B:11, VI-a, an applicant for an apprentice certificate shall not be required to provide a social security number as a prerequisite for obtaining a certificate.

4 Expiration and Renewal of Licenses and Certificates. Amend RSA 313-A:20 to read as follows:

313-A:20 Expiration and Renewal of Licenses ***and Certificates***. Each barber, master barber, barber instructor, [~~apprentice,~~] barbershop, barber school, esthetician, esthetics instructor, esthetics school, esthetics salon, manicurist, [~~apprentice,~~] beauty salon, or manicuring salon license issued under this chapter***, and any apprentice certificate issued under RSA 313-A:24,*** shall expire on the last day of the birth month of the licensee ***or certificate holder*** in the odd year next succeeding

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1 its date of issuance. Each cosmetologist, cosmetology instructor, or cosmetology school license issued
2 under this chapter shall expire on the last day of the birth month of the licensee in the even year
3 next succeeding its date of issuance. Any personal license ***or apprentice certificate*** which has
4 expired may be renewed within 6 months by payment of the renewal fee and a late fee established by
5 the board. After 6 months and within 5 years, a personal license ***or apprentice certificate*** may be
6 renewed by paying the renewal fee and a late fee established by the board. Any school or shop
7 license which has expired may be renewed upon payment of the renewal fee plus a late fee
8 established by the board.
9 5 Effective Date. Part VIII of this act shall take effect 60 days after its passage.
10
11 PART IX
12 Relative to telemedicine provided by out-of-state psychologists.
13 1 Psychologists; Electronic Practice of Psychology. RSA 329-B:16 is repealed and reenacted to
14 read as follows:
15 329-B:16 Electronic Practice of Psychology, Telehealth, Telemedicine.
16 I. Telepsychology, telehealth, and telemedicine services, as provided by psychologists,
17 include those psychology services that utilize electronic means, including audio, video, or other
18 electronic media, to engage in visual or virtual presence in contemporaneous time. A New
19 Hampshire tele-pass license shall be required for provision of such care to people in New Hampshire.
20 Contacts that are exempt from this requirement are:
21 (a) Persons exempted by 329-B:28.
22 (b) Screenings for inclusion in voluntary research projects that have been properly
23 approved by a New Hampshire based institutional review board.
24 (c) Psychologists licensed by the board, who may provide tele-psychology services to a
25 person within the state of New Hampshire without acquiring a tele-pass psychology license.
26 (d) Persons exempted by RSA 329-D.
27 II. A doctoral level psychologist who is not licensed in New Hampshire shall be eligible to
28 provide telepsychology services to a person in New Hampshire pursuant to RSA 329-D, or providing
29 that the psychologist:
30 (a) Is licensed in one of the jurisdictions in the United States or Canada;
31 (b) Is in good standing in all license jurisdictions in the United States and Canada;
32 (c) Has satisfied conditions determined in rules adopted by the board;
33 and
34 (d) Has applied for and obtained a valid New Hampshire tele-pass psychology license in
35 accordance with board rules and payment of license fees with effective dates that cover the dates of
36 services provided.

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1 III. The tele-pass psychology licensee shall agree to conditions including, but not limited to,
2 conditions stipulated by the board that the licensee shall:
3 (a) Conform to all New Hampshire statutes and rules.
4 (b) Agree that electronic attendance for appearances shall be deemed adequate for
5 regulatory enforcement purposes and that in-person appearances by the licensee are optional and
6 such associated costs for in-person attendance are the full responsibility of the tele-pass psychology
7 licensee.
8 (c) Understand that false statements or failure to comply with official requests and
9 official orders shall constitute sufficient cause for revocation of the tele-pass psychology license.
10 (d) Understand that all conditions of tele-pass psychology license to practice and
11 enforcement shall be pursuant to New Hampshire law.
12 (e) Grant the New Hampshire board of psychologists and its investigators authority to
13 disclose to law enforcement and related regulatory authorities, at their discretion, information
14 including but not limited to status of application, actions and information pertinent to investigations
15 and enforcement of the laws and rules pertaining to the licensee's conduct.
16 (f) Not conduct face-to-face in-person psychological services in New Hampshire.
17 IV. The board shall adopt rules pursuant to RSA 541-A for:
18 (a) The application procedure for a New Hampshire tele-pass psychology license;
19 (b) Additional requirements for a psychologist licensed in another state of Canada to
20 acquire a tele-pass psychology license, including attestations;
21 (c) The standards of care for telemedicine practice of psychology and their enforcement;
22 and
23 (d) Procedures for investigation and discipline pursuant to all means authorized in this
24 chapter, including but not limited to suspension or revocation of a tele-pass psychology license.
25 V. Persons who have been granted emergency licenses to practice psychology under the
26 Covid 19 emergency pursuant to the Governor's Emergency Order #29 shall be granted a tele-pass
27 license upon application to the board.
28 2 Effective Date. Part IX of this act shall take effect upon its passage.
29
30 PART X
31 Relative to certified food protection managers.
32 1 New Section; Food Service Licensure; Certified Food Protection Manager. Amend RSA 143-A
33 by inserting after RSA 143-A:11 the following new section:
34 143-A:11-a Certified Food Protection Manager.
35 I.(a) Each food service establishment licensed by the state under RSA 143-A:6 shall have a
36 person in charge and present during all hours of operation trained as a certified food protection

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1 manager by a program approved by the Conference for Food Protection or other equivalent industry
2 standards program.
3 (b) The requirement in subparagraph (a) shall not apply under these conditions:
4 (1) Food establishments having at least one certified food protection manager on
5 staff shall not be required to have the certified food protection manager present when no food
6 preparation is taking place;
7 (2) Food establishments having at least one certified food protection manager on
8 staff shall not be required to have the certified food protection manager present when food
9 preparation is limited to reheating commercially prepared food or ready to eat food; or
10 (3) Food establishments having 5 food employees or less on duty are required to have
11 only one certified food protection manager on staff who is available, although not required to be
12 present, during all hours of operation.
13 II. This section shall not apply to any food service establishment exempt from licensure or
14 inspection under RSA 143-A:5.
15 III. This section shall not apply to food establishments licensed under RSA 143-A:6 as food
16 processing plants, cold storage or refrigerating warehouses; retail stores with no food preparation or
17 limited to self service foods, servicing areas, bed and breakfasts, lodging facilities serving continental
18 breakfasts, home delivery services of packaged frozen food; pushcarts and other mobile food units,
19 those serving packaged food and non-potentially hazardous unwrapped foods only;
20 wholesalers/distributors; on-site vending machines, bars/lounges without a food preparation area;
21 arena/theater concessions serving non-potentially hazardous; sellers of pre-packaged frozen meat or
22 poultry that is processed in a USDA-inspected plant; homestead food operations.
23 2 Effective Date. Part X of this act shall take effect upon its passage.
24
25 PART XI
26 Establishing minimum qualifications for certification as a child care associate teacher.
27 1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education
28 Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after
29 subparagraph (m) the following new subparagraph:
30 (n) The following qualification for certification as an associate teacher: a minimum of
31 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of
32 training in child growth and development, the latter of which may be documented life experience.
33 Documented life experience in lieu of training in child growth and development shall include
34 experience with the same age children the associate teacher supervises, such as a family child care
35 provider; service as a foster parent; work as a school teacher; work as a camp counselor; and
36 experience as a group leader for children in sports or other activities, such as scouts or little league,
37 or closely related experience.

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1 2 Effective Date. Part XI of this act shall take effect 60 days after its passage.

2021-1579h

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Licensing places of assembly.

II. Repealing the emergency medical services personnel licensure interstate compact.

III. Hearings at the board of nursing.

IV. Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

V. The authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

VI. Temporary licensure of certain licensed nursing assistants.

VII. The revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

VIII. Schools for barbering, cosmetology, and esthetics.

IX. Telemedicine provided by out-of-state psychologists.

X. Sanitary production and distribution of food.

XI. Minimum qualifications for certification as a child care associate teacher.

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PART VI

Relative to the licensure and regulation of music therapists.

1 New Chapter; Music Therapists. Amend RSA by inserting after chapter 326-L the following new chapter:

CHAPTER 326-M

MUSIC THERAPISTS

326-M:1 Definitions. In this chapter and RSA 328-F:

I. "Board" means the music therapists governing board established in RSA 328-F.

II. "Board certified music therapist" means an individual who holds current board certification from the Certification Board for Music Therapists.

III. "Executive director" means the executive director of the office of professional licensure and certification.

IV. "Music therapist" means a person licensed to practice music therapy pursuant to this chapter.

V. "Music therapy" means the clinical and evidence based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a board certified music therapist. The music therapy interventions may include, music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention and movement to music. The practice of music therapy does not include the screening, diagnosis, or assessment of any physical, mental, or communication disorder. This term may include:

(a) Acceptance of clients referred for music therapy by other health care or educational professionals, family members, or caregivers.

(b) Assessment of clients to determine appropriate music therapy services.

(c) Development and implementation of individualized music therapy treatment plans that identify goals, objectives, and strategies of music therapy that are appropriate for clients.

(d) Use of music therapy techniques such as improvisation, performance, receptive

music listening, song writing, lyric discussion, guided imagery with music, learning through music, and movement to music.

(e) Evaluation of a client's response to music therapy techniques and to the client's individualized music therapy treatment plan.

(f) Any necessary modification of the client's individualized music therapy treatment plan.

(g) Any necessary collaboration with the other health care professionals treating a client.

(h) Minimizing of barriers that may restrict a client's ability to receive or fully benefit from music therapy services.

326-M:2 Prohibition on Unlicensed Practice; Professional Identification.

I. No person without a license as a music therapist shall use the title "music therapist" or similar title or practice music therapy.

II. Nothing in this chapter shall be construed to prohibit or restrict the practice, services, or activities of the following:

(a) Any person licensed, certified, or regulated under the laws of this state in another profession or occupation or personnel supervised by a licensed professional in this state performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation, if that person does not represent himself or herself as a music therapist; or

(b) Any person whose training and national certification attests to the individual's preparation and ability to practice his or her certified profession or occupation, if that person does not represent himself or herself as a music therapist; or

(c) Any practice of music therapy as an integral part of a program of study for students enrolled in an accredited music therapy program, if the student does not represent himself or herself as a music therapist; or

(d) Any person who practices music therapy under the supervision of a licensed music therapist, if the person does not represent himself or herself as a music therapist.

III. Subject to Subsection (V) of this section, unless authorized to practice speech–language pathology under this title or unless otherwise provided for under this article, a person may not represent to the public by title, by description of services, methods, or procedures, or otherwise that the person:

(a) Is authorized to practice speech–language pathology in this State; or

(b) Evaluates, examines, instructs, or counsels individuals suffering from disorders or conditions that affect speech, language, communication, and swallowing.

IV. Subject to Subsection (V) of this section, unless authorized to practice speech–language pathology under RSA 326-F, a person may not use any word or term connoting professional proficiency in speech–language pathology, including but not limited to "communication disorders."

V. (a) Expect as provided in paragraph (b) of this subsection, an individual licensed under this title to engage in the practice of music therapy may not represent to the public that the individual is authorized to treat a communication disorder.

(b) This section may not be construed to prohibit an individual licensed under this title to engage in the practice of music therapy from representing to the public that the individual may work with a client who has a communication disorder to address communication skills.

326-M:3 Licensure of Music Therapists. In addition to requirements under RSA 328-F:

I. The board shall issue a license to an applicant for a music therapy license when such

applicant has completed and submitted an application upon a form and in such manner as the

executive director prescribes, accompanied by applicable fees, and evidence satisfactory to the board

that:

(a) The applicant is in good standing based on a review of the applicant's music therapy

licensure history in other jurisdictions, including a review of any alleged misconduct or neglect in the

practice of music therapy on the part of the applicant, and a review of the criminal background check

required under RSA 328-F:18-a.

(b) The applicant provides proof of passing the examination for board certification

offered by the Certification Board for Music Therapists or any successor organization or provides

proof that the applicant is currently a board certified music therapist.

II. The board shall issue a license to an applicant for a music therapist license when such

applicant has completed and submitted an application upon a form and in such manner as the

executive director prescribes, accompanied by applicable fees, and evidence satisfactory to the board

that the applicant is licensed and in good standing as a music therapist in another jurisdiction where

the qualifications required are equal to or greater than those required in this chapter at the date of

application.

326-M:4 Music Therapists Governing Board; Duties. In addition to the duties of a governing board under RSA 328-F:

I. The board may facilitate the development of materials that the office of professional licensure and certification may utilize to educate the public concerning music therapist licensure, the benefits of music therapy, and utilization of music therapy by individuals and in facilities or institutional settings.

II. The board may act as a facilitator of statewide dissemination of information between music therapists, the American Music Therapy Association or any successor organization, the Certification Board for Music Therapists or any successor organization, and the executive director.

III. The executive director shall seek the advice of the board for issues related to the regulation of music therapists.

2 Allied Health Professionals; Definition; Governing Board. Amend RSA 328-F:2, II to read as follows:

II. "Governing boards" means individual licensing boards of athletic trainers, occupational therapy assistants, occupational therapists, recreational therapists, physical therapists, physical therapist assistants, respiratory care practitioners, speech-language pathologists, [and] genetic counselors, and music therapists.

3 New Paragraph; Allied Health Professionals; Music Therapists. Amend RSA 328-F:2 by inserting after paragraph X the following new paragraph:

XI. "Music therapist" means music therapist as defined in RSA 326-M:1.

4 Governing Board; Establishment. Amend RSA 328-F:3, I to read as follows:

I. There shall be established governing boards of athletic trainers, occupational therapists, recreational therapists, respiratory care practitioners, physical therapists, speech-language pathologists, [and] genetic counselors, and music therapists.

5 New Paragraph; Music Therapists Governing Board; Appointment. Amend RSA 328-F:4 by inserting after paragraph X the following new paragraph:

XI. The music therapists governing board shall consist of 3 licensed music therapists, who have actively engaged in the practice of music therapy in this state for at least 2 years, one member who is a licensed health care provider who is not a music therapist, and one public member. Initial appointment of professional members by the governor and council shall be qualified persons practicing music therapy in this state. All subsequent appointments or reappointments shall require licensure.

6 Renewals; Reference to Music Therapists Added. Amend RSA 328-F:19, I to read as follows:

I. Initial licenses and renewals shall be valid for 2 years, except that timely and complete application for license renewal by eligible applicants shall continue the validity of the licenses being renewed until the governing board has acted on the renewal application. Licenses issued pursuant to RSA 328-A, RSA 326-G, [and] RSA 326-J, and RSA 326-M shall expire in even-numbered years and licenses issued pursuant to RSA 326-C, RSA 326-E, RSA 326-F, and RSA 326-K shall expire in odd-numbered years.

7 Office of Professional Licensure and Certification; New Classified Position; Appropriation.

I. One program assistant II position, labor grade 15, is hereby established as a classified position in the office of professional licensure and certification.

II. The amount necessary to pay for the position established in paragraph I and for the per diem and travel reimbursement as required under RSA 328-F:6 for the music therapy governing board established in this act is hereby appropriated to the executive director of the office of professional licensure and certification. Salaries and necessary expenses shall be a charge against the office of professional licensure and certification fund established in RSA 310-A:1-e.

8 Effective Date. Part VI of this act shall take effect July 1, 2021.

PART IX

Relative to temporary licensure of certain licensed nursing assistants.

1 Statement of Purpose. The general court acknowledges the critical importance of ensuring the quality, accessibility, and sustainability of Medicaid services provided in nursing homes, and recognizes the critical shortage of licensed nursing assistants throughout the state. The purpose of this act is to strengthen the frontline staffing in nursing homes. The general court finds that during the COVID-19 pandemic federal regulatory and statutory provisions were waived to facilitate the hiring of nurse aides by nursing homes. Under state emergency order, these individuals were allowed to work in nursing homes as temporary health partners following no less than 8 hours of training provided either by a national association or a New Hampshire educational program. As a matter of public policy, the general court finds that these workers were indispensable as facilities struggled with staffing issues, particularly during outbreaks of the COVID-19 virus. Accordingly, this act shall provide the board of nursing with the additional authority to expand the workforce of licensed nursing assistants by recognizing the service of temporary health partners during the COVID-19 pandemic.

2 Special Licensure as a Licensed Nursing Assistant; Applicants Who Served as Temporary Health Partners.

I. Persons who have worked no fewer than 100 hours as temporary health partners in a licensed nursing home by April 1, 2021 have demonstrated, through their work experience during a national and state public health emergency, the competency to transition to status as a licensed nursing assistant ***shall be deemed to have taken a board-approved nursing assistant course and may apply for a license as a licensed nursing assistant in New Hampshire.***

II. Notwithstanding any provision of law to the contrary, the state-approved training program for licensed nursing assistants shall take into account the training and experience acquired during the COVID-19 pandemic to transition these individuals to placement on the state's licensed nursing assistant registry pursuant to RSA 326-B:26. Such individuals shall be subject to all continuing education requirements under RSA 326-B:31.

III. For purposes of this act:

(a) “COVID-19” means the novel coronavirus first identified in 2019, or SARS-CoV-2.

(b) “Temporary health partner” means anyone authorized to work in a nursing home by Emergency Order 42 issued by the governor on May 11, 2020, and required to complete training of no less than eight hours and work under the supervision of an RN, APRN, or LPN, as is required of LNAs under RSA 326-B:14.

3 Effective Date. Part IX of this act shall take effect 60 days after its passage.

PART IX

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1 Statement of Purpose. The general court acknowledges the critical importance of ensuring the quality, accessibility, and sustainability of Medicaid services provided in nursing homes, and recognizes the critical shortage of licensed nursing assistants throughout the state. The purpose of this act is to strengthen the frontline staffing in nursing homes. The general court finds that during the COVID-19 pandemic federal regulatory and statutory provisions were waived to facilitate the hiring of nurse aides by nursing homes. Under state emergency order, these individuals were allowed to work in nursing homes as temporary health partners following no less than 8 hours of training provided either by a national association or a New Hampshire educational program. As a matter of public policy, the general court finds that these workers were indispensable as facilities struggled with staffing issues, particularly during outbreaks of the COVID-19 virus. Accordingly, this act shall provide the board of nursing with the additional authority to expand the workforce of licensed nursing assistants by recognizing the service of temporary health partners during the COVID-19 pandemic.

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I. Persons who have worked no fewer than 100 hours as temporary health partners in a licensed nursing home by April 1, 2021 have demonstrated, through their work experience during a national and state public health emergency, the competency to transition to status as a licensed nursing assistant ***shall be deemed to have taken a board-approved nursing assistant course and may apply for a license as a licensed nursing assistant in New Hampshire.***

II. Notwithstanding any provision of law to the contrary, the state-approved training program for licensed nursing assistants shall take into account the training and experience acquired during the COVID-19 pandemic to transition these individuals to placement on the state's licensed nursing assistant registry pursuant to RSA 326-B:26. Such individuals shall be subject to all continuing education requirements under RSA 326-B:31.

III. For purposes of this act:

(a) “COVID-19” means the novel coronavirus first identified in 2019, or SARS-CoV-2.

(b) “Temporary health partner” means anyone authorized to work in a nursing home by Emergency Order 42 issued by the governor on May 11, 2020, and required to complete training of no less than eight hours and work under the supervision of an RN, APRN, or LPN, as is required of LNAs under RSA 326-B:14.

3 Effective Date. Part IX of this act shall take effect 60 days after its passage.

PART VII

Relative to the authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

1 Office of Professional Licensure and Certification; Administration; Rulemaking. Amend RSA 310-A:1-d, II(h)(2) to read as follows:

(2) Such organizational and procedural rules necessary to administer the boards, commissions, and councils in the office of professional licensure and certification, including rules governing the administration of complaints and investigations, ***hearings, disciplinary proceedings,*** payment processing procedures, and application procedures; and

2 Office of Professional Licensure and Certification; Administration, Standing Orders. Amend RSA 310-A:1-d by inserting section IV after section III to read as follows:

IV. All boards, councils, and commissions may issue standing orders delegating non-discretionary tasks to staff of the office of professional licensure and certification.

2 New Sections; Office of Professional Licensure and Certification; Investigations; Hearings; Penalties; Appeals. Amend RSA 310-A by inserting after section 1-g the following new sections:

310-A:1-h Investigations.

I. Boards, which shall include all boards, councils, and commissions within the office of professional licensure and certification, may authorize an investigation of allegations of misconduct by licensees (a) upon their own initiative or (b) upon written complaint of any person that charges that a person licensed by the board has committed misconduct. ~~In consultation with~~ ***When requested by*** the board, the office shall assign an investigator ***who may assist in the investigation.*** ~~who shall complete the investigation in accordance with rules adopted by the executive director.~~

I-a. The procedures set forth in RSA 310-A:1-h through RSA 310-A:1-l are supplementary and shall not supplant or supersede any procedures expressly set forth in any board's individual practice act.

II. The following information obtained during investigations shall be held confidential and shall be exempt from the disclosure requirements of RSA 91-A:

(a) Complaints received by the office.

(b) Information and records acquired by the office during the investigation.

(c) Reports and records made by the office as a result of its investigation.

III. For the purpose of carrying out investigations, the executive director is authorized to:

(a) Retain qualified experts.

(b) Conduct inspections of places of business of licensees or certificate holders.

(c) Retain legal counsel when authorized to do so by the attorney general.

(d) Issue subpoenas for persons, relevant documents and relevant things in accordance with the following conditions:

(1) Subpoenas for persons shall not require compliance in less than 48 hours after receipt of service.

(2) Subpoenas for documents and things shall not require compliance in fewer than 15 days after receipt of service.

(3) Service shall be made on licensees and certified individuals by certified mail to the address on file with the office or by hand and shall not entitle them to witness or mileage fees.

(4) Service shall be made on persons who are not licensees or certified individuals in accordance with the procedures and fee schedules of the superior court, and the subpoenas served on them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure and Certification."

IV. The office or the boards, councils, and commissions within the office may disclose information acquired in an investigation to law enforcement ***if it involves suspected criminal activity, to*** ~~or~~ health licensing agencies in this state or any other jurisdiction, or in response to specific statutory requirements or court orders.

V. Allegations of professional misconduct shall be brought within 5 years from the time the office reasonably could have discovered the act, omission or failure complained of, except that conduct which

resulted in a criminal conviction or in a disciplinary action by a relevant licensing authority in another jurisdiction may be considered by the board without time limitation in making licensing or disciplinary decisions if the conduct would otherwise be a ground for discipline. The board may also consider licensee conduct without time limitation when the ultimate issue before the board involves a pattern of conduct or the cumulative effect of conduct which becomes apparent as a result of conduct which has occurred within the 5-year limitation period prescribed by this paragraph.

VI. ~~The~~ ***Each*** board***, council, or commission*** may dismiss a complaint if the allegations do not state a claim of professional misconduct.

310-A:1-i Disciplinary Proceedings; Remedial Proceedings.

I. Boards, which shall include all boards, councils, and commissions within the office of professional licensure and certification, are authorized to conduct disciplinary proceedings in accordance with procedural rules adopted by the executive director.

II. For the purpose of carrying out disciplinary proceedings, each board***, council, or commission*** is authorized to issue subpoenas for persons, relevant documents and relevant things in accordance with the following conditions:

(a) Subpoenas for persons shall not require compliance in less than 48 hours after receipt of service.

(b) Subpoenas for documents and things shall not require compliance in fewer than 15 days after receipt of service.

(c) Service shall be made on licensees and certified individuals by certified mail to the address on file with the office or by hand and shall not entitle them to witness or mileage fees.

(d) Service shall be made on persons who are not licensees or certified individuals in accordance with the procedures and fee schedules of the superior court, and the subpoenas served on them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure and Certification."

III. At any time before or during disciplinary proceedings, complaints may be dismissed or disposed of, in whole or in part, by written settlement agreement approved by the board and the licensees or certified individuals involved, provided that any complainant shall have the opportunity, before the settlement agreement has been executed, to comment on the terms of the proposed settlement. The board, council, or commission may hold a settlement agreement hearing prior to its approval of the settlement agreement.

IV. ~~Disciplinary proceedings shall be open to the public.~~ Final board actions having the effect of terminating disciplinary proceedings, whether taken before, during or after the completion of the proceedings, shall be set forth in a written record that shall be available to the public after service upon the licensees or certified individuals involved.

V. In carrying out disciplinary or licensing proceedings, each board shall have the authority to:

(a) Hold pre-hearing conferences exempt from the provisions of RSA 91-A.

(b) Appoint a board member or other qualified person as presiding officer.

(c) Administer, and authorize an appointed presiding officer to administer, oaths and affirmations.

VI. Neither the office nor the boards, councils, and commissions shall have an obligation or authority to appoint or pay the fees of attorneys representing licensees, certified individuals, or witnesses during investigations or adjudicatory proceedings.

VII. Boards, councils, and commissions may take non-disciplinary remedial action against any person licensed by it upon finding that the person is afflicted with physical or mental disability, disease, disorder, or condition deemed dangerous to the public health. Upon making an affirmative finding ***after notice and an opportunity for a hearing***, the board, council, or commission may take non-disciplinary remedial action:

(a) By suspension, limitation, or restriction of a license for a period of time as determined reasonable by the board.

(b) By revocation of license.

(c) By requiring the person to submit to the care, treatment, or observation of a physician, counseling service, health care facility, professional assistance program, or any combination thereof which is acceptable to the board.

VIII. All proceedings for non-disciplinary remedial action shall be exempt from the provisions of RSA 91-A, except that the board may disclose any final remedial action that affects the status of a license, including any non-disciplinary restrictions imposed.

310-A:1-j Hearings, Decisions and Appeals.
I. Disciplinary proceedings shall be open to the public, except upon order by the board, council, or commission upon good cause shown. The public docket file for each such proceeding shall be retained in accordance with the retention policy established by the office of professional licensure and certification.
II. Notwithstanding any other provision of law, allegations of misconduct or lack of professional qualifications that are not settled shall be heard by the board, council, or commission, or a panel of the board, council, or commission with a minimum of 3 members appointed by the chair of the board or other designee. Any member of the board, or other person qualified to act as presiding officer and duly designated by the board, shall have the authority to preside at such hearing and to issue oaths or affirmations to witnesses, rule on evidentiary and other procedural matters, and prepare a recommended decision. In the case of a hearing before a panel, the presiding officer shall prepare a recommended decision for the board, council, or commission, which shall determine sanctions.
III. Except as otherwise provided by RSA 541-A:30, the board, council, or commission shall furnish the respondent and the complainant, if any, at least 15 days' written notice of the date, time and place of a hearing. Such notice shall include an itemization of the issues to be heard, and, in the case of a disciplinary hearing, a statement as to whether the action has been initiated by a written complaint or upon the board's own motion, or both. If a written complaint is involved, the notice shall provide the complainant with a reasonable opportunity to intervene as a party.
IV. In disciplinary and licensing proceedings, the presiding officer may hold prehearing conferences that are closed to the public and exempt from the provisions of RSA 91-A until such time as a public evidentiary hearing is convened. In all instances, settlement discussions engaged in by the parties at prehearing conferences may be conducted off the record.
V. The board***, council, or commission*** may dispose of issues or allegations at any time during an investigation or disciplinary proceeding by approving a settlement agreement or issuing a consent order or an order of dismissal for default or failure to state a proper basis for disciplinary action. Disciplinary action taken by the board at any stage of a proceeding, and any dispositive action taken after the issuance of a public hearing notice, shall be reduced to writing and made available to the public. Such decisions shall not be public until they are served upon the parties.
~~VI. All proceedings for non-disciplinary remedial action shall be exempt from the provisions of RSA 91-A, except that the board may disclose any final remedial action that affects the status of a license, including any non-disciplinary restrictions imposed.~~
VII. No civil action shall be maintained against the board or any member of the board or its agents or employees, against any organization or its members, or against any other person for or by reason of any statement, report, communication, or testimony to the board or determination by the board in relation to proceedings under this chapter.
310-A:1-k Penalties.
I. Upon making an affirmative finding that a licensee or certificate holder has committed professional misconduct, boards, which shall include all boards, councils, and commissions within the office of professional licensure and certification, may take disciplinary action in any one or more of the following ways:
(a) By reprimand.
(b) By suspension of a license or certificate for a period of time as determined reasonable by the board.
(c) By revocation of license.
(d) By placing the licensee or certificate holder on probationary status. The board may require the person to submit to any of the following:
(1) Regular reporting to the board concerning the matters which are the basis of the probation.
(2) Continuing professional education until a satisfactory degree of skill has been achieved in those areas which are the basis of probation.

(3) Submitting to the care, counseling, or treatment of a physician, counseling service, health care facility, professional assistance program, or any comparable person or facility approved by the board.
(4) Practicing under the direct supervision of another licensee for a period of time specified by the board.
(e) By assessing administrative fines in amounts established by the board which shall not exceed $3,000 per offense, or, in the case of continuing offenses, $300 for each day that the violation continues, whichever is greater.
II. The board may issue a non-disciplinary confidential letter of concern to a licensee advising that while there is insufficient evidence to support disciplinary action, the board believes the licensee or certificate holder should modify or eliminate certain practices, and that continuation of the activities which led to the information being submitted to the board may result in action against the licensee's license. This letter shall not be released to the public or any other licensing authority, except that the letter may be used as evidence in subsequent adjudicatory proceedings by the board.
III. In the case of sanctions for discipline in another jurisdiction, the decision of the other jurisdiction's disciplinary authority may not be collaterally attacked and the board may impose any of the sanctions set forth in this chapter, but shall provide notice and an opportunity to be heard prior to imposing any se*an*ctions.
IV. In cases involving imminent danger to life or health, a board may order suspension of a license or certification pending hearing for a period of no more than 10 business days, unless the licensee or certified individual agrees in writing to a longer period. In such cases, the board shall comply with RSA 541-A:30.
V. Any person whose license has been suspended or revoked by the board may apply to the board, in writing, to request a hearing for reinstatement. Upon a hearing, the board may issue a new license or modify the suspension or revocation of the license.
VI. For any order issued in resolution of an disciplinary proceeding by the board, where the board has found misconduct sufficient to support disciplinary action, the board may require the licensee or certificate holder who is the subject of such finding to pay the office a sum not to exceed the reasonable cost of investigation and prosecution of the proceeding. This sum shall not exceed $10,000. This sum may be imposed in addition to any otherwise authorized administrative fines levied by the board as part of the penalty. The investigative and prosecution costs shall be assessed by the board and any sums recovered shall be credited to the office’s fund and disbursed by the office for any future investigations of complaints and activities that violate this chapter or rules adopted under this chapter.
VII. When an investigation of a complaint is determined to be unfounded, the board shall dismiss the complaint and explain in writing to the complainant and the licensee or certificate holder its reason for dismissing the complaint. After six years, the board may destroy all information concerning the investigation, retaining only a record noting that an investigation was conducted and that the board determined the complaint to be unfounded. For the purpose of this paragraph, a complaint shall be deemed to be unfounded if it does not fall within the jurisdiction of the board, does not relate to the actions of the licensee or certificate holder, or is determined by the board to be frivolous.
VIII. Whoever, not being licensed or otherwise authorized to practice according to the laws of this state, shall advertise oneself as engaging in a profession licensed or certified by the office of professional licensure and certification, shall engage in activity requiring professional licensure, or in any way hold oneself out as qualified to do so, or call oneself a licensed professional, or whoever does such acts after receiving notice that such person’s license to practice has been suspended or revoked, is engaged in unlawful practice. After hearing and upon making an affirmative finding of unlawful practice, the board, council, or commission may take action in any one of the following ways:
(a) Issue a cease and desist order against any person or entity engaged in unlawful, which shall be enforceable in superior court.
(b) Impose a fine not to exceed the amount of any gain or economic benefit that the person derived from the violation or $10,000 for each offense, whichever amount is greater. Each violation of unlicensed or unlawful practice shall be deemed a separate offense.

(c) The attorney general, board, council, or commission, or prosecuting attorney of any county or municipality where the act to unlawful practice takes place may maintain an action to enjoin any person or entity from continuing to do acts of unlawful practice. The action to enjoin shall not replace any other civil, criminal, or regulatory remedy. An injunction without bond is available to any board, council, or commission.
310-A:1-l Rehearing; Appeals.
I. Any person who has been refused a license or certification by the board, which shall include all boards, councils, and commissions within the office of professional licensure and certification, or has been disciplined by the board shall have the right to petition for a rehearing within 30 days after the original final decision.
II. Appeals from a decision on rehearing shall be by appeal to the supreme court pursuant to RSA 541.
III. No sanction shall be stayed by the board during an appeal.
3 Effective Date. Part VII of this act shall take effect January 1, 2022.

I. No person shall enter an apprenticeship or enroll in a school under this chapter unless such person has registered with the board as an apprentice and been issued an apprentice [~~license~~] ***certificate***. The board shall have sole authority to regulate apprentices and apprenticeship under this chapter. The board shall issue an apprentice [~~license~~] ***certificate*** to any student receiving instruction within a licensed school or shop to learn barbering, cosmetology, esthetics, or manicuring.

II. A person applying for [~~a license~~] ***an apprentice certificate*** under this section shall be granted such [~~license~~] ***certificate*** upon:

(a) Submitting proof sufficient to the board to show that such person is at least 16 years of age;

(b) Paying a fee established by the [~~board~~] ***office of professional licensure and certification***; and

(c) Being deemed by the board to be of good professional character.

III. No salon or barbershop shall at any one time have more than one apprentice per licensed professional, except as follows:

(a) Each licensed barber may have up to 2 apprentices for barbering.

(b) Each licensed master barber may have up to 2 apprentices for barbering, or one apprentice master barber and one apprentice barber.

IV. Upon completing the number of hours specified in the board's apprentice rules, an apprentice shall be eligible to apply to the board for licensure.

V. Notwithstanding RSA 161-B:11, VI-a, an applicant for an apprentice certificate shall not be required to provide a social security number as a prerequisite for obtaining a certificate.

4 Effective Date. Part XI of this act shall take effect 60 days after its passage.

PART XII

Relative to telemedicine provided by out of state psychologists.

1 Psychologists; Electronic Practice of Psychology. RSA 329-B:16 is repealed and reenacted to read as follows:

329-B:16 Electronic Practice of Psychology, Telehealth, Telemedicine.

I. Telepsychology, telehealth, and telemedicine services, as provided by psychologists, include those psychology services that utilize electronic means to engage in visual or virtual presence in contemporaneous time. Such provision of services shall require a New Hampshire tele-pass license for provision of such care to people in New Hampshire. Contacts that are exempt from this requirement are:

(a) Persons exempted by 329-B:28.

(b) Screenings for inclusion in voluntary research projects that have been properly approved by a New Hampshire based institutional review board.

1 (c) Psychologists licensed by the board, who may provide tele-psychology services to a
2 person within the state of New Hampshire without acquiring a tele-pass psychology license.
3 II. A doctoral level psychologist who is not licensed in New Hampshire shall be eligible to
4 provide telepsychology services to a person in New Hampshire, providing that the psychologist:
5 (a) Is licensed in one of the jurisdictions in the United States or Canada;
6 (b) Is in good standing in all license jurisdictions in the United States and Canada;
7 (c) Has satisfied conditions determined in rules adopted by the board;
8 and
9 (d) Has applied for and obtained a valid New Hampshire tele-pass psychology license
10 with effective dates that cover the dates of care provided.
11 III. The tele-pass psychology licensee shall agree to conditions including, but not limited to,
12 conditions stipulated by the board that the licensee shall:
13 (a) Conform to all New Hampshire statutes and rules.
14 (b) Agree that electronic attendance for appearances shall be deemed adequate for
15 regulatory enforcement purposes and that in-person appearances by the licensee are optional and
16 such associated costs for in-person attendance are the full responsibility of the tele-pass psychology
17 licensee.
18 (c) Understand that false statements or failure to comply with official requests and
19 official orders shall constitute sufficient cause for revocation of the tele-pass psychology license.
20 (d) Understand that all conditions of tele-pass psychology license to practice and
21 enforcement shall be pursuant to New Hampshire law.
22 (e) Grant the New Hampshire board of psychologists and its investigators authority to
23 disclose to law enforcement and related regulatory authorities, at their discretion, information
24 including but not limited to status of application, actions and information pertinent to investigations
25 and enforcement of the laws and rules pertaining to the licensee's conduct.
26 IV. The board shall adopt rules pursuant to RSA 541-A for:
27 (a) The application procedure for a New Hampshire tele-pass psychology license;
28 (b) Additional requirements for a psychologist licensed in another state of Canada to
29 acquire a tele-pass psychology license, including attestations;
30 (c) Any fees required to apply for or to be issued a tele-pass psychology license;
31 (d) The standards of care for telemedicine practice of psychology and their enforcement;
32 and
33 (e) Procedures for the revocation of a tele-pass psychology license.
34 2 Effective Date. Part XII of this act shall take effect July 1, 2021.
35
36
37

Amendment for Psychology Tele-Pass license, Part XII of SB133, May 9, 2021, by Board of Psych Dr Warner following input from NHPA request and other updates from recent statutes passed and refinements for the language of the bill.

PART XII Relative to telemedicine provided by out of state psychologists.

1 Psychologists; Electronic Practice of Psychology. RSA 329-B:16 is repealed and reenacted to read as follows:

329-B:16 Electronic Practice of Psychology, Telehealth, Telemedicine.

I. Telepsychology, telehealth, and telemedicine services, as provided by psychologists, include those psychology services that utilize electronic means including audio, video, or other electronic media to engage in visual or virtual presence in contemporaneous time. A New Hampshire tele-pass license shall be required for provision of such care to people in New Hampshire. Contacts that are exempt from this requirement are:

(a) Persons exempted by 329-B:28.

(b) Screenings for inclusion in voluntary research projects that have been properly approved by a New Hampshire based institutional review board.

(c) Psychologists licensed by the board, who may provide tele-psychology services to a person within the state of New Hampshire without acquiring a tele-pass psychology license.

(d) Persons exempted by RSA 329-D.

II. A doctoral level psychologist who is not licensed in New Hampshire shall be eligible to provide telepsychology services to a person in New Hampshire pursuant to RSA 329-D, or providing that the psychologist:

(a) Is licensed in one of the jurisdictions in the United States or Canada;

(b) Is in good standing in all license jurisdictions in the United States and Canada;

(c) Has satisfied conditions determined in rules adopted by the board; and

(d) Has applied for and obtained a valid New Hampshire tele-pass psychology license in accordance with board rules and payment of license fees with effective dates that cover the dates of services provided.

III. The tele-pass psychology licensee shall agree to conditions including, but not limited to, conditions stipulated by the board that the licensee shall:

(a) Conform to all New Hampshire statutes and rules.

(b) Agree that electronic attendance for appearances shall be deemed adequate for regulatory enforcement purposes and that in-person appearances by the licensee are optional and such associated costs for in-person attendance are the full responsibility of the tele-pass psychology licensee.

(c) Understand that false statements or failure to comply with official requests and official orders shall constitute sufficient cause for revocation of the tele-pass psychology license.

(d) Understand that all conditions of tele-pass psychology license to practice and enforcement shall be pursuant to New Hampshire law.

(e) Grant the New Hampshire board of psychologists and its investigators authority to disclose to law enforcement and related regulatory authorities, at their discretion, information including but not limited to status of application, actions and information pertinent to investigations and enforcement of the laws and rules pertaining to the licensee's conduct.

(f) Not conduct face-to-face in-person psychological services in NH.

IV. The board shall adopt rules pursuant to RSA 541-A for:

(a) The application procedure for a New Hampshire tele-pass psychology license;

(b) Additional requirements for a psychologist licensed in another state of Canada to acquire a tele-pass psychology license, including attestations;

(c)

The standards of care for telemedicine practice of psychology and their enforcement; and

(d) Procedures for the investigation and discipline pursuant to all means authorized in this chapter including but not limited to suspension or revocation of a tele-pass psychology license.

OPLC Draft Legislation 4-28-21 (LBC)

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

Amendment to SB 133

Amend the bill to include the following:

Section 328-F:18

328-F:18 Allied Health Professionals; Issuance of Licenses; Conditional Licenses. –
I. Each governing board shall issue initial licenses and license renewals to applicants who have completed the required application procedures and have met the eligibility requirements established by the practice act and the rules of the governing board. If a governing board is authorized by its practice act to issue provisional licenses, it shall issue such licenses to applicants who have completed the required application procedures and have met the eligibility requirements for provisional licensure established by the practice act and the rules of the governing board.
II. The governing boards shall take no action on an application for any type of license, or reinstate any lapsed or suspended license, until the applicant has completed the application procedures required by the practice acts and the rules of the governing boards.
III. To insure the competency of licensees, the governing boards are authorized to issue initial licenses, license renewals, and reinstatements of licensure after lapse or suspension for disciplinary reasons that are conditional in nature. Such conditional licenses may include the following conditions on the licensee's authorization to practice:
(a) A limit on the duration of the license.
(b) A requirement that specified education, clinical experience, or training is completed by the licensee before removal of the condition.
(c) A requirement that the conditional licensee be supervised in his or her practice.
(d) A limitation on the scope of the practice of the conditional licensee.
IV. Initial licenses, including conditional licenses that are the first license issued to the individual, and provisional licenses shall be:
~~(a) Signed and dated by the chairperson of the governing board issuing them~~.
(b) Numbered consecutively and recorded.
V. Nothing in this chapter or in the practice acts of the governing boards shall be construed to restrict persons licensed under any other law of this state from engaging in a profession or practice for which they are licensed.
VI. Occupational therapists, occupational therapist assistants, recreational therapists, speech pathologists, respiratory care practitioners, physical therapists, and physical therapist assistants from the states of Connecticut, Rhode Island, Massachusetts, Maine, New York, and Vermont, who are currently licensed, shall be eligible for temporary licensure for 120 days while the person makes application for licensure to the respective governing board under this chapter. An applicant for temporary licensure to practice, who is currently licensed or certified in Connecticut, Rhode Island, Massachusetts, Maine, New York, or Vermont, shall:

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(a) Hold an active unencumbered license; and
(b) Have committed no acts or omissions which are grounds for disciplinary action in another jurisdiction, or, if such acts have been committed, would be grounds for disciplinary action.

Section 317-A:10

317-A:10 License. – ~~All licenses issued by the board shall be signed by all the members thereof and attested by its president and vice-president~~.

Section 325:20

325:20 Licensure. – The board shall issue to each applicant successfully passing the examination, where an examination is required, and who otherwise satisfies the board of his qualifications, a license~~, signed by all the members of the board,~~ entitling him to practice or engage in the business in this state as a funeral director, embalmer, or both, as the case may be.

Section 329:14

329:14 Action on License Applications. –
I. The board shall make no final decision concerning the qualifications of a new or reinstatement applicant until it has received the results of all required examinations, criminal history record checks, and all third-party certifications required to be submitted with the license application, and the time periods specified by RSA 541-A:29 shall be calculated from the date the last of the required documents is received by the board.
II. No application shall be granted unless the board finds that the applicant possesses the necessary educational, character and other professional qualifications to practice medicine, and that no circumstances exist which would be grounds for disciplinary action against a licensed physician pursuant to RSA 329:17, I.
III. The board shall grant an unrestricted permanent license to persons it finds to have the necessary professional qualifications. The board may also, by consent or after notice and the opportunity to be heard, resolve issues concerning professional qualifications or circumstances that would be grounds for non-disciplinary remedial action against a licensed physician by granting a temporary license, or a temporary or permanent license with restrictions.
IV. Licenses shall ~~be signed and dated by the president of the board,~~ stating~~e~~ that the licensee is authorized to engage in the practice of medicine, be numbered consecutively, and be recorded.
V. (a) The board shall issue special training licenses to persons of good professional character who are enrolled in a regular residency or graduate fellowship training program accredited by the Council on Graduate Medical Education, and who possess such further education and training as the board may require by rule.
(b) Persons holding training licenses shall be subject to the disciplinary provisions of RSA 329:17 and such additional professional character and competency requirements as the board may require by rule.
(c) Training licenses shall be confined to activities performed in the course of the qualifying residency or graduate fellowship training program, shall expire automatically upon the licensee's separation from the residency or graduate fellowship training program for any reason, and may be issued on a restricted or conditional basis.

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VI. The board may issue special licenses containing conditions, limitations, or restrictions, including licenses limited to specific periods of time in accordance with rules adopted under RSA 329:9, VIII.
VII. The board may issue courtesy licenses authorizing the practice of medicine under limited conditions as defined by the board by rule. Courtesy licenses shall not exceed 100 days and shall be limited in location. All applicants shall hold an active, unrestricted license in another state and meet the same character qualifications as other licensees.
VIII. The board may issue licenses authorizing the practice of medicine limited to administrative medicine for physicians whose practice does not include the provision of clinical services to patients.

Section 151-A:7

151-A:7 Licenses. –
I. An applicant for a license as a nursing home administrator who has:
(a) Successfully complied with the requirements of RSA 151-A:5 and the standards provided for therein; and
(b) Passed the examination provided for in RSA 151-A:6 shall be issued a license on a form provided for that purpose by the board, certifying that such applicant has met the requirements of the laws and rules entitling the applicant to serve, act, practice and otherwise hold such applicant out as a duly licensed nursing home administrator.
II. Under emergency conditions the secretary of the board in the secretary's discretion subject to the confirmation of the board may issue a non-renewable temporary emergency permit to a person of good character and suitability to act in the capacity of an administrator under the supervision of a licensed administrator pending action by the board until the next examination or not to exceed 6 months.
II-a. If the board is satisfied that a candidate for licensure under the reciprocity provisions of RSA 151-A:9 meets all the requirements and needs only sit for the state examination, the board may, if an urgent need is demonstrated, provide the candidate with a temporary permit to work as an administrator in a nursing home within the state of New Hampshire. This temporary permit shall only be valid for a period of 6 months and shall not be renewable or reissued to the same candidate.
~~III. Any license issued by the board under or pursuant to the provisions of this section shall be under the hand and seal of the secretary of the board~~.
IV. If the board finds that programs of training and instruction conducted within the state are not sufficient in number or content to enable nursing home administrators to meet requirements established pursuant to this chapter, the board may request the department of health and human services to institute and conduct or arrange with others to conduct one or more such programs, and shall make provision for their accessibility to residents of this state. The department of health and human services may approve programs conducted within and without this state as sufficient to meet education and training requirements established pursuant to this chapter. For purposes of this paragraph, the department of health and human services shall have the authority to receive and disburse state funds allocated for this purpose and federal funds received pursuant to section 1908(e)(1) of the Social Security Act. .

Section 310-A:18

310-A:18 Certificates; Seals. – The board shall issue a license, upon payment of the registration fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed professional engineer while the license remains valid. Each licensee shall upon licensure obtain a seal of the design authorized by the board, bearing the registrant's name and the legend, "Licensed Professional Engineer." All papers or documents involving the practice of engineering under this subdivision, when issued or filed for public record, shall be dated and bear the signature and seal of the licensed professional engineer who prepared or had responsibility for and approved them. It shall be a class B misdemeanor for the licensee to stamp or seal any documents with such seal after the license of the licensee has expired or has been revoked, unless such license shall have been renewed or reissued.

Section 310-A:44

310-A:44 Certificates; Seals. – The board shall issue a license upon payment of the registration fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed architect while the license remains valid. Each licensee shall upon licensure obtain a seal of the design authorized by the board, bearing the registrant's name and the legend, "Licensed Architect." All papers or documents involving the practice of a profession under this subdivision, when issued or filed for public record, shall be dated and bear the signature and seal of the licensed professional who prepared or had responsibility for and approved them. It shall be a class B misdemeanor for the licensee to stamp or seal any documents with such seal after the license of the licensee has expired or has been revoked, unless such license shall have been renewed, reinstated, or reissued.

Section 310-A:87

310-A:87 Certificates. – Certificates shall show the full name of the certified soil scientist, apprentice soil scientist, certified wetland scientist, or apprentice wetland scientist~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. Each certified soil scientist or certified wetland scientist shall obtain a seal of the design authorized by the board bearing the name of the certified individual, the legend "Certified Soil Scientist" or "Certified Wetland Scientist," as appropriate, and a place for the certified individual's signature. Plans and reports prepared by a certified individual shall be stamped with the seal and signed by the certified individual during the life of the certificate.

Section 310-A:107

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310-A:107 Issuance of License; Endorsement of Documents. – The board shall issue a license upon payment of the fee as provided in this subdivision to any applicant, who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be evidence that the person named in the license is entitled to all rights and privileges of a licensed forester while such license remains unrevoked or unexpired. Plans, maps, and reports issued by the licensee shall be endorsed with the licensee's name and license number during the life of the license. It shall be a class B misdemeanor for anyone to endorse any document with such name and license number after the license of the named licensee has expired or has been revoked, unless said license has been renewed or reissued. It shall be a class B misdemeanor for any licensed forester to endorse any plan, map or report unless the licensed forester shall have actually prepared such plan, map or report, or shall have been in the actual charge of the preparation of the same.

Section 310-A:130

310-A:130 Certificates; Seals. – The board shall issue a license, upon payment of the licensing fee established by the board, to any applicant who has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed professional geologist while the license remains valid. Each licensee shall upon licensure obtain a seal of the design authorized by the board, bearing the registrant's name and the legend, "Licensed Professional Geologist." All papers or documents involving the practice of geology affecting public health, safety, and welfare, under this subdivision, when issued or filed for public record, shall be dated and bear the signature and seal of the licensed professional geologist who prepared or had responsibility for and approved them.

Section 310-A:152

310-A:152 Certificates; Seals. – The board shall issue a license upon payment of the license fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed landscape architect while the license remains valid. Each licensee shall upon licensure obtain a seal of the design authorized by the board, bearing the registrant's name and the legend, "licensed landscape architect." All papers or documents involving the practice of landscape architecture under this subdivision, when issued or filed for public record, shall be dated and bear the signature and seal of the licensed professional who prepared or had responsibility for and approved them. It shall be a class B misdemeanor for the licensee to stamp or seal any documents with such seal after the license of the licensee has expired or has been revoked, unless such license shall have been renewed, reinstated, or reissued.

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Section 310-A:193

310-A:193 Issuance of Licenses. – The board shall issue a license upon payment of the license fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board.~~ The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a licensed home inspector while the license remains valid. It shall be a class B misdemeanor for the licensee to perform home inspections after the license of the licensee has expired or has been revoked, unless such license shall have been renewed, reinstated, or reissued.

Section 310-A:213

310-A:213 Issuance of Licenses. – The board shall issue a license upon payment of the license fee established by the board, to any applicant who, in the opinion of the board, has satisfactorily met all the requirements of this subdivision. Licenses shall show the full name of the licensee~~,~~ ***and*** have a serial number~~, and be signed by the chairperson and the secretary of the board under seal of the board~~. The issuance of a license by the board shall be prima facie evidence that the person named in the license is entitled to all the rights and privileges of a certified septic system evaluator while the license remains valid. It shall be a class B misdemeanor for the license holder to perform septic system evaluations after the license of the evaluator has expired or has been revoked, unless such license shall have been renewed, reinstated, or reissued.

Section 319-C:7

319-C:7 Licensing Requirements. –
I. [Repealed.]
II. After June 30, 1976, the board shall issue a license as a master or journeyman electrician to any person who files an application and meets the following qualifications:
(a) Completion of 8,000 hours of service as an apprentice electrician. The board may give credit toward such service for the satisfactory completion of a course of instruction in the field at a school recognized by the board; and
(b) Satisfactory passing of an examination conducted by said board as provided in RSA 319-C:8 to determine his fitness to receive such license.
II-a. The board shall issue a license as a high/medium voltage electrician to any person who files an application and meets the following qualifications:
(a) Shows proof of successfully completing a state, national, or employer certification program approved by the board or;
(b) Prior to January 1, 2003, shows proof of having been employed for a minimum of 5 years as a high/medium voltage electrician working for a company with an approved training program.
III. All persons licensed by the board shall receive a certificate ~~under the seal of the board and with the signature of the board chairman~~, which must be publicly displayed at the principal place of business of said electrician, or, if no such place of business, must be carried on his or her person and displayed at any time upon request to any electrical inspector appointed by the board

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under this chapter, as long as said person continues in the business as herein defined. The certificate shall specify the name of the person licensed who, in the case of a firm, shall be one of its members or employees and, in the case of a corporation, one of its officers or employees passing the examination. In the case of a firm or corporation, the license shall be void upon the death of or the severance from the company of said person.
IV. Apprentice electricians shall register with the board.

Section 310-B:16

310-B:16 License or Certificate. –
I. A license or certificate issued under authority of this chapter shall bear ~~the signature of the board chairperson or a designee who is a member of the board and~~ a license or certificate number assigned by the board.
II. Each licensed or certified real estate appraiser shall place such appraiser's license or certificate number adjacent to or immediately below the appraiser's signature whenever the appraiser's signature is used in an appraisal report or in a contract or other instrument used by the license or certificate holder in conducting real estate appraisal activities.

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OPLC Draft Legislation 5-3-21 (LBC)

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

Amendment to SB 133

Amend the bill to include the following:

329-B:20 ~~Temporary and Emergency~~ Applicants From Other States. –
Any psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist practicing pursuant to this section shall conform his or her practice to the mandates of this chapter and the rules of the board. Any psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist seeking to practice under this section shall register with the board in a manner determined by the board.
I. An individual licensed to practice psychology or school psychology in another jurisdiction may practice psychology, licensed school psychology-doctoral, or licensed school psychology-specialist in accordance with this chapter in New Hampshire by applying for a license, if:
(a) The psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist limits her or his practice in New Hampshire to no more than 30 days per year; and
(b) The psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist is not the subject of a past or pending disciplinary action in another jurisdiction; and
(c) At least one of the following is true:
(1) The psychologist is the holder of one of the following credentials:
(A) The Association of State and Provincial Psychology Boards (ASPPB) Certificate of Professional Qualification in Psychology (CPQ);
(B) The ASPPB Interjurisdictional Practice Certificate (IPC);
(C) The American Board of Professional Psychology (ABPP) certification;
(D) The National Register of Health Providers in Psychology certification; or
(E) Other equivalent qualifications determined by the board.
(2) The school psychologist is:
(A) The holder of the Nationally Certified School Psychologist (NCSP), credentialed by the National Association of School Psychologists, or other equivalent qualifications determined by the board; and
(B) Approved by the board to be knowledgeable in state practice as determined by the board.
(d) An individual licensed to practice psychology in another jurisdiction seeking to perform an evaluation under a court order may be allowed a temporary license for no more than 30 days which may be non-consecutive during a 12 month period, providing he or she qualifies under subparagraphs (b) and (c)(1).
(e) An individual seeking temporary licensure shall submit the application and pay the fee determined by the office of professional licensure and certification.
II. An individual licensed to practice psychology or school psychology in another jurisdiction who is providing services in response to a declared disaster, under the American Red Cross or the American Psychological Association's Disaster Response Network, or other such agency so designated by the board, may practice psychology in New Hampshire for no more than 60 days per year without applying for a state license. Any psychologist practicing pursuant to this

paragraph shall conform his or her practice to the mandates of this chapter and rules of the board. Any psychologist seeking to practice under this paragraph shall register with the board or cause said organization to make such registration in a manner determined by the board.
III. The board may issue a temporary license to practice for not more than 90 days in a 12-month period to a psychologist who is licensed in another jurisdiction and who has applied for a temporary license to practice psychology in New Hampshire, provided that:
(a) The requirements for licensure in the licensing jurisdiction are equal to or exceed the requirements for licensure in New Hampshire;
(b) The applying psychologist meets the requirements for admission to the examination process in New Hampshire;
(c) The psychologist is not the subject of a past or pending disciplinary action in another jurisdiction and
(d) The individual submits an application and pays the fee determined by the office of professional licensure and certification.
IV. Notwithstanding any other provision of state law to the contrary, the office of professional licensure and certification shall issue a license to practice psychology or school psychology to any individual who has met the following requirements:

(a) ***The individual has practiced in New Hampshire under a temporary or emergency license for a period of at least ninety (90) days;***
(b) ***That license remains in good standing;***
(c) ***The individual has completed an application and paid the fee established by the office.***

OPLC Draft Legislation 5-3-21 (LBC)

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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Amend the bill to include the following:

329-B:20 ~~Temporary and Emergency~~ Applicants From Other States. –
Any psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist practicing pursuant to this section shall conform his or her practice to the mandates of this chapter and the rules of the board. Any psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist seeking to practice under this section shall register with the board in a manner determined by the board.
I. An individual licensed to practice psychology or school psychology in another jurisdiction may practice psychology, licensed school psychology-doctoral, or licensed school psychology-specialist in accordance with this chapter in New Hampshire by applying for a license, if:
(a) The psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist limits her or his practice in New Hampshire to no more than 30 days per year; and
(b) The psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist is not the subject of a past or pending disciplinary action in another jurisdiction; and
(c) At least one of the following is true:
(1) The psychologist is the holder of one of the following credentials:
(A) The Association of State and Provincial Psychology Boards (ASPPB) Certificate of Professional Qualification in Psychology (CPQ);
(B) The ASPPB Interjurisdictional Practice Certificate (IPC);
(C) The American Board of Professional Psychology (ABPP) certification;
(D) The National Register of Health Providers in Psychology certification; or
(E) Other equivalent qualifications determined by the board.
(2) The school psychologist is:
(A) The holder of the Nationally Certified School Psychologist (NCSP), credentialed by the National Association of School Psychologists, or other equivalent qualifications determined by the board; and
(B) Approved by the board to be knowledgeable in state practice as determined by the board.
(d) An individual licensed to practice psychology in another jurisdiction seeking to perform an evaluation under a court order may be allowed a temporary license for no more than 30 days which may be non-consecutive during a 12 month period, providing he or she qualifies under subparagraphs (b) and (c)(1).
(e) An individual seeking temporary licensure shall submit the application and pay the fee determined by the office of professional licensure and certification.
II. An individual licensed to practice psychology or school psychology in another jurisdiction who is providing services in response to a declared disaster, under the American Red Cross or the American Psychological Association's Disaster Response Network, or other such agency so designated by the board, may practice psychology in New Hampshire for no more than 60 days per year without applying for a state license. Any psychologist practicing pursuant to this

paragraph shall conform his or her practice to the mandates of this chapter and rules of the board. Any psychologist seeking to practice under this paragraph shall register with the board or cause said organization to make such registration in a manner determined by the board.
III. The board may issue a temporary license to practice for not more than 90 days in a 12-month period to a psychologist who is licensed in another jurisdiction and who has applied for a temporary license to practice psychology in New Hampshire, provided that:
(a) The requirements for licensure in the licensing jurisdiction are equal to or exceed the requirements for licensure in New Hampshire;
(b) The applying psychologist meets the requirements for admission to the examination process in New Hampshire;
(c) The psychologist is not the subject of a past or pending disciplinary action in another jurisdiction and
(d) The individual submits an application and pays the fee determined by the office of professional licensure and certification.
IV. Notwithstanding any other provision of state law to the contrary, the office of professional licensure and certification shall issue a license to practice psychology or school psychology to any individual who has met the following requirements:
(a) ***The individual has practiced in New Hampshire under a temporary or emergency license for a period of at least ninety (90) days;***
(b) ***That license remains in good standing;***
(c) ***The individual has completed an application and paid the fee established by the office.***

House ED&A Committee Amendment to SB 133

All page, line numbers and part numbers refer to the bill as amended by the Senate

All changes to the **bill as amended by the Senate** are highlighted.

Sections and paragraphs have not been renumbered in this draft.

No changes to:

- Part I
- Part II
- Part III
- Part X
- Part XIII

Remove from bill:

- Part IV
- Part VI
- Part VIII

Part V

Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

- Add new section to amend RSA 310-A:1-e as follows:

  Office of Professional Licensure and Certification; Fees; Financing of Interstate Compacts. Amend RSA 310-A:1-e, by inserting a new paragraph III after paragraph II, to read as follows:

  III. The office of professional licensure and certification shall be responsible for the financing of any interstate compact joined by the state that affects a profession governed by a board listed in 310-A:1-a. Such financing shall be from money deposited in the office of professional licensure and certification fund.

- **Delete** page 3, line 26 – page 4, line 16 – no change to RSA 329-D chapter heading, delete duplicate language relative to the audiology/speech language compact.

- **Amend** page 4, line 17 to create a bill section and amend RSA 326-F:9 (rather than 326-F:15) by inserting the audiology/speech language pathology compact

  326-F:~~15~~ ***9*** Interstate Compact Adopted. The state of New Hampshire hereby adopts the provisions of the Audiology and Speech-Language Pathology Compact as follows:

- **Amend** page 20, line 31; create a bill section to place the OT compact into RSA 326-C:9

  ~~329-D:3~~ ***326-C:9*** Occupational Therapy Licensure Compact. The state of New Hampshire hereby adopts the provisions of the Occupational Therapy Licensure Compact as follows:

Part VII amend as indicated by highlighting

Relative to the authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

1 Office of Professional Licensure and Certification; Administration; Rulemaking. Amend RSA 310-A:1-d, II(h)(2) to read as follows:

(2) Such organizational and procedural rules necessary to administer the boards, commissions, and councils in the office of professional licensure and certification, including rules governing the administration of complaints and investigations, ***hearings, disciplinary proceedings,*** payment processing procedures, and application procedures; and

2 Office of Professional Licensure and Certification; Administration, Standing Orders. Amend RSA 310-A:1-d by inserting section IV after section III to read as follows:
IV. All boards, councils, and commissions may issue standing orders delegating non-discretionary tasks to staff of the office of professional licensure and certification.

2 New Sections; Office of Professional Licensure and Certification; Investigations; Hearings; Penalties; Appeals. Amend RSA 310-A by inserting after section 1-g the following new sections:

310-A:1-h Investigations.

I. Boards, which shall include all boards, councils, and commissions within the office of professional licensure and certification, may authorize an investigation of allegations of misconduct by licensees (a) upon their own initiative or (b) upon written complaint of any person that charges that a person licensed by the board has committed misconduct. ~~In consultation with~~ ***When requested by*** the board, the office shall assign an investigator ***who may assist in the investigation***. ~~who shall complete the investigation in accordance with rules adopted by the executive director.~~

I-a. The procedures set forth in RSA 310-A:1-h through RSA 310-A:1-l are supplementary and shall not supplant or supersede any procedures expressly set forth in any board's individual practice act.

II. The following information obtained during investigations shall be held confidential and shall be exempt from the disclosure requirements of RSA 91-A:
(a) Complaints received by the office.
(b) Information and records acquired by the office during the investigation.
(c) Reports and records made by the office as a result of its investigation.

III. For the purpose of carrying out investigations, the executive director is authorized to:
(a) Retain qualified experts.
(b) Conduct inspections of places of business of licensees or certificate holders.
(c) Retain legal counsel when authorized to do so by the attorney general.
(d) Issue subpoenas for persons, relevant documents and relevant things in accordance with the following conditions:
(1) Subpoenas for persons shall not require compliance in less than 48 hours after receipt of service.
(2) Subpoenas for documents and things shall not require compliance in fewer than 15 days after receipt of service.

(3) Service shall be made on licensees and certified individuals by certified mail to the address on file with the office or by hand and shall not entitle them to witness or mileage fees.
(4) Service shall be made on persons who are not licensees or certified individuals in accordance with the procedures and fee schedules of the superior court, and the subpoenas served on them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure and Certification."

IV. The office or the boards, councils, and commissions within the office may disclose information acquired in an investigation to law enforcement ***if it involves suspected criminal activity, to*** ~~or~~ health licensing agencies in this state or any other jurisdiction, or in response to specific statutory requirements or court orders.

V. Allegations of professional misconduct shall be brought within 5 years from the time the office reasonably could have discovered the act, omission or failure complained of, except that conduct which resulted in a criminal conviction or in a disciplinary action by a relevant licensing authority in another jurisdiction may be considered by the board without time limitation in making licensing or disciplinary decisions if the conduct would otherwise be a ground for discipline. The board may also consider licensee conduct without time limitation when the ultimate issue before the board involves a pattern of conduct or the cumulative effect of conduct which becomes apparent as a result of conduct which has occurred within the 5-year limitation period prescribed by this paragraph.

VI. ~~The~~ ***Each*** board***, council, or commission*** may dismiss a complaint if the allegations do not state a claim of professional misconduct.

310-A:1-i Disciplinary Proceedings; Remedial Proceedings.

I. Boards, which shall include all boards, councils, and commissions within the office of professional licensure and certification, are authorized to conduct disciplinary proceedings in accordance with procedural rules adopted by the executive director.

II. For the purpose of carrying out disciplinary proceedings, each board***, council, or commission*** is authorized to issue subpoenas for persons, relevant documents and relevant things in accordance with the following conditions:
(a) Subpoenas for persons shall not require compliance in less than 48 hours after receipt of service.
(b) Subpoenas for documents and things shall not require compliance in fewer than 15 days after receipt of service.
(c) Service shall be made on licensees and certified individuals by certified mail to the address on file with the office or by hand and shall not entitle them to witness or mileage fees.
(d) Service shall be made on persons who are not licensees or certified individuals in accordance with the procedures and fee schedules of the superior court, and the subpoenas served on them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure and Certification."

III. At any time before or during disciplinary proceedings, complaints may be dismissed or disposed of, in whole or in part, by written settlement agreement approved by the board and the licensees or certified individuals involved, provided that any complainant shall have the opportunity, before the settlement agreement has been executed, to comment on the terms of the proposed settlement. The board, council, or commission may hold a settlement agreement hearing prior to its approval of the settlement agreement.

IV. ~~Disciplinary proceedings shall be open to the public.~~ Final board actions having the effect of terminating disciplinary proceedings, whether taken before, during or after the completion of the

proceedings, shall be set forth in a written record that shall be available to the public after service upon the licensees or certified individuals involved.

V. In carrying out disciplinary or licensing proceedings, each board shall have the authority to:
(a) Hold pre-hearing conferences exempt from the provisions of RSA 91-A.
(b) Appoint a board member or other qualified person as presiding officer.
(c) Administer, and authorize an appointed presiding officer to administer, oaths and affirmations.

VI. Neither the office nor the boards, councils, and commissions shall have an obligation or authority to appoint or pay the fees of attorneys representing licensees, certified individuals, or witnesses during investigations or adjudicatory proceedings.

VII. Boards, councils, and commissions may take non-disciplinary remedial action against any person licensed by it upon finding that the person is afflicted with physical or mental disability, disease, disorder, or condition deemed dangerous to the public health. Upon making an affirmative finding ***after notice and an opportunity for a hearing***, the board, council, or commission may take non-disciplinary remedial action:
(a) By suspension, limitation, or restriction of a license for a period of time as determined reasonable by the board.
(b) By revocation of license.
(c) By requiring the person to submit to the care, treatment, or observation of a physician, counseling service, health care facility, professional assistance program, or any combination thereof which is acceptable to the board.

VIII. All proceedings for non-disciplinary remedial action shall be exempt from the provisions of RSA 91-A, except that the board may disclose any final remedial action that affects the status of a license, including any non-disciplinary restrictions imposed.

310-A:1-j Hearings, Decisions and Appeals.

I. Disciplinary proceedings shall be open to the public, except upon order by the board, council, or commission upon good cause shown. The public docket file for each such proceeding shall be retained in accordance with the retention policy established by the office of professional licensure and certification.

II. Notwithstanding any other provision of law, allegations of misconduct or lack of professional qualifications that are not settled shall be heard by the board, council, or commission, or a panel of the board, council, or commission with a minimum of 3 members appointed by the chair of the board or other designee. Any member of the board, or other person qualified to act as presiding officer and duly designated by the board, shall have the authority to preside at such hearing and to issue oaths or affirmations to witnesses, rule on evidentiary and other procedural matters, and prepare a recommended decision. In the case of a hearing before a panel, the presiding officer shall prepare a recommended decision for the board, council, or commission, which shall determine sanctions.

III. Except as otherwise provided by RSA 541-A:30, the board, council, or commission shall furnish the respondent and the complainant, if any, at least 15 days' written notice of the date, time and place of a hearing. Such notice shall include an itemization of the issues to be heard, and, in the case of a disciplinary hearing, a statement as to whether the action has been initiated by a written complaint or upon the board's own motion, or both. If a written complaint is involved, the notice shall provide the complainant with a reasonable opportunity to intervene as a party.

IV. In disciplinary and licensing proceedings, the presiding officer may hold prehearing conferences that are closed to the public and exempt from the provisions of RSA 91-A until such time as a public

evidentiary hearing is convened. In all instances, settlement discussions engaged in by the parties at prehearing conferences may be conducted off the record.

V. The board*, **council, or commission*** may dispose of issues or allegations at any time during an investigation or disciplinary proceeding by approving a settlement agreement or issuing a consent order or an order of dismissal for default or failure to state a proper basis for disciplinary action. Disciplinary action taken by the board at any stage of a proceeding, and any dispositive action taken after the issuance of a public hearing notice, shall be reduced to writing and made available to the public. Such decisions shall not be public until they are served upon the parties.

~~VI. All proceedings for non-disciplinary remedial action shall be exempt from the provisions of RSA 91-A, except that the board may disclose any final remedial action that affects the status of a license, including any non-disciplinary restrictions imposed.~~

VII. No civil action shall be maintained against the board or any member of the board or its agents or employees, against any organization or its members, or against any other person for or by reason of any statement, report, communication, or testimony to the board or determination by the board in relation to proceedings under this chapter.

310-A:1-k Penalties.

I. Upon making an affirmative finding that a licensee or certificate holder has committed professional misconduct, boards, which shall include all boards, councils, and commissions within the office of professional licensure and certification, may take disciplinary action in any one or more of the following ways:
(a) By reprimand.
(b) By suspension of a license or certificate for a period of time as determined reasonable by the board.
(c) By revocation of license.
(d) By placing the licensee or certificate holder on probationary status. The board may require the person to submit to any of the following:
(1) Regular reporting to the board concerning the matters which are the basis of the probation.
(2) Continuing professional education until a satisfactory degree of skill has been achieved in those areas which are the basis of probation.
(3) Submitting to the care, counseling, or treatment of a physician, counseling service, health care facility, professional assistance program, or any comparable person or facility approved by the board.
(4) Practicing under the direct supervision of another licensee for a period of time specified by the board.
(e) By assessing administrative fines in amounts established by the board which shall not exceed $3,000 per offense, or, in the case of continuing offenses, $300 for each day that the violation continues, whichever is greater.

II. The board may issue a non-disciplinary confidential letter of concern to a licensee advising that while there is insufficient evidence to support disciplinary action, the board believes the licensee or certificate holder should modify or eliminate certain practices, and that continuation of the activities which led to the information being submitted to the board may result in action against the licensee's license. This letter shall not be released to the public or any other licensing authority, except that the letter may be used as evidence in subsequent adjudicatory proceedings by the board.
III. In the case of sanctions for discipline in another jurisdiction, the decision of the other jurisdiction's disciplinary authority may not be collaterally attacked and the board may impose any of the sanctions set forth in this chapter, but shall provide notice and an opportunity to be heard prior to imposing any se***an***ctions.

IV. In cases involving imminent danger to life or health, a board may order suspension of a license or certification pending hearing for a period of no more than 10 business days, unless the licensee or certified individual agrees in writing to a longer period. In such cases, the board shall comply with RSA 541-A:30.

V. Any person whose license has been suspended or revoked by the board may apply to the board, in writing, to request a hearing for reinstatement. Upon a hearing, the board may issue a new license or modify the suspension or revocation of the license.

VI. For any order issued in resolution of an disciplinary proceeding by the board, where the board has found misconduct sufficient to support disciplinary action, the board may require the licensee or certificate holder who is the subject of such finding to pay the office a sum not to exceed the reasonable cost of investigation and prosecution of the proceeding. This sum shall not exceed $10,000. This sum may be imposed in addition to any otherwise authorized administrative fines levied by the board as part of the penalty. The investigative and prosecution costs shall be assessed by the board and any sums recovered shall be credited to the office's fund and disbursed by the office for any future investigations of complaints and activities that violate this chapter or rules adopted under this chapter.

VII. When an investigation of a complaint is determined to be unfounded, the board shall dismiss the complaint and explain in writing to the complainant and the licensee or certificate holder its reason for dismissing the complaint. After six years, the board may destroy all information concerning the investigation, retaining only a record noting that an investigation was conducted and that the board determined the complaint to be unfounded. For the purpose of this paragraph, a complaint shall be deemed to be unfounded if it does not fall within the jurisdiction of the board, does not relate to the actions of the licensee or certificate holder, or is determined by the board to be frivolous.

VIII. Whoever, not being licensed or otherwise authorized to practice according to the laws of this state, shall advertise oneself as engaging in a profession licensed or certified by the office of professional licensure and certification, shall engage in activity requiring professional licensure, or in any way hold oneself out as qualified to do so, or call oneself a licensed professional, or whoever does such acts after receiving notice that such person's license to practice has been suspended or revoked, is engaged in unlawful practice. After hearing and upon making an affirmative finding of unlawful practice, the board, council, or commission may take action in any one of the following ways:
(a) Issue a cease and desist order against any person or entity engaged in unlawful, which shall be enforceable in superior court.
(b) Impose a fine not to exceed the amount of any gain or economic benefit that the person derived from the violation or $10,000 for each offense, whichever amount is greater. Each violation of unlicensed or unlawful practice shall be deemed a separate offense.
(c) The attorney general, board, council, or commission, or prosecuting attorney of any county or municipality where the act to unlawful practice takes place may maintain an action to enjoin any person or entity from continuing to do acts of unlawful practice. The action to enjoin shall not replace any other civil, criminal, or regulatory remedy. An injunction without bond is available to any board, council, or commission.

310-A:1-l Rehearing; Appeals.

I. Any person who has been refused a license or certification by the board, which shall include all boards, councils, and commissions within the office of professional licensure and certification, or has been disciplined by the board shall have the right to petition for a rehearing within 30 days after the original final decision.

II. Appeals from a decision on rehearing shall be by appeal to the supreme court pursuant to RSA 541.

III. No sanction shall be stayed by the board during an appeal.

3 Effective Date. Part VII of this act shall take effect January 1, 2022.

Part IX amend as indicated by highlighting

Relative to temporary licensure of certain licensed nursing assistants.

1 Statement of Purpose. The general court acknowledges the critical importance of ensuring the quality, accessibility, and sustainability of Medicaid services provided in nursing homes, and recognizes the critical shortage of licensed nursing assistants throughout the state. The purpose of this act is to strengthen the frontline staffing in nursing homes. The general court finds that during the COVID-19 pandemic federal regulatory and statutory provisions were waived to facilitate the hiring of nurse aides by nursing homes. Under state emergency order, these individuals were allowed to work in nursing homes as temporary health partners following no less than 8 hours of training provided either by a national association or a New Hampshire educational program. As a matter of public policy, the general court finds that these workers were indispensable as facilities struggled with staffing issues, particularly during outbreaks of the COVID-19 virus. Accordingly, this act shall provide the board of nursing with the additional authority to expand the workforce of licensed nursing assistants by recognizing the service of temporary health partners during the COVID-19 pandemic.

2 Special Licensure as a Licensed Nursing Assistant; Applicants Who Served as Temporary Health Partners.

I. Persons who have worked no fewer than 100 hours as temporary health partners in a licensed nursing home ~~by April 1, 2021~~ ***and*** have demonstrated, through their work experience during a national and state public health emergency, the competency to transition to status as a licensed nursing assistant, ***shall be deemed to have taken a board-approved nursing assistant course and may apply for a license as a licensed nursing assistant in New Hampshire.***

II. Notwithstanding any provision of law to the contrary, the state-approved training program for licensed nursing assistants shall take into account the training and experience acquired during the COVID-19 pandemic to transition these individuals to placement on the state's licensed nursing assistant registry pursuant to RSA 326-B:26. Such individuals shall be subject to all continuing education requirements under RSA 326-B:31.

III. For purposes of this act:

(a) “COVID-19” means the novel coronavirus first identified in 2019, or SARS-CoV-2.
(b) “Temporary health partner” means anyone authorized to work in a nursing home by Emergency Order 42 issued by the governor on May 11, 2020, and required to complete training of no less than eight hours and work under the supervision of an RN, APRN, or LPN, as is required of LNAs under RSA 326-B:14.

3 Effective Date. Part IX of this act shall take effect ~~60 days after its~~ ***upon*** passage.

Part XI

Insert amendment **1260h Lekas** (attached)

Part XII

PART XII

Relative to licensing psychologists from other states.

1 Amend RSA 329-B:20 as follows:

329-B:20 ~~Temporary and Emergency~~ Applicants From Other States. –

Any psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist practicing pursuant to this section shall conform his or her practice to the mandates of this chapter and the rules of the board. Any psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist seeking to practice under this section shall register with the board in a manner determined by the board.

I. An individual licensed to practice psychology or school psychology in another jurisdiction may practice psychology, licensed school psychology-doctoral, or licensed school psychology-specialist in accordance with this chapter in New Hampshire by applying for a license, if:
(a) The psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist limits her or his practice in New Hampshire to no more than 30 days per year; and
(b) The psychologist, licensed school psychologist-doctoral, or licensed school psychologist-specialist is not the subject of a past or pending disciplinary action in another jurisdiction; and
(c) At least one of the following is true:
(1) The psychologist is the holder of one of the following credentials:
(A) The Association of State and Provincial Psychology Boards (ASPPB) Certificate of Professional Qualification in Psychology (CPQ);
(B) The ASPPB Interjurisdictional Practice Certificate (IPC);
(C) The American Board of Professional Psychology (ABPP) certification;
(D) The National Register of Health Providers in Psychology certification; or
(E) Other equivalent qualifications determined by the board.
(2) The school psychologist is:
(A) The holder of the Nationally Certified School Psychologist (NCSP), credentialed by the National Association of School Psychologists, or other equivalent qualifications determined by the board; and
(B) Approved by the board to be knowledgeable in state practice as determined by the board.
(d) An individual licensed to practice psychology in another jurisdiction seeking to perform an evaluation under a court order may be allowed a temporary license for no more than 30 days which may be non-consecutive during a 12 month period, providing he or she qualifies under subparagraphs (b) and (c)(1).
(e) An individual seeking temporary licensure shall submit the application and pay the fee determined by the office of professional licensure and certification.

II. An individual licensed to practice psychology or school psychology in another jurisdiction who is providing services in response to a declared disaster, under the American Red Cross or the American Psychological Association's Disaster Response Network, or other such agency so designated by the board, may practice psychology in New Hampshire for no more than 60 days per year without applying for a state license. Any psychologist practicing pursuant to this paragraph shall conform his or her practice to the mandates of this chapter and rules of the board. Any psychologist seeking to practice under this paragraph shall register with the board or cause said organization to make such registration in a manner determined by the board.

III. The board may issue a temporary license to practice for not more than 90 days in a 12-month period to a psychologist who is licensed in another jurisdiction and who has applied for a temporary license to practice psychology in New Hampshire, provided that:
(a) The requirements for licensure in the licensing jurisdiction are equal to or exceed the requirements for licensure in New Hampshire;
(b) The applying psychologist meets the requirements for admission to the examination process in New Hampshire;
(c) The psychologist is not the subject of a past or pending disciplinary action in another jurisdiction and
(d) The individual submits an application and pays the fee determined by the office of professional licensure and certification.

IV. Notwithstanding any other provision of state law to the contrary, the office of professional licensure and certification shall issue a license to practice psychology or school psychology to any individual who has met the following requirements:

- (a) ***The individual has practiced in New Hampshire under a temporary or emergency license for a period of at least ninety (90) days;***
- (a) ***That license remains in good standing;***
- (b) ***The individual has completed an application and paid the fee established by the office.***

2 Effective Date. Part XII of this act shall take effect July 1, 2021.

Part XIV – add new part

Establishing minimum qualifications for certification as a child care associate teacher.

1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after subparagraph (m) the following new subparagraph:

(n) The following qualification for certification as an associate teacher: a minimum of 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of training in child growth and development, the latter of which may be documented life experience. Documented life experience in lieu of training in child growth and development shall include experience with the same age children the associate teacher supervises, such as a family child care provider; service as a foster parent; work as a school teacher; work as a camp counselor; and experience as a group leader for children in sports or other activities, such as scouts or little league, or closely related experience.

2 Effective Date. This act shall take effect 60 days after its passage.

Hearing Minutes

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

PUBLIC HEARING ON SB 133-FN

BILL TITLE: **adopting omnibus legislation relative to occupational licensure.**

DATE: **April 21, 2021**

LOB ROOM: **Remote / Hybrid** **Time Public Hearing Called to Order:** **10:00 a.m.**

Time Adjourned: **4:10 p.m.**

Committee Members: **Reps. McGuire, Roy, Sytek, S. Pearson, Yakubovich, T. Lekas, Alliegro, Bailey, Lanzara, Santonastaso, Goley, Schuett, Jeudy, P. Schmidt, Schultz, Fellows, Grote and O'Brien (Absent = Rep Fontneau)**

Bill Sponsors:
Sen. Carson

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

April 21, 2021
The entire ED&A Committee was present for all hearings except for Rep. Fontneau, who was absent.

SB 133 adopting omnibus legislation relative to occupational licensure. (10:00 AM/4:10 PM)

Omnibus Bill – Public Hearing on each Part –

I. Licensing places of assembly. (10:00 AM/10:10 AM)

Sen. Carson, sponsor of this section of the bill, introduced the bill and spoke in favor. She described the bill as permitting the Fire Marshall's office to issue a license for public assembly where there is no local authority.

Paul Parisi, Fire Marshall, spoke in support and provided additional details as to why this was useful.

- There was a question concerning jurisdiction.

II. Repealing the emergency medical services personnel licensure interstate compact. (10:10 AM/11:00 AM)

Sen. Rosenwald introduced the bill and spoke in favor of repealing the emergency medical services personnel licensure interstate compact (REPLICA). She said that it was not necessary since we already have the same standards for certification and licensure, that the nearest state in the compact was 500 miles away, traced the history of this bill which was vetoed as part of bill last session.

Christopher Arnold, Dept. of Defense, NE Liaison Office, spoke in opposition. He said it would have a negative impact on NH military personnel and their spouses by restricting their eligibility to practice in the other 22 compact states. He described the policy aspects of "basing" decisions, one of which was participation in the REPLICA compact. He pointed out that NH has limited personnel from compact states from picking up full shifts. He said that NH is having

difficulty recruiting EMS personnel and leaving the compact would make that situation more difficult. He noted that there can be a “state only” license under the compact.

- He cited the advantages of the compact and addressed some misapprehensions. He then a wide variety of Committee questions.

***Brian Ryll, NH President of Professional Firefighters spoke in support.** He said that compact could be detrimental to health care by creating confusion. He said that NH could lose revenue as a result of others coming in and working on an intermittent basis and that no bordering state was a member of the compact. He felt that the Governor could invoke the compact provisions in an emergency situation and that distant compact states had a less robust EMS system than NH.

- He answered Committee questions concerning equivalent standards and whether out of state personnel would actually be used in NH.
-

Justin Romanello, Chief of Bureau of EMS for NH spoke in opposition. He did not want to see this “tool” removed from NH even though it has not yet been used in state. However, we have had NH personnel used in another compact state. He said the compact does not bypass NH state requirements. He concludes that there was no harm to NH and that it allows our personnel to work in other compact states.

Warren Perry, Deputy Adjutant General for Military Affairs and Veteran Services, spoke in opposition and “echoed” Mr. Arnold’s earlier remarks.
***Eric Shelberg, President of NH Paramedic Association, spoke in opposition.** He described the use of the compact in NH in natural disaster or emergency situations. He said that while there were “nuances” in NH EMS response, there was a base level of standards in the compact and that there was no “freelancing” permitted.

- He answered Committee questions concerning Emergency Orders.

Christopher Stawasz, Regional Director of Emergency Medical Response, spoke in opposition. He said that the compact provided a defined, specific mechanism for EMS personnel to cross state borders. He pointed out that NH participates in many other compacts with similar language and intent. He described how NH entered the compact with input from the various stakeholders.

- He clarified what the compact did and did not do. He described the compact’s data base and its utility.

Clay Odell, firefighter, EMT, and RN, spoke in opposition. He said that the compact was good for everyone and that there were no flaws. He said the “driving force” behind the repeal was International Association of Firefighters as being potentially harmful to its members.

III. Hearings at the board of nursing. (11:00 AM/11:10 AM)

Sen. Ward, sponsor, introduced the bill and spoke in favor. She stated the content of the bill permitting any member to preside over Board of Nursing hearings and that the bill was introduced at its request.

Lindsey Courtney, ED of the OPLC, spoke in support. The BofN is the only board that does not permit the public member to be the presiding officer in disciplinary hearings. She answered questions concerning the presiding officer of other boards.

IV. Membership of the professional standards board. (11:10 AM/11:15 AM)

Sen. Carson introduced the bill on behalf of Sen. Kahn, sponsor, and spoke in favor. It is a request of the Dept. of Education and changes the serving role specifications for the role of the professional standards board.

V. Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact. (11:15 AM/12:10 PM)

Sen. Sherman, sponsor, introduced the bill and spoke in favor. He said it was a request of the American Speech Language Hearing Association and was supported by the boards and the OPLC. He cites the advantages of compacts including expanding our work force and are working well.

- In answer to a question, he said there was no opposition to the bill; he also distinguished reciprocity versus a compact.

Christopher Arnold, Dept. of Defense, NE Liaison Office, spoke in support. He concentrated on the advantages of the compact with respect to military personnel and spouses. He said that the terms "reciprocity" and "expedited" have various meanings in different states. He cited advantages of a compact such as portability and shared data base.

- There was a question about whether this compact would interact with the REPLICA compact in section II of the bill.

Tina Kelly, OPLC, speaks for information.
She said that the compact grants the privilege but that the therapist is bound by NH scope of practice and discipline. She said that the compact will grant mobility while keeping all safeguards in place. She said it would be questionable to just single out military personnel.

- In answer to a question, she said that if someone moves to NH that person would have to get a NH license, regardless of coming from a compact state. There were several questions regarding the authority of NH over compact participants, ability to modify the compact.

Susan Adams, Director of State Legislative and Regulatory Affairs for the American Speech-Language Hearing Association, spoke in support. She recapped the provisions of the compact. She gave a history of the development of the compact.

- There was a Committee question as to why near-by states were not in the compact.

VI. Licensure and regulation of music therapists. (1:30 PM/1:50 PM)

Rep. McGhee, co-sponsor, introduced the bill on behalf of Sen. Avard and spoke in support. She introduced the bill at the request of a constituent, Shannon Laine, a board-certified music therapist, the current director of music therapy and adaptive lessons in early childhood at the Manchester Community Music School. She spoke of her personal learning in this area and experience with therapy.

Marissa Scott, a board-certified music therapist, who served on the state task force for music therapist recognition, spoke in support. She said it would increase access to services and there was no opposition in the Senate. There was a question concerning a conflict concerning the scope of practice between the speech language pathologists and the music therapists.

- Ms. Scott answered that there were conversations at the national level between the American Music Therapy Association and American Speech Therapy Association and that the bill contains agreed-on language.

Susan Adams, Director of State Legislative and Regulatory Affairs for the American Speech-Language Hearing Association, spoke and said that an amendment would be needed; that there was not yet any agreed-on language. While not opposed to the licensure of music therapists, she was concerned about scope of practice issues. She described speech language therapy. She distinguished between communication skills and language skills.

- There was a question concerning the language of this bill reflected the work of a subcommittee last year.

Tina Kelly, OPLC, was neutral on the bill and spoke as a matter of information but **had some concerns regarding definitions**, confusion as to the autonomy of the board. Also: OPLC would need an additional position.

Grant Bosse, aide to Sen. Avard, said that the senator would be submitting written testimony.

VII. The authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals. (1:50 PM/2:15 PM)

Rep. McGuire introduced the bill on behalf of the sponsor, Senator Reagan. She spoke in favor and said that it was a technical cleanup bill dealing with administration, rulemaking and enforcement of investigations, hearings and appeals. It consolidates existing law putting it under OPLC.

Michael Porter, an attorney and Administrator of OPLC enforcement, spoke in favor. He reviewed the role of OPLC and that his division serves to protect health and safety. There are 55 boards operating with 55 sets of rules. He described the development of consistent complaint procedures which would provide effectiveness and efficiency but respecting due process. He made clear that the boards do not relinquish any authority in the consolidation. He discussed "standing orders" and gave statistics about the number of complaints handled since the enforcement arm was formed on Sept. 1, 2020. He discussed the handling of unlicensed practitioners under this bill.

- There was a question as to how a complaint that is also a criminal act would be handled.

VIII. Skilled professional medical personnel. (2:15 PM/2:30 PM)

Sen. Ward, sponsor, introduced the bill and spoke in favor. This would require only RNs on behalf of the department to make clinical eligibility decisions.

Douglas Osterhoudt, with the Bureau of General Counsel for the Dept. of HHS spoke in opposition. He said that this would reverse the broadening of the law in 2015 to allow skilled medical personnel, not just RN's, to make these determinations. This broadening was done to reduce delays. He discussed unnecessary restrictions on supervision of personnel and other unnecessary restrictions; the bill made greater restrictions than required by federal CFR's. He referred to the work done by a House subcommittee in the development of the 2015 bill. There were questions about the meaning of "adverse determinations" and a Committee request to get input from the HHS Committee.

IX. Temporary licensure of certain licensed nursing assistants. (2:30 PM/2:50 PM)

Senator Hennessey introduced the bill and spoke in favor. She said that the bill would permit temporary licensure of certified LNA's who had worked during the COVID pandemic and who had fulfilled certain other professional requirements.

- In response to a question: this was available only to people who met certain criteria before April1; it was not a continuing program.

Teresa Rosenberger, an attorney with The Bernstein Shur Group representing the NH Health Care Association, and spoke in favor. She gave the history of the bill. The federal government granted a temporary waiver because health care facilities were losing too many people during the COVID pandemic.

- There were questions: could this be made permanent; role of wages, problems with Medicaid reimbursement.

X. The revocation of licensure for licensed emergency medical service units and emergency medical service vehicles. (2:50 PM/3:05 PM)

Senator Prentiss, sponsor, a paramedic and former chief of EMS in NH, introduced the bill and spoke in favor. Goals of the bill are to align suspension and revocation procedures with other health care professions. Also, to promote just culture in performance. She pointed out

the "shall" is used for discipline whereas "may" is used for other medical professions and this change of language was sought.

Justin Romanello, Chief of Bureau of EMS for NH spoke in favor. He supported the concept of giving the Commissioner discretion such as a letter of concern.

XI. Schools for barbering, cosmetology, and esthetics. (3:05 PM/3:15 PM)

Rep. McGuire introduced the bill on behalf of the sponsor, Sen. Reagan and spoke in favor. She said the bill changes definition of a school of barbering and cosmetology by allowing the use of a dedicated program, for example, in a high school and provides for apprentices to register.
There was a bill HB575 deals with a similar topic but has conflicting language.

Tom Broderick, legal counsel for OPLC, and spoke for the OPLC. This bill was a request of OPLC. He discussed in detail the issues mentioned by Rep. McGuire. Another issue for HS students is the requirement by licensing boards to provide a social security number – something the HS does not have.

XII. Telemedicine provided by out of state psychologists. (3:15 PM/3:35 PM)

Rep. Alliegro introduces the bill on behalf of the sponsor, Sen. Reagan. He took no questions.

Tom Broderick, legal counsel for OPLC, spoke for explanation. OPLC was neutral on the bill. He was speaking about administrative aspects, not from the Board's perspective. He explained that the bill established a new licensure category that is, for out-of-state psychologists to practice via remote technology. The two existing ways to practice are through regular license or through PsyPact (a compact). He described the impact on the workload on OPLC. There is the possibility of confusion between PsyPact and this third avenue.

Dr. Deborah Warner, Vice-Chair of the Board of Psychologists, spoke in favor. The Board's experience with the Governor's EO's and PsyPact has been good. To participate, the provider has to be at the doctoral level and have a clean record. She discusses the mechanics and interaction of the types of licenses.

XIII. Sanitary production and distribution of food. (3:35 PM/4:10 PM)

Sen. Guida, prime sponsor, introduced the bill and spoke in favor. This bill grew out of rule passed by the food services division of public health which adopted a federal standard. That requirements of which, namely having a certified food protection manager on scene, were met by the provisions of this bill. His concern is that for small restaurants, this bill could be onerous. So small establishments are exempted by this bill.

Mike Sisson, one of the founders of Aroma Joe's chain, spoke in support and described his business practices. He also described the burden the food protection manager would impose on his small establishment; all his food is heat and serve.

Colleen Smith, Administrator of the Food Protection Section within the Dept. of HHS, Division of Public Health Services spoke in support. She described the development of the bill, the work being done with HHS and Sen. Guida. She said rules are being developed to be presented to HHS. There was a question about how a food protection manager would work when there were many small stores, such as Aroma Joe's.

- There were questions concerning administrative rules being proposed prior to the passage of this legislation.

Minutes respectfully submitted by,

Rep. John Sytek, Committee Clerk

HOUSE SCHEDULING NOTICE

Executive Departments and Administration

PUBLIC HEARING

-on Non Germane And SB 133 # 2021-1162h

Tuesday, 4/27/21

Hybrid

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2:30 p.m. **Public Hearing on non-germane amendment #2021-1162h to SB 133-**FN, adopting omnibus legislation relative to occupational licensure. The amendment adds a section establishing minimum qualifications for certification as a child care associate teacher. Copies of the amendment are available in the Sergeant-at-Arms office, Room 318, State House and on the General Court website.

Executive session on pending legislation may be held throughout the day (time permitting) from the time the committee is initially convened.

Committee members will receive secure Zoom invitations via email.

Members of the public may attend using the following links:

1. To join the webinar: https://zoom.us/j/93185691814
2. Or Telephone: 1-929-205-6099
3. Webinar ID: 931 8569 1814

The following email will be monitored throughout the meeting by someone who can assist with and alert the committee to any technical issues: hcs@leg.state.nh.us or call (603-271-3600).

Sponsors:
SB 104-FN-A
Sen. Reagan
SB 155-FN
Sen. Bradley

Committee Asst: Miriam Simmons

Carol M. McGuire, Chairman

Scheduled By: Miriam Simmons - 271-3600

Created: April 21, 2021 11:31 a.m.

HOUSE COMMITTEE ON EXECUTIVE DEPARTMENTS AND ADMINISTRATION

PUBLIC HEARING ON SB 133-FN **non-germane amendment 2021-1162h** to SB 133-FN

BILL TITLE:	**adopting omnibus legislation relative to occupational licensure.**
DATE:	**April 27, 2021**
LOB ROOM:	**Remote / Hybrid** **Time Public Hearing Called to Order:** **3:45 p.m.**
	Time Adjourned: **4:45 p.m.**

Committee Members: **Reps. McGuire, Roy, Sytek, S. Pearson, Yakubovich, T. Lekas, Alliegro, Bailey, Lanzara, Santonastaso, Goley, Schuett, Jeudy, P. Schmidt, Schultz, Fellows, Grote and O'Brien** Rep Grassie attended in place of Rep Fontneau

Bill Sponsors:
Sen. Carson

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

April 27, 2021
The entire ED&A Committee was present for all hearings except for Rep. Fontneau, who was absent and replaced by Rep. Grassie.

SB133 Public Hearing on proposed non-germane amendment 2021-1162h to SB 155 adopting omnibus legislation relative to occupational licensure. (3:45 PM/4:45 PM)

Rep. Wallner, sponsor, introduced the amendment and spoke in favor. She said the bill deals with the qualifications to be an associate teacher in a child care program. This is an excerpt from HB 230 presently being retained by the Committee. It is very narrow and provides an additional pathway for becoming an associate teacher. She said that child care providers are facing a crisis because they cannot hire for vacant positions. She said this is being done by waivers but that will end when the state of emergency ends. However, the crisis is now; it's not known when the state of emergency will end; and in any case, child care providers' hiring shortage situation is likely to continue. She said the problem is a large one and this bill is a small piece in the puzzle but it will help. Parents are returning to work while some child care centers are closing or not accepting all the children they could. She answered questions about the present certification process.

Rep. McWilliams spoke in support. She also said that more child care meant more parents being able to get back to work. She said that the problem was not money since federal funds were available. The problem was meeting the qualifications

- There were questions about why this amendment would appear in rule-making section of the statutes rather than in licensing.

Karen Juall spoke in opposition. She understood the problems facing child care centers but felt the system was broken. She said that kids that child care centers have more problems than previously. Staff needs tools to meet the challenges presented by these kids. One of those tools is education. That should not be taken away; also, there is risk in the bill in that associate teachers are permitted to be alone with the kids who could present problems for which the associate teacher has not been trained. She discusses solutions and groups that would support training.

- There were Committee questions concerning the shortage, the number of closings; what to do for an immediate solution; when will they get a training; detailed discussion about getting training and supervision while working on the job.

Emily Johnson, State Manager of Save The Children Network, spoke in opposition. She said the amendment although well-intentioned was a step backward in the delivery of quality child care services. This would lower the bar rather than providing more resources.

- She answered Committee questions concerning whether this would provide an entry-level career path for those who do not fit the mold. How soon would we see results from the longer-range efforts.

Maryanne Barter, ED of the Merrimack Valley Day Care Service and Blueberry Express Day Care, spoke in non-enthusiastic support. She said that it was not ideal to lower qualifications but that it was necessary to keep the doors open and serve low-income families.

Melissa Clement, Chief of Child Care Licensing Unit in the Dept. of HHS, said that the Dept. has expedited waivers to permit assistant teachers to act as associate teachers during the emergency and gave statistics. **The Dept. is opposed to the amendment** and feels that qualifications should stay in rulemaking. The Dept. will present a comprehensive revision rules to JLCAR in September. The Dept. would like to see a definition of "life experience" as used in the amendment.

Lisa Ranfos, ED of the Child Study and Development Center at UNH, spoke in opposition. She said this was an old problem highlighted by the pandemic situation. She is opposed to lowering the standards for associate teachers. She said that higher salaries would draw more people to the field. She enumerated programs that would assist in the training of teachers.

Minutes respectfully submitted by,

Rep John Sytek
Committee Clerk

Rep. Wallner, Merr. 10
Rep. McWilliams, Merr. 27
April 19, 2021
2021-1162h
08/05

Amendment to SB 133-FN

1 Amend section 2 of the bill by inserting after Part XIII the following:
2
3 Part XIV
4 Establishing minimum qualifications for certification as a child care associate teacher.
5 1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education
6 Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after
7 subparagraph (m) the following new subparagraph:
8 (n) The following qualification for certification as an associate teacher: a minimum of
9 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of
10 training in child growth and development, the latter of which may be documented life experience.
11 2 Effective Date. This act shall take effect 60 days after its passage.

UNAPPROVED

2021-1162h

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Licensing places of assembly.

II. Repealing the emergency medical services personnel licensure interstate compact.

III. Hearings at the board of nursing.

IV. Membership of the professional standards board.

V. Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

VI. Licensure and regulation of music therapists.

VII. The authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

VIII. Skilled professional medical personnel.

IX. Temporary licensure of certain licensed nursing assistants.

X. The revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

XI. Schools for barbering, cosmetology, and esthetics.

XII. Telemedicine provided by out of state psychologists.

XIII. Sanitary production and distribution of food.

XIV. Establishes minimum qualifications for certification as a child care associate teacher.

UNAPPROVED

House Remote Testify

Executive Departments and Administration Committee Testify List for Bill SB133 on 2

Support: 22 Oppose: 6 Neutral: 1 Total to Testify: 26

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Name	City, State Email Address	Title	Representing	Position	Testifying	S
Porter, Michael	Manchester, NH Michael.W.Porter@oplc.nh.gov	State Agency Staff	Office of Professional Licensure and Certification	Support	Yes (7m)	4
Kelley, Tina	Rochester, NH tina.m.kelley@oplc.nh.gov	State Agency Staff	Office of Professional Licensure and Certification	Support	Yes (5m)	4
Courtney, Lindsey	Concord, NH Lindsey.Courtney@oplc.nh.gov	State Agency Staff	Office of professional licensure	Support	Yes (5m)	4
Osterhoudt, Douglas	Bow, NH douglas.j.osterhoudt@dhhs.nh.gov	State Agency Staff	DHHS/BEAS	Oppose	Yes (5m)	4
Rosenwald, Cindy	Concord, NH cindy.rosenwald@leg.state.nh.us	An Elected Official	SD 13	Support	Yes (5m)	4
Carson, Sharon	Londonderry, NH deborah.chroniak@leg.state.nh.us	An Elected Official	SD 14, PRIME SPONSOR on PART I, co-sponsor on Parts II, V, VI, VII, XI and XII	Support	Yes (5m)	4
Prentiss, Sue	Lebanon, NH jessica.bourque@leg.state.nh.us	An Elected Official	Senate District 5	Support	Yes (5m)	4
Kahn, Jay	Keene, NH jessica.bourque@leg.state.nh.us	An Elected Official	Senate District 10	Support	Yes (5m)	4
Sherman, Senator Tom	SD24, NH jennifer.horgan@leg.state.nh.us	An Elected Official	SD24	Support	Yes (5m)	4
Arnold, Christopher	Pentagon, DC christopher.r.arnold18.civ@mail.mil	A Member of the Public	United States Department of Defense	Oppose	Yes (5m)	4
stawasz, christopher	hollis, NH cstawasz@gmr.net	A Member of the Public	Myself	Oppose	Yes (5m)	4
PERRY, WARREN	Bow, NH warren.m.perry.nfg@mail.mil	State Agency Staff	The Dept of Military Affairs and Veterans Services	Oppose	Yes (5m)	4
Schelberg, Eric	Milford, NH eschelberg@msn.com	A Member of the Public	NH Paramedic Association	Neutral	Yes (5m)	4
Romanello, Justin	Hollis, NH justin.s.romanello@dos.nh.gov	State Agency Staff	Department of Safety	Support	Yes (5m)	4
Sillon, Mike	Dover, NH mike@aromajoes.com	A Member of the Public	Myself	Support	Yes (3m)	4
Smith, Colleen	Concord, NH colleen.smith@dhhs.nh.gov	State Agency Staff	NH DHHS	Support	Yes (3m)	4
Ryll, Brian	CONCORD, NH brian@pffnh.org	A Lobbyist	Professional Fire Fighters of NH	Support	Yes (3m)	4
Adams, Susan	Rockville, MD sadams@asha.org	A Lobbyist	American Speech-Language-Hearing Association	Support	Yes (3m)	4
WARNER, DR DEBORAH	LITTLETON, NH warner@330608.com	A Member of the Public	Board of Psychologists	Support	Yes (3m)	4
Odell, Clay	West Lebanon, NH clay.odell@outlook.com	A Member of the Public	Myself	Oppose	Yes (2m)	4
Parisi, Paul	Concord, NH paul.j.parisi@dos.nh.gov	State Agency Staff	NH State Fire Marshal's Office	Support	Yes (2m)	4
Scott, Marissa	Dover, NH marissa@thesonatinacenter.com	A Member of the Public	Myself	Support	Yes (1m)	4

Broderick, Tom	Concord, NH Thomas.R.Broderick@oplc.nh.gov	State Agency Staff	Office of Professional Licensure and Certification	Support	Yes (10m)	4
Reagan, Senator John	Deerfield, NH kathryn.cummings@leg.state.nh.us	An Elected Official	Senate District 17	Support	Yes (0m)	4
Ward, Senator Ruth	Stoddard, NH ruth.ward@leg.state.nh.us	An Elected Official	Senate District 8 Supporting Parts III and VIII only PRIME	Support	Yes (0m)	4
McGhee, Kat	Hollis, NH Kat.mcghee@leg.state.nh.us	An Elected Official	Hillsborough 27	Support	Yes (0m)	4
Brooks, Alexis	Hollis, NH atj.brooks@gmail.com	A Member of the Public	Myself	Support	No	4
lindbom, daniel	Merrimack, NH daniel.lindbom@comcast.net	A Member of the Public	Myself	Oppose	No	4
Laine, Shannon	Hollis, NH shannonlaine.mtbc@gmail.com	A Member of the Public	Myself	Support	No	4

House Remote Testify

Executive Departments and Administration Committee Testify List for Bill SB133 on 2

Support: 29 Oppose: 22 Neutral: 1 Total to Testify: 4

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Name	City, State Email Address	Title	Representing	Position	Testifying	Non-Germane
McWilliams, Rebecca	Concord, NH rebecca.mcwilliams@leg.state.nh.us	An Elected Official	Merrimack 27	Neutral	Yes (5m)	Yes
Johnson, Emily	Center Conway, NH ejohnson@savechildren.org	A Lobbyist	Myself	Oppose	Yes (5m)	Yes
Wallner, Mary Jane	Concord, NH MJWallnernh@gmail.com	An Elected Official	Myself	Support	Yes (2m)	Yes
Juall, Karen	Concord, NH kajuall@comcast.net	A Member of the Public	Myself	Oppose	Yes (0m)	No
Wallace, Cynthia	Manchester, NH holycrossecc@yahoo.com	A Member of the Public	Myself	Oppose	No	No
McCosker, Stephanie	Somersworth, NH kidsculturechildcare1@gmail.com	A Member of the Public	Myself	Support	No	No
Ferguson, Lindsay	Concord, NH thelinz2484@gmail.com	A Member of the Public	Myself	Support	No	No
Bolduc, Elizabeth	Loudon, NH mvdc.cacfp.elizabeth@gmail.com	A Member of the Public	Myself	Support	No	No
Barter, Marianne	Concord, NH mariannebarter@gmail.com	A Member of the Public	Myself	Support	No	Yes
Hanson, Lindsay	Hopkinton, NH lindsayhanson@savechildren.org	A Lobbyist	Save the Children Action Network & Myself	Oppose	No	No
Daigneault, Michele	Thornton, NH trumansmom47@aol.com	A Member of the Public	Myself	Oppose	No	No
Baril, Amanda	Goffstown, NH amandabaril0619@gmail.com	A Member of the Public	Myself	Oppose	No	No
Brabec, Megan	Newmarket, NH mbrabec18@gmail.com	A Member of the Public	Myself	Oppose	No	No
Johnson, Hillary	Freedom, NH xxhilliexx@yahoo.com	A Member of the Public	Myself	Oppose	No	No
Englert, Heidi	Gilford, NH Readysetgrowclc@gmail.com	A Member of the Public	Myself	Support	No	No
Englert, Nick	Laconia, NH Englert33@gmail.com	A Member of the Public	Myself	Support	No	No
Tremblay, Linda	Claremont, NH lindasuet24@aol.com	A Member of the Public	Myself	Support	No	No
Hoyt, Cellissa	STRAFFORD, NH cellissa_b_h@hotmail.com	A Member of the Public	Myself	Support	No	Yes
Flanders, Kaitlin	Bristol, NH kaitlinjaide@yahoo.com	A Member of the Public	Myself	Support	No	Yes
Black-Norton, Susan	Sandown, NH susan.black.norton@gmail.com	A Member of the Public	Myself	Oppose	No	Yes
Belanger, Kathy	Hampstead, NH director@agesandstageslc.com	A Member of the Public	Myself	Support	No	No
Carter, Jaime	Londonderry, NH gundyja@hotmail.com	A Member of the Public	Myself	Support	No	No

Meaney, Pamela	Merrimack, NH pamelameaney1@gmail.com	A Member of the Public	Myself	Support	No	No
Menard, Diana	Chichester, NH dmenard@ccsnh.edu	A Member of the Public	Myself	Oppose	No	No
Johnson, Justina	Pembroke, NH jrjohnson883@gmail.com	A Member of the Public	Myself	Oppose	No	No
Babcock, Shaunna	New Boston, NH shaunna.reidy@yahoo.com	A Member of the Public	Myself	Oppose	No	No
McKim-Haddock, Sydney	Belmont, NH Sydney.mckimhaddock@gmail.com	A Member of the Public	Myself	Support	No	No
Johnson, Jane	Freedom, NH janemjohnsonssw@yahoo.com	A Member of the Public	Myself	Oppose	No	No
Johnson, Larry	Freedom, NH haraumi@hotmail.com	A Member of the Public	Myself	Oppose	No	Yes
Weigold, Victoria	Jackson, NH victoria.weigold@gmail.com	A Member of the Public	Myself	Oppose	No	No
Ghelfi, Sarah	North Conway, NH lotusorganichairstudio@gmail.com	A Member of the Public	Myself	Oppose	No	Yes
Campbell, Margaret	West Lebanon, NH macatmf@aol.com	A Member of the Public	Myself	Oppose	No	No
Pelletier, Laura	Moultonboro, NH laura@ildcc.org	A Member of the Public	Myself	Support	No	No
Southard, Barbara	Bradford, NH Barbsouthard@gmail.com	A Member of the Public	Myself	Oppose	No	No
WOITKOWSKI, REBECCA	Concord, NH rwoitkowski@new-futures.org	A Lobbyist	New Futures Kids Count	Oppose	No	Yes
Ranfos, Lisa	Allenstown, NH lisaranfos@comcast.net	A Member of the Public	Myself	Oppose	No	Yes
Kelly, Rachel	Penacook, NH mcdonrachel@aol.com	A Member of the Public	Myself	Support	No	No
Bradley, Susan	Concord, NH Frankobradley@comcast.net	A Member of the Public	Myself	Support	No	No
Thibeault, Erica	Penacook, NH Ericathibeault@comcast.net	A Member of the Public	Myself	Support	No	No
Gaides, Janet	Contoocook, NH Strumminghome@gmail.com	A Member of the Public	Myself	Support	No	No
Clement, Melissa	Concord, NH melissa.clement@dhhs.nh.gov	State Agency Staff	DHHS-Child Care Licensing Unit	Oppose	No	Yes
Biron, Kristen	Manchester, NH childguidance@comcast.net	A Member of the Public	Myself	Support	No	No
Wuellenweber, Sally	Dunbarton, NH sally@totspotnh.com	A Member of the Public	Myself	Support	No	No
Martin, KRYSTLE	HANOVER, NH childcaredirector@kah.kendal.org	A Member of the Public	Myself	Support	No	No
French, Anita	Stratham, NH periwinkleyb@gmail.com	A Member of the Public	Myself	Oppose	No	No
Larochelle, Kitty	Bedford, NH KittyLaro@gmail.com	A Member of the Public	Myself	Support	No	No
Smith, Abigail	Manchester, NH absmith1996abby@aol.com	A Member of the Public	Myself	Support	No	No
Lavoie, Jill	Penacook, NH jill@thegrowingyears.org	A Member of the Public	Myself	Support	No	No
Harrington, Jordan	Manchester, NH jjh96@yahoo.com	A Member of the Public	Myself	Support	No	No

Pizzutillo, Donna	Manchester, NH fdapizza@gmail.net	A Member of the Public	Myself	Support	No	Yes	·
Green, Betsy	Manchester, NH info@childrenselc.net	A Member of the Public	Myself	Support	No	Yes	·
Slafsky, Hannah	Croydon, NH hannah@coniston.org	A Member of the Public	Myself	Support	No	No	·

Testimony

SB 133
Testimony

...divided into 3 separate
saved
Testimony files

(see separate scanned file for all individual emailed testimony)

Bill as Introduced

SB 133-FN - AS AMENDED BY THE SENATE

03/18/2021 0779s

2021 SESSION

21-0964
05/04

SENATE BILL ***133-FN***

AN ACT adopting omnibus legislation relative to occupational licensure.

SPONSORS: Sen. Carson, Dist 14

COMMITTEE: Executive Departments and Administration

AMENDED ANALYSIS

This bill adopts legislation relative to:

I. Licensing places of assembly.

II. Repealing the emergency medical services personnel licensure interstate compact.

III. Hearings at the board of nursing.

IV. Membership of the professional standards board.

V. Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

VI. Licensure and regulation of music therapists.

VII. The authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

VIII. Skilled professional medical personnel.

IX. Temporary licensure of certain licensed nursing assistants.

X. The revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

XI. Schools for barbering, cosmetology, and esthetics.

XII. Telemedicine provided by out of state psychologists.

XIII. Sanitary production and distribution of food.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT adopting omnibus legislation relative to occupational licensure.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 Sponsorship. This act consists of the following proposed legislation:
2 Part I: LSR 21-0964, relative to the definition of "licensing agency" for purposes of licensing
3 places of assembly, sponsored by Sen. Carson, Prime/Dist 14.
4 Part II: LSR 21-0506, repealing the emergency medical services personnel licensure
5 interstate compact, sponsored by Sen. Rosenwald, Prime/Dist 13, Sen. Cavanaugh, Dist 16; Sen.
6 Carson, Dist 14; Rep. Goley, Hills. 8; Rep. Milz, Rock. 6; Rep. O'Brien, Hills. 36; Rep. S. Pearson,
7 Rock. 6.
8 Part III: LSR 21-0207, relative to hearings of the New Hampshire board of nursing,
9 sponsored by Sen. Ward, Prime/Dist 8.
10 Part IV: LSR 21-0838, relative to membership of the professional standards board,
11 sponsored by Sen. Kahn, Prime/Dist 10; Sen. Prentiss, Dist 5.
12 Part V: LSR 21-0846, adopting the Audiology and Speech-Language Pathology Compact and
13 the Occupational Therapy Licensure Compact, sponsored by Sen. Sherman, Prime/Dist 24; Sen.
14 Soucy, Dist 18; Sen. Carson, Dist 14; Rep. March, Carr. 8.
15 Part VI: LSR 21-0859, relative to the licensure and regulation of music therapists, sponsored
16 by Sen. Avard, Prime/Dist 12; Sen. Watters, Dist 4; Sen. Carson, Dist 14; Sen. Reagan, Dist 17; Sen.
17 Kahn, Dist 10; Sen. Sherman, Dist 24; Sen. Prentiss, Dist 5; Sen. Perkins Kwoka, Dist 21; Rep.
18 McGhee, Hills. 27.
19 Part VII: LSR 21-0899, relative to the authority of the office of professional licensure and
20 certification for administration, rulemaking, and enforcement of investigations, hearings, and
21 appeals, sponsored by Sen. Reagan, Prime/ Dist 17, Sen. Carson, Dist 14; Sen. French, Dist 7; Sen.
22 Kahn, Dist 10; Sen. Prentiss, Dist 5; Sen. Rosenwald, Dist 13; Sen. Bradley, Dist 3; Sen.
23 D'Allesandro, Dist 20; Sen. Ward, Dist 8; Sen. Soucy, Dist 18; Sen. Giuda, Dist 2; Rep. Spillane,
24 Rock. 2; Rep. McGuire, Merr. 29; Rep. Seaworth, Merr. 20.
25 Part VIII: LSR 21-0928, relative to skilled professional medical personnel, sponsored by Sen.
26 Ward, Prime/Dist 8.
27 Part IX: LSR 21-0973, relative to temporary licensure of certain licensed nursing assistants,
28 sponsored by Sen. Hennessey, Dist 1; Sen. Rosenwald, Dist 13; Rep. Dostie, Coos 1; Rep. Thompson,
29 Coos 1.

1 Part X: LSR 21-1011, relative to the revocation of licensure for licensed emergency medical
2 service units and emergency medical service vehicles, sponsored by Sen. Prentiss, Prime/Dist 5; Rep.
3 Merchant, Sull. 4; Rep. Goley, Hills. 8; Rep. McGuire, Merr. 29.
4 Part XI: LSR 21-1050, relative to schools for barbering, cosmetology, and esthetics,
5 sponsored by Sen. Reagan, Prime/Dist 17; Sen. Rosenwald, Dist 13; Sen. Prentiss, Dist 5; Sen.
6 Carson, Dist 14; Sen. Bradley, Dist 3; Sen. D'Allesandro, Dist 20; Sen. Gannon, Dist 23; Rep.
7 McGuire, Merr. 29; Rep. Roy, Rock. 32; Rep. Harrington, Straf. 3.
8 Part XII: LSR 21-0277, relative to telemedicine provided by out of state psychologists,
9 sponsored by Sen. Reagan, Prime/Dist 17; Sen. Carson, Dist 14; Sen. Bradley, Dist 3; Sen. Prentiss,
10 Dist 5; Sen. French, Dist 7; Sen. Giuda, Dist 2; Sen. Hennessey, Dist 1; Sen. D'Allesandro, Dist 20;
11 Rep. Spillane, Rock. 2; Rep. Tudor, Rock. 1.
12 Part XIII: LSR 21-1049, establishing program rules within the department of health and
13 human services for sanitary production and distribution of food, sponsored by Sen. Giuda,
14 Prime/Dist 2; Sen. Gannon, Dist 23.
15 2 Legislation Enacted. The general court hereby enacts the following legislation:
16 PART I
17 Relative to the definition of "licensing agency" for purposes of licensing places of assembly.
18 1 Places of Assembly; Definition of Licensing Agency. Amend RSA 155:17, II to read as follows:
19 II. "Licensing agency" shall mean the chief of the fire department, the firewards or
20 engineers, if any, otherwise the selectmen of the town or the commissioners of village district as the
21 case may be***, or the state fire marshal, as he or she deems necessary, in consultation with the***
22 ***local licensing agency, if any***.
23 2 Places of Assembly; License Required. Amend RSA 155:18 to read as follows:
24 155:18 License Required. No person shall own or operate a place of assembly within this state
25 unless licensed so to do by the licensing agency of the ***state,*** city, town, or village district where said
26 place of assembly is located, including assemblies occurring on state waters or ice formed on state
27 waters, in accordance with the regulations herein promulgated. In the application of this act to
28 existing places of assembly the licensing agency may modify such of its provisions as would require
29 structural changes if in his or her opinion adequate safety may be obtained otherwise and provided
30 that a permanent record is kept of such modifications and the reasons therefor.
31 3 Effective Date. Part I of this act shall take effect 60 days after its passage.
32 PART II
33 Repealing the emergency medical services personnel licensure interstate compact.
34 1 Repeal. The following are repealed:
35 I. RSA 153-A:36 and the subdivision heading preceding RSA 153-A:36, relative to the
36 emergency medical services personnel licensure interstate compact.

1 II. RSA 153-A:20, XXIV, relative to rulemaking by the department of safety regarding
2 implementation of the compact.
3 2 Effective Date. Part II of this act shall take effect 60 days after its passage.
4 PART III
5 Relative to hearings of the New Hampshire board of nursing.
6 1 Board of Nursing; Adjudicative Hearings. Amend 326-B:38, VIII to read as follows:
7 VIII. The board may hold adjudicative hearings concerning allegations of misconduct or
8 other matters within the scope of this chapter. Such hearings shall be public proceedings. Any
9 member of the board [~~other than the public members~~], or any other qualified person appointed by the
10 board, shall have authority to preside at such a hearing and to issue oaths or affirmations to
11 witnesses.
12 2 Effective Date. Part III of this act shall take effect upon its passage.
13 PART IV
14 Relative to membership of the professional standards board.
15 1 State School Organization; Professional Standards Board. Amend RSA 186:60, I(c) to read as
16 follows:
17 (c) 9 members***, 3*** representing higher education and ***6 representing*** education
18 administration; and
19 2 Professional Standards Board. Amend RSA 186:60, III to read as follows:
20 III. The appointed members of the board shall serve for 3-year terms and may not serve for
21 more than 2 ***consecutive*** full terms.
22 3 Effective Date. Part IV of this act shall take effect 60 days after its passage.
23 PART V
24 Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy
25 Licensure Compact.
26 1 Chapter Heading Amended; Occupational Compacts. Amend the chapter heading of RSA 329-
27 D to read as follows:
28 [~~PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT)~~]
29 ***OCCUPATIONAL COMPACTS***
30 2 New Sections; .Audiology and Speech-Language Pathology Compact; Occupational Therapy
31 Licensure Compact. Amend RSA 329-D by inserting after section 1 the following new sections:
32 329-D:2 Interstate Compact Adopted. The state of New Hampshire hereby adopts the provisions
33 of the Audiology and Speech-Language Pathology Compact as follows:
34 SECTION 1. PURPOSE
35 The purpose of this Compact is to facilitate interstate practice of audiology and speech-language
36 pathology with the goal of improving public access to audiology and speech-language pathology
37 services. The practice of audiology and speech-language pathology occurs in the state where the

patient/client/student is located at the time of the patient/client/student encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other member state licenses;

2. Enhance the states' ability to protect the public's health and safety;

3. Encourage the cooperation of member states in regulating multistate audiology and speech-language pathology practice;

4. Support spouses of relocating active duty military personnel;

5. Enhance the exchange of licensure, investigative and disciplinary information between member states;

6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards; and

7. Allow for the use of telehealth technology to facilitate increased access to audiology and speech-language pathology services.

326-F:15 Interstate Compact Adopted. The state of New Hampshire hereby adopts the provisions of the Audiology and Speech-Language Pathology Compact as follows:

SECTION 1: PURPOSE

The purpose of this Compact is to facilitate interstate practice of audiology and speech-language pathology with the goal of improving public access to audiology and speech-language pathology services. The practice of audiology and speech-language pathology occurs in the state where the patient/client/student is located at the time of the patient/client/student encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other member state licenses;

2. Enhance the states' ability to protect the public's health and safety;

3. Encourage the cooperation of member states in regulating multistate audiology and speech-language pathology practice;

4. Support spouses of relocating active duty military personnel;

5. Enhance the exchange of licensure, investigative and disciplinary information between member states;

6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards; and

1 7. Allow for the use of telehealth technology to facilitate increased access to audiology and
2 speech-language pathology services.
3 SECTION 2. DEFINITIONS
4 As used in this Compact, and except as otherwise provided, the following definitions shall apply:
5 A. "Active duty military" means full-time duty status in the active uniformed service of the
6 United States, including members of the National Guard and Reserve on active duty orders
7 pursuant to 10 U.S.C. Chapter 1209 and 10 U.S.C Chapter 1211.
8 B. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a
9 state's laws which is imposed by a licensing board or other authority against an audiologist or
10 speech-language pathologist, including actions against an individual's license or privilege to practice
11 such as revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee's
12 practice.
13 C. "Alternative program" means a non-disciplinary monitoring process approved by an audiology
14 or speech-language pathology licensing board to address impaired practitioners.
15 D. "Audiologist" means an individual who is licensed by a state to practice audiology.
16 E. "Audiology" means the care and services provided by a licensed audiologist as set forth in the
17 member state's statutes and rules.
18 F. "Audiology and Speech-Language Pathology Compact Commission" or "Commission" means
19 the national administrative body whose membership consists of all states that have enacted the
20 Compact.
21 G. "Audiology and speech-language pathology licensing board," "audiology licensing board,"
22 "speech-language pathology licensing board," or "licensing board" means the agency of a state that is
23 responsible for the licensing and regulation of audiologists and/or speech-language pathologists.
24 H. "Compact privilege" means the authorization granted by a remote state to allow a licensee
25 from another member state to practice as an audiologist or speech-language pathologist in the
26 remote state under its laws and rules. The practice of audiology or speech-language pathology
27 occurs in the member state where the patient/client/student is located at the time of the
28 patient/client/student encounter.
29 I. "Current significant investigative information" means investigative information that a
30 licensing board, after an inquiry or investigation that includes notification and an opportunity for
31 the audiologist or speech-language pathologist to respond, if required by state law, has reason to
32 believe is not groundless and, if proved true, would indicate more than a minor infraction.
33 J. "Data system" means a repository of information about licensees, including, but not limited
34 to, continuing education, examination, licensure, investigative, compact privilege and adverse action.
35 K. "Encumbered license" means a license in which an adverse action restricts the practice of
36 audiology or speech-language pathology by the licensee and said adverse action has been reported to
37 the National Practitioners Data Bank (NPDB).

1 L. "Executive committee" means a group of directors elected or appointed to act on behalf of, and
2 within the powers granted to them by, the Commission.
3 M. "Home state" means the member state that is the licensee's primary state of residence.
4 N. "Impaired practitioner" means individuals whose professional practice is adversely affected
5 by substance abuse, addiction, or other health-related conditions.
6 O. "Licensee" means an individual who currently holds an authorization from the state licensing
7 board to practice as an audiologist or speech-language pathologist.
8 P. "Member state" means a state that has enacted the Compact.
9 Q. "Privilege to practice" means a legal authorization permitting the practice of audiology or
10 speech-language pathology in a remote state.
11 R. "Remote state" means a member state other than the home state where a licensee is
12 exercising or seeking to exercise the compact privilege.
13 S. "Rule" means a regulation, principle or directive promulgated by the Commission that has the
14 force of law.
15 T. "Single-state license" means an audiology or speech-language pathology license issued by a
16 member state that authorizes practice only within the issuing state and does not include a privilege
17 to practice in any other member state.
18 U. "Speech-language pathologist" means an individual who is licensed by a state to practice
19 speech-language pathology.
20 V. "Speech-language pathology means the care and services provided by a licensed speech-
21 language pathologist as set forth in the member state's statutes and rules.
22 W. "State" means any state, commonwealth, district or territory of the United States of America
23 that regulates the practice of audiology and speech-language pathology.
24 X. "State practice laws" means a member state's laws, rules and regulations that govern the
25 practice of audiology or speech-language pathology, define the scope of audiology or speech-language
26 pathology practice, and create the methods and grounds for imposing discipline.
27 Y. "Telehealth" means the application of telecommunication technology to deliver audiology or
28 speech-language pathology services at a distance for assessment, intervention and/or consultation.
29 SECTION 3. STATE PARTICIPATION IN THE COMPACT
30 A. A license issued to an audiologist or speech-language pathologist by a home state to a
31 resident in that state shall be recognized by each member state as authorizing an audiologist or
32 speech-language pathologist to practice audiology or speech-language pathology, under a privilege to
33 practice, in each member state.
34 B. A state must implement or utilize procedures for considering the criminal history records of
35 applicants for initial privilege to practice. These procedures shall include the submission of
36 fingerprints or other biometric-based information by applicants for the purpose of obtaining an

1 applicant's criminal history record information from the Federal Bureau of Investigation and the
2 agency responsible for retaining that state's criminal records

3 1. A member state must fully implement a criminal background check requirement, within a
4 time frame established by rule, by receiving the results of the Federal Bureau of Investigation record
5 search on criminal background checks and use the results in making licensure decisions.

6 2. Communication between a member state, the Commission and among member states
7 regarding the verification of eligibility for licensure through the Compact shall not include any
8 information received from the Federal Bureau of Investigation relating to a federal criminal records
9 check performed by a member state under Public Law 92-544.

10 C. Upon application for a privilege to practice, the licensing board in the issuing remote state
11 shall ascertain, through the data system, whether the applicant has ever held, or is the holder of, a
12 license issued by any other state, whether there are any encumbrances on any license or privilege to
13 practice held by the applicant, whether any adverse action has been taken against any license or
14 privilege to practice held by the applicant.

15 D. Each member state shall require an applicant to obtain or retain a license in the home state
16 and meet the home state's qualifications for licensure or renewal of licensure, as well as, all other
17 applicable state laws.

18 E. For an audiologist:

19 1. Must meet one of the following educational requirements:

20 a. On or before, Dec. 31, 2007, has graduated with a master's degree or doctorate in audiology,
21 or equivalent degree regardless of degree name, from a program that is accredited by an accrediting
22 agency recognized by the Council for Higher Education Accreditation, or its successor, or by the
23 United States Department of Education and operated by a college or university accredited by a
24 regional or national accrediting organization recognized by the board; or

25 b. On or after, Jan. 1, 2008, has graduated with a Doctoral degree in audiology, or equivalent
26 degree, regardless of degree name, from a program that is accredited by an accrediting agency
27 recognized by the Council for Higher Education Accreditation, or its successor, or by the United
28 States Department of Education and operated by a college or university accredited by a regional or
29 national accrediting organization recognized by the board; or

30 c. Has graduated from an audiology program that is housed in an institution of higher education
31 outside of the United States (a) for which the program and institution have been approved by the
32 authorized accrediting body in the applicable country and (b) the degree program has been verified
33 by an independent credentials review agency to be comparable to a state licensing board-approved
34 program.

35 2. Has completed a supervised clinical practicum experience from an accredited educational
36 institution or its cooperating programs as required by the commission;

37 3. Has successfully passed a national examination approved by the Commission;

1 4. Holds an active, unencumbered license;
2 5. Has not been convicted or found guilty, and has not entered into an agreed disposition, of a
3 felony related to the practice of audiology, under applicable state or federal criminal law;
4 6. Has a valid United States Social Security or National Practitioner Identification number.
5 F. For a speech-language pathologist:
6 1. Must meet one of the following educational requirements:
7 a. Has graduated with a master's degree from a speech-language pathology program that is
8 accredited by an organization recognized by the United States Department of Education and
9 operated by a college or university accredited by a regional or national accrediting organization
10 recognized by the board; or
11 b. Has graduated from a speech-language pathology program that is housed in an institution of
12 higher education outside of the United States (a) for which the program and institution have been
13 approved by the authorized accrediting body in the applicable country and (b) the degree program
14 has been verified by an independent credentials review agency to be comparable to a state licensing
15 board-approved program.
16 2. Has completed a supervised clinical practicum experience from an educational institution or
17 its cooperating programs as required by the Commission;
18 3. Has completed a supervised postgraduate professional experience as required by the
19 Commission
20 4. Has successfully passed a national examination approved by the Commission;
21 5. Holds an active, unencumbered license;
22 6. Has not been convicted or found guilty, and has not entered into an agreed disposition, of a
23 felony related to the practice of speech-language pathology, under applicable state or federal
24 criminal law;
25 7. Has a valid United States Social Security or National Practitioner Identification number.
26 G. The privilege to practice is derived from the home state license.
27 H. An audiologist or speech-language pathologist practicing in a member state must comply
28 with the state practice laws of the state in which the client is located at the time service is provided.
29 The practice of audiology and speech-language pathology shall include all audiology and speech-
30 language pathology practice as defined by the state practice laws of the member state in which the
31 client is located. The practice of audiology and speech-language pathology in a member state under
32 a privilege to practice shall subject an audiologist or speech-language pathologist to the jurisdiction
33 of the licensing board, the courts and the laws of the member state in which the client is located at
34 the time service is provided.
35 I. Individuals not residing in a member state shall continue to be able to apply for a member
36 state's single-state license as provided under the laws of each member state. However, the single-
37 state license granted to these individuals shall not be recognized as granting the privilege to practice

audiology or speech-language pathology in any other member state. Nothing in this Compact shall affect the requirements established by a member state for the issuance of a single-state license.

J. Member states may charge a fee for granting a compact privilege.

K. Member states must comply with the bylaws and rules and regulations of the Commission.

SECTION 4. COMPACT PRIVILEGE

A. To exercise the compact privilege under the terms and provisions of the Compact, the audiologist or speech-language pathologist shall:

1. Hold an active license in the home state;

2. Have no encumbrance on any state license;

3. Be eligible for a compact privilege in any member state in accordance with Section 3;

4. Have not had any adverse action against any license or compact privilege within the previous 2 years from date of application;

5. Notify the Commission that the licensee is seeking the compact privilege within a remote state(s);

6. Pay any applicable fees, including any state fee, for the compact privilege;

7. Report to the Commission adverse action taken by any non-member state within 30 days from the date the adverse action is taken.

B. For the purposes of the compact privilege, an audiologist or speech-language pathologist shall only hold one home state license at a time.

C. Except as provided in Section 6, if an audiologist or speech-language pathologist changes primary state of residence by moving between two-member states, the audiologist or speech-language pathologist must apply for licensure in the new home state, and the license issued by the prior home state shall be deactivated in accordance with applicable rules adopted by the Commission.

D. The audiologist or speech-language pathologist may apply for licensure in advance of a change in primary state of residence.

E. A license shall not be issued by the new home state until the audiologist or speech-language pathologist provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a license from the new home state.

F. If an audiologist or speech-language pathologist changes primary state of residence by moving from a member state to a non-member state, the license issued by the prior home state shall convert to a single-state license, valid only in the former home state.

G. The compact privilege is valid until the expiration date of the home state license. The licensee must comply with the requirements of Section 4A to maintain the compact privilege in the remote state.

H. A licensee providing audiology or speech-language pathology services in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

1 I. A licensee providing audiology or speech-language pathology services in a remote state is
2 subject to that state's regulatory authority. A remote state may, in accordance with due process and
3 that state's laws, remove a licensee's compact privilege in the remote state for a specific period of
4 time, impose fines, and/or take any other necessary actions to protect the health and safety of its
5 citizens.
6 J. If a home state license is encumbered, the licensee shall lose the compact privilege in any
7 remote state until the following occur:
8 1. The home state license is no longer encumbered; and
9 2. Two years have elapsed from the date of the adverse action.
10 K. Once an encumbered license in the home state is restored to good standing, the licensee must
11 meet the requirements of Section 4A to obtain a compact privilege in any remote state.
12 L. Once the requirements of Section 4J have been met, the licensee must meet the requirements
13 in Section 4A to obtain a compact privilege in a remote state.
14 SECTION 5. COMPACT PRIVILEGE TO PRACTICE TELEHEALTH
15 Member states shall recognize the right of an audiologist or speech-language pathologist, licensed by
16 a home state in accordance with Section 3 and under rules promulgated by the Commission, to
17 practice audiology or speech-language pathology in any member state via telehealth under a
18 privilege to practice as provided in the Compact and rules promulgated by the Commission.
19 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES
20 Active duty military personnel, or their spouse, shall designate a home state where the individual
21 has a current license in good standing. The individual may retain the home state designation during
22 the period the service member is on active duty. Subsequent to designating a home state, the
23 individual shall only change their home state through application for licensure in the new state.
24 SECTION 7. ADVERSE ACTIONS
25 A. In addition to the other powers conferred by state law, a remote state shall have the
26 authority, in accordance with existing state due process law, to:
27 1. Take adverse action against an audiologist's or speech-language pathologist's privilege to
28 practice within that member state.
29 2. Issue subpoenas for both hearings and investigations that require the attendance and
30 testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board
31 in a member state for the attendance and testimony of witnesses or the production of evidence from
32 another member state shall be enforced in the latter state by any court of competent jurisdiction,
33 according to the practice and procedure of that court applicable to subpoenas issued in proceedings
34 pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and
35 other fees required by the service statutes of the state in which the witnesses or evidence are
36 located.

1 3. Only the home state shall have the power to take adverse action against a audiologist's or
2 speech-language pathologist's license issued by the home state.
3 B. For purposes of taking adverse action, the home state shall give the same priority and effect
4 to reported conduct received from a member state as it would if the conduct had occurred within the
5 home state. In so doing, the home state shall apply its own state laws to determine appropriate
6 action.
7 C. The home state shall complete any pending investigations of an audiologist or speech-
8 language pathologist who changes primary state of residence during the course of the investigations.
9 The home state shall also have the authority to take appropriate action(s) and shall promptly report
10 the conclusions of the investigations to the administrator of the data system. The administrator of
11 the coordinated licensure information system shall promptly notify the new home state of any
12 adverse actions.
13 D. If otherwise permitted by state law, the member state may recover from the affected
14 audiologist or speech-language pathologist the costs of investigations and disposition of cases
15 resulting from any adverse action taken against that audiologist or speech-language pathologist.
16 E. The member state may take adverse action based on the factual findings of the remote state,
17 provided that the member state follows the member state's own procedures for taking the adverse
18 action.
19 F. Joint Investigations
20 1. In addition to the authority granted to a member state by its respective audiology or speech-
21 language pathology practice act or other applicable state law, any member state may participate
22 with other member states in joint investigations of licensees.
23 2. Member states shall share any investigative, litigation, or compliance materials in
24 furtherance of any joint or individual investigation initiated under the Compact.
25 G. If adverse action is taken by the home state against an audiologist's or speech language
26 pathologist's license, the audiologist's or speech-language pathologist's privilege to practice in all
27 other member states shall be deactivated until all encumbrances have been removed from the state
28 license. All home state disciplinary orders that impose adverse action against an audiologist's or
29 speech language pathologist's license shall include a statement that the audiologist's or speech-
30 language pathologist's privilege to practice is deactivated in all member states during the pendency
31 of the order.
32 H. If a member state takes adverse action, it shall promptly notify the administrator of the data
33 system. The administrator of the data system shall promptly notify the home state of any adverse
34 actions by remote states.
35 I. Nothing in this Compact shall override a member state's decision that participation in an
36 alternative program may be used in lieu of adverse action.

1 SECTION 8. ESTABLISHMENT OF THE AUDIOLOGY AND SPEECH-LANGUAGE
2 PATHOLOGY COMPACT COMMISSION
3 A. The Compact member states hereby create and establish a joint public agency known as the
4 Audiology and Speech-Language Pathology Compact Commission:
5 1. The Commission is an instrumentality of the Compact states.
6 2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely
7 and exclusively in a court of competent jurisdiction where the principal office of the Commission is
8 located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or
9 consents to participate in alternative dispute resolution proceedings.
10 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
11 B. Membership, Voting and Meetings
12 1. Each member state shall have two (2) delegates selected by that member state's licensing
13 board. The delegates shall be current members of the licensing board. One shall be an audiologist
14 and one shall be a speech-language pathologist.
15 2. An additional five (5) delegates, who are either a public member or board administrator from
16 a state licensing board, shall be chosen by the Executive Committee from a pool of nominees
17 provided by the Commission at Large.
18 3. Any delegate may be removed or suspended from office as provided by the law of the state
19 from which the delegate is appointed.
20 4. The member state board shall fill any vacancy occurring on the Commission, within 90 days.
21 5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and
22 creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs
23 of the Commission.
24 6. A delegate shall vote in person or by other means as provided in the bylaws. The bylaws may
25 provide for delegates' participation in meetings by telephone or other means of communication.
26 7. The Commission shall meet at least once during each calendar year. Additional meetings
27 shall be held as set forth in the bylaws.
28 C. The Commission shall have the following powers and duties:
29 1. Establish the fiscal year of the Commission;
30 2. Establish bylaws;
31 3. Establish a Code of Ethics;
32 4. Maintain its financial records in accordance with the bylaws;
33 5. Meet and take actions as are consistent with the provisions of this Compact and the bylaws;
34 6. Promulgate uniform rules to facilitate and coordinate implementation and administration of
35 this Compact. The rules shall have the force and effect of law and shall be binding in all member
36 states;

1 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided
2 that the standing of any state audiology or speech-language pathology licensing board to sue or be
3 sued under applicable law shall not be affected;
4 8. Purchase and maintain insurance and bonds;
5 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees
6 of a member state;
7 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant individuals
8 appropriate authority to carry out the purposes of the Compact, and to establish the Commission's
9 personnel policies and programs relating to conflicts of interest, qualifications of personnel, and
10 other related personnel matters;
11 11. Accept any and all appropriate donations and grants of money, equipment, supplies,
12 materials and services, and to receive, utilize and dispose of the same; provided that at all times the
13 Commission shall avoid any appearance of impropriety and/or conflict of interest;
14 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve
15 or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid
16 any appearance of impropriety;
17 13. Sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any
18 property real, personal, or mixed;
19 14. Establish a budget and make expenditures;
20 15. Borrow money;
21 16. Appoint committees, including standing committees composed of members, and other
22 interested persons as may be designated in this Compact and the bylaws;
23 17. Provide and receive information from, and cooperate with, law enforcement agencies;
24 18. Establish and elect an Executive Committee; and
25 19. Perform other functions as may be necessary or appropriate to achieve the purposes of this
26 Compact consistent with the state regulation of audiology and speech-language pathology licensure
27 and practice.
28 D. The Executive Committee
29 The Executive Committee shall have the power to act on behalf of the Commission according to the
30 terms of this Compact:
31 1. The Executive Committee shall be composed of ten (10) members:
32 a. Seven (7) voting members who are elected by the Commission from the current membership
33 of the Commission;
34 b. Two (2) ex-officios, consisting of one nonvoting member from a recognized national audiology
35 professional association and one nonvoting member from a recognized national speech-language
36 pathology association; and

c. One (1) ex-officio, nonvoting member from the recognized membership organization of the audiology and speech-language pathology licensing boards.

E. The ex-officio members shall be selected by their respective organizations.

1. The Commission may remove any member of the Executive Committee as provided in bylaws.

2. The Executive Committee shall meet at least annually.

3. The Executive Committee shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact legislation, fees paid by Compact member states such as annual dues, and any commission Compact fee charged to licensees for the compact privilege;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in rules or bylaws.

4. Meetings of the Commission

All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section 10.

5. The Commission or the Executive Committee or other committees of the Commission may convene in a closed, non-public meeting if the Commission or Executive Committee or other committees of the Commission must discuss:

a. Non-compliance of a member state with its obligations under the Compact;

b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigative records compiled for law enforcement purposes;

1 i. Disclosure of information related to any investigative reports prepared by or on behalf of or for
2 use of the Commission or other committee charged with responsibility of investigation or
3 determination of compliance issues pursuant to the Compact; or
4 j. Matters specifically exempted from disclosure by federal or member state statute.
5 6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's
6 legal counsel or designee shall certify that the meeting may be closed and shall reference each
7 relevant exempting provision.
8 7. The Commission shall keep minutes that fully and clearly describe all matters discussed in a
9 meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore,
10 including a description of the views expressed. All documents considered in connection with an
11 action shall be identified in minutes. All minutes and documents of a closed meeting shall remain
12 under seal, subject to release by a majority vote of the Commission or order of a court of competent
13 jurisdiction.
14 8. Financing of the Commission
15 a. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
16 establishment, organization, and ongoing activities.
17 b. The Commission may accept any and all appropriate revenue sources, donations, and grants
18 of money, equipment, supplies, materials, and services.
19 c. The Commission may levy on and collect an annual assessment from each member state or
20 impose fees on other parties to cover the cost of the operations and activities of the Commission and
21 its staff, which must be in a total amount sufficient to cover its annual budget as approved each year
22 for which revenue is not provided by other sources. The aggregate annual assessment amount shall
23 be allocated based upon a formula to be determined by the Commission, which shall promulgate a
24 rule binding upon all member states.
25 9. The Commission shall not incur obligations of any kind prior to securing the funds adequate
26 to meet the same; nor shall the Commission pledge the credit of any of the member states, except by
27 and with the authority of the member state.
28 10. The Commission shall keep accurate accounts of all receipts and disbursements. The
29 receipts and disbursements of the Commission shall be subject to the audit and accounting
30 procedures established under its bylaws. However, all receipts and disbursements of funds handled
31 by the Commission shall be audited yearly by a certified or licensed public accountant, and the
32 report of the audit shall be included in and become part of the annual report of the Commission.
33 F. Qualified Immunity, Defense, and Indemnification
34 1. The members, officers, executive director, employees and representatives of the Commission
35 shall be immune from suit and liability, either personally or in their official capacity, for any claim
36 for damage to or loss of property or personal injury or other civil liability caused by or arising out of
37 any actual or alleged act, error or omission that occurred, or that the person against whom the claim

1 is made had a reasonable basis for believing occurred within the scope of Commission employment,
2 duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any
3 person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or
4 willful or wanton misconduct of that person.

5 2. The Commission shall defend any member, officer, executive director, employee or
6 representative of the Commission in any civil action seeking to impose liability arising out of any
7 actual or alleged act, error, or omission that occurred within the scope of Commission employment,
8 duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis
9 for believing occurred within the scope of Commission employment, duties, or responsibilities;
10 provided that nothing herein shall be construed to prohibit that person from retaining his or her own
11 counsel; and provided further, that the actual or alleged act, error, or omission did not result from
12 that person's intentional or willful or wanton misconduct.

13 3. The Commission shall indemnify and hold harmless any member, officer, executive director,
14 employee, or representative of the Commission for the amount of any settlement or judgment
15 obtained against that person arising out of any actual or alleged act, error or omission that occurred
16 within the scope of Commission employment, duties, or responsibilities, or that person had a
17 reasonable basis for believing occurred within the scope of Commission employment, duties, or
18 responsibilities, provided that the actual or alleged act, error, or omission did not result from the
19 intentional or willful or wanton misconduct of that person.

20 SECTION 9. DATA SYSTEM

21 A. The Commission shall provide for the development, maintenance, and utilization of a
22 coordinated database and reporting system containing licensure, adverse action, and investigative
23 information on all licensed individuals in member states.

24 B. Notwithstanding any other provision of state law to the contrary, a member state shall
25 submit a uniform data set to the data system on all individuals to whom this Compact is applicable
26 as required by the rules of the Commission, including:

27 1. Identifying information;

28 2. Licensure data;

29 3. Adverse actions against a license or compact privilege;

30 4. Non-confidential information related to alternative program participation;

31 5. Any denial of application for licensure, and the reason(s) for denial; and

32 6. Other information that may facilitate the administration of this Compact, as determined by
33 the rules of the Commission.

34 C. Investigative information pertaining to a licensee in any member state shall only be available
35 to other member states.

1 D. The Commission shall promptly notify all member states of any adverse action taken against
2 a licensee or an individual applying for a license. Adverse action information pertaining to a licensee
3 in any member state shall be available to any other member state.
4 E. Member states contributing information to the data system may designate information that
5 may not be shared with the public without the express permission of the contributing state.
6 F. Any information submitted to the data system that is subsequently required to be expunged
7 by the laws of the member state contributing the information shall be removed from the data
8 system.
9 SECTION 10. RULEMAKING
10 A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in
11 this Section and the rules adopted thereunder. Rules and amendments shall become binding as of
12 the date specified in each rule or amendment.
13 B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute
14 or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
15 the rule, the rule shall have no further force and effect in any member state.
16 C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the
17 Commission.
18 D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least
19 thirty (30) days in advance of the meeting at which the rule shall be considered and voted upon, the
20 Commission shall file a Notice of Proposed Rulemaking:
21 1. On the website of the Commission or other publicly accessible platform; and
22 2. On the website of each member state audiology or speech-language pathology licensing board
23 or other publicly accessible platform or the publication in which each state would otherwise publish
24 proposed rules.
25 E. The Notice of Proposed Rulemaking shall include:
26 1. The proposed time, date, and location of the meeting in which the rule shall be considered and
27 voted upon;
28 2. The text of the proposed rule or amendment and the reason for the proposed rule;
29 3. A request for comments on the proposed rule from any interested person; and
30 4. The manner in which interested persons may submit notice to the Commission of their
31 intention to attend the public hearing and any written comments.
32 F. Prior to the adoption of a proposed rule, the Commission shall allow persons to submit
33 written data, facts, opinions and arguments, which shall be made available to the public.
34 G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or
35 amendment if a hearing is requested by:
36 1. At least twenty-five (25) persons;
37 2. A state or federal governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings shall be recorded. A copy of the recording shall be made available on request.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

K. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds; or

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the

1 revision shall take effect without further action. If the revision is challenged, the revision may not
2 take effect without the approval of the Commission.
3 SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT
4 A. Dispute Resolution
5 1. Upon request by a member state, the Commission shall attempt to resolve disputes related to
6 the Compact that arise among member states and between member and non-member states.
7 2. The Commission shall promulgate a rule providing for both mediation and binding dispute
8 resolution for disputes as appropriate.
9 B. Enforcement
10 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
11 rules of this Compact.
12 2. By majority vote, the Commission may initiate legal action in the United States District
13 Court for the District of Columbia or the federal district where the Commission has its principal
14 offices against a member state in default to enforce compliance with the provisions of the Compact
15 and its promulgated rules and bylaws. The relief sought may include both injunctive relief and
16 damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all
17 costs of litigation, including reasonable attorney's fees.
18 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
19 may pursue any other remedies available under federal or state law.
20 SECTION 12. DATE OF IMPLEMENTATION OF THE INTERstate COMMISSION FOR
21 AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY PRACTICE AND ASSOCIATED RULES,
22 WITHDRAWAL, AND AMENDMENT
23 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
24 law in the 10th member state. The provisions, which become effective at that time, shall be limited
25 to the powers granted to the Commission relating to assembly and the promulgation of rules.
26 Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the
27 implementation and administration of the Compact.
28 B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules
29 shall be subject to the rules as they exist on the date on which the Compact becomes law in that
30 state. Any rule that has been previously adopted by the Commission shall have the full force and
31 effect of law on the day the Compact becomes law in that state.
32 C. Any member state may withdraw from this Compact by enacting a statute repealing the
33 same.
34 1. A member state's withdrawal shall not take effect until six (6) months after enactment of the
35 repealing statute.

1 2. Withdrawal shall not affect the continuing requirement of the withdrawing state's audiology
2 or speech-language pathology licensing board to comply with the investigative and adverse action
3 reporting requirements of this act prior to the effective date of withdrawal.
4 D. Nothing contained in this Compact shall be construed to invalidate or prevent any audiology
5 or speech-language pathology licensure agreement or other cooperative arrangement between a
6 member state and a non-member state that does not conflict with the provisions of this Compact.
7 E. This Compact may be amended by the member states. No amendment to this Compact shall
8 become effective and binding upon any member state until it is enacted into the laws of all member
9 states.
10 SECTION 13. CONSTRUCTION AND SEVERABILITY
11 This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of
12 this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is
13 declared to be contrary to the constitution of any member state or of the United States or the
14 applicability thereof to any government, agency, person or circumstance is held invalid, the validity
15 of the remainder of this Compact and the applicability thereof to any government, agency, person or
16 circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution
17 of any member state, the Compact shall remain in full force and effect as to the remaining member
18 states and in full force and effect as to the member state affected as to all severable matters.
19 SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS
20 A. Nothing herein prevents the enforcement of any other law of a member state that is not
21 inconsistent with the Compact.
22 B. All laws in a member state in conflict with the Compact are superseded to the extent of the
23 conflict.
24 C. All lawful actions of the Commission, including all rules and bylaws promulgated by the
25 Commission, are binding upon the member states.
26 D. All agreements between the Commission and the member states are binding in accordance
27 with their terms.
28 E. In the event any provision of the Compact exceeds the constitutional limits imposed on the
29 legislature of any member state, the provision shall be ineffective to the extent of the conflict with
30 the constitutional provision in question in that member state.
31 329-D:3 Occupational Therapy Licensure Compact. The state of New Hampshire hereby adopts
32 the provisions of the Occupational Therapy Licensure Compact as follows:
33 SECTION 1. PURPOSE
34 The purpose of this Compact is to facilitate interstate practice of occupational therapy with the goal
35 of improving public access to occupational therapy services. The Practice of occupational therapy
36 occurs in the state where the patient/client is located at the time of the patient/client encounter. The

1 Compact preserves the regulatory authority of states to protect public health and safety through the
2 current system of state licensure.
3 This Compact is designed to achieve the following objectives:
4 A. Increase public access to occupational therapy services by providing for the mutual
5 recognition of other member state licenses;
6 B. Enhance the states' ability to protect the public's health and safety;
7 C. Encourage the cooperation of member states in regulating multi-state occupational therapy
8 practice;
9 D. Support spouses of relocating military members;
10 E. Enhance the exchange of licensure, investigative, and disciplinary information between
11 Member states;
12 F. Allow a remote state to hold a provider of services with a Compact privilege in that state
13 accountable to that state's practice standards; and
14 G. Facilitate the use of telehealth technology in order to increase access to occupational therapy
15 services.
16 SECTION 2. DEFINITIONS
17 As used in this Compact, and except as otherwise provided, the following definitions shall apply:
18 A. "Active Duty Military" means full-time duty status in the active uniformed service of the
19 United States, including members of the National Guard and Reserve on active duty orders
20 pursuant to 10 U.S.C. Chapter 1209 and Section 1211.
21 B. "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a
22 state's laws which is imposed by a licensing board or other authority against an occupational
23 therapist or occupational therapy assistant, including actions against an individual's license or
24 Compact privilege such as censure, revocation, suspension, probation, monitoring of the licensee, or
25 restriction on the licensee's practice.
26 C. "Alternative Program" means a non-disciplinary monitoring process approved by an
27 occupational therapy licensing board.
28 D. "Compact privilege" means the authorization, which is equivalent to a license, granted by a
29 remote state to allow a licensee from another member state to practice as an occupational therapist
30 or practice as an occupational therapy assistant in the remote state under its laws and rules. The
31 practice of occupational therapy occurs in the member state where the patient/client is located at the
32 time of the patient/client encounter.
33 E. "Continuing Competence/Education" means a requirement, as a condition of license renewal,
34 to provide evidence of participation in, and/or completion of, educational and professional activities
35 relevant to practice or area of work.
36 F. "Current significant investigative information" means investigative information that a
37 licensing board, after an inquiry or investigation that includes notification and an opportunity for

1 the occupational therapist or occupational therapy assistant to respond, if required by state law, has
2 reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.
3 G. "Data system" means a repository of information about licensees, including but not limited to
4 license status, investigative information, Compact privileges, and adverse actions.
5 H. "Encumbered license" means a license in which an adverse action restricts the practice of
6 occupational therapy by the licensee or said adverse action has been reported to the National
7 Practitioners Data Bank (NPDB).
8 I. "Executive Committee" means a group of directors elected or appointed to act on behalf of, and
9 within the powers granted to them by, the Commission.
10 J. "Home state" means the member state that is the licensee's Primary state of residence.
11 K. "Impaired practitioner" means individuals whose professional practice is adversely affected
12 by substance abuse, addiction, or other health-related conditions.
13 L. "Investigative Information" means information, records, and/or documents received or
14 generated by an occupational therapy licensing board pursuant to an investigation.
15 M. "Jurisprudence requirement" means the assessment of an individual's knowledge of the laws
16 and rules governing the practice of occupational therapy in a state.
17 N. "Licensee" means an individual who currently holds an authorization from the state to
18 practice as an occupational therapist or as an occupational therapy assistant.
19 O. "Member state" means a state that has enacted the Compact.
20 P. "Occupational therapist" means an individual who is licensed by a state to practice
21 occupational therapy.
22 Q. "Occupational therapy assistant" means an individual who is licensed by a state to assist in
23 the practice of occupational therapy.
24 R. "Occupational therapy," "occupational therapy practice," and the "practice of occupational
25 therapy" mean the care and services provided by an occupational therapist or an occupational
26 therapy assistant as set forth in the member state's statutes and regulations.
27 S. "Occupational therapy Compact Commission" or "Commission" means the national
28 administrative body whose membership consists of all states that have enacted the Compact.
29 T. "Occupational therapy licensing board" or "licensing board" means the agency of a state that
30 is authorized to license and regulate occupational therapists and occupational therapy assistants.
31 U. "Primary state of residence" means the state (also known as the home state) in which an
32 occupational therapist or occupational therapy assistant who is not Active Duty Military declares a
33 primary residence for legal purposes as verified by: driver's license, federal income tax return, lease,
34 deed, mortgage or voter registration or other verifying documentation as further defined by
35 Commission rules.
36 V. "Remote state" means a member state other than the home state, where a licensee is
37 exercising or seeking to exercise the Compact privilege.

1 W. "Rule" means a regulation promulgated by the Commission that has the force of law.
2 X. "State" means any state, commonwealth, district, or territory of the United States of America
3 that regulates the practice of occupational therapy.
4 Y. "Single-state license" means an occupational therapist or occupational therapy assistant
5 license issued by a member state that authorizes practice only within the issuing state and does not
6 include a Compact privilege in any other member state.
7 Z. "Telehealth" means the application of telecommunication technology to deliver occupational
8 therapy services for assessment, intervention and/or consultation.
9 SECTION 3. STATE PARTICIPATION IN THE COMPACT
10 A. To participate in the Compact, a member state shall:
11 1. License occupational therapists and occupational therapy assistants
12 2. Participate fully in the Commission's data system, including but not limited to using the
13 Commission's unique identifier as defined in rules of the Commission;
14 3. Have a mechanism in place for receiving and investigating complaints about licensees;
15 4. Notify the Commission, in compliance with the terms of the Compact and rules, of any
16 adverse action or the availability of investigative information regarding a licensee;
17 5. Implement or utilize procedures for considering the criminal history records of applicants for
18 an initial Compact privilege. These procedures shall include the submission of fingerprints or other
19 biometric-based information by applicants for the purpose of obtaining an applicant's criminal
20 history record information from the Federal Bureau of Investigation and the agency responsible for
21 retaining that state's criminal records;
22 a. A member state shall, within a time frame established by the Commission, require a criminal
23 background check for a licensee seeking/applying for a Compact privilege whose Primary state of
24 residence is that member state, by receiving the results of the Federal Bureau of Investigation
25 criminal record search, and shall use the results in making licensure decisions.
26 b. Communication between a member state, the Commission and among member states
27 regarding the verification of eligibility for licensure through the Compact shall not include any
28 information received from the Federal Bureau of Investigation relating to a federal criminal records
29 check performed by a member state under Public Law 92-544.
30 6. Comply with the rules of the Commission;
31 7. Utilize only a recognized national examination as a requirement for licensure pursuant to the
32 rules of the Commission; and
33 8. Have Continuing Competence/Education requirements as a condition for license renewal.
34 B. A member state shall grant the Compact privilege to a licensee holding a valid unencumbered
35 license in another member state in accordance with the terms of the Compact and rules.
36 C. Member states may charge a fee for granting a Compact privilege.

1 D. A member state shall provide for the state's delegate to attend all occupational therapy
2 Compact Commission meetings.
3 E. Individuals not residing in a member state shall continue to be able to apply for a member
4 state's Single-state license as provided under the laws of each member state. However, the Single-
5 state license granted to these individuals shall not be recognized as granting the Compact privilege
6 in any other member state.
7 F. Nothing in this Compact shall affect the requirements established by a member state for the
8 issuance of a Single-state license.
9 SECTION 4. COMPACT PRIVILEGE
10 A. To exercise the Compact privilege under the terms and provisions of the Compact, the
11 licensee shall:
12 1. Hold a license in the home state;
13 2. Have a valid United States Social Security Number or National Practitioner Identification
14 number;
15 3. Have no encumbrance on any state license;
16 4. Be eligible for a Compact privilege in any member state in accordance with Section 4D, F, G,
17 and H;
18 5. Have paid all fines and completed all requirements resulting from any adverse action against
19 any license or Compact privilege, and two years have elapsed from the date of such completion;
20 6. Notify the Commission that the licensee is seeking the Compact privilege within a remote
21 state(s);
22 7. Pay any applicable fees, including any state fee, for the Compact privilege;
23 8. Complete a criminal background check in accordance with Section 3A(5);
24 a. The licensee shall be responsible for the payment of any fee associated with the completion of
25 a criminal background check.
26 9. Meet any jurisprudence requirements established by the remote state(s) in which the licensee
27 is seeking a Compact privilege; and
28 10. Report to the Commission adverse action taken by any non-member state within 30 days
29 from the date the adverse action is taken.
30 B. The Compact privilege is valid until the expiration date of the home state license. The
31 licensee must comply with the requirements of Section 4A to maintain the Compact privilege in the
32 remote state.
33 C. A licensee providing occupational therapy in a remote state under the Compact privilege
34 shall function within the laws and regulations of the remote state.
35 D. Occupational therapy assistants practicing in a remote state shall be supervised by an
36 occupational therapist licensed or holding a Compact privilege in that remote state.

1 E. A licensee providing occupational therapy in a remote state is subject to that state's
2 regulatory authority. A remote state may, in accordance with due process and that state's laws,
3 remove a licensee's Compact privilege in the remote state for a specific period of time, impose fines,
4 and/or take any other necessary actions to protect the health and safety of its citizens. The licensee
5 may be ineligible for a Compact privilege in any state until the specific time for removal has passed
6 and all fines are paid.
7 F. If a home state license is encumbered, the licensee shall lose the Compact privilege in any
8 remote state until the following occur:
9 1. The home state license is no longer encumbered; and
10 2. Two years have elapsed from the date on which the home state license is no longer
11 encumbered in accordance with Section 4(F)(1).
12 G. Once an Encumbered license in the home state is restored to good standing, the licensee must
13 meet the requirements of Section 4A to obtain a Compact privilege in any remote state.
14 H. If a licensee's Compact privilege in any remote state is removed, the individual may lose the
15 Compact privilege in any other remote state until the following occur:
16 1. The specific period of time for which the Compact privilege was removed has ended;
17 2. All fines have been paid and all conditions have been met;
18 3. Two years have elapsed from the date of completing requirements for 4(H)(1) and (2); and
19 4. The Compact privileges are reinstated by the Commission, and the compact data system is
20 updated to reflect reinstatement.
21 I. If a licensee's Compact privilege in any remote state is removed due to an erroneous charge,
22 privileges shall be restored through the compact data system.
23 J. Once the requirements of Section 4H have been met, the license must meet the requirements
24 in Section 4A to obtain a Compact privilege in a remote state.
25 SECTION 5: OBTAINING A NEW HOME state LICENSE BY VIRTUE OF COMPACT PRIVILEGE
26 A. An occupational therapist or occupational therapy assistant may hold a home state license,
27 which allows for Compact privileges in member states, in only one member state at a time.
28 B. If an occupational therapist or occupational therapy assistant changes primary state of
29 residence by moving between two member states:
30 1. The occupational therapist or occupational therapy assistant shall file an application for
31 obtaining a new home state license by virtue of a Compact privilege, pay all applicable fees, and
32 notify the current and new home state in accordance with applicable rules adopted by the
33 Commission.
34 2. Upon receipt of an application for obtaining a new home state license by virtue of compact
35 privilege, the new home state shall verify that the occupational therapist or occupational therapy
36 assistant meets the pertinent criteria outlined in Section 4 via the data system, without need for
37 primary source verification except for:

1 a. An FBI fingerprint based criminal background check if not previously performed or updated
2 pursuant to applicable rules adopted by the Commission in accordance with Public Law 92-544;
3 b. Other criminal background check as required by the new home state; and
4 c. Submission of any requisite jurisprudence requirements of the new home state.
5 3. The former home state shall convert the former home state license into a Compact privilege
6 once the new home state has activated the new home state license in accordance with applicable
7 rules adopted by the Commission.
8 4. Notwithstanding any other provision of this Compact, if the occupational therapist or
9 occupational therapy assistant cannot meet the criteria in Section 4, the new home state shall apply
10 its requirements for issuing a new Single-state license.
11 5. The occupational therapist or the occupational therapy assistant shall pay all applicable fees
12 to the new home state in order to be issued a new home state license.
13 C. If an occupational therapist or occupational therapy assistant changes primary state of
14 residence by moving from a member state to a non-member state, or from a non-member state to a
15 member state, the state criteria shall apply for issuance of a Single-state license in the new state.
16 D. Nothing in this compact shall interfere with a licensee's ability to hold a Single-state license
17 in multiple states; however, for the purposes of this compact, a licensee shall have only one home
18 state license.
19 E. Nothing in this Compact shall affect the requirements established by a member state for the
20 issuance of a Single-state license.
21 SECTION 6. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES
22 A. Active Duty Military personnel, or their spouses, shall designate a home state where the
23 individual has a current license in good standing. The individual may retain the home state
24 designation during the period the service member is on active duty. Subsequent to designating a
25 home state, the individual shall only change their home state through application for licensure in the
26 new state or through the process described in Section 5.
27 SECTION 7. ADVERSE ACTIONS
28 A. A home state shall have exclusive power to impose adverse action against an occupational
29 therapist's or occupational therapy assistant's license issued by the home state.
30 B. In addition to the other powers conferred by state law, a remote state shall have the
31 authority, in accordance with existing state due process law, to:
32 1. Take adverse action against an occupational therapist's or occupational therapy assistant's
33 Compact privilege within that member state.
34 2. Issue subpoenas for both hearings and investigations that require the attendance and
35 testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board
36 in a member state for the attendance and testimony of witnesses or the production of evidence from
37 another member state shall be enforced in the latter state by any court of competent jurisdiction,

1 according to the practice and procedure of that court applicable to subpoenas issued in proceedings
2 pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and
3 other fees required by the service statutes of the state in which the witnesses or evidence are
4 located.
5 C. For purposes of taking adverse action, the home state shall give the same priority and effect
6 to reported conduct received from a member state as it would if the conduct had occurred within the
7 home state. In so doing, the home state shall apply its own state laws to determine appropriate
8 action.
9 D. The home state shall complete any pending investigations of an occupational therapist or
10 occupational therapy assistant who changes primary state of residence during the course of the
11 investigations. The home state, where the investigations were initiated, shall also have the
12 authority to take appropriate action(s) and shall promptly report the conclusions of the
13 investigations to the OT Compact Commission data system. The occupational therapy Compact
14 Commission data system administrator shall promptly notify the new home state of any adverse
15 actions.
16 E. A member state, if otherwise permitted by state law, may recover from the affected
17 occupational therapist or occupational therapy assistant the costs of investigations and disposition of
18 cases resulting from any adverse action taken against that occupational therapist or occupational
19 therapy assistant.
20 F. A member state may take adverse action based on the factual findings of the remote state,
21 provided that the member state follows its own procedures for taking the adverse action.
22 G. Joint Investigations
23 1. In addition to the authority granted to a member state by its respective state occupational
24 therapy laws and regulations or other applicable state law, any member state may participate with
25 other member states in joint investigations of licensees.
26 2. Member states shall share any investigative, litigation, or compliance materials in
27 furtherance of any joint or individual investigation initiated under the Compact.
28 H. If an adverse action is taken by the home state against an occupational therapist's or
29 occupational therapy assistant's license, the occupational therapist's or occupational therapy
30 assistant's Compact privilege in all other member states shall be deactivated until all encumbrances
31 have been removed from the state license. All home state disciplinary orders that impose adverse
32 action against an occupational therapist's or occupational therapy assistant's license shall include a
33 statement that the occupational therapist's or occupational therapy assistant's Compact privilege is
34 deactivated in all member states during the pendency of the order.
35 I. If a member state takes adverse action, it shall promptly notify the administrator of the data
36 system. The administrator of the data system shall promptly notify the home state of any adverse
37 actions by remote states.

J. Nothing in this Compact shall override a member state's decision that participation in an Alternative Program may be used in lieu of adverse action.

SECTION 8. ESTABLISHMENT OF THE OCCUPATIONAL THERAPY COMPACT COMMISSION.

A. The Compact member states hereby create and establish a joint public agency known as the occupational therapy Compact Commission:

1. The Commission is an instrumentality of the Compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings

1. Each member state shall have and be limited to one (1) delegate selected by that member state's licensing board.

2. The delegate shall be either:

a. A current member of the licensing board, who is an occupational therapist, occupational therapy assistant, or public member; or

b. An administrator of the licensing board.

3. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

4. The member state board shall fill any vacancy occurring in the Commission within 90 days.

5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

6. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

7. The Commission shall establish by rule a term of office for delegates.

C. The Commission shall have the following powers and duties:

1. Establish a Code of Ethics for the Commission;

2. Establish the fiscal year of the Commission;

3. Establish bylaws;

4. Maintain its financial records in accordance with the bylaws;

5. Meet and take such actions as are consistent with the provisions of this Compact and the bylaws;

1 6. Promulgate uniform rules to facilitate and coordinate implementation and administration of
2 this Compact. The rules shall have the force and effect of law and shall be binding in all member
3 states;
4 7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided
5 that the standing of any state occupational therapy licensing board to sue or be sued under
6 applicable law shall not be affected;
7 8. Purchase and maintain insurance and bonds;
8 9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees
9 of a member state;
10 10. Hire employees, elect or appoint officers, fix compensation, define duties, grant such
11 individuals appropriate authority to carry out the purposes of the Compact, and establish the
12 Commission's personnel policies and programs relating to conflicts of interest, qualifications of
13 personnel, and other related personnel matters;
14 11. Accept any and all appropriate donations and grants of money, equipment, supplies,
15 materials and services, and receive, utilize and dispose of the same; provided that at all times the
16 Commission shall avoid any appearance of impropriety and/or conflict of interest;
17 12. Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or
18 use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any
19 appearance of impropriety;
20 13. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any
21 property real, personal, or mixed;
22 14. Establish a budget and make expenditures;
23 15. Borrow money;
24 16. Appoint committees, including standing committees composed of members, state regulators,
25 state legislators or their representatives, and consumer representatives, and such other interested
26 persons as may be designated in this Compact and the bylaws;
27 17. Provide and receive information from, and cooperate with, law enforcement agencies;
28 18. Establish and elect an Executive Committee; and
29 19. Perform such other functions as may be necessary or appropriate to achieve the purposes of
30 this Compact consistent with the state regulation of occupational therapy licensure and practice.
31 D. The Executive Committee. The Executive Committee shall have the power to act on behalf of
32 the Commission according to the terms of this Compact.
33 1. The Executive Committee shall be composed of nine members:
34 a. Seven voting members who are elected by the Commission from the current membership of
35 the Commission;
36 b. One ex-officio, nonvoting member from a recognized national occupational therapy
37 professional association; and

1 c. One ex-officio, nonvoting member from a recognized national occupational therapy
2 certification organization.
3 2. The ex-officio members will be selected by their respective organizations.
4 3. The Commission may remove any member of the Executive Committee as provided in bylaws.
5 4. The Executive Committee shall meet at least annually.
6 5. The Executive Committee shall have the following duties and responsibilities:
7 a. Recommend to the entire Commission changes to the rules or bylaws, changes to this
8 Compact legislation, fees paid by Compact member states such as annual dues, and any Commission
9 Compact fee charged to licensees for the Compact privilege;
10 b. Ensure Compact administration services are appropriately provided, contractual or
11 otherwise;
12 c. Prepare and recommend the budget;
13 d. Maintain financial records on behalf of the Commission;
14 e. Monitor Compact compliance of member states and provide compliance reports to the
15 Commission;
16 f. Establish additional committees as necessary; and
17 g. Perform other duties as provided in rules or bylaws.
18 E. Meetings of the Commission
19 1. All meetings shall be open to the public, and public notice of meetings shall be given in the
20 same manner as required under the rulemaking provisions in Section 10.
21 2. The Commission or the Executive Committee or other committees of the Commission may
22 convene in a closed, non-public meeting if the Commission or Executive Committee or other
23 committees of the Commission must discuss:
24 a. Non-compliance of a member state with its obligations under the Compact;
25 b. The employment, compensation, discipline or other matters, practices or procedures related to
26 specific employees or other matters related to the Commission's internal personnel practices and
27 procedures;
28 c. Current, threatened, or reasonably anticipated litigation;
29 d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;
30 e. Accusing any person of a crime or formally censuring any person;
31 f. Disclosure of trade secrets or commercial or financial information that is privileged or
32 confidential;
33 g. Disclosure of information of a personal nature where disclosure would constitute a clearly
34 unwarranted invasion of personal privacy;
35 h. Disclosure of investigative records compiled for law enforcement purposes;

1 i. Disclosure of information related to any investigative reports prepared by or on behalf of or for
2 use of the Commission or other committee charged with responsibility of investigation or
3 determination of compliance issues pursuant to the Compact; or
4 j. Matters specifically exempted from disclosure by federal or member state statute.
5 3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's
6 legal counsel or designee shall certify that the meeting may be closed and shall reference each
7 relevant exempting provision.
8 4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a
9 meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore,
10 including a description of the views expressed. All documents considered in connection with an
11 action shall be identified in such minutes. All minutes and documents of a closed meeting shall
12 remain under seal, subject to release by a majority vote of the Commission or order of a court of
13 competent jurisdiction.
14 F. Financing of the Commission
15 1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its
16 establishment, organization, and ongoing activities.
17 2. The Commission may accept any and all appropriate revenue sources, donations, and grants
18 of money, equipment, supplies, materials, and services.
19 3. The Commission may levy on and collect an annual assessment from each member state or
20 impose fees on other parties to cover the cost of the operations and activities of the Commission and
21 its staff, which must be in a total amount sufficient to cover its annual budget as approved by the
22 Commission each year for which revenue is not provided by other sources. The aggregate annual
23 assessment amount shall be allocated based upon a formula to be determined by the Commission,
24 which shall promulgate a rule binding upon all member states.
25 4. The Commission shall not incur obligations of any kind prior to securing the funds adequate
26 to meet the same; nor shall the Commission pledge the credit of any of the member states, except by
27 and with the authority of the member state.
28 5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts
29 and disbursements of the Commission shall be subject to the audit and accounting procedures
30 established under its bylaws. However, all receipts and disbursements of funds handled by the
31 Commission shall be audited yearly by a certified or licensed public accountant, and the report of the
32 audit shall be included in and become part of the annual report of the Commission.
33 G. Qualified Immunity, Defense, and Indemnification
34 1. The members, officers, executive director, employees and representatives of the Commission
35 shall be immune from suit and liability, either personally or in their official capacity, for any claim
36 for damage to or loss of property or personal injury or other civil liability caused by or arising out of
37 any actual or alleged act, error or omission that occurred, or that the person against whom the claim

is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 9. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. A member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable (utilizing a unique identifier) as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Adverse actions against a license or Compact privilege;
4. Non-confidential information related to Alternative Program participation;
5. Any denial of application for licensure, and the reason(s) for such denial;
6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission; and
7. Current significant investigative information.

C. Current significant investigative information and other investigative information pertaining to a licensee in any member state will only be available to other member states.

1 D. The Commission shall promptly notify all member states of any adverse action taken against
2 a licensee or an individual applying for a license. adverse action information pertaining to a licensee
3 in any member state will be available to any other member state.
4 E. Member states contributing information to the data system may designate information that
5 may not be shared with the public without the express permission of the contributing state.
6 F. Any information submitted to the data system that is subsequently required to be expunged
7 by the laws of the member state contributing the information shall be removed from the data
8 system.
9 SECTION 10. RULEMAKING
10 A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in
11 this Section and the rules adopted thereunder. Rules and amendments shall become binding as of
12 the date specified in each rule or amendment.
13 B. The Commission shall promulgate reasonable rules in order to effectively and efficiently
14 achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Commission
15 exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the
16 Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid
17 and have no force and effect.
18 C. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute
19 or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of
20 the rule, then such rule shall have no further force and effect in any member state.
21 D. Rules or amendments to the rules shall be adopted at a regular or special meeting of the
22 Commission.
23 E. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least
24 thirty (30) days in advance of the meeting at which the rule will be considered and voted upon, the
25 Commission shall file a notice of proposed rulemaking:
26 1. On the website of the Commission or other publicly accessible platform; and
27 2. On the website of each member state occupational therapy licensing board or other publicly
28 accessible platform or the publication in which each state would otherwise publish proposed rules.
29 F. The notice of proposed rulemaking shall include:
30 1. The proposed time, date, and location of the meeting in which the rule will be considered and
31 voted upon;
32 2. The text of the proposed rule or amendment and the reason for the proposed rule;
33 3. A request for comments on the proposed rule from any interested person; and
34 4. The manner in which interested persons may submit notice to the Commission of their
35 intention to attend the public hearing and any written comments.
36 G. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written
37 data, facts, opinions, and arguments, which shall be made available to the public.

1 H. The Commission shall grant an opportunity for a public hearing before it adopts a rule or
2 amendment if a hearing is requested by:
3 1. At least twenty five (25) persons;
4 2. A state or federal governmental subdivision or agency; or
5 3. An association or organization having at least twenty five (25) members.
6 I. If a hearing is held on the proposed rule or amendment, the Commission shall publish the
7 place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the
8 Commission shall publish the mechanism for access to the electronic hearing.
9 1. All persons wishing to be heard at the hearing shall notify the executive director of the
10 Commission or other designated member in writing of their desire to appear and testify at the
11 hearing not less than five (5) business days before the scheduled date of the hearing.
12 2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair
13 and reasonable opportunity to comment orally or in writing.
14 3. All hearings will be recorded. A copy of the recording will be made available on request.
15 4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules
16 may be grouped for the convenience of the Commission at hearings required by this section.
17 J. Following the scheduled hearing date, or by the close of business on the scheduled hearing
18 date if the hearing was not held, the Commission shall consider all written and oral comments
19 received.
20 K. If no written notice of intent to attend the public hearing by interested parties is received, the
21 Commission may proceed with promulgation of the proposed rule without a public hearing.
22 L. The Commission shall, by majority vote of all members, take final action on the proposed rule
23 and shall determine the effective date of the rule, if any, based on the rulemaking record and the full
24 text of the rule.
25 M. Upon determination that an emergency exists, the Commission may consider and adopt an
26 emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual
27 rulemaking procedures provided in the Compact and in this section shall be retroactively applied to
28 the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective
29 date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted
30 immediately in order to:
31 1. Meet an imminent threat to public health, safety, or welfare;
32 2. Prevent a loss of Commission or member state funds;
33 3. Meet a deadline for the promulgation of an administrative rule that is established by federal
34 law or rule; or
35 4. Protect public health and safety.
36 N. The Commission or an authorized committee of the Commission may direct revisions to a
37 previously adopted rule or amendment for purposes of correcting typographical errors, errors in

format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 11. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

1 4. A state that has been terminated is responsible for all assessments, obligations, and liabilities
2 incurred through the effective date of termination, including obligations that extend beyond the
3 effective date of termination.
4 5. The Commission shall not bear any costs related to a state that is found to be in default or
5 that has been terminated from the Compact, unless agreed upon in writing between the Commission
6 and the defaulting state.
7 6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District
8 Court for the District of Columbia or the federal district where the Commission has its principal
9 offices. The prevailing member shall be awarded all costs of such litigation, including reasonable
10 attorney's fees.
11 C. Dispute Resolution
12 1. Upon request by a member state, the Commission shall attempt to resolve disputes related to
13 the Compact that arise among member states and between member and non-member states.
14 2. The Commission shall promulgate a rule providing for both mediation and binding dispute
15 resolution for disputes as appropriate.
16 D. Enforcement
17 1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and
18 rules of this Compact.
19 2. By majority vote, the Commission may initiate legal action in the United States District
20 Court for the District of Columbia or the federal district where the Commission has its principal
21 offices against a member state in default to enforce compliance with the provisions of the Compact
22 and its promulgated rules and bylaws. The relief sought may include both injunctive relief and
23 damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all
24 costs of such litigation, including reasonable attorney's fees.
25 3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission
26 may pursue any other remedies available under federal or state law.
27 SECTION 12. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR
28 OCCUPATIONAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND
29 AMENDMENT
30 A. The Compact shall come into effect on the date on which the Compact statute is enacted into
31 law in the tenth member state. The provisions, which become effective at that time, shall be limited
32 to the powers granted to the Commission relating to assembly and the promulgation of rules.
33 Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the
34 implementation and administration of the Compact.
35 B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules
36 shall be subject to the rules as they exist on the date on which the Compact becomes law in that

1 state. Any rule that has been previously adopted by the Commission shall have the full force and
2 effect of law on the day the Compact becomes law in that state.
3 C. Any member state may withdraw from this Compact by enacting a statute repealing the
4 same.
5 1. A member state's withdrawal shall not take effect until six (6) months after enactment of the
6 repealing statute.
7 2. Withdrawal shall not affect the continuing requirement of the withdrawing state's
8 occupational therapy licensing board to comply with the investigative and adverse action reporting
9 requirements of this act prior to the effective date of withdrawal.
10 D. Nothing contained in this Compact shall be construed to invalidate or prevent any
11 occupational therapy licensure agreement or other cooperative arrangement between a member state
12 and a non-member state that does not conflict with the provisions of this Compact.
13 E. This Compact may be amended by the member states. No amendment to this Compact shall
14 become effective and binding upon any member state until it is enacted into the laws of all member
15 states.
16 SECTION 13. CONSTRUCTION AND SEVERABILITY
17 This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of
18 this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is
19 declared to be contrary to the constitution of any member state or of the United States or the
20 applicability thereof to any government, agency, person, or circumstance is held invalid, the validity
21 of the remainder of this Compact and the applicability thereof to any government, agency, person, or
22 circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution
23 of any member state, the Compact shall remain in full force and effect as to the remaining member
24 states and in full force and effect as to the member state affected as to all severable matters.
25 SECTION 14. BINDING EFFECT OF COMPACT AND OTHER LAWS
26 A. A licensee providing occupational therapy in a remote state under the Compact privilege
27 shall function within the laws and regulations of the remote state.
28 B. Nothing herein prevents the enforcement of any other law of a member state that is not
29 inconsistent with the Compact.
30 C. Any laws in a member state in conflict with the Compact are superseded to the extent of the
31 conflict.
32 D. Any lawful actions of the Commission, including all rules and bylaws promulgated by the
33 Commission, are binding upon the member states.
34 E. All agreements between the Commission and the member states are binding in accordance
35 with their terms.

1 F. In the event any provision of the Compact exceeds the constitutional limits imposed on the
2 legislature of any member state, the provision shall be ineffective to the extent of the conflict with
3 the constitutional provision in question in that member state.
4 3 Effective Date. Part V of this act shall take effect July 1, 2021.
5 PART VI
6 Relative to the licensure and regulation of music therapists.
7 1 New Chapter; Music Therapists. Amend RSA by inserting after chapter 326-L the following
8 new chapter:
9 CHAPTER 326-M
10 MUSIC THERAPISTS
11 326-M:1 Definitions. In this chapter and RSA 328-F:
12 I. "Board" means the music therapists governing board established in RSA 328-F.
13 II. "Board certified music therapist" means an individual who holds current board
14 certification from the Certification Board for Music Therapists.
15 III. "Executive director" means the executive director of the office of professional licensure
16 and certification.
17 IV. "Music therapist" means a person licensed to practice music therapy pursuant to this
18 chapter.
19 V. "Music therapy" means the clinical and evidence based use of music interventions to
20 accomplish individualized goals for people of all ages and ability levels within a therapeutic
21 relationship by a board certified music therapist. The music therapy interventions may include,
22 music improvisation, receptive music listening, song writing, lyric discussion, music and imagery,
23 singing, music performance, learning through music, music combined with other arts, music-assisted
24 relaxation, music-based patient education, electronic music technology, adapted music intervention
25 and movement to music. The practice of music therapy does not include the screening, diagnosis, or
26 assessment of any physical, mental, or communication disorder. This term may include:
27 (a) Acceptance of clients referred for music therapy by other health care or educational
28 professionals, family members, or caregivers.
29 (b) Assessment of clients to determine appropriate music therapy services.
30 (c) Development and implementation of individualized music therapy treatment plans
31 that identify goals, objectives, and strategies of music therapy that are appropriate for clients.
32 (d) Use of music therapy techniques such as improvisation, performance, receptive
33 music listening, song writing, lyric discussion, guided imagery with music, learning through music,
34 and movement to music.
35 (e) Evaluation of a client's response to music therapy techniques and to the client's
36 individualized music therapy treatment plan.

1 (f) Any necessary modification of the client's individualized music therapy treatment
2 plan.
3 (g) Any necessary collaboration with the other health care professionals treating a client.
4 (h) Minimizing of barriers that may restrict a client's ability to receive or fully benefit
5 from music therapy services.
6 326-M:2 Prohibition on Unlicensed Practice; Professional Identification.
7 I. No person without a license as a music therapist shall use the title "music therapist" or
8 similar title or practice music therapy.
9 II. Nothing in this chapter shall be construed to prohibit or restrict the practice, services, or
10 activities of the following:
11 (a) Any person licensed, certified, or regulated under the laws of this state in another
12 profession or occupation or personnel supervised by a licensed professional in this state performing
13 work, including the use of music, incidental to the practice of his or her licensed, certified, or
14 regulated profession or occupation, if that person does not represent himself or herself as a music
15 therapist; or
16 (b) Any person whose training and national certification attests to the individual's
17 preparation and ability to practice his or her certified profession or occupation, if that person does
18 not represent himself or herself as a music therapist; or
19 (c) Any practice of music therapy as an integral part of a program of study for students
20 enrolled in an accredited music therapy program, if the student does not represent himself or herself
21 as a music therapist; or
22 (d) Any person who practices music therapy under the supervision of a licensed music
23 therapist, if the person does not represent himself or herself as a music therapist.
24 326-M:3 Licensure of Music Therapists. In addition to requirements under RSA 328-F:
25 I. The board shall issue a license to an applicant for a music therapy license when such
26 applicant has completed and submitted an application upon a form and in such manner as the
27 executive director prescribes, accompanied by applicable fees, and evidence satisfactory to the board
28 that:
29 (a) The applicant is in good standing based on a review of the applicant's music therapy
30 licensure history in other jurisdictions, including a review of any alleged misconduct or neglect in the
31 practice of music therapy on the part of the applicant, and a review of the criminal background check
32 required under RSA 328-F:18-a.
33 (b) The applicant provides proof of passing the examination for board certification
34 offered by the Certification Board for Music Therapists or any successor organization or provides
35 proof that the applicant is currently a board certified music therapist.
36 II. The board shall issue a license to an applicant for a music therapist license when such
37 applicant has completed and submitted an application upon a form and in such manner as the

executive director prescribes, accompanied by applicable fees, and evidence satisfactory to the board that the applicant is licensed and in good standing as a music therapist in another jurisdiction where the qualifications required are equal to or greater than those required in this chapter at the date of application.

326-M:4 Music Therapists Governing Board; Duties. In addition to the duties of a governing board under RSA 328-F:

I. The board may facilitate the development of materials that the office of professional licensure and certification may utilize to educate the public concerning music therapist licensure, the benefits of music therapy, and utilization of music therapy by individuals and in facilities or institutional settings.

II. The board may act as a facilitator of statewide dissemination of information between music therapists, the American Music Therapy Association or any successor organization, the Certification Board for Music Therapists or any successor organization, and the executive director.

III. The executive director shall seek the advice of the board for issues related to the regulation of music therapists.

2 Allied Health Professionals; Definition; Governing Board. Amend RSA 328-F:2, II to read as follows:

II. "Governing boards" means individual licensing boards of athletic trainers, occupational therapy assistants, occupational therapists, recreational therapists, physical therapists, physical therapist assistants, respiratory care practitioners, speech-language pathologists, [~~and~~] genetic counselors***, and music therapists***.

3 New Paragraph; Allied Health Professionals; Music Therapists. Amend RSA 328-F:2 by inserting after paragraph X the following new paragraph:

XI. "Music therapist" means music therapist as defined in RSA 326-M:1.

4 Governing Board; Establishment. Amend RSA 328-F:3, I to read as follows:

I. There shall be established governing boards of athletic trainers, occupational therapists, recreational therapists, respiratory care practitioners, physical therapists, speech-language pathologists, [~~and~~] genetic counselors***, and music therapists***.

5 New Paragraph; Music Therapists Governing Board; Appointment. Amend RSA 328-F:4 by inserting after paragraph X the following new paragraph:

XI. The music therapists governing board shall consist of 3 licensed music therapists, who have actively engaged in the practice of music therapy in this state for at least 2 years, one member who is a licensed health care provider who is not a music therapist, and one public member. Initial appointment of professional members by the governor and council shall be qualified persons practicing music therapy in this state. All subsequent appointments or reappointments shall require licensure.

6 Renewals; Reference to Music Therapists Added. Amend RSA 328-F:19, I to read as follows:

I. Initial licenses and renewals shall be valid for 2 years, except that timely and complete application for license renewal by eligible applicants shall continue the validity of the licenses being renewed until the governing board has acted on the renewal application. Licenses issued pursuant to RSA 328-A, RSA 326-G, [~~and~~] RSA 326-J***, and RSA 326-M*** shall expire in even-numbered years and licenses issued pursuant to RSA 326-C, RSA 326-E, RSA 326-F, and RSA 326-K shall expire in odd-numbered years.

7 Office of Professional Licensure and Certification; New Classified Position; Appropriation.

I. One program assistant II position, labor grade 15, is hereby established as a classified position in the office of professional licensure and certification.

II. The amount necessary to pay for the position established in paragraph I and for the per diem and travel reimbursement as required under RSA 328-F:6 for the music therapy governing board established in this act is hereby appropriated to the executive director of the office of professional licensure and certification. Salaries and necessary expenses shall be a charge against the office of professional licensure and certification fund established in RSA 310-A:1-e.

8 Effective Date. Part VI of this act shall take effect July 1, 2021.

PART VII

Relative to the authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

1 Office of Professional Licensure and Certification; Administration; Rulemaking. Amend RSA 310-A:1-d, II(h)(2) to read as follows:

(2) Such organizational and procedural rules necessary to administer the boards, commissions, and councils in the office of professional licensure and certification, including rules governing the administration of complaints and investigations, ***hearings, disciplinary proceedings,*** payment processing procedures, and application procedures; and

2 New Sections; Office of Professional Licensure and Certification; Investigations; Hearings; Penalties; Appeals. Amend RSA 310-A by inserting after section 1-g the following new sections:

310-A:1-h Investigations.

I. Boards, which shall include all boards, councils, and commissions within the office of professional licensure and certification, may authorize an investigation of allegations of misconduct by licensees (a) upon their own initiative or (b) upon written complaint of any person that charges that a person licensed by the board has committed misconduct. In consultation with the board, the office shall assign an investigator, who shall complete the investigation in accordance with rules adopted by the executive director.

II. The following information obtained during investigations shall be held confidential and shall be exempt from the disclosure requirements of RSA 91-A:

(a) Complaints received by the office.

(b) Information and records acquired by the office during the investigation.

1 (c) Reports and records made by the office as a result of its investigation.
2 III. For the purpose of carrying out investigations, the executive director is authorized to:
3 (a) Retain qualified experts.
4 (b) Conduct inspections of places of business of licensees or certificate holders.
5 (c) Retain legal counsel when authorized to do so by the attorney general.
6 (d) Issue subpoenas for persons, relevant documents and relevant things in accordance
7 with the following conditions:
8 (1) Subpoenas for persons shall not require compliance in less than 48 hours after
9 receipt of service.
10 (2) Subpoenas for documents and things shall not require compliance in fewer than
11 15 days after receipt of service.
12 (3) Service shall be made on licensees and certified individuals by certified mail to
13 the address on file with the office or by hand and shall not entitle them to witness or mileage fees.
14 (4) Service shall be made on persons who are not licensees or certified individuals in
15 accordance with the procedures and fee schedules of the superior court, and the subpoenas served on
16 them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure
17 and Certification."
18 IV. The office or the boards, councils, and commissions within the office may disclose
19 information acquired in an investigation to law enforcement or health licensing agencies in this state
20 or any other jurisdiction, or in response to specific statutory requirements or court orders.
21 V. Allegations of professional misconduct shall be brought within 5 years from the time the
22 office reasonably could have discovered the act, omission or failure complained of, except that
23 conduct which resulted in a criminal conviction or in a disciplinary action by a relevant licensing
24 authority in another jurisdiction may be considered by the board without time limitation in making
25 licensing or disciplinary decisions if the conduct would otherwise be a ground for discipline. The
26 board may also consider licensee conduct without time limitation when the ultimate issue before the
27 board involves a pattern of conduct or the cumulative effect of conduct which becomes apparent as a
28 result of conduct which has occurred within the 5-year limitation period prescribed by this
29 paragraph.
30 VI. The board may dismiss a complaint if the allegations do not state a claim of professional
31 misconduct.
32 310-A:1-i Disciplinary Proceedings; Remedial Proceedings.
33 I. Boards, which shall include all boards, councils, and commissions within the office of
34 professional licensure and certification, are authorized to conduct disciplinary proceedings in
35 accordance with procedural rules adopted by the executive director.

1 II. For the purpose of carrying out disciplinary proceedings, each board is authorized to
2 issue subpoenas for persons, relevant documents and relevant things in accordance with the
3 following conditions:
4 (a) Subpoenas for persons shall not require compliance in less than 48 hours after
5 receipt of service.
6 (b) Subpoenas for documents and things shall not require compliance in fewer than 15
7 days after receipt of service.
8 (c) Service shall be made on licensees and certified individuals by certified mail to the
9 address on file with the office or by hand and shall not entitle them to witness or mileage fees.
10 (d) Service shall be made on persons who are not licensees or certified individuals in
11 accordance with the procedures and fee schedules of the superior court, and the subpoenas served on
12 them shall be annotated "Fees Guaranteed by the New Hampshire Office of Professional Licensure
13 and Certification."
14 III. At any time before or during disciplinary proceedings, complaints may be dismissed or
15 disposed of, in whole or in part, by written settlement agreement approved by the board and the
16 licensees or certified individuals involved, provided that any complainant shall have the opportunity,
17 before the settlement agreement has been executed, to comment on the terms of the proposed
18 settlement. The board, council, or commission may hold a settlement agreement hearing prior to its
19 approval of the settlement agreement.
20 IV. Disciplinary proceedings shall be open to the public. Final board actions having the
21 effect of terminating disciplinary proceedings, whether taken before, during or after the completion
22 of the proceedings, shall be set forth in a written record that shall be available to the public after
23 service upon the licensees or certified individuals involved.
24 V. In carrying out disciplinary or licensing proceedings, each board shall have the authority
25 to:
26 (a) Hold pre-hearing conferences exempt from the provisions of RSA 91-A.
27 (b) Appoint a board member or other qualified person as presiding officer.
28 (c) Administer, and authorize an appointed presiding officer to administer, oaths and
29 affirmations.
30 VI. Neither the office nor the boards, councils, and commissions shall have an obligation or
31 authority to appoint or pay the fees of attorneys representing licensees, certified individuals, or
32 witnesses during investigations or adjudicatory proceedings.
33 VII. Boards, councils, and commissions may take non-disciplinary remedial action against
34 any person licensed by it upon finding that the person is afflicted with physical or mental disability,
35 disease, disorder, or condition deemed dangerous to the public health. Upon making an affirmative
36 finding, the board, council, or commission may take non-disciplinary remedial action:

1 (a) By suspension, limitation, or restriction of a license for a period of time as
2 determined reasonable by the board.
3 (b) By revocation of license.
4 (c) By requiring the person to submit to the care, treatment, or observation of a
5 physician, counseling service, health care facility, professional assistance program, or any
6 combination thereof which is acceptable to the board.
7 310-A:1-j Hearings, Decisions and Appeals.
8 I. Disciplinary proceedings shall be open to the public, except upon order by the board,
9 council, or commission upon good cause shown. The public docket file for each such proceeding shall
10 be retained in accordance with the retention policy established by the office of professional licensure
11 and certification.
12 II. Notwithstanding any other provision of law, allegations of misconduct or lack of
13 professional qualifications that are not settled shall be heard by the board, council, or commission, or
14 a panel of the board, council, or commission with a minimum of 3 members appointed by the chair of
15 the board or other designee. Any member of the board, or other person qualified to act as presiding
16 officer and duly designated by the board, shall have the authority to preside at such hearing and to
17 issue oaths or affirmations to witnesses, rule on evidentiary and other procedural matters, and
18 prepare a recommended decision. In the case of a hearing before a panel, the presiding officer shall
19 prepare a recommended decision for the board, council, or commission, which shall determine
20 sanctions.
21 III. Except as otherwise provided by RSA 541-A:30, the board, council, or commission shall
22 furnish the respondent and the complainant, if any, at least 15 days' written notice of the date, time
23 and place of a hearing. Such notice shall include an itemization of the issues to be heard, and, in the
24 case of a disciplinary hearing, a statement as to whether the action has been initiated by a written
25 complaint or upon the board's own motion, or both. If a written complaint is involved, the notice
26 shall provide the complainant with a reasonable opportunity to intervene as a party.
27 IV. In disciplinary and licensing proceedings, the presiding officer may hold prehearing
28 conferences that are closed to the public and exempt from the provisions of RSA 91-A until such time
29 as a public evidentiary hearing is convened. In all instances, settlement discussions engaged in by
30 the parties at prehearing conferences may be conducted off the record.
31 V. The board may dispose of issues or allegations at any time during an investigation or
32 disciplinary proceeding by approving a settlement agreement or issuing a consent order or an order
33 of dismissal for default or failure to state a proper basis for disciplinary action. Disciplinary action
34 taken by the board at any stage of a proceeding, and any dispositive action taken after the issuance
35 of a public hearing notice, shall be reduced to writing and made available to the public. Such
36 decisions shall not be public until they are served upon the parties.

1 VI. All proceedings for non-disciplinary remedial action shall be exempt from the provisions
2 of RSA 91-A, except that the board may disclose any final remedial action that affects the status of a
3 license, including any non-disciplinary restrictions imposed.
4 VII. No civil action shall be maintained against the board or any member of the board or its
5 agents or employees, against any organization or its members, or against any other person for or by
6 reason of any statement, report, communication, or testimony to the board or determination by the
7 board in relation to proceedings under this chapter.
8 310-A:1-k Penalties.
9 I. Upon making an affirmative finding that a licensee or certificate holder has committed
10 professional misconduct, boards, which shall include all boards, councils, and commissions within
11 the office of professional licensure and certification, may take disciplinary action in any one or more
12 of the following ways:
13 (a) By reprimand.
14 (b) By suspension of a license or certificate for a period of time as determined reasonable
15 by the board.
16 (c) By revocation of license.
17 (d) By placing the licensee or certificate holder on probationary status. The board may
18 require the person to submit to any of the following:
19 (1) Regular reporting to the board concerning the matters which are the basis of the
20 probation.
21 (2) Continuing professional education until a satisfactory degree of skill has been
22 achieved in those areas which are the basis of probation.
23 (3) Submitting to the care, counseling, or treatment of a physician, counseling
24 service, health care facility, professional assistance program, or any comparable person or facility
25 approved by the board.
26 (4) Practicing under the direct supervision of another licensee for a period of time
27 specified by the board.
28 (e) By assessing administrative fines in amounts established by the board which shall
29 not exceed $3,000 per offense, or, in the case of continuing offenses, $300 for each day that the
30 violation continues, whichever is greater.
31 II. The board may issue a non-disciplinary confidential letter of concern to a licensee
32 advising that while there is insufficient evidence to support disciplinary action, the board believes
33 the licensee or certificate holder should modify or eliminate certain practices, and that continuation
34 of the activities which led to the information being submitted to the board may result in action
35 against the licensee's license. This letter shall not be released to the public or any other licensing
36 authority, except that the letter may be used as evidence in subsequent adjudicatory proceedings by
37 the board.

1 III. In the case of sanctions for discipline in another jurisdiction, the decision of the other
2 jurisdiction's disciplinary authority may not be collaterally attacked and the board may impose any
3 of the sanctions set forth in this chapter, but shall provide notice and an opportunity to be heard
4 prior to imposing any sections.
5 IV. In cases involving imminent danger to life or health, a board may order suspension of a
6 license or certification pending hearing for a period of no more than 10 business days, unless the
7 licensee or certified individual agrees in writing to a longer period. In such cases, the board shall
8 comply with RSA 541-A:30.
9 V. Any person whose license has been suspended or revoked by the board may apply to the
10 board, in writing, to request a hearing for reinstatement. Upon a hearing, the board may issue a
11 new license or modify the suspension or revocation of the license.
12 VI. For any order issued in resolution of an disciplinary proceeding by the board, where the
13 board has found misconduct sufficient to support disciplinary action, the board may require the
14 licensee or certificate holder who is the subject of such finding to pay the office a sum not to exceed
15 the reasonable cost of investigation and prosecution of the proceeding. This sum shall not exceed
16 $10,000. This sum may be imposed in addition to any otherwise authorized administrative fines
17 levied by the board as part of the penalty. The investigative and prosecution costs shall be assessed
18 by the board and any sums recovered shall be credited to the office’s fund and disbursed by the office
19 for any future investigations of complaints and activities that violate this chapter or rules adopted
20 under this chapter.
21 VII. When an investigation of a complaint is determined to be unfounded, the board shall
22 dismiss the complaint and explain in writing to the complainant and the licensee or certificate
23 holder its reason for dismissing the complaint. After six years, the board may destroy all
24 information concerning the investigation, retaining only a record noting that an investigation was
25 conducted and that the board determined the complaint to be unfounded. For the purpose of this
26 paragraph, a complaint shall be deemed to be unfounded if it does not fall within the jurisdiction of
27 the board, does not relate to the actions of the licensee or certificate holder, or is determined by the
28 board to be frivolous.
29 VIII. Whoever, not being licensed or otherwise authorized to practice according to the laws
30 of this state, shall advertise oneself as engaging in a profession licensed or certified by the office of
31 professional licensure and certification, shall engage in activity requiring professional licensure, or
32 in any way hold oneself out as qualified to do so, or call oneself a licensed professional, or whoever
33 does such acts after receiving notice that such person’s license to practice has been suspended or
34 revoked, is engaged in unlawful practice. After hearing and upon making an affirmative finding of
35 unlawful practice, the board, council, or commission may take action in any one of the following
36 ways:

(a) Issue a cease and desist order against any person or entity engaged in unlawful, which shall be enforceable in superior court.

(b) Impose a fine not to exceed the amount of any gain or economic benefit that the person derived from the violation or $10,000 for each offense, whichever amount is greater. Each violation of unlicensed or unlawful practice shall be deemed a separate offense.

(c) The attorney general, board, council, or commission, or prosecuting attorney of any county or municipality where the act to unlawful practice takes place may maintain an action to enjoin any person or entity from continuing to do acts of unlawful practice. The action to enjoin shall not replace any other civil, criminal, or regulatory remedy. An injunction without bond is available to any board, council, or commission.

310-A:1-l Rehearing; Appeals.

I. Any person who has been refused a license or certification by the board, which shall include all boards, councils, and commissions within the office of professional licensure and certification, or has been disciplined by the board shall have the right to petition for a rehearing within 30 days after the original final decision.

II. Appeals from a decision on rehearing shall be by appeal to the supreme court pursuant to RSA 541.

III. No sanction shall be stayed by the board during an appeal.

3 Effective Date. Part VII of this act shall take effect January 1, 2022.

PART VIII

Relative to skilled professional medical personnel.

1 Long Term Care; Eligibility and Service Coverage Authorization. Amend RSA 151-E:3, II to read as follows:

151-E:3 Eligibility ***and Service Coverage Authorization***.

II. Skilled professional medical personnel employed by or designated to act on behalf of the department shall determine clinical eligibility in accordance with the criteria in subparagraph I(a). The clinical eligibility determination shall be based upon an assessment tool, approved by the department, performed by skilled professional medical personnel employed by the department[~~,~~] or [~~by an individual with equivalent training~~] designated by the department. The department shall train all persons performing the assessment to use the assessment tool. [~~For the purposes of this section, "skilled professional medical personnel" shall have the same meaning as in 42 C.F.R. section 432.50(d)(1)(ii).~~] ***Only skilled professional medical personnel who are registered nurses and currently licensed in accordance with RSA 326-B may render an adverse clinical eligibility determination.***

2 New Paragraph; Service Coverage Authorization; Skilled Professional Medical Personnel. Amend RSA 151-E: 3 by inserting after paragraph III the following new paragraph:

1 III-a. Skilled professional medical personnel shall oversee service coverage prior
2 authorizations for Medicaid home and community-based care waiver services. Only skilled
3 professional medical personnel who are registered nurses and currently licensed in accordance with
4 RSA 326-B may render an adverse service coverage determination.
5 3 New Paragraph; Definition; Skilled Professional Medical Personnel. Amend RSA 151-E: 3 by
6 inserting after paragraph IV the following new paragraph:
7 V. In this section "skilled professional medical personnel" shall have the same meaning as in
8 42 C.F.R. section 432.2, except that the skilled professional medical personnel need not be in an
9 employer-employee relationship with the department. Additionally, the skilled professional medical
10 personnel shall have “professional education and training,” as that term is defined in 42 C.F.R.
11 section 432.50(d)(1)(ii).
12 4 Effective Date. Part VIII of this act shall take effect 60 days after its passage.
13 PART IX
14 Relative to temporary licensure of certain licensed nursing assistants.
15 1 Statement of Purpose. The general court acknowledges the critical importance of ensuring the
16 quality, accessibility, and sustainability of Medicaid services provided in nursing homes, and
17 recognizes the critical shortage of licensed nursing assistants throughout the state. The purpose of
18 this act is to strengthen the frontline staffing in nursing homes. The general court finds that during
19 the COVID-19 pandemic federal regulatory and statutory provisions were waived to facilitate the
20 hiring of nurse aides by nursing homes. Under state emergency order, these individuals were
21 allowed to work in nursing homes as temporary health partners following no less than 8 hours of
22 training provided either by a national association or a New Hampshire educational program. As a
23 matter of public policy, the general court finds that these workers were indispensable as facilities
24 struggled with staffing issues, particularly during outbreaks of the COVID-19 virus. Accordingly,
25 this act shall provide the board of nursing with the additional authority to expand the workforce of
26 licensed nursing assistants by recognizing the service of temporary health partners during the
27 COVID-19 pandemic.
28 2 Special Licensure as a Licensed Nursing Assistant; Applicants Who Served as Temporary
29 Health Partners.
30 I. Persons who have worked no fewer than 100 hours as temporary health partners in a
31 licensed nursing home by April 1, 2021 have demonstrated, through their work experience during a
32 national and state public health emergency, the competency to transition to status as a licensed
33 nursing assistant.
34 II. Notwithstanding any provision of law to the contrary, the state-approved training
35 program for licensed nursing assistants shall take into account the training and experience acquired
36 during the COVID-19 pandemic to transition these individuals to placement on the state's licensed

nursing assistant registry pursuant to RSA 326-B:26. Such individuals shall be subject to all continuing education requirements under RSA 326-B:31.

III. For purposes of this act:

(a) "COVID-19" means the novel coronavirus first identified in 2019, or SARS-CoV-2.

(b) "Temporary health partner" means anyone authorized to work in a nursing home by Emergency Order 42 issued by the governor on May 11, 2020, and required to complete training of no less than eight hours and work under the supervision of an RN, APRN, or LPN, as is required of LNAs under RSA 326-B:14.

3 Effective Date. Part IX of this act shall take effect 60 days after its passage.

PART X

Relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

1 Emergency Medical and Trauma Services; Revocation of License. Amend the introductory paragraph of RSA 153-A:13, I to read as follows:

I. The commissioner [~~shall~~] ***may*** deny an application for issuance or renewal of a license, or ***issue a letter of concern,*** suspend***,*** or revoke a license, when the commissioner finds that the applicant is guilty of any of the following acts or offenses:

2 Effective Date. Part X of this act shall take effect 60 days after its passage.

PART XI

Relative to schools for barbering, cosmetology, and esthetics.

1 Barbering, Cosmetology, and Esthetics; Definition; School. Amend RSA 313-A:1, XIII to read as follows:

XIII. "School" means a school or other institution***, or a dedicated program within such school or institution,*** conducted for the purpose of teaching cosmetology, manicuring, barbering, or esthetics.

2 Duties of the Board; Schools; Manicuring, Cosmetology, Barbering, Esthetics RSA 313-A:7, II is repealed and reenacted to read as follows:

II. The board may license a school to operate either:

(a) Dedicated programs within secondary schools, the purpose of which is to teach cosmetology, manicuring, barbering, or esthetics; or

(b) Postsecondary programs conducted for the purpose of teaching cosmetology, manicuring, barbering, or esthetics, including postsecondary programs leading to a certificate in manicuring, barbering, cosmetology, or esthetics.

3 Barbering, Cosmetology, Esthetics, Manicuring; Apprenticeship Certificates. Amend RSA 313-A:24 to read as follows:

313-A:24 Apprentice Registration and [~~Licensure~~] ***Certificates***.

I. No person shall enter an apprenticeship or enroll in a school under this chapter unless such person has registered with the board as an apprentice and been issued an apprentice [~~license~~] ***certificate***. The board shall have sole authority to regulate apprentices and apprenticeship under this chapter. The board shall issue an apprentice [~~license~~] ***certificate*** to any student receiving instruction within a licensed school or shop to learn barbering, cosmetology, esthetics, or manicuring.

II. A person applying for [~~a license~~] ***an apprentice certificate*** under this section shall be granted such [~~license~~] ***certificate*** upon:

(a) Submitting proof sufficient to the board to show that such person is at least 16 years of age;

(b) Paying a fee established by the [~~board~~] ***office of professional licensure and certification***; and

(c) Being deemed by the board to be of good professional character.

III. No salon or barbershop shall at any one time have more than one apprentice per licensed professional, except as follows:

(a) Each licensed barber may have up to 2 apprentices for barbering.

(b) Each licensed master barber may have up to 2 apprentices for barbering, or one apprentice master barber and one apprentice barber.

IV. Upon completing the number of hours specified in the board's apprentice rules, an apprentice shall be eligible to apply to the board for licensure.

V. Notwithstanding RSA 161-B:11, VI-a, an applicant for an apprentice certificate shall not be required to provide a social security number as a prerequisite for obtaining a certificate.

4 Effective Date. Part XI of this act shall take effect 60 days after its passage.

PART XII

Relative to telemedicine provided by out of state psychologists.

1 Psychologists; Electronic Practice of Psychology. RSA 329-B:16 is repealed and reenacted to read as follows:

329-B:16 Electronic Practice of Psychology, Telehealth, Telemedicine.

I. Telepsychology, telehealth, and telemedicine services, as provided by psychologists, include those psychology services that utilize electronic means to engage in visual or virtual presence in contemporaneous time. Such provision of services shall require a New Hampshire tele-pass license for provision of such care to people in New Hampshire. Contacts that are exempt from this requirement are:

(a) Persons exempted by 329-B:28.

(b) Screenings for inclusion in voluntary research projects that have been properly approved by a New Hampshire based institutional review board.

1 (c) Psychologists licensed by the board, who may provide tele-psychology services to a
2 person within the state of New Hampshire without acquiring a tele-pass psychology license.
3 II. A doctoral level psychologist who is not licensed in New Hampshire shall be eligible to
4 provide telepsychology services to a person in New Hampshire, providing that the psychologist:
5 (a) Is licensed in one of the jurisdictions in the United States or Canada;
6 (b) Is in good standing in all license jurisdictions in the United States and Canada;
7 (c) Has satisfied conditions determined in rules adopted by the board;
8 and
9 (d) Has applied for and obtained a valid New Hampshire tele-pass psychology license
10 with effective dates that cover the dates of care provided.
11 III. The tele-pass psychology licensee shall agree to conditions including, but not limited to,
12 conditions stipulated by the board that the licensee shall:
13 (a) Conform to all New Hampshire statutes and rules.
14 (b) Agree that electronic attendance for appearances shall be deemed adequate for
15 regulatory enforcement purposes and that in-person appearances by the licensee are optional and
16 such associated costs for in-person attendance are the full responsibility of the tele-pass psychology
17 licensee.
18 (c) Understand that false statements or failure to comply with official requests and
19 official orders shall constitute sufficient cause for revocation of the tele-pass psychology license.
20 (d) Understand that all conditions of tele-pass psychology license to practice and
21 enforcement shall be pursuant to New Hampshire law.
22 (e) Grant the New Hampshire board of psychologists and its investigators authority to
23 disclose to law enforcement and related regulatory authorities, at their discretion, information
24 including but not limited to status of application, actions and information pertinent to investigations
25 and enforcement of the laws and rules pertaining to the licensee's conduct.
26 IV. The board shall adopt rules pursuant to RSA 541-A for:
27 (a) The application procedure for a New Hampshire tele-pass psychology license;
28 (b) Additional requirements for a psychologist licensed in another state of Canada to
29 acquire a tele-pass psychology license, including attestations;
30 (c) Any fees required to apply for or to be issued a tele-pass psychology license;
31 (d) The standards of care for telemedicine practice of psychology and their enforcement;
32 and
33 (e) Procedures for the revocation of a tele-pass psychology license.
34 2 Effective Date. Part XII of this act shall take effect July 1, 2021.
35
36 PART XIII
37 Relative to certified food protection managers.

1 1 New Section; Food Service Licensure; Certified Food Protection Manager. Amend RSA 143-A
2 by inserting after RSA 143-A:11 the following new section:
3 143-A:11-a Certified Food Protection Manager
4 I. Each food service establishment licensed by the state under RSA 143-A:6 shall:
5 (a) Have a person in charge and present during all hours of operation trained as a
6 certified food protection manager by a program approved by the Conference for Food Protection or
7 other equivalent industry standards program.
8 (b) The requirement in RSA 143-A:11-a, I(a) shall not apply under these conditions:
9 (1) Food establishments having at least one certified food protection manager on
10 staff shall not be required to have the certified food protection manager present when no food
11 preparation is taking place;
12 (2) Food establishments having at least one certified food protection manager on
13 staff shall not be required to have the certified food protection manager present when food
14 preparation is limited to reheating commercially prepared food or ready to eat food; or
15 (3) Food establishments having 5 food employees or less on duty are required to have
16 only one certified food protection manager on staff who is available, although not required to be
17 present, during all hours of operation.
18 II. This section shall not apply to any food service establishment exempt from licensure or
19 inspection under RSA 143-A:5.
20 III. This section shall not apply to food establishments licensed under RSA 143-A:6 as food
21 processing plants, cold storage or refrigerating warehouses; retail stores with no food preparation or
22 limited to self service foods, servicing areas, bed and breakfasts, lodging facilities serving continental
23 breakfasts, home delivery services of packaged frozen food; pushcarts and other mobile food units,
24 those serving packaged food and non-potentially hazardous unwrapped foods only;
25 wholesalers/distributors; on-site vending machines, bars/lounges without a food preparation area;
26 arena/theater concessions serving non-potentially hazardous; sellers of pre-packaged frozen meat or
27 poultry that is processed in a USDA-inspected plant; homestead food operations.
28 2 Effective Date. Part XIII of this act shall take effect upon its passage.

Fiscal Note

LBA
21-0964
Amended 5/3/21

SB 133-FN FISCAL NOTE
AMENDED BY THE SENATE (AMENDMENT #2021-0779s)

AN ACT adopting omnibus legislation relative to occupational licensure.

PART I Relative to the definition of "licensing agency" for purposes of licensing places of assembly.

This part has no fiscal impact.

PART II Repealing the emergency medical services personnel licensure interstate Compact.

This part has no fiscal impact.

PART III Relative to hearings of the New Hampshire board of nursing.

This part has no fiscal impact.

PART IV Relative to membership of the professional standards board.

This part has no fiscal impact.

PART V Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

This part has no fiscal impact.

PART VI Relative to the licensure and regulation of music therapists.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$65,460	$68,460	$71,460
Revenue	$0	$27,000	$0	$22,000
Expenditures	$0	$65,460	$68,460	$71,460
Funding Source:	[X] General [ ] Education [ ] Highway [X] Other- Office of Professional Licensure and Certification Fund (RSA 310-A:1-e,I(b)) and Criminal Records Check Fund (RSA 106-B:7, II)			

METHODOLOGY:

This part of the bill requires the licensure of individuals engaged in music therapy beginning July 1, 2021 and establishes a 5 member governing board within the office of allied health professionals. The bill establishes a new classified position of program assistant II (labor grade 15) to assist the board in its duties. The bill appropriates funds for the salary and benefits of the position and for the per diem and mileage expenses of board members from the Office of Professional Licensure and Certification Fund (OPLC) established in RSA 310-A:1-e.

The OPLC estimates the salary and benefits for the new full-time position to cost $60,000 in FY22, $63,000 in FY23 and $66,000 in FY24.

The OPLC estimates the 5 member board would meet 12 times per year, with expenses for annual per diem and mileage totaling $5,460 per year, as shown below:

5 members x 12 meetings x $50 per diem = $3,000
5 members x 12 meetings x $41 average mileage reimbursement = $2,460

The OPLC estimates that approximately 200 licenses would be granted. Such licenses would be renewed every 2 years and all allied health initial licenses are currently set at $110 payable biennially. This amount would generate $22,000 in license revenue every 2 years ($110 x 200 = $22,000).

The bill prohibits the practice of music therapy without a license but there is no penalty. The addition of this license category also subjects licensees to the allied health criminal records check provision pursuant to RSA 328-F:18-a and performed by the Department of Safety. The $25 fee associated with such checks is payable by the license applicant. Based on the OPLC estimate of 200 applicants, potential initial revenue of $5,000 would be generated for the Criminal Records Check Fund pursuant to RSA 106-B:7, II, with an indeterminable amount thereafter based on an unknown number of new applicants.

AGENCIES CONTACTED:

Office of Professional Licensure and Certification

PART VII Relative to the authority of the office of professional licensure and

certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

This part has no fiscal impact.

PART VIII Relative to skilled professional medical personnel.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[ ] Other

METHODOLOGY:

This section proposes changes to RSA 151-E:3, Long Term Care; Eligibility. Skilled professional medical personnel shall oversee clinical eligibility determinations and service coverage prior authorizations for Medicaid home and community-based care waiver services. Only skilled professional medical personnel who are registered nurses and currently licensed in accordance with RSA 326-B may render an adverse service coverage determination or adverse clinical eligibility determination.

The Department of Health and Human Services states the Department may need to replace supervisors for affected programs with registered nurses, at significantly higher wage rates. The Department may also be unable to fill positions and issue timely decisions, delaying services, and require medically trained staff for determinations that may be denied for non-clinical reasons.

AGENCIES CONTACTED:

Department of Health and Human Services

PART IX Relative to temporary licensure of certain licensed nursing assistants.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

STATE:	Estimated Increase / (Decrease)			
	FY 2021	FY 2022	FY 2023	FY 2024
Appropriation	$0	$0	$0	$0
Revenue	$0	$7,000	$0	$7,000
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General [ ] Education [ ] Highway [X] Other- Office of Professional Licensure and Certification Fund (RSA 310-A:1-e,I(b))			

METHODOLOGY:

This part of the bill allows licensure as licensed nursing assistants for individuals who served as temporary health partners for a minimum of 100 hours prior to April 1, 2021. The Office of Professional Licensure and Certification estimates 200 temporary health partners would be eligible for licensure at the current license fee of $35, yielding an estimated biennial revenue of $7,000. The amount of resources needed to create a new licensure category via the licensing portal and processing these applications is indeterminable.

It is assumed this section would be effective July 1, 2021.

AGENCIES CONTACTED:

Office of Professional Licensure and Certification

PART X Relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

This part has no fiscal impact.

PART XI Relative to schools for barbering, cosmetology, and esthetics.

This part has no fiscal impact.

PART XII Relative to telemedicine provided by out of state psychologists.

This part has no fiscal impact.

PART XIII Relative to certified food protection managers.

This part has no fiscal impact.

LBA
21-0964
Revised 2/10/21

SB 133-FN- FISCAL NOTE
AS INTRODUCED

AN ACT adopting omnibus legislation relative to occupational licensure.

PART I Relative to the definition of "licensing agency" for purposes of licensing places of assembly.

This part has no fiscal impact.

PART II Establishing a limited plumbing specialist license.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$95,000	$95,000	$190,000
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General [ ] Education [ ] Highway [X] Other- Office of Professional Licensure and Certification Fund (RSA 310-A:1-e,I(b))			

METHODOLOGY:

This part establishes a new limited plumbing specialist license category. The Office of Professional Licensure and Certification estimates there would be 500 such licenses issued annually with a $190.00 license fee comparable to that of a journeyman license. The license would be renewed biennially. The OPLC states there would be an indeterminable cost associated with the administrative processing for such licenses.

It is assumed this section of the bill will be effective July 1, 2021.

AGENCIES CONTACTED:

Office of Professional Licensure and Certification

PART III Repealing the emergency medical services personnel licensure interstate Compact.

This part has no fiscal impact.

PART IV Relative to hearings of the New Hampshire board of nursing.

This part has no fiscal impact.

PART V Relative to membership of the professional standards board.

This part has no fiscal impact.

PART VI Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact.

This part has no fiscal impact.

PART VII Relative to the licensure and regulation of music therapists.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$65,460	$68,460	$71,460
Revenue	$0	$27,000	$0	$22,000
Expenditures	$0	$65,460	$68,460	$71,460
Funding Source:	[X] General [ ] Education [ ] Highway [X] Other- Office of Professional Licensure and Certification Fund (RSA 310-A:1-e,I(b)) and Criminal Records Check Fund (RSA 106-B:7, II)			

METHODOLOGY:

This part of the bill requires the licensure of individuals engaged in music therapy beginning July 1, 2021 and establishes a 5 member governing board within the office of allied health professionals. The bill establishes a new classified position of program assistant II (labor grade 15) to assist the board in its duties. The bill appropriates funds for the salary and benefits of the position and for the per diem and mileage expenses of board members from the Office of Professional Licensure and Certification Fund (OPLC) established in RSA 310-A:1-e.

The OPLC estimates the salary and benefits for the new full-time position to cost $60,000 in FY22, $63,000 in FY23 and $66,000 in FY24.

The OPLC estimates the 5 member board would meet 12 times per year, with expenses for annual per diem and mileage totaling $5,460 per year, as shown below:

5 members x 12 meetings x $50 per diem = $3,000

5 members x 12 meetings x $41 average mileage reimbursement = $2,460

The OPLC estimates that approximately 200 licenses would be granted. Such licenses would be renewed every 2 years and all allied health initial licenses are currently set at $110 payable biennially. This amount would generate $22,000 in license revenue every 2 years ($110 x 200 = $22,000).

The bill prohibits the practice of music therapy without a license but there is no penalty. The addition of this license category also subjects licensees to the allied health criminal records check provision pursuant to RSA 328-F:18-a and performed by the Department of Safety. The $25 fee associated with such checks is payable by the license applicant. Based on the OPLC estimate of 200 applicants, potential initial revenue of $5,000 would be generated for the Criminal Records Check Fund pursuant to RSA 106-B:7, II, with an indeterminable amount thereafter based on an unknown number of new applicants.

AGENCIES CONTACTED:

Office of Professional Licensure and Certification

PART VIII Relative to the authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals.

This part has no fiscal impact.

PART IX Relative to skilled professional medical personnel.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[ ] Other

METHODOLOGY:

This section proposes changes to RSA 151-E:3, Long Term Care; Eligibility. Skilled professional medical personnel shall oversee clinical eligibility determinations and service coverage prior authorizations for Medicaid home and community-based care waiver services. Only skilled professional medical personnel who are registered nurses and currently licensed in accordance with RSA 326-B may render an adverse service coverage determination or adverse clinical eligibility determination.

The Department of Health and Human Services states the Department may need to replace supervisors for affected programs with registered nurses, at significantly higher wage rates. The Department may also be unable to fill positions and issue timely decisions, delaying services, and require medically trained staff for determinations that may be denied for non-clinical reasons.

AGENCIES CONTACTED:

Department of Health and Human Services

PART X Relative to temporary licensure of certain licensed nursing assistants.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

STATE:	Estimated Increase / (Decrease)			
	FY 2021	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	$7,000	$0	$7,000
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General [ ] Education [ ] Highway [X] Other- Office of Professional Licensure and Certification Fund (RSA 310-A:1-e,I(b))			

METHODOLOGY:

This part of the bill allows licensure as licensed nursing assistants for individuals who served as temporary health partners for a minimum of 100 hours prior to April 1, 2021. The Office of Professional Licensure and Certification estimates 200 temporary health partners would be eligible for licensure at the current license fee of $35, yielding an estimated biennial revenue of $7,000. The amount of resources needed to create a new licensure category via the licensing portal and processing these applications is indeterminable.

It is assumed this section would be effective July 1, 2021.

AGENCIES CONTACTED:

Office of Professional Licensure and Certification

PART XI Relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

This part has no fiscal impact.

PART XII Relative to schools for barbering, cosmetology, and esthetics.

This part has no fiscal impact.

PART XIII Relative to telemedicine provided by out of state psychologists.

This part has no fiscal impact.

PART XIV Establishing program rules within the department of health and human services for sanitary production and distribution of food.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Appropriation	$0	$0	$0	$0
Revenue	$0	Indeterminable	Indeterminable	Indeterminable
Expenditures	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source:	[X] General	[ ] Education	[ ] Highway	[ ] Other

METHODOLOGY:

The Department of Health and Human Services assumes the intent of Part XIV is to codify the program rules for the sanitary production and distribution of food into state law. The language contained in Part XIV repeals the rulemaking authority of the Commissioner of the Department of Health and Human Services for the following: food licensure codified in RSA 143-A:9, homestead food operations codified in RSA 143-A:13, and the sale of uninspected poultry and rabbits codified in RSA 143-A:17.

It is the Department's interpretation that this legislation aims to revert to a previous version of the Food Protection Regulations (NH Code of Administrative Rules, Chapter He-P 2300, Rules for the Sanitary Production and Distribution of Food) that were effective in February 2019, by placing the text of the previously adopted rules into statute. The Department updated its Food Protection Regulations (Chapter He-P 2300) in August of 2019, including incorporating by reference the most recent version of the US Food and Drug Administration's (FDA) Food Code (2017 Food Code). By codifying the rules that were in place in February of 2019 into statute, the current Certified Food Protection Manager (CFPM) requirement (specified in He-P 2303.02, effective August 20, 2019) would not exist, as this was not a requirement in the previous version of the Food Protection Regulations. The Food Protection Regulations that were effective in February of 2019 referenced the 2009 version of the Food Code. The 2009 version of the Food Code did not include a requirement for a Certified Food Protection Manager.

The proposed legislation also contains a requirement for the Department to offer a training course for interested parties to become a CFPM every 30 days. The Department states it will need to hire at least one new trainer Program Specialist III (LG 23) position to conduct the Certified Food Protection Manager training every 30 days. This position is estimated to include salary and benefits totaling $77,000 in FY 2022, $81,000 in FY 2023 and $85,000 in FY 2024. There is no appropriation in this section for this position.

The Department estimates a cost of $75 per attendee for a textbook and exam. The Department cannot estimate the number of registrations for classes from approximately 8,000 food establishments, or where such training may be offered and space requirements, what software may be needed for registration and certificates of course completion, or accommodations for multiple language or interpreter services. Therefore the total fiscal impact is indeterminable.

AGENCIES CONTACTED:

Department of Health and Human Services

Testimony

SB 133
Testimony

…divided into 3 separate

saved

Testimony files

Testimony
1 of 3 files

Archived: Tuesday, May 18, 2021 9:12:04 AM
From: Pam Smarling
Sent: Tuesday, May 18, 2021 9:07:45 AM
To: ~House Executive Departments and Administration
Cc: Rod Pimentel
Subject: subcommittee draft for SB 133 and New Warner proposals for XII
Response requested: Yes
Importance: Normal
Attachments:
Draft Committee Amendment to SB 133.docx NEW 2021 05 14 p OPLC confer - Sug amendment for SB133 Part XII Tele-Pass license by Dr Deborah Warner +.doc

---

TO: All Members of he House ED&A Committee,

I have not yet received the OLS amendment to SB 133. Attached is the language that I sent to them with the request for an amendment. Also attached is a proposal sent by Dr. Warner this morning for Part XII. Copies of both of these documents are in the committee room.

Pam

Pam Smarling, Senior Committee Researcher
House Committee Research, Room 409, LOB
33 N. State St., Concord, NH 03301
(603) 271-3387

Archived: Tuesday, May 11, 2021 8:41:31 AM
From: Pam Smarling
Sent: Monday, May 10, 2021 3:45:33 PM
To: ~House Executive Departments and Administration
Cc: Mark Pearson
Subject: SB 133 proposed revision for discussion tomorrow
Response requested: No
Importance: Normal

TO: All members of the House ED&A Committee,

As you know, the subcommittee on SB 155 will be meeting at 10:00 am tomorrow. The full committee will be discussing SB 133 at 1:00 p.m. The Zoom link that was sent out last Friday will be sent again tomorrow morning. **The same link should be used for both meetings.**

One of the Parts of SB 133 that the committee will discuss in exec session tomorrow is Part XIV.

The subcommittee has adopted a revision to this part. Rep. McGuire asked me to distribute a further revision proposed by Melissa Clement, Chief of the Child Care Licensing Unit.

Subcommittee Proposal, Part XIV, Establishing minimum qualifications for certification as a child care associate teacher.

1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after subparagraph (m) the following new subparagraph:

(n) The following qualification for certification as an associate teacher: a minimum of 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of training in child growth and development, the latter of which may be documented life experience. *Documented life experience shall include work for a family child care provider; service as a foster parent; work as a school teacher; work as a camp counselor; and experience as a group leader for children in sports or other activities, such as scouts, little league , or closely related activity.*

2 Effective Date. This act shall take effect 60 days after its passage.

Department Proposal; revision to final sentence

Documented life experience in lieu of training in child growth and development shall include experience with the same age children the associate teacher supervises, such as a family child care provider; service as a foster parent; work as a school teacher; work as a camp counselor; and experience as a group leader for children in sports or other activities, such as scouts or little league, or closely related experience.

I'll see you in the morning.

Pam

Pam Smarling, Senior Committee Researcher
House Committee Research, Room 409, LOB
33 N. State St., Concord, NH 03301
(603) 271-3387

Archived: Tuesday, May 25, 2021 1:25:47 PM
From: Victoria Chesterley
Sent: Wednesday, May 5, 2021 9:18:22 PM
To: ~House Executive Departments and Administration
Subject: SB 133
Importance: Normal
Attachments:
NHSLHA Letter to ED&A Music Therapy.pdf NHSLHA Letter to ED & A Interstate Compact.pdf

---

Please see the attached e-mails.

Thank you,

Victoria Chesterley

--
Victoria Chesterley, MS, CCC-SLP
Consulting Speech-Language Pathologist
(Retired) VP of Governmental Affairs, New Hampshire Speech-Language-Hearing Association

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Payment: http://www.nhslha.org/store/

Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Susan Adams
Sent: Wednesday, May 5, 2021 1:01:14 PM
To: ~House Executive Departments and Administration
Cc: Thomas Prasol
Subject: FW: SB 133 - Music Therapy amendment
Importance: High
Attachments:
Amendments to SB 133.docx ;

Chairwoman McGuire and Members of the E&A Committee,

I understand the House E&A committee will be debating SB 133, Section 5, the music therapy licensure section. I'm attaching the language that was agreed to by ASHA & AMTA as an amendment to the bill and pasting below:

> III. Subject to Subsection (V) of this section, unless authorized to practice speech–language pathology under RSA 326-F or unless otherwise provided for under this article, a person may not represent to the public by title, by description of services, methods, or procedures, or otherwise that the person:
> (a) Is authorized to practice speech–language pathology in this State; or
> (b) Evaluates, examines, instructs, or counsels individuals suffering from disorders or conditions that affect speech, language, communication, and swallowing.
>
> IV. Subject to Subsection (V) of this section, unless authorized to practice speech–language pathology under RSA 326-F, a person may not use any word or term connoting professional proficiency in speech–language pathology, including but not limited to "communication disorders."
>
> V. (a) Expect as provided in paragraph (b) of this subsection, an individual licensed under this title to engage in the practice of music therapy may not represent to the public that the individual is authorized to treat a communication disorder.
> (b) This section may not be construed to prohibit an individual licensed under this title to engage in the practice of music therapy from representing to the public that the individual may work with a client who has a communication disorder to address communication skills.

Please let me know if there is anything I can do to assist.

Thank you,

~Susan

Susan Adams, Esq., CAE
Pronouns: she/her/hers
Director, State Legislative & Regulatory Affairs
American Speech-Language-Hearing Association
Direct Line: 301-296-5665

"This information is based on the facts you provided to ASHA staff. ASHA has not verified the information you provided and is not responsible for the accuracy or completeness of this information. Information provided by ASHA does not supersede the clinical, legal or financial judgement of the practitioner, nor does

it dictate a payer's reimbursement policy. In all cases, practitioners remain responsible for their clinical practice and the use of correct coding procedures. ASHA's response to your question is not and should not be construed as legal advice, which can only be provided by an attorney."

From: Susan Adams
Sent: Wednesday, April 21, 2021 3:00 PM
To: HouseExecutiveDepartmentsandAdministration@leg.state.nh.us
Subject: SB 133 - Music Therapy amendment
Importance: High

Chairwoman McGuire and E&A Committee Members,

Thank you for the opportunity to share our concerns on Section VI of SB 133, which would license and regulate music therapists. I am sharing here a draft amendment of that section that would address our concerns with language was agreed upon by all parties in Maryland SB 82.

Should you have additional questions, please reach out. I can also be available to the sub-committee.

Best,
~Susan

Susan Adams, Esq., CAE
Pronouns: she/her/hers
Director, State Legislative & Regulatory Affairs
American Speech-Language-Hearing Association
2200 Research Boulevard, #220
Rockville, MD 20850

Direct Line: 301-296-5665
National Office: 301-296-5700
Email: sadams@asha.org
http://www.asha.org

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"This information is based on the facts you provided to ASHA staff. ASHA has not verified the information you provided and is not responsible for the accuracy or completeness of this information. Information provided by ASHA does not supersede the clinical, legal or financial judgement of the practitioner, nor does it dictate a payer's reimbursement policy. In all cases, practitioners remain responsible for their clinical practice and the use of correct coding procedures. ASHA's response to your question is not and should not be construed as legal advice, which can only be provided by an attorney."

Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Miriam Simmons
Sent: Thursday, April 29, 2021 3:22:28 PM
To: ~House Executive Departments and Administration
Cc: Pam Smarling; Miriam Simmons
Subject: : additional information requested by Subcommittee for SB 133 amendment
Response requested: No
Importance: Normal
Attachments:
SB 133 .docx

---

see attached -
-additional information on SB 133 non-germane amendment -
Provided to the Subcommittee and for the EDA Committee members.

Miriam

From: Carol McGuire <mcguire4house@gmail.com>

---------- Forwarded message ---------
From: **Marianne Barter** <mariannebarter@gmail.com>
Date: Thu, Apr 29, 2021 at 2:13 PM
Subject: additional information requested by committee for SB 133 amendment
To: <carol@mcguire4house.com>
CC: Mary Jane Wallner <mjwallnernh@gmail.com>

Dear Representative McGuire,
Representative Jaci Grote requested additional information regarding the non- germane amendment on SB133. I have attached the requested information, but was not sure if I should send it to the committee assistant or the full committee.
Thank you for your help in this matter,
Marianne Barter

Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Carol McGuire
Sent: Thursday, April 29, 2021 2:23:30 PM
To: Miriam Simmons
Subject: Fwd: additional information requested by committee for SB 133 amendment
Importance: Normal
Attachments:
SB 133 .docx

---------- Forwarded message ---------
From: **Marianne Barter** <mariannebarter@gmail.com>
Date: Thu, Apr 29, 2021 at 2:13 PM
Subject: additional information requested by committee for SB 133 amendment
To: <carol@mcguire4house.com>
CC: Mary Jane Wallner <mjwallnernh@gmail.com>

Dear Representative McGuire,
Representative Jaci Grote requested additional information regarding the non- germane amendment on SB133. I have attached the requested information, but was not sure if I should send it to the committee assistant or the full committee.
Thank you for your help in this matter,
Marianne Barter

Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Teresa Rhodes Rosenberger
Sent: Wednesday, April 28, 2021 6:49:00 PM
To: ~House Executive Departments and Administration
Subject: SB 133 Temporary Health Partners
Importance: Normal
Attachments:
NHHCA Temporary Health Partner Memo .pdf

Attached is a memo from Brendan Williams, the President of the NH Healthcare Association, giving a bit of history on how the Temporary Health Partners category came about during the pandemic due last year. They were a tremendous help particularly with the staffing shortages. We so hope you will pass the sections of SB 133 and SB 155 dealing with the Temporary Health Partners.

Thanks you for your consideration.

Teresa

Teresa Rhodes Rosenberger
Senior Advisor
603 665-8834 direct
603 623-8700 main
LinkedIn | Twitter

BERNSTEIN SHUR

Manchester, NH | Portland, ME | Augusta, ME | bernsteinshur.com

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Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Courtney, Lindsey
Sent: Tuesday, April 27, 2021 2:32:43 PM
To: ~House Executive Departments and Administration
Subject: NH House Remote Testify: 1:00 pm - SB155 in House Executive Departments and Administration
Importance: Normal
Attachments:
Testimony regarding SB133 House.pdf

Attached is OPLC's testimony regarding SB 133. Thank you!

Lindsey B. Courtney, J.D. | **Executive Director**
NH Office of Professional Licensure and Certification
7 Eagle Square, Suite 200, Concord, New Hampshire 03301
603.271.6985 (Office) 603.406.4018 (Cell) | lindsey.courtney@oplc.nh.gov| www.oplc.nh.gov

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Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Johnson, Emily
Sent: Tuesday, April 27, 2021 2:10:01 PM
To: ~House Executive Departments and Administration
Subject: SB 133 Amendment Testimony
Importance: Normal
Attachments:
SB 133 2021 Testimony - E Johnson, SCAN.pdf

Madam Chairman McGuire and Esteemed Members of the Committee:

I hope this message finds you well.

Please find attached written testimony in opposition to the amendment to SB 133, which you will hear today during your 2:30 p.m. hearing.

Please let me know if you have any questions. Thank you for your consideration of my testimony.

Best,
Emily

Emily Johnson
Pronouns: she, her
NH, RI, VT State Manager, State & National Campaigns
Save the Children Action Network
----
(603) 986-8151 | ejohnson@savechildren.org
https://www.SavetheChildrenActionNetwork.org/

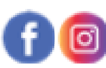
Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Diana Menard
Sent: Tuesday, April 27, 2021 10:40:51 AM
To: ~House Executive Departments and Administration
Subject: NH House Remote Testify: 2:30 pm - SB133 in House Executive Departments and Administration
Importance: Normal
Attachments:
scan0001.pdf ;

Please see attached letter of testimony in opposition of SB133

Thank you,

Diana Menard
Department Chair
Child and Family Studies

office: 603-271-6484 x4281



Archived: Tuesday, May 25, 2021 1:25:48 PM
From: mansy.moy88@gmail.com
Sent: Tuesday, May 11, 2021 12:39:55 AM
To: ~House Executive Departments and Administration
Importance: Normal

April 27, 2021

Distinguished Members of the
House Executive Departments
and Administration Committee:

At Save the Children Action Network, we believe all children deserve access to high-quality early childhood education. Since 2014, we have worked in partnership with community volunteers, policy advocates, and state legislators to improve accessibility and quality of New Hampshire's child care and early learning programs. While well-intentioned, we believe the amendment to SB 133 would be a step backward in our mission to provide equitable access to high-quality early childhood education to all Granite Staters, which is why I am testifying in opposition to this bill.

Early childhood educators are responsible for the care and education of our youngest citizens during some of the most consequential years in their lives. While they provide an essential service to working families and help shape the leaders of tomorrow, they are a routinely undervalued workforce. SB 133 seeks to answer this shameful undervaluing of teachers by lowering the bar for higher education required of child care employees. Early childhood educators that I have worked closely with in my role understand that their jobs are increasingly difficult as our state copes with multiple crises impacting children, including the opioid epidemic and the COVID-19 pandemic. More children are coming into their care with Adverse Childhood Experiences associated with the aforementioned crises. Child care providers should be supported by the state with more resources and training to help them provide high-quality care. Answering these crises by diminishing teacher education requirements would be a grave mistake that would negatively impact generations of Granite Staters. Even setting public health crises aside, the quality of care of our children is a direct reflection of the competence of the early childhood educator, and we should not consider compromising the health and safety of our children under any circumstances.

In conclusion, I urge members of this committee not to support this amendment to SB 133. Thank you for your time and consideration of mine and others' testimony today.

Syenna Whitley
Save the children action network advocate

Sent from Yahoo Mail for iPad

Archived: Tuesday, May 25, 2021 1:25:48 PM
From: James Bloomer
Sent: Monday, May 17, 2021 5:08:25 PM
To: ~House Executive Departments and Administration
Cc: governorsununu@nh.gov
Subject: James Bloomer MD regarding HB155
Importance: Normal

Dear Sir/Ma'am,

I am writing to encourage you, in the strongest terms, to defeat this proposed amendment. I feel it is poor public policy and puts residents at risk. As someone who is proud to live and practice in NH, a state which prides itself in 'doing the right thing', such an amendment is poorly considered and has no place being codified in our laws. It is difficult to know where to start given a number of serious concerns with this amendment. I understand, however, that the hearing is tomorrow, and having just heard about this amendment, I am compelled to send at least a brief message.

I would implore you to not make the job of keeping NH residents healthy more difficult by supporting this amendment.

Respectively,

James Bloomer MD
21 Hampton Road
Exeter, NH 03833

Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Margaret A. Campbell
Sent: Tuesday, May 11, 2021 10:08:20 AM
To: ~House Executive Departments and Administration
Subject: SB 133-Amendment #2021
Importance: Normal

To Members of the House Executive Departments & Administration Committee:

Regarding today's vote on SB 133, specifically the **non**-germane Amendment # 2021-1162h, I strongly urge Committee members to vote no on this measure.
The work of Child Care teachers is so important in its impact on the healthy growth and development of young children, that education and training requirements for these workers should be maintained as is if not increased.

I am opposed to this measure. Please vote no.

Thank you for your consideration.

Margaret A. Campbell
Ward #1, Lebanon, NH

Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Pam Smarling
Sent: Tuesday, May 4, 2021 10:18:56 AM
To: ~House Executive Departments and Administration
Subject: FW: words
Response requested: Yes
Importance: Normal

This is the language from Rep. Grote.

Pam

From: Jaci Grote <Jaci.Grote@leg.state.nh.us>
Sent: Tuesday, May 4, 2021 10:18 AM
To: Pam Smarling <Pam.Smarling@leg.state.nh.us>
Subject: Fwd: words

Can you forward this to the committee?

Begin forwarded message:

> **From:** Jaci Grote <Jaci.Grote@leg.state.nh.us>
> **Date:** April 28, 2021 at 5:37:00 PM EDT
> **To:** Carol McGuire <mcguire4house@gmail.com>, "Sytek, John" <johnsytek@aol.com>, Pam Smarling <Pam.Smarling@leg.state.nh.us>
> **Subject: Re: words**
>
> I think it is important that these experience include groups of children. Fostering one child in your home is different than being with a group of children. How about this:
>
> Documented life experience shall include work for a family child care provider; service as a foster parent; work as a school teacher; work as a camp counselor; and experience as a group leader for children in sports or other activities, such as scouts or little league. Each these cases the experience shall involve three or more children during the experience.
>
> *Jaci Grote*
> Representative Jaci Grote
> Rockingham District 24 - Rye and New Castle
> Executive Departments and Administration
> 603-235-6287
>
> ---
>
> **From:** Carol McGuire <mcguire4house@gmail.com>
> **Sent:** Wednesday, April 28, 2021 3:47 PM
> **To:** Sytek, John <johnsytek@aol.com>; Jaci Grote <Jaci.Grote@leg.state.nh.us>; Pam

Smarling <Pam.Smarling@leg.state.nh.us>
Subject: words

suggested amendment to the non-germane amendment to SB 133:

Documented life experience shall include work for a family child care provider; service as a foster parent; work as a school teacher; work as a camp counselor; and experience as a group leader for children in sports or other activities, such as scouts or little league

I talked with Mary Jane and we agreed adding some definition would be a good idea. We came up with this list. Comments?

Carol

Archived: Tuesday, May 25, 2021 1:25:48 PM
From: Karen Juall
Sent: Wednesday, April 28, 2021 9:35:23 AM
To: ~House Executive Departments and Administration
Subject: SB133: Child Care
Importance: Normal

Madam Chair and Committee Members,

I wish to thank you for hearing my testimony at yesterday's Hearing on SB133 regarding the removal of the training requirement for Associate Child Care Teacher. I also want to apologize for being so nervous - I'm retired and definitely out of practice.

I also wanted to correct the reference to me as "Dr. Juall". Although I deeply appreciate it, my doctoral studies unfortunately did not lead to a degree, and I apologize if I mislead you in my introduction. However, I sure learned a great deal about poverty and its effects on child development.

Just to re-iterate, removing the training hours will be very difficult to reinstate in the Licensing Rules down-the-road; and there ARE ways now to circumvent those 9 hours, giving programs the flexibility they need to deal with the workforce crisis. There are a lot of smart people in NH working to solve the broken child care system. Passing this legislation will be a major setback to their work.

Again, thank you for your dedication to this important issue and time spent reading what I have to offer.

Respectfully,
Karen Juall

Archived: Tuesday, May 25, 2021 11:58:56 AM
From: Romanello, Justin
Sent: Thursday, April 22, 2021 7:43:39 AM
To: ~House Executive Departments and Administration
Subject: SB133 Testimony and Letter of Support
Importance: Normal
Attachments:
CB SB133 Letter.pdf ;

Dear members of the House of Representatives,

Please find an additional letter from the New Hampshire Medical and Trauma Services Coordinating Board voicing their concerns with the repeal of REPLICA and the support for Section X regarding amendments to adjust and add language giving the Commissioner of the Department of Safety more tools and flexibility in his/her duties of regulation of the New Hampshire EMS system.

I want to apologize for the errors in both this letter from the board and in my submitted testimony yesterday. I somehow was using an older and non-amended form of the Bill text which caused the Sections to be missed numbered.

Thank you for all that you do for our State and I look forward to attended the sub-committee meeting next week.

Justin

Justin Romanello
Bureau Chief
NH DOS, Division of Fire Standards and Training & EMS
Email: justin.s.romanello@dos.nh.gov
Office: 603-223-4211
Cell: 603-573-6307
Fax: 603-271-1091
http://www.nh.gov/ems

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From: Romanello, Justin
Sent: Tuesday, April 20, 2021 6:54 PM
To: houseexecutivedepartmentsandadministration@leg.state.nh.us <houseexecutivedepartmentsandadministration@leg.state.nh.us>
Subject: SB133 Testimony and Letter of Support

Dear Sir/Ma'am,

Please find the attached document of my personal testimony that I will be presenting at tomorrow's session as well as a letter of support from the New Hampshire Medical Control Board.

Thank you,

Justin

Justin Romanello
Bureau Chief
NH DOS, Division of Fire Standards and Training & EMS
Email: justin.s.romanello@dos.nh.gov

Office: 603-223-4211
Cell: 603-573-6307
Fax: 603-271-1091
http://www.nh.gov/ems

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Archived: Tuesday, May 25, 2021 11:58:56 AM
From: Susan Adams
Sent: Wednesday, April 21, 2021 2:59:56 PM
To: ~House Executive Departments and Administration
Subject: SB 133 - Music Therapy amendment
Response requested: No
Importance: High
Attachments:
Amendments to SB 133.docx ;

Chairwoman McGuire and E&A Committee Members,

Thank you for the opportunity to share our concerns on Section VI of SB 133, which would license and regulate music therapists. I am sharing here a draft amendment of that section that would address our concerns with language was agreed upon by all parties in Maryland SB 82.

Should you have additional questions, please reach out. I can also be available to the sub-committee.

Best,
~Susan

Susan Adams, Esq., CAE
Pronouns: she/her/hers
Director, State Legislative & Regulatory Affairs
American Speech-Language-Hearing Association
2200 Research Boulevard, #220
Rockville, MD 20850

Direct Line: 301-296-5665
National Office: 301-296-5700
Email: sadams@asha.org
http://www.asha.org

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Archived: Tuesday, May 25, 2021 11:58:56 AM
From: Tricia Melillo
Sent: Wednesday, April 21, 2021 2:12:59 PM
To: ~House Executive Departments and Administration
Cc: Grant Bosse; Josh Elliott; Kevin Avard
Subject: SB 133 Testimony
Importance: Normal
Attachments:
Avard Remarks Part VI.docx

Good afternoon,

Please accept the attached testimony for Part VI of SB 133.

Thank you,

Tricia

Tricia Melillo
Legislative Aide
Senator Kevin Avard
Senator Bill Gannon
Senate Election Law and Municipal Affairs
Phone: (603) 271-3077
E-mail: tricia.melillo@leg.state.nh.us

Archived: Tuesday, May 25, 2021 11:58:56 AM
From: Clay E. Odell
Sent: Wednesday, April 21, 2021 9:25:15 AM
To: ~House Executive Departments and Administration
Subject: Written testimony on SB133, specifically the repeal of the EMS Compact
Importance: Normal
Attachments:
ODELL - TESTIMONY ON SB133 - APRIL 21 2021.docx

Honorable Committee Members

Please accept my written testimony asking for an amendment to SB133 to strike out Section II of the amended Senate Bill (Section III of the Bill as originally introduced). This is the section calling for the repeal of NH's participation in the EMS Compact. I believe the EMS Compact is good for NH EMS providers and the public benefits from the Compact. Thank you for your consideration.

Sincerely your,
Clay Odell

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Archived: Tuesday, May 25, 2021 11:58:56 AM
From: Jason Grey
Sent: Wednesday, April 21, 2021 9:03:17 AM
To: ~House Executive Departments and Administration
Subject: NH House Remote Testify: 10:00 am - SB133 in House Executive Departments and Administration
Importance: Normal
Attachments:
Grey SB133.pdf Tauber SB133.pdf

Dear Chair and Committee members,

I am writing to the Committee this morning in opposition to SB133, specifically section III, addressing the withdrawal of New Hampshire from the EMS compact known as REPLICA.

I have attached further statements as well as a letter from our Associations Vice President, Mr. Tauber.

Respectfully,

Jason Grey BS, NRP, CCT-C, FP-C, IC
President
New Hampshire Association of Emergency Medical Technicians

Archived: Tuesday, May 25, 2021 11:58:56 AM
From: Rogers, Abigail
Sent: Tuesday, April 20, 2021 8:48:26 PM
To: ~House Executive Departments and Administration
Subject: DHHS Testimony SB 133 Part XIII of the omnibus legislation relative to occupational licensure
Importance: Normal
Attachments:
DHHS Testimony SB133 Part XIII House ED&A.docx

Dear Chair McGuire and Members of the Committee:

Please find attached DHHS testimony in support of Part XIII of SB 133FN relative to sanitary production and distribution of food.
Colleen Smith from the Food Protection Program, DHHS, DPHS will be providing the testimony tomorrow during the hearing scheduled at 10am.

Thank you!

Abby Rogers

Abigail Rogers
Legislative Liaison

Division of Public Health Services
New Hampshire Department of Health and Human Services
29 Hazen Drive, Concord, NH 03301
603-333-6309 (cell)
603-271-4593 (O)
Abigail.Rogers@dhhs.nh.gov

ATTENTION: please visit the DHHS COVID-19 website for the latest COVID-19 information, resources and guidance: https://www.nh.gov/covid19/

Archived: Tuesday, May 25, 2021 11:58:56 AM
From: Romanello, Justin
Sent: Tuesday, April 20, 2021 6:54:38 PM
To: ~House Executive Departments and Administration
Subject: SB133 Testimony and Letter of Support
Importance: Normal
Attachments:
SB133 Letter of Support - NHMCB.pdf ;SB133 Testimony - Romanello DOS.pdf ;

Dear Sir/Ma'am,

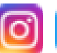
Please find the attached document of my personal testimony that I will be presenting at tomorrow's session as well as a letter of support from the New Hampshire Medical Control Board.

Thank you,

Justin

Justin Romanello
Bureau Chief
NH DOS, Division of Fire Standards and Training & EMS
Email: justin.s.romanello@dos.nh.gov

Office: 603-223-4211
Cell: 603-573-6307
Fax: 603-271-1091
http://www.nh.gov/ems



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Archived: Tuesday, May 25, 2021 11:58:57 AM
From: Arnold, Christopher R CIV OSD OUSD P-R (USA)
Sent: Tuesday, April 20, 2021 4:19:31 PM
To: ~House Executive Departments and Administration
Subject: DoD Memo: SB-133, Pt II (Oppose), Pt V (Support)
Importance: Normal
Digitally Signed: Yes
Attachments:
20210420_MCFP_AM_New_Hampshire_SB133_v2.pdf ;

Dear Members of the House Executive Departments and Administration Committee,

Attached please find testimony regarding Senate Bill SB-133 from the United States Department of Defense, which is on tomorrow's committee agenda. The Department opposes the policies set forth in Part II of the bill; and supports those set forth in Part V of the bill.

I am available to answer whatever questions you may have. Thank you for your continued support of our service members and their families.

Sincerely,

Christopher R. Arnold
Northeast Regional Liaison (CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT)
Defense-State Liaison Office
DoD, Military Community and Family Policy
(571) 309-4712
https://statepolicy.militaryonesource.mil

Celebrate Month of the Military Child

https://www.militaryonesource.mil/family-relationships/family-life/month-of-the-military-child

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Marissa Scott
Sent: Tuesday, April 20, 2021 3:35:23 PM
To: ~House Executive Departments and Administration
Subject: [CAUTION: SUSPECT SENDER] NH House Remote Testify: 10:00 am - SB133 in House Executive Departments and Administration
Importance: Normal
Attachments:
SB 133 Testimony for House ED&A Committee - Marissa Scott.pdf

---

Dear Chairwoman McGuire and members of the Committee,

I will be speaking tomorrow on behalf of the NH Task Force for Music Therapy State Recognition. I have enclosed my brief testimony here. In addition, I wanted to share a quick story with you about a client.

Addison came to The Sonatina Center for music therapy in 2018 when she was just under the age of 3 with a diagnosis of Autism Spectrum Disorder. Mom had concerns about Addie's interpersonal skills, her ability to follow directions for cues of safety, and her relational communication skills. Ultimately, Mom wanted to be more connected to her child and help her daughter ease the frustrations of not being able to communicate her needs. Addison had zero attention span and if she was doing something dangerous and Mom yelled stop, Addie would just keep going. Also, Addie couldn't say yes or no with purpose and meaning. Over the course of therapy, Addie was able to greatly increase her relational communication skills along with her attention span and her ability to connect meaningfully with others, and most importantly with mom. I've included a short clip of my work with Addie. In this clip, we'd been working together for a few months and I know you haven't seen a before clip, but her attention span for the length of this video is amazing. She's also having a back and forth conversation with me, making eye contact, and laughing at things that are silly. All things that seemed impossible when she began.

Handbells - Identifying Colors - Yes & No - Att...

She's doing well today and still making strides, but she is no longer in music therapy because she was only receiving funding for it through a short grant that ran out. Unfortunately, insurance won't cover music therapy for Addie and they can't afford to pay out of pocket - insurance will rarely cover any services by an "unlicensed" provider. I know this because I've spent hours and hours of my own personal time on the phone trying to help my clients get reimbursed for therapy. Addie is not our only client who had to stop services due to a loss of grant funding. You can help people like Addie and many others by passing this bill. Not everyone benefits from the same type of service as

everyone else. People deserve to have choices in their health care, and for someone like Addie who benefited greatly from music therapy, it's a shame that it's because of "unlicensed provider" limitations on her insurance plan she is unable to access services.

I look forward to speaking with you tomorrow and welcome any questions you have regarding the training and education of a music therapist or the rationale for passing a state license for our profession.

Sincerely,
Marissa Scott

Marissa Scott, MA, MT-BC, CLD
Board Certified Music Therapist, Certified Labor Doula
Owner & Executive Director
She/Her

The Sonatina Center
750 Central Ave, Suite U
Dover, NH 03820
(W) 603-978-4808
www.thesonatinacenter.com

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Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Perry, Warren M NFG NG NHARNG (USA)
Sent: Tuesday, April 20, 2021 3:31:19 PM
To: ~House Executive Departments and Administration
Cc: Arnold, Christopher R CIV OSD OUSD P-R (USA)
Subject: SB 133 written testimony
Importance: Normal
Digitally Signed: Yes
Attachments:
SB 133 written testimony- Dept of Mil Affairs and Vets Services.pdf

---

Member of the Executive Departments and Administration,

Please find the attached written testimony regarding part II of SB 133 (as amended) from the Department of Military Affairs

Warren M. Perry
Deputy Adjutant General

State of New Hampshire
The Department of Military Affairs and Veterans Services
4 Pembroke Road
Concord, NH 03301

(603) 225-1302 Office
(603) 717-6284 Cell

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Osterhoudt, Douglas
Sent: Tuesday, April 20, 2021 1:47:30 PM
To: ~House Executive Departments and Administration
Subject: Douglas Osterhoudt, SB 133, part VIII, written testimony
Importance: Normal
Attachments:
SB 133 Part VIII DHHS-BEAS Testimony (04-21-2021).pdf

Hello,

I have signed up to testify at the EDA Committee hearing on SB 133 tomorrow morning and would like to provide the Committee members with the attached written testimony as well.

Douglas J. Osterhoudt, Esq.
BEAS Assignment Legal Coordinator
Bureau of General Counsel
Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301
603-271-9647
douglas.j.osterhoudt@dhhs.nh.gov

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Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Kaytlynn Monroe
Sent: Tuesday, April 20, 2021 11:46:21 AM
To: ~House Executive Departments and Administration
Cc: Brian Ryll
Subject: Testimony in support of SB133
Importance: Normal
Attachments:
Testimony in support of SB 133 Part II.pdf ;Testimony in support of SB 133 Part X.pdf ;

Good morning committee members,

I am sending along written testimony on behalf of the Professional Fire Fighters of New Hampshire in support of SB 133 being heard in House ED&A tomorrow. Please see attached testimony for Part II & Part X.

Please let us know if you have any questions. Thank you for your time.

Kaytlynn

Kaytlynn Monroe
Government & Political Affairs Director
Professional Fire Fighters of New Hampshire
43 Centre Street, Concord, NH 03301
603-223-3304 (O) | 603-219-8815 (C)
Email: kaytlynn@pffnh.org

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Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Eric Schelberg
Sent: Monday, April 19, 2021 10:38:32 PM
To: ~House Executive Departments and Administration
Cc: Eric Schelberg
Subject: SB133 Amended Written Testimony
Response requested: No
Importance: Normal
Attachments:
ED&A SB133 Amended Testimony 2021-04-21.docx

Chairwoman McGuire,

Please find attached written testimony on SB133 Amended regarding striking 'repealing the emergency medical services personnel licensure interstate compact'.

I plan on testifying before your committee this Wednesday, April 21st.

Please do not hesitate to contact me with any questions you may have regarding this request.

Respectfully submitted,

Eric Schelberg
President - NHPA
Milford

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Miriam Simmons
Sent: Monday, April 19, 2021 8:06:46 AM
To: Miriam Simmons
Subject: SB 133 Sunrise reviews of proposals to license music therapists.
Response requested: No
Importance: Normal
Attachments:
2017_Illinois_MusicTherapists.pdf 014_Colorado_MusicTherapists.pdf 017_WestVirginia_MusicTherapy.pdf 012_Washington_MusicTherapists.pdf

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From: Carol McGuire <mcguire4house@gmail.com>
Sent: Sunday, April 18, 2021 7:31 PM
To: ~House Executive Departments and Administration <HouseExecutiveDepartmentsandAdministration@leg.state.nh.us>; Pam Smarling <Pam.Smarling@leg.state.nh.us>
Subject: Fwd: Sunrise reviews of proposals to license music therapists.
---------- Forwarded message ---------
From: **Lee McGrath** <lmcgrath@ij.org>
Date: Wed, Apr 14, 2021 at 8:33 PM
Subject: Sunrise reviews of proposals to license music therapists.
To: carol@mcguire4house.com <carol@mcguire4house.com>
Cc: Meagan Forbes <mforbes@ij.org>, Jessica Gandy <jgandy@ij.org>

Dear Representative McGuire:

- Researchers from the University of Chicago found "*no conclusive evidence to regulate music therapy*" in Illinois on page 122 of the first attachment.

- Colorado's Department of Regulatory Agencies concluded "*there is no demonstrated public interest or need to warrant the creation of a new regulatory program or to protect the title, 'music therapist' or 'board-certified music therapist'*" on page 34 of the second attachment.

- West Virginia's Legislative Auditor observed "*there is no documented evidence of harm to the public caused by music therapists that rises to the level needed for state regulation as stated by W.Va. §30-1A-3, and the hypothetical examples of harm provided by the applicant do not support the need for licensure*" on page 19 of the third attachment.

- Washington State's Department of Health determined it "*does not support the proposal to require state certification for music therapists*" on page 17 of the fourth attachment.

My colleagues and I stand ready to assist you and other members of the Committee on Executive Departments and Administration. Thank you.

Best regards,
Lee U. McGrath
Managing Attorney
Institute for Justice
520 Nicollet Mall-Suite 550
Minneapolis MN 55402-2626
Cell: (612) 963-0296
Email: lmcgrath@ij.org
Web: www.ij.org

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Carol McGuire
Sent: Sunday, April 18, 2021 7:32:25 PM
To: ~House Executive Departments and Administration; Pam Smarling
Subject: Fwd: Sunrise reviews of proposals to license music therapists.
Response requested: No
Importance: Normal
Attachments:
2017_Illinois_MusicTherapists.pdf 2014_Colorado_MusicTherapists.pdf 2017_WestVirginia_MusicTherapy.pdf 2012_Washington_MusicTherapists.pdf

---

FYI, since this is coming back in SB 133.

Carol
---------- Forwarded message ---------
From: **Lee McGrath** <lmcgrath@ij.org>
Date: Wed, Apr 14, 2021 at 8:33 PM
Subject: Sunrise reviews of proposals to license music therapists.
To: carol@mcguire4house.com <carol@mcguire4house.com>
Cc: Meagan Forbes <mforbes@ij.org>, Jessica Gandy <jgandy@ij.org>

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My colleagues and I stand ready to assist you and other members of the Committee on Executive Departments and Administration. Thank you.

Best regards,

Lee U. McGrath

Managing Attorney

Institute for Justice

520 Nicollet Mall-Suite 550

Minneapolis MN 55402-2626

Cell: (612) 963-0296

Email: lmcgrath@ij.org

Web: www.ij.org

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Parisi, Paul
Sent: Saturday, April 17, 2021 8:05:32 AM
To: ~House Executive Departments and Administration
Subject: NH House Remote Testify: 10:00 am - SB133 in House Executive Departments and Administration
Importance: Normal
Attachments:
FMO Position Paper - SB 133 - POA Licensing.pdf ;

Good morning,

Please find my testimony for SB 133, Part 1. Please let me know if you have any questions. Thank you!

Paul

Paul J. Parisi
State Fire Marshal

Department of Safety | Division of Fire Safety
New Hampshire State Fire Marshal's Office (FMO)

Physical: 110 Smokey Bear Boulevard (IPOC), Concord NH
Mailing: 33 Hazen Drive
Concord, NH 03305

Office: 603-223-4289
Direct: 603-223-4293
Fax: 603-223-4294
Arson Hotline: 1-800-400-3526
Email: **paul.parisi@dos.nh.gov**

"Saving lives and property through education, engineering & enforcement"

Web Site Address: http://www.nh.gov/safety/divisions/firesafety
Subscribe to our list serve to receive public safety notices and press releases.

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Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Williams, John
Sent: Wednesday, April 14, 2021 9:35:55 AM
To: Carol McGuire
Cc: Sharon Carson; Deborah Chroniak; Pam Smarling; Osterhoudt, Douglas; audrey mulliner; Miriam Simmons
Subject: RE: SB 133 PART VIII Skilled Professional Medical Personnel - DHHS Request to Remove PART VIII from Omnibus Bill
Importance: High
Attachments:
SB 133 Part IX DHHS-BEAS Testimony (02-10-2021).docx Process Summary for Eligibility Determinations.docx

---

Dear Representative McGuire,

Please find attached testimony to SB 133-FN, formerly Part IX, which is presently Part VIII, in addition to the Process Summary for Clinical Eligibility Determination for Choices for Independence (CFI) and Nursing Facility (NF) Services which explains the Department's present process which is "working" and why we are considerately requesting that Part VIII be deleted from SB 133-FN.

Attorney Douglas Osterhoudt, Legislative Liaison and General Counsel for our agency's Bureau of Elderly and Adult Services, and I would like to schedule a brief conference call with you prior to the public hearing on SB 133 if your calendar permits. In any event, Douglas may be reached at either (603) 271-9647 or douglas.j.osterhoudt@dhhs.nh.gov as a resource to you and your Committee on the critical nature of this request.

Respectfully yours,

John

John L. Williams, Esquire, Director of Legislative Affairs, New Hampshire Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

(603) 271-9395 (office)
(603) 545-2934 (cell)

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Archived: Tuesday, May 25, 2021 11:58:58 AM
From: mansy.moy88@gmail.com
Sent: Tuesday, May 11, 2021 1:26:14 AM
To: ~House Executive Departments and Administration
Importance: Normal

Distinguished Members of the
House Executive Departments
and Administration Committee:

At Save the Children Action Network, we believe all children deserve access to high-quality early childhood education. Since 2014, we have worked in partnership with community volunteers, policy advocates, and state legislators to improve accessibility and quality of New Hampshire's child care and early learning programs. While well-intentioned, we believe the amendment to SB 133 would be a step backward in our mission to provide equitable access to high-quality early childhood education to all Granite Staters, which is why I am testifying in opposition to this bill.

Early childhood educators are responsible for the care and education of our youngest citizens during some of the most consequential years in their lives. While they provide an essential service to working families and help shape the leaders of tomorrow, they are a routinely undervalued workforce. SB 133 seeks to answer this shameful undervaluing of teachers by lowering the bar for higher education required of child care employees. Early childhood educators that I have worked closely with in my role understand that their jobs are increasingly difficult as our state copes with multiple crises impacting children, including the opioid epidemic and the COVID-19 pandemic. More children are coming into their care with Adverse Childhood Experiences associated with the aforementioned crises. Child care providers should be supported by the state with more resources and training to help them provide high-quality care. Answering these crises by diminishing teacher education requirements would be a grave mistake that would negatively impact generations of Granite Staters. Even setting public health crises aside, the quality of care of our children is a direct reflection of the competence of the early childhood educator, and we should not consider compromising the health and safety of our children under any circumstances.

In conclusion, I urge members of this committee not to support this amendment to SB 133. Thank you for your time and consideration of mine and others' testimony today.

Syenna Whitley
Londonderry, NH 03053

Sent from Yahoo Mail for iPad

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Shannon Laine
Sent: Tuesday, April 20, 2021 2:34:50 PM
To: ~House Executive Departments and Administration
Subject: In Support of SB-133, Part VI
Importance: Normal

Dear Members of the House Executive Departments and Administration Committee-

I write to you today in support of music therapy licensure. Having worked in the music therapy field in New Hampshire for the last 15 years, I have seen just how powerful music therapy can be for Granite State Residents.

Today I would like to share with you two recent stories that have been published about music therapy in New Hampshire:
NHPR, The Exchange, highlighted music therapy in an hour-long program:
https://www.nhpr.org/post/therapeutic-power-music#stream/0

Speaking with the Senator, discussing music therapy in New Hampshire and the need for licensure:
https://www.youtube.com/watch?v=zi6uwg6t4io&t=13s

As I am unable to make the hearing tomorrow, I am always available to answer any specific questions via e-mail.

Thank you,
Shannon Laine

Shannon Laine, MT-BC

Director, Music Therapy, Adaptive Lessons, Early Childhood

Manchester Community Music School
2291 Elm Street
Manchester, NH 03104

(603) 689-6250 Cell
(603) 644-4548 Office

Certification Board
MT-BC
for Music Therapists

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Dr Debi Warner
Sent: Wednesday, April 21, 2021 3:42:27 PM
To: ~House Executive Departments and Administration
Cc: John Reagan
Subject: SB133-FN Section XII please OTP House ED&A Committee
Importance: Normal

Testimony for SB133-FN by Dr Deborah Warner for the Board of Psychologists to the House ED&A Committee April 21, 2021

Thank you Madam Chairman. It is privilege to address the ED&A committee concerning part XII of SB 133-FN.

My name is Dr Deborah Warner from Littleton. I am representing the Board of Psychologists who authored the part XII of this bill. We appreciate Senator John Reagan for bringing this forward on behalf of the Board.

Section XII of SB133 continues an aspect of the emergency licenses that the board likes. The board likes the rapid and durable telemedicine license that expands the access for NH people to receive service by qualified psychologists who must also adhere to NH's laws and rules. It turns out that Telemedicine is very popular in mental health service delivery.

Thanks to legislation in 2019 we have an interstate compact PsyPact, but so far it has a small number of state subscriptions and so is not widely available as a method to allow cross state practice for our citizens. The board sees this Tele-Pass license as an adjunct to PsyPact that allows a quick and universal option to enhance service access for our citizens.

This Tele-Pass license will provide a rapid entry for licensed psychologists from other states to quickly obtain a tele medicine license to provide telemedicine for our citizens. Its rapid (even instant) issuance and low cost will help our citizens obtain a wide pool of psychologists to help in areas we are not able to meet in our own provider pool. This is important with the mobility of our citizens and visitors. It helps with continuity of care for those who may need to continue with a psychologist from elsewhere when coming home to NH or when on vacation here, (thinking of snowbirds as well).

PsyPact is a large vehicle for interstate licensing that has 16 states, for which I am NH's commissioner, although I am not speaking for PsyPact, I am representing the NH Board of Psychologists in this hearing today and advocating for section XII of this bill.

PsyPact has the potential capacity to allow wide access to many states for psychologists to provide care beyond our boundaries. Yet with PsyPact's small number of states so far (16), longer application process (often 3 months) and high cost to licensee ($440), the NH Bd Psychologists wishes to have an additional method to provide immediate and low cost access to psychologists to provide care in NH. The Tele-Pass license of Section XII is similar in processing to the emergency licenses we have used during the Covid Emergency that are quickly and easily processed by clerical staff. PsyPact will work well for psychologists who consider the long range need to obtain access to the member states. But the Board of Psychologists wanted to provide access to more states, the 34 states who are not involved in PsyPact yet and also to provide rapid low cost telemedicine licenses even after the Covid emergency is over.

This Tele-Pass license will fill a need for those who come to NH and wish to continue with their psychologists from other states, or to obtain care from specialties that are sparse in NH. This may apply also when someone comes to NH for a family gathering, perhaps to attend complex events such as hospice or funeral and need the support of familiar psychology care.

It is our hope that this easy-to-implement, easy-to-use, low-cost, and quick/instant Tele-Pass license will also catch on in our neighboring states and provide more access in reciprocal fashion in a "good neighbor" climate to facilitate continuity of care in our regional neighborhood.

Regular licensed psychologists in NH will not need this Tele-Pass license to provide telemedicine care in NH; it is already covered by their regular license.

I can answer any questions you may have officially concerning the Board of Psychologists and also unofficially on PsyPact, as NH's Commissioner to PsyPact.

Thank you very much for your time and for the opportunity to testify.
Dr Deborah Warner
Littleton
603-444-1512
warner@330608.com

Board of Psychologists, Vice Chair

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Kris Schultz
Sent: Wednesday, April 21, 2021 2:55:37 PM
To: ~House Executive Departments and Administration
Subject: one part of the answer on LNAs
Importance: Normal

Can be found here: https://nhneedscaregivers.org/ They explain the initial trainings there, and this website & recruitment program has some support & collaboration with a few different state agencies.

My mother-in-law went through the Red Cross training, which was fast-tracked. There is a cost but it is repaid fairly quickly upon working in the field.

For whatever that is worth.

State Representative Kris Schultz

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Kris Schultz
Sent: Wednesday, April 21, 2021 10:25:31 AM
To: Miriam Simmons
Subject: request for a pdf of SB 133
Response requested: No
Importance: Normal

Good morning, Miriam,

I am having a hard time finding a copy of the version we are hearing for SB133 online. I am sure you have sent it to me, but I cannot find it. Would you mind please sending it to me?

Thank you,

Kris Schultz

State Representative Kris Schultz

Archived: Tuesday, May 25, 2021 11:58:58 AM
From: Jason Grey
Sent: Wednesday, April 21, 2021 9:10:33 AM
To: ~House Executive Departments and Administration
Subject: For clarification regarding SB133
Importance: Normal

I am opposed to Part II

PART II

Repealing the emergency medical services personnel licensure interstate compact.

1 Repeal. The following are repealed:

I. RSA 153-A:36 and the subdivision heading preceding RSA 153-A:36, relative to the emergency medical services personnel licensure interstate compact.

II. RSA 153-A:20, XXIV, relative to rulemaking by the department of safety regarding implementation of the compact.

2 Effective Date. Part II of this act shall take effect 60 days after its passage.

Respectfully,

Jason Grey BS, NRP, CCP-C, FP-C, IC
President
New Hampshire Association of Emergency Medical Technicians

Archived: Wednesday, April 21, 2021 9:09:32 AM
From: Williams, John
Sent: Wednesday, April 14, 2021 9:35:55 AM
To: Carol McGuire
Cc: Sharon Carson; Deborah Chroniak; Pam Smarling; Osterhoudt, Douglas; audrey mulliner; Miriam Simmons
Subject: RE: SB 133 PART VIII Skilled Professional Medical Personnel - DHHS Request to Remove PART VIII from Omnibus Bill
Importance: High
Attachments:
SB 133 Part IX DHHS-BEAS Testimony (02-10-2021).docx Process Summary for Eligibility Determinations.docx

---

Dear Representative McGuire,

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Attorney Douglas Osterhoudt, Legislative Liaison and General Counsel for our agency's Bureau of Elderly and Adult Services, and I would like to schedule a brief conference call with you prior to the public hearing on SB 133 if your calendar permits. In any event, Douglas may be reached at either (603) 271-9647 or douglas.j.osterhoudt@dhhs.nh.gov as a resource to you and your Committee on the critical nature of this request.

Respectfully yours,

John

John L. Williams, Esquire, Director of Legislative Affairs, New Hampshire Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

(603) 271-9395 (office)
(603) 545-2934 (cell)

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Archived: Wednesday, April 21, 2021 9:09:32 AM
From: Marie Marston
Sent: Friday, April 16, 2021 3:38:42 PM
To: Miriam Simmons
Subject: SB133-FN
Response requested: Yes
Importance: High

Good Afternoon Miriam: I just wanted to let you know that I signed Senator Ward up for the wrong parts on this Omnibus Bill. She is the PRIME on Parts III and VIII and she will be speaking to those parts and is in Support of those parts only.

House ED&A

SB 133, adopting omnibus legislation relative to elections. 10:00am

Part I: LSR 21-0964, relative to the definition of "licensing agency" for purposes of licensing places of assembly, sponsored by **Sen. Carson, Prime**/Dist 14.

Part II: LSR 21-0506, repealing the emergency medical services personnel licensure interstate compact, sponsored by **Sen. Rosenwald, Prime**/Dist 13, Sen. Cavanaugh, Dist 16; Sen. Carson, Dist 14; Rep. Goley, Hills. 8; Rep. Milz, Rock. 6; Rep. O'Brien, Hills. 36; Rep. S. Pearson, Rock. 6.

Part III: LSR 21-0207, relative to hearings of the New Hampshire board of nursing, sponsored by **Sen. Ward, Prime**/Dist 8.

Part IV: LSR 21-0838, relative to membership of the professional standards board, sponsored by **Sen. Kahn, Prime**/Dist 10; Sen. Prentiss, Dist 5.

Part V: LSR 21-0846, adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact, sponsored by **Sen. Sherman, Prime**/Dist 24; Sen. Soucy, Dist 18; Sen. Carson, Dist 14; Rep. March, Carr. 8.

Part VI: LSR 21-0859, relative to the licensure and regulation of music therapists, sponsored by **Sen. Avard, Prime**/Dist 12; Sen. Watters, Dist 4; Sen. Carson, Dist 14; Sen. Reagan, Dist 17; Sen. Kahn, Dist 10; Sen. Sherman, Dist 24; Sen. Prentiss, Dist 5; Sen. Perkins Kwoka, Dist 21; Rep. McGhee, Hills. 27.

Part VII: LSR 21-0899, relative to the authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals, sponsored by **Sen. Reagan, Prime**/ Dist 17, Sen. Carson, Dist 14; Sen. French, Dist 7; Sen. Kahn, Dist 10; Sen. Prentiss, Dist 5; Sen. Rosenwald, Dist 13; Sen. Bradley, Dist 3; Sen. D'Allesandro, Dist 20; Sen. Ward, Dist 8; Sen. Soucy, Dist 18; Sen. Giuda, Dist 2; Rep. Spillane, Rock. 2; Rep. McGuire, Merr. 29; Rep. Seaworth, Merr. 20.

Part VIII: LSR 21-0928, relative to skilled professional medical personnel, sponsored by **Sen. Ward, Prime**/Dist 8.

Part IX: LSR 21-0973, relative to temporary licensure of certain licensed nursing assistants, sponsored by **Sen. Hennessey**, Dist 1; Sen. Rosenwald, Dist 13; Rep. Dostie, Coos 1; Rep. Thompson, Coos 1.

Part X: LSR 21-1011, relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles, sponsored by **Sen. Prentiss, Prime**/Dist 5; Rep. Merchant, Sull. 4; Rep. Goley, Hills. 8; Rep. McGuire, Merr. 29.

Part XI: LSR 21-1050, relative to schools for barbering, cosmetology, and esthetics, sponsored by **Sen. Reagan, Prime**/Dist 17; Sen. Rosenwald, Dist 13; Sen. Prentiss, Dist 5; Sen. Carson, Dist 14; Sen. Bradley, Dist 3; Sen. D'Allesandro, Dist 20; Sen. Gannon, Dist 23; Rep. McGuire, Merr. 29; Rep. Roy, Rock. 32; Rep. Harrington, Straf. 3.

Part XII: LSR 21-0277, relative to telemedicine provided by out of state psychologists, sponsored by **Sen. Reagan, Prime**/Dist 17; Sen. Carson, Dist 14; Sen. Bradley, Dist 3; Sen. Prentiss, Dist 5; Sen. French, Dist 7; Sen. Giuda, Dist 2; Sen. Hennessey, Dist 1; Sen. D'Allesandro, Dist 20; Rep. Spillane, Rock. 2; Rep. Tudor, Rock. 1.

Part XIII: LSR 21-1049, establishing program rules within the department of health and human services for sanitary production and distribution of food, sponsored by **Sen. Giuda, Prime**/Dist 2; Sen. Gannon, Dist 23.

Thank you,

If you could delete the sign up sheets with her support parts iv and ix, I will sign her up again with the appropriate information. Please feel free to call me at 568-0284 if you have any questions.

Many thanks,

Marie

Marie Marston, Administrative Assistant
Administrative Assistant to Senator Regina Birdsell
Administrative Assistant to Senator Denise Ricciardi
Administrative Assistant to Senator Ruth Ward
107 North Main Street
State House Room 302
Concord, NH 03301
(603) 271-2609

From: Miriam Simmons <miriam.simmons@leg.state.nh.us>
Sent: Thursday, April 15, 2021 2:30 PM
To: Erin Hennessey <Erin.Hennessey@leg.state.nh.us>; Suzanne Prentiss <Suzanne.Prentiss@leg.state.nh.us>; Bob Giuda <Bob.Giuda@leg.state.nh.us>; David Watters <David.Watters@leg.state.nh.us>; James Gray <James.Gray@leg.state.nh.us>; John Reagan <john.reagan111@gmail.com>; Harold French <Harold.French@leg.state.nh.us>; Kevin Avard <Kevin.Avard@leg.state.nh.us>; Ruth Ward <Ruth.Ward@leg.state.nh.us>; Lou D'Allesandro <dalas@leg.state.nh.us>; Denise Ricciardi <denise.ricciardi@leg.state.nh.us>; Jay Kahn <Jay.Kahn@leg.state.nh.us>; Gary Daniels <Gary.Daniels@leg.state.nh.us>; Cindy Rosenwald

<cindy.rosenwald@leg.state.nh.us>; Becky Whitley <Becky.Whitley@leg.state.nh.us>; Donna Soucy <Donna.Soucy@leg.state.nh.us>; Rebecca Perkins Kwoka <Rebecca.PerkinsKwoka@leg.state.nh.us>; Jeb Bradley <Jeb.Bradley@leg.state.nh.us>; Chuck Morse <Chuck.Morse@leg.state.nh.us>; William Gannon <William.Gannon@leg.state.nh.us>; Tom Sherman <Tom.Sherman@leg.state.nh.us>; Senator David Watters <watterssenate@gmail.com>; Cindy Rosenwald <Cindy.Rosenwald@gmail.com>; Sharon Carson <Sharon.Carson@leg.state.nh.us>; Kevin Cavanaugh <Kevin.Cavanaugh@leg.state.nh.us>; Carol McGuire <mcguire4house@gmail.com>
Cc: Ava Hawkes <Ava.Hawkes@leg.state.nh.us>; Jennifer Gallagher <jennifer.gallagher@leg.state.nh.us>; Kathryn Cummings <Kathryn.Cummings@leg.state.nh.us>; Marie Marston <Marie.Marston@leg.state.nh.us>; Jessica Bourque <jessica.bourque@leg.state.nh.us>; Griffin Roberge <Griffin.Roberge@leg.state.nh.us>; Cameron Lapine <Cameron.Lapine@leg.state.nh.us>; Shannon Girard <Shannon.Girard@leg.state.nh.us>; Ava Hawkes <Ava.Hawkes@leg.state.nh.us>; Kathryn Cummings <Kathryn.Cummings@leg.state.nh.us>; Debra Martone <Debra.Martone@leg.state.nh.us>; Tricia Melillo <Tricia.Melillo@leg.state.nh.us>; Deborah Chroniak <deborah.chroniak@leg.state.nh.us>; Aaron Jones <Aaron.Jones@leg.state.nh.us>; Shannon Girard <Shannon.Girard@leg.state.nh.us>; Jennifer Gallagher <jennifer.gallagher@leg.state.nh.us>; Sonja Caldwell <Sonja.Caldwell@leg.state.nh.us>; Tricia Melillo <Tricia.Melillo@leg.state.nh.us>; Jennifer Horgan <jennifer.horgan@leg.state.nh.us>
Subject: RESCHEDULED House ED&A Notice - 04-21-2021
Importance: High

Notice to Senate Bill Sponsorship:

SB 133 scheduled for Public Hearing before House ED&A
.. see attached notice.

Miriam Simmons
Committee Assistant
271-3600 (leave msg for remote contact)
.or email -
miriam.simmons@leg.state.nh.us

Archived: Wednesday, April 21, 2021 9:09:33 AM
From: Carol McGuire
Sent: Sunday, April 18, 2021 7:32:25 PM
To: ~House Executive Departments and Administration; Pam Smarling
Subject: Fwd: Sunrise reviews of proposals to license music therapists.
Response requested: No
Importance: Normal
Attachments:
2017_Illinois_MusicTherapists.pdf 2014_Colorado_MusicTherapists.pdf 2017_WestVirginia_MusicTherapy.pdf 2012_Washington_MusicTherapists.pdf

---

FYI, since this is coming back in SB 133.

Carol
---------- Forwarded message ---------
From: **Lee McGrath** <lmcgrath@ij.org>
Date: Wed, Apr 14, 2021 at 8:33 PM
Subject: Sunrise reviews of proposals to license music therapists.
To: carol@mcguire4house.com <carol@mcguire4house.com>
Cc: Meagan Forbes <mforbes@ij.org>, Jessica Gandy <jgandy@ij.org>

Dear Representative McGuire:

- Researchers from the University of Chicago found "*no conclusive evidence to regulate music therapy*" in Illinois on page 122 of the first attachment.

- Colorado's Department of Regulatory Agencies concluded "*there is no demonstrated public interest or need to warrant the creation of a new regulatory program or to protect the title, 'music therapist' or 'board-certified music therapist'"* on page 34 of the second attachment.

- West Virginia's Legislative Auditor observed "*there is no documented evidence of harm to the public caused by music therapists that rises to the level needed for state regulation as stated by W.Va. §30-1A-3, and the hypothetical examples of harm provided by the applicant do not support the need for licensure*" on page 19 of the third attachment.

- Washington State's Department of Health determined it "*does not support the proposal to require state certification for music therapists"* on page 17 of the fourth attachment.

My colleagues and I stand ready to assist you and other members of the Committee on Executive Departments and Administration. Thank you.

Best regards,

Lee U. McGrath

Managing Attorney

Institute for Justice

520 Nicollet Mall-Suite 550

Minneapolis MN 55402-2626

Cell: (612) 963-0296

Email: lmcgrath@ij.org

Web: www.ij.org

Archived: Wednesday, April 21, 2021 9:09:33 AM
From: Parisi, Paul
Sent: Saturday, April 17, 2021 8:05:32 AM
To: ~House Executive Departments and Administration
Subject: NH House Remote Testify: 10:00 am - SB133 in House Executive Departments and Administration
Importance: Normal
Attachments:
FMO Position Paper - SB 133 - POA Licensing.pdf ;

Good morning,

Please find my testimony for SB 133, Part 1. Please let me know if you have any questions. Thank you!

Paul

Paul J. Parisi
State Fire Marshal

Department of Safety | Division of Fire Safety
New Hampshire State Fire Marshal's Office (FMO)

Physical: 110 Smokey Bear Boulevard (IPOC), Concord NH
Mailing: 33 Hazen Drive
Concord, NH 03305

Office: 603-223-4289
Direct: 603-223-4293
Fax: 603-223-4294
Arson Hotline: 1-800-400-3526
Email: **paul.parisi@dos.nh.gov**

"Saving lives and property through education, engineering & enforcement"

Web Site Address: http://www.nh.gov/safety/divisions/firesafety
Subscribe to our list serve to receive public safety notices and press releases.

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Archived: Wednesday, April 21, 2021 9:09:33 AM
From: Miriam Simmons
Sent: Monday, April 19, 2021 8:06:46 AM
To: Miriam Simmons
Subject: SB 133 Sunrise reviews of proposals to license music therapists.
Response requested: No
Importance: Normal
Attachments:
2017_Illinois_MusicTherapists.pdf 2014_Colorado_MusicTherapists.pdf 2017_WestVirginia_MusicTherapy.pdf 2012_Washington_MusicTherapists.pdf

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From: Carol McGuire <mcguire4house@gmail.com>
Sent: Sunday, April 18, 2021 7:31 PM
To: ~House Executive Departments and Administration <HouseExecutiveDepartmentsandAdministration@leg.state.nh.us>; Pam Smarling <Pam.Smarling@leg.state.nh.us>
Subject: Fwd: Sunrise reviews of proposals to license music therapists.
---------- Forwarded message ---------
From: **Lee McGrath** <lmcgrath@ij.org>
Date: Wed, Apr 14, 2021 at 8:33 PM
Subject: Sunrise reviews of proposals to license music therapists.
To: carol@mcguire4house.com <carol@mcguire4house.com>
Cc: Meagan Forbes <mforbes@ij.org>, Jessica Gandy <jgandy@ij.org>

Dear Representative McGuire:

- Researchers from the University of Chicago found "*no conclusive evidence to regulate music therapy*" in Illinois on page 122 of the first attachment.

- Colorado's Department of Regulatory Agencies concluded "*there is no demonstrated public interest or need to warrant the creation of a new regulatory program or to protect the title, 'music therapist' or 'board-certified music therapist'*" on page 34 of the second attachment.

- West Virginia's Legislative Auditor observed "*there is no documented evidence of harm to the public caused by music therapists that rises to the level needed for state regulation as stated by W.Va. §30-1A-3, and the hypothetical examples of harm provided by the applicant do not support the need for licensure*" on page 19 of the third attachment.

- Washington State's Department of Health determined it "*does not support the proposal to require state certification for music therapists*" on page 17 of the fourth attachment.

My colleagues and I stand ready to assist you and other members of the Committee on Executive Departments and Administration. Thank you.

Best regards,
Lee U. McGrath
Managing Attorney
Institute for Justice
520 Nicollet Mall-Suite 550
Minneapolis MN 55402-2626
Cell: (612) 963-0296
Email: lmcgrath@ij.org
Web: www.ij.org

Archived: Wednesday, April 21, 2021 9:09:33 AM
From: Eric Schelberg
Sent: Monday, April 19, 2021 10:38:32 PM
To: ~House Executive Departments and Administration
Cc: Eric Schelberg
Subject: SB133 Amended Written Testimony
Response requested: No
Importance: Normal
Attachments:
ED&A SB133 Amended Testimony 2021-04-21.docx

Chairwoman McGuire,

Please find attached written testimony on SB133 Amended regarding striking 'repealing the emergency medical services personnel licensure interstate compact'.

I plan on testifying before your committee this Wednesday, April 21st.

Please do not hesitate to contact me with any questions you may have regarding this request.

Respectfully submitted,

Eric Schelberg
President - NHPA
Milford

Archived: Wednesday, April 21, 2021 9:09:33 AM
From: Arnold, Christopher R CIV OSD OUSD P-R (USA)
Sent: Tuesday, April 20, 2021 4:19:31 PM
To: ~House Executive Departments and Administration
Subject: DoD Memo: SB-133, Pt II (Oppose), Pt V (Support)
Importance: Normal
Digitally Signed: Yes
Attachments:
20210420_MCFP_AM_New_Hampshire_SB133_v2.pdf ;

Dear Members of the House Executive Departments and Administration Committee,

Attached please find testimony regarding Senate Bill SB-133 from the United States Department of Defense, which is on tomorrow's committee agenda. The Department opposes the policies set forth in Part II of the bill; and supports those set forth in Part V of the bill.

I am available to answer whatever questions you may have. Thank you for your continued support of our service members and their families.

Sincerely,

Christopher R. Arnold
Northeast Regional Liaison (CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT)
Defense-State Liaison Office
DoD, Military Community and Family Policy
(571) 309-4712
https://statepolicy.militaryonesource.mil

Celebrate Month of the Military Child

https://www.militaryonesource.mil/family-relationships/family-life/month-of-the-military-child

Archived: Wednesday, April 21, 2021 9:09:35 AM
From: Marissa Scott
Sent: Tuesday, April 20, 2021 3:35:23 PM
To: ~House Executive Departments and Administration
Subject: [CAUTION: SUSPECT SENDER] NH House Remote Testify: 10:00 am - SB133 in House Executive Departments and Administration
Importance: Normal
Attachments:
SB 133 Testimony for House ED&A Committee - Marissa Scott.pdf

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Dear Chairwoman McGuire and members of the Committee,

I will be speaking tomorrow on behalf of the NH Task Force for Music Therapy State Recognition. I have enclosed my brief testimony here. In addition, I wanted to share a quick story with you about a client.

Addison came to The Sonatina Center for music therapy in 2018 when she was just under the age of 3 with a diagnosis of Autism Spectrum Disorder. Mom had concerns about Addie's interpersonal skills, her ability to follow directions for cues of safety, and her relational communication skills. Ultimately, Mom wanted to be more connected to her child and help her daughter ease the frustrations of not being able to communicate her needs. Addison had zero attention span and if she was doing something dangerous and Mom yelled stop, Addie would just keep going. Also, Addie couldn't say yes or no with purpose and meaning. Over the course of therapy, Addie was able to greatly increase her relational communication skills along with her attention span and her ability to connect meaningfully with others, and most importantly with mom. I've included a short clip of my work with Addie. In this clip, we'd been working together for a few months and I know you haven't seen a before clip, but her attention span for the length of this video is amazing. She's also having a back and forth conversation with me, making eye contact, and laughing at things that are silly. All things that seemed impossible when she began.

Handbells - Identifying Colors - Yes & No - Att...

She's doing well today and still making strides, but she is no longer in music therapy because she was only receiving funding for it through a short grant that ran out. Unfortunately, insurance won't cover music therapy for Addie and they can't afford to pay out of pocket - insurance will rarely cover any services by an "unlicensed" provider. I know this because I've spent hours and hours of my own personal time on the phone trying to help my clients get reimbursed for therapy. Addie is not our only client who had to stop services due to a loss of grant funding. You can help people like Addie and many others by passing this bill. Not everyone benefits from the same type of service as

everyone else. People deserve to have choices in their health care, and for someone like Addie who benefited greatly from music therapy, it's a shame that it's because of "unlicensed provider" limitations on her insurance plan she is unable to access services.

I look forward to speaking with you tomorrow and welcome any questions you have regarding the training and education of a music therapist or the rationale for passing a state license for our profession.

Sincerely,
Marissa Scott

Marissa Scott, MA, MT-BC, CLD
Board Certified Music Therapist, Certified Labor Doula
Owner & Executive Director
She/Her

The Sonatina Center
750 Central Ave, Suite U
Dover, NH 03820
(W) 603-978-4808
www.thesonatinacenter.com

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Archived: Wednesday, April 21, 2021 9:09:35 AM
From: Perry, Warren M NFG NG NHARNG (USA)
Sent: Tuesday, April 20, 2021 3:31:19 PM
To: ~House Executive Departments and Administration
Cc: Arnold, Christopher R CIV OSD OUSD P-R (USA)
Subject: SB 133 written testimony
Importance: Normal
Digitally Signed: Yes
Attachments:
SB 133 written testimony- Dept of Mil Affairs and Vets Services.pdf

---

Member of the Executive Departments and Administration,

Please find the attached written testimony regarding part II of SB 133 (as amended) from the Department of Military Affairs

Warren M. Perry
Deputy Adjutant General

State of New Hampshire
The Department of Military Affairs and Veterans Services
4 Pembroke Road
Concord, NH 03301

(603) 225-1302 Office
(603) 717-6284 Cell

Archived: Wednesday, April 21, 2021 9:09:35 AM
From: Shannon Laine
Sent: Tuesday, April 20, 2021 2:34:50 PM
To: ~House Executive Departments and Administration
Subject: In Support of SB-133, Part VI
Importance: Normal

Dear Members of the House Executive Departments and Administration Committee-

I write to you today in support of music therapy licensure. Having worked in the music therapy field in New Hampshire for the last 15 years, I have seen just how powerful music therapy can be for Granite State Residents.

Today I would like to share with you two recent stories that have been published about music therapy in New Hampshire:
NHPR, The Exchange, highlighted music therapy in an hour-long program:
https://www.nhpr.org/post/therapeutic-power-music#stream/0

Speaking with the Senator, discussing music therapy in New Hampshire and the need for licensure:
https://www.youtube.com/watch?v=zi6uwg6t4io&t=13s

As I am unable to make the hearing tomorrow, I am always available to answer any specific questions via e-mail.

Thank you,
Shannon Laine

Shannon Laine, MT-BC

Director, Music Therapy, Adaptive Lessons, Early Childhood

Manchester Community Music School
2291 Elm Street
Manchester, NH 03104

(603) 689-6250 Cell
(603) 644-4548 Office

Certification Board
MT-BC
for Music Therapists

Archived: Wednesday, April 21, 2021 9:09:35 AM
From: Osterhoudt, Douglas
Sent: Tuesday, April 20, 2021 1:47:30 PM
To: ~House Executive Departments and Administration
Subject: Douglas Osterhoudt, SB 133, part VIII, written testimony
Importance: Normal
Attachments:
SB 133 Part VIII DHHS-BEAS Testimony (04-21-2021).pdf

Hello,

I have signed up to testify at the EDA Committee hearing on SB 133 tomorrow morning and would like to provide the Committee members with the attached written testimony as well.

Douglas J. Osterhoudt, Esq.
BEAS Assignment Legal Coordinator
Bureau of General Counsel
Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301
603-271-9647
douglas.j.osterhoudt@dhhs.nh.gov

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Archived: Wednesday, April 21, 2021 9:09:35 AM
From: Kaytlynn Monroe
Sent: Tuesday, April 20, 2021 11:46:21 AM
To: ~House Executive Departments and Administration
Cc: Brian Ryll
Subject: Testimony in support of SB133
Importance: Normal
Attachments:
Testimony in support of SB 133 Part II.pdf ;Testimony in support of SB 133 Part X.pdf ;

Good morning committee members,

I am sending along written testimony on behalf of the Professional Fire Fighters of New Hampshire in support of SB 133 being heard in House ED&A tomorrow. Please see attached testimony for Part II & Part X.

Please let us know if you have any questions. Thank you for your time.

Kaytlynn

Kaytlynn Monroe
Government & Political Affairs Director
Professional Fire Fighters of New Hampshire
43 Centre Street, Concord, NH 03301
603-223-3304 (O) | 603-219-8815 (C)
Email: kaytlynn@pffnh.org

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Archived: Wednesday, April 21, 2021 9:09:35 AM
From: Rogers, Abigail
Sent: Tuesday, April 20, 2021 8:48:26 PM
To: ~House Executive Departments and Administration
Subject: DHHS Testimony SB 133 Part XIII of the omnibus legislation relative to occupational licensure
Importance: Normal
Attachments:
DHHS Testimony SB133 Part XIII House ED&A.docx

Dear Chair McGuire and Members of the Committee:

Please find attached DHHS testimony in support of Part XIII of SB 133FN relative to sanitary production and distribution of food.
Colleen Smith from the Food Protection Program, DHHS, DPHS will be providing the testimony tomorrow during the hearing scheduled at 10am.

Thank you!

Abby Rogers

Abigail Rogers
Legislative Liaison

Division of Public Health Services
New Hampshire Department of Health and Human Services
29 Hazen Drive, Concord, NH 03301
603-333-6309 (cell)
603-271-4593 (O)
Abigail.Rogers@dhhs.nh.gov

ATTENTION: please visit the DHHS COVID-19 website for the latest COVID-19 information, resources and guidance: https://www.nh.gov/covid19/

Archived: Wednesday, April 21, 2021 9:09:35 AM
From: Romanello, Justin
Sent: Tuesday, April 20, 2021 6:54:38 PM
To: ~House Executive Departments and Administration
Subject: SB133 Testimony and Letter of Support
Importance: Normal
Attachments:
SB133 Letter of Support - NHMCB.pdf ;SB133 Testimony - Romanello DOS.pdf ;

Dear Sir/Ma'am,

Please find the attached document of my personal testimony that I will be presenting at tomorrow's session as well as a letter of support from the New Hampshire Medical Control Board.

Thank you,

Justin

Justin Romanello
Bureau Chief
NH DOS, Division of Fire Standards and Training & EMS
Email: justin.s.romanello@dos.nh.gov

Office: 603-223-4211
Cell: 603-573-6307
Fax: 603-271-1091
http://www.nh.gov/ems

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SB 133, adopting omnibus legislation relative to occupational licensure.
(Part VIII Skilled professional medical personnel.)
Overview of Current Department Practices

The System under the Current Definition Works:

The system developed and implemented by the Department of Health and Human Services using the current definition of skilled professional medical personnel under 151-E:3, II is working for the citizens of New Hampshire. Under the current definition, the Department is able to issue timely decisions made by qualified individuals.

Changing the definition as proposed in Part VIII will provide no gains to citizens and create the possibility of causing harm if, in the future, as had happened before the language was changed in 2015, the Department is unable to find Registered Nurses to fill the positions of those making eligibility determinations. Staffing shortages are likely to lead to delays in eligibility determinations and, ultimately, delays in much needed services.

General Overview of Statutory Requirements:

RSA 151-E:3 covers the clinical Medicaid eligibility requirements for an individual who is seeking nursing facility services or Medicaid home and community-based care waiver services (known as the Choices for Independence program, or CFI, in New Hampshire). RSA 151-E:3, II requires skilled professional medical personnel, or an individual with equivalent training, to conduct clinical eligibility determinations.

The individual conducting the assessment uses an assessment tool, approved by the Department, in making their determination. If is unclear from the assessment tool if an applicant meets the eligibility criteria, skilled professional medical personnel review an applicant’s medical records and give the records substantial weight for the purposes of determining eligibility.

Skilled professional medical personnel has the same meaning as in 42 C.F.R section 432.50(d)(1)(ii), which requires the possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization.

General Overview of Department Practices:

The Department currently uses a vendor, Kepro, to conduct clinical eligibility assessments, with the use of the Department approved assessment tool, for individuals in the community seeking nursing facility or CFI services. All Kepro staff conducting assessments are registered nurses, and meet the current definition of skilled professional medical personnel under RSA 151-E:3. If Kepro staff determine and individual meets the criteria under the statute, Kepro staff open the applicant for services.

If Kepro staff do not find an applicant meets the eligibility criteria, Kepro sends the applicant's assessment to the Department where Department staff who meet the definition of skilled professional medical personnel request additional medical records from the applicant. Once the Department receives the medical records, skilled professional medical personnel employed by the Department review the records, giving them substantial weight in making the determination. If, in light of the new medical records, Department staff find the applicant meets the eligibility criteria, the applicant is opened for services.

If the Department staff reviewing the assessment and medical records finds the applicant does not meet eligibility criteria, a second skilled professional medical personnel employed by the Department conducts an independent review of the assessment and medical records. Again, if this second reviewer finds the applicant meets eligibility criteria, the applicant is opened for services. If the applicant is found to not meet eligibility criteria, the application is sent to a supervisor who conducts an administrative review, i.e. checks to ensure the determination is timely, checks to ensure the application has undergone the appropriate number of reviews, etc.. A denial letter is sent to the applicant only after this supervisor review. It is important to point out Department staff that meet the definition of skilled professional medical personnel make eligibility determinations, not supervisors.

Respectfully submitted,

Douglas J. Osterhoudt, Esquire
Bureau of Elderly and Adult Services (BEAS) Assignment Legal Coordinator
Bureau of General Counsel
Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301
603-271-9647
douglas.j.osterhoudt@dhhs.nh.gov

April 29, 2021

Regarding SB133, non-germane amendment

Dear Representative McGuire,

At the hearing on for the non-germane amendment on SB 133 on Tuesday, April 27, Representative Grote asked for some clarifying information on early childhood workforce initiatives that are currently being developed:

The T.E.A.C.H. Program is run by Child Care Aware of NH, and it helps workers already in the field get their college degree in early childhood education. It currently has 31 recipients and is growing. It is currently offered statewide. [T.E.A.C.H. Early Childhood® NH - Child Care Aware of NH (nh-connections.org)]

The Apprenticeship Program is also run by Child Care Aware of NH. It combines classroom instruction with on-the-job training. This program is still in the pilot phase and has 4 recipients, although it is anticipated that it will be statewide within the next year. [Early Childhood Apprenticeship Program - Child Care Aware of NH (nh-connections.org)]

The Bureau of Child Development and Head Start Collaboration is working with Employment Security to work on a program to recruit unemployed and underemployed workers interested in a career in childcare. This is currently in development and does not have a timeline.

NHTI is working on a "childcare boot camp" that would make it possible for someone to complete the 9 credits currently required to be an associate teacher in one semester. This is also in development and does not have a timeline.

There may be other initiatives that I am unaware of, but those are the ones that have been discussed.

I was unable to find out how many centers have closed due to the lack of staff, but Melissa Clement from Child Care Licensing may be able to answer that question.

There was a childcare staffing survey in March 2021. 40% of licensed childcare programs responded and cited that they needed 483 staff to remain open but hiring 643 staff was ideal. The lack of staff meant that 1,034 childcare spaces for children under 3, and 1,255 spaces for children over 3, were unable to be filled.

According to the *Constraints on New Hampshire's Workforce Recovery* report commissioned by DHHS, as of March 2020 there were "approximately 5,700 employees working in childcare centers in New Hampshire, and the unemployment rate was near zero (reflecting structural workforce shortage)" (Page 73).

Thank you,

Marianne Barter
Executive Director, Merrimack Valley Day Care Service/ Blueberry Express Day Care
Vice Chair, NH Child Care Advisory Council

April 27, 2021

Distinguished Members of the
House Executive Departments
and Administration Committee:

At Save the Children Action Network, we believe all children deserve access to high-quality early childhood education. Since 2014, we have worked in partnership with community volunteers, policy advocates, and state legislators to improve accessibility and quality of New Hampshire's child care and early learning programs. While well-intentioned, we believe the amendment to SB 133 would be a step backward in our mission to provide equitable access to high-quality early childhood education to all Granite Staters, which is why I am testifying in opposition to this bill.

Early childhood educators are responsible for the care and education of our youngest citizens during some of the most consequential years in their lives. While they provide an essential service to working families and help shape the leaders of tomorrow, they are a routinely undervalued workforce. SB 133 seeks to answer this shameful undervaluing of teachers by lowering the bar for higher education required of child care employees. Early childhood educators that I have worked closely with in my role understand that their jobs are increasingly difficult as our state copes with multiple crises impacting children, including the opioid epidemic and the COVID-19 pandemic. More children are coming into their care with Adverse Childhood Experiences associated with the aforementioned crises. Child care providers should be supported by the state with more resources and training to help them provide high-quality care. Answering these crises by diminishing teacher education requirements would be a grave mistake that would negatively impact generations of Granite Staters. Even setting public health crises aside, the quality of care of our children is a direct reflection of the competence of the early childhood educator, and we should not consider compromising the health and safety of our children under any circumstances.

In conclusion, I urge members of this committee not to support this amendment to SB 133. Thank you for your time and consideration of mine and others' testimony today.

Emily Johnson
New Hampshire State Manager
Save the Children Action Network
Representing over 3,000 supporters and activists across the Granite State

Senate Executive Departments and Administration Committee
Wednesday, February 10, 2021 @ 9:00 a.m.
Remote Public Hearing

SB 133, adopting omnibus legislation relative to occupational licensure.
(Part IX Skilled professional medical personnel.)

1. The language of RSA 151-E:3, II, limiting those permitted to render adverse clinical eligibility determinations to only skilled professional medical personnel who are registered nurses and currently licensed in accordance with RSA 326-B has the potential to inhibit the New Hampshire Department of Health and Human Services (hereinafter "department") in its ability to issue timely determinations, which in turn could lead to delays in services, placing the citizens of New Hampshire at risk.

Senator John Reagan sponsored SB 49 in 2015 to change the language identifying who is permitted to determine clinical eligibility under RSA 151-E:3 from "registered nurses" to "skilled professional medical personnel." The department requested the legislation and testified in favor of this change as it would broaden the scope of individuals permitted to conduct clinical eligibility assessments and issue determinations, for example, by allowing for APRNs or LPNs to conduct assessments, so the department could fill key positions and avoid delays in the provision of services to the citizens of New Hampshire. Prior to the change, the limiting language had a certain times placed the department in the position of being unable to fill the roles of those tasked with issuing determinations, which in turn lead to delays in issuing decisions, which in turn led to delays in services.

It is also worth noting that there is a recognized shortage of registered nurses throughout the state, leading to staffing shortages in hospitals and a struggle to find adequate nursing coverage for those meeting nursing home level of care in residential care facilities and in individual homes.

2. The language of the proposed paragraph III-a would require skilled professional medical personnel to oversee service coverage prior authorizations for Medicaid home and community-based care waiver services. It is not necessary to meet the definition of skilled professional medical personnel in order to administer, or supervise staff of, a program in which staff render determinations. This language singles out the department and department staff, who administer the home and community-based care waiver services, and places restrictions on program administrators and supervisors beyond those required for similarly situated entities. For example, there is no requirement that an administrator or supervisor in a nursing facility meet the definition. The Office of Professional Licensure has confirmed that non-clinical personnel may supervise clinical personnel; it is the licensee who is responsible for their clinical decisions. Additionally, there is no specialized training included in skilled professional medical personnel training, for example that of a registered nurse, that would provide the trainee with administrative or supervisor capabilities beyond those of administrators or supervisors who have not undergone training as skilled professional medical personnel.

The language of RSA 151-E:3, III-a, limiting those permitted to render adverse service coverage determinations to only skilled professional medical personnel who are registered nurses and currently licensed in accordance with RSA 326-B, would require the department to devote medically trained staff to render adverse determinations for requests that may be denied for non-clinical reasons, e.g. incomplete applications or failure to exhaust third party liability. Denials such as these do not need the specific skill set of a registered nurse, as they are programmatic or administrative in nature.

3. The language of proposed paragraph V defines "skilled professional medical personnel" as having the same meaning as in 42 C.F.R. section 432.2, with the exception of the need for skilled professional medical personnel to be in an employer-employee relationship with the department. While the employer-employee relationship is the only explicit exception to the definition found in section 432.2, the requirement that only registered nurses may render adverse clinical eligibility or service coverage determinations creates additional exceptions to the definition under section 432.2, which includes as skilled professional medical personal "…physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice…." The additional exception results in the definition of "skilled professional medical personnel" under RSA 151-E:3, V being more restrictive than the federal definition, and places additional restrictions on who may render adverse determinations. For example, under the current, more encompassing definition of "skilled professional medical personnel" stricken from section II of RSA 151-E:3, which defines "skilled professional medical personnel" as having the same meaning as in 42 C.F.R. section 432.50(d)(1)(ii), it would be permissible for a Licensed Practical Nurse, also subject to the licensing requirements of RSA 326-B, to render adverse determinations. The proposed definition, in conjunction with other proposed language, would prohibit a Licensed Practical Nurse from doing the same.

Additionally, when SB 49 was introduced in 2015, a subcommittee of the House Health, Human Services and Elderly Affairs Committee worked diligently over the course of two work sessions on the definition of "skilled professional medical personnel" and came to the decision to remove the reference to 42 C.F.R section 432.2 under the belief that the inclusion of two C.F.R. definitions for the same term, as is currently proposed, could lead to confusion. Further, the subcommittee decided to define "skilled professional medical personnel" with the broader language of 42 C.F.R 432.50(d)(1)(ii) for its reliance on the use of the term "professional education and training."

Respectfully submitted,

Douglas J. Osterhoudt, Esquire
Bureau of Elderly and Adult Services (BEAS) Assignment Legal Coordinator
Bureau of General Counsel
Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301
603-271-9647
douglas.j.osterhoudt@dhhs.nh.gov

House Executive Departments and Administration Committee
Wednesday, April 21, 2021 @ 10:00 a.m.
Remote Public Hearing

SB 133, adopting omnibus legislation relative to occupational licensure.
(Part VIII Skilled professional medical personnel.)

1. The language of RSA 151-E:3, II, limiting those permitted to render adverse clinical eligibility determinations to only skilled professional medical personnel who are registered nurses and currently licensed in accordance with RSA 326-B has the potential to inhibit the New Hampshire Department of Health and Human Services (hereinafter "department") in its ability to issue timely determinations, which in turn could lead to delays in services, placing the citizens of New Hampshire at risk.

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It is also worth noting that there is a recognized shortage of registered nurses throughout the state, leading to staffing shortages in hospitals and a struggle to find adequate nursing coverage for those meeting nursing home level of care in residential care facilities and in individual homes.

2. The language of the proposed paragraph III-a would require skilled professional medical personnel to oversee service coverage prior authorizations for Medicaid home and community-based care waiver services. It is not necessary to meet the definition of skilled professional medical personnel in order to administer, or supervise staff of, a program in which staff render determinations. This language singles out the department and department staff, who administer the home and community-based care waiver services, and places restrictions on program administrators and supervisors beyond those required for similarly situated entities. For example, there is no requirement that an administrator or supervisor in a nursing facility meet the definition. The Office of Professional Licensure and Certification has confirmed that non-clinical personnel may supervise clinical personnel; it is the licensee who is responsible for their clinical decisions. Additionally, there is no specialized training included in skilled professional medical personnel training, for example that of a registered nurse, that would provide the trainee with administrative or supervisor capabilities beyond those of administrators or supervisors who have not undergone training as skilled professional medical personnel.

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3. The language of proposed paragraph V defines "skilled professional medical personnel" as having the same meaning as in 42 C.F.R. section 432.2, with the exception of the need for skilled professional medical personnel to be in an employer-employee relationship with the department. While the employer-employee relationship is the only explicit exception to the definition found in section 432.2, the requirement that only registered nurses may render adverse clinical eligibility or service coverage determinations creates additional exceptions to the definition under section 432.2, which includes as skilled professional medical personal "…physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice…." The additional exception results in the definition of "skilled professional medical personnel" under RSA 151-E:3, V being more restrictive than the federal definition, and places additional restrictions on who may render adverse determinations. For example, under the current, more encompassing definition of "skilled professional medical personnel" stricken from section II of RSA 151-E:3, which defines "skilled professional medical personnel" as having the same meaning as in 42 C.F.R. section 432.50(d)(1)(ii), it would be permissible for a Licensed Practical Nurse, also subject to the licensing requirements of RSA 326-B, to render adverse determinations. The proposed definition, in conjunction with other proposed language, would prohibit a Licensed Practical Nurse from doing the same.

Additionally, when SB 49 was introduced in 2015, a subcommittee of the House Health, Human Services and Elderly Affairs Committee worked diligently over the course of two work sessions on the definition of "skilled professional medical personnel" and came to the decision to remove the reference to 42 C.F.R section 432.2 under the belief that the inclusion of two C.F.R. definitions for the same term, as is currently proposed, could lead to confusion. Further, the subcommittee decided to define "skilled professional medical personnel" with the broader language of 42 C.F.R 432.50(d)(1)(ii) for its reliance on the use of the term "professional education and training."

Respectfully submitted,

Douglas J. Osterhoudt, Esquire
Bureau of Elderly and Adult Services (BEAS) Assignment Legal Coordinator
Bureau of General Counsel
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The Sonatina Center
for creative arts therapy

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(603) 978 - 4808
www.thesonatinacenter.com
info@thesonatinacenter.com

Good afternoon Chairwoman McGuire and members of the Committee. Thank you for your listening ears today. I am Marissa Scott and I speak to you today on behalf of the NH Music Therapy Task Force as the chair. I am also a board certified music therapist and a NH female business owner. I live in Dover, NH where my business is based with my husband and 4 sons. I am in support of this bill, and specifically I am in support of part VII regarding the licensure of a music therapist.

I have previously come before you to discuss how a music therapy license will help NH constituents by increasing access to services by a qualified provider, including potential options for insurance reimbursement. It will also protect consumers from harm that could be caused by an uneducated and untrained person improperly claiming to provide "music therapy."

Since I have already spoken at great length on this topic, I would like to be mindful of your time and just wanted you to know that I am here in support and I am more than happy to answer any questions you may have regarding this section of the bill.

I urge you to vote YES for NH SB133 part VII.

Sincerely,

Marissa Scott, MA, MT-BC
NH Task Force for Music Therapy State Recognition, Chair
Board-Certified Music Therapist
Owner & Executive Director of The Sonatina Center, LLC

DEPARTMENT OF MILITARY AFFAIRS AND VETERANS SERVICES WRITTEN TESTIMONY TO THE HOUSE EXECUTIVE DEPARTMENTS AND ADMINISTRATION COMMITTEE ON SB 133 AN ACT RELATIVE TO ADOPTING OMNIBUS LEGISLATION RELATIVE TO OCCUPATIONAL LICENSURE
For Committee Hearing, April 21, 2021
Warren Perry, Deputy Adjutant General

Members of the Honorable Executive Departments and Administration Committee,

The Department of Military Affairs and Veterans Services is opposed to part II of SB 133 (as amended). The repeal of Emergency Medical Services Personnel Licensure Compact will have an adverse impact on Service Members, Veterans, and their Families.

The purpose of the compact, as originally passed, included the support of "licensing for military members who are separating from an active duty tour and their spouses." Specifically, part VII of the compact requires member states to:

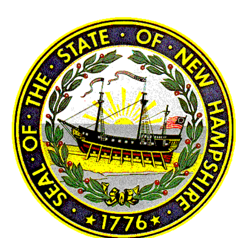
> "expedite the processing of licensure applications submitted by veterans, active military service members, and members of the National Guard and Reserves separating from an active duty tour, and their spouses" if they have a "current valid and unrestricted National Registry of Emergency Medical Technicians (NREMT) certification at or above the level of licensing required by the state."

The portability of certifications and licenses for Service Members, Veterans and their Families has been a priority for several years. In fact, the 2019 National Defense Authorization Act (NDAA) required the Secretary of Defense to assist with the funding the development of interstate compacts on licensed occupation to alleviate the burden on military members and their spouses forced to relocate due to military orders.

This issue is also important in the veteran community where we continue to make progress in offering credit toward licensing and certification based on military training.

Repealing the 2018 Emergency Medical Services Personnel Licensure Compact would be a step backward in the progress we have made in recent years. Other parts of the bill including the Occupational Therapist's Compact and Licenses Professional Counselors Compact are clear examples of the value of interstate compacts. It seems counterintuitive to add these two compacts while repealing another.

We respectfully ask that the committee consider amending SB 133 by eliminating part II from the bill.



Robert L. Quinn
Commissioner

2021

Robert Rix, MD
Chair
Michelle Nathan, MD
Vice-Chair

Voting Members:

Region 1
Thomas Trimarco, MD

Region 2
Marc Grossman, DO
Patrick Lee, MD
Michelle Nathan, MD
James Suozzi, DO
Brian Sweeney, DO

Region 3
John Freese, MD
Harry Wallus, DO

Region 4
Joshua Morrison, DO
Robert Rix, MD
Andrew Seefeld, MD

Region 5
Jared Blum, MD
David Hirsch, MD
Frank Hubbell, DO

State of New Hampshire

Department of Safety

New Hampshire Medical Services

Medical Control Board

April 20, 2021

Dear House of Representatives - Committee Members,

My name is Dr. Robert Rix and I am the Chair of the State Emergency Medical Services (EMS) Medical Control Board, Medical Director for the Capital Area EMS, and practicing emergency physician at Concord Hospital.

I am writing this letter in support of sb133, part IX, page 49, “Relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles”.

On November 19, 2020 the State Medical Control Board voted unanimously to support changing the language in NH RSA 153-A:13 regarding Revocation of License from “The commissioner shall deny an application for issuance or renewal of a license, or suspend or revoke a license, when the commissioner finds that the applicant is guilty of any of the following acts or offenses”, to “The commissioner *may* deny…”.

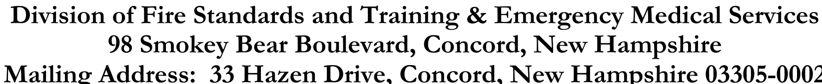
Not only does this language align with other medical professions within the State (see Chapter 329 section 329:17 for Physicians and Surgeons, Chapter 326-B of the Nurse Practice Act section 326-B:37, Chapter 328-D for Physicians Assistants section 328-D:7, and Chapter 317-A for Dentists and Dentistry section 317-A:17), but it also follows the concept of “Just Culture” which is practiced throughout the EMS community and much of medicine. A Just Culture emphasizes that mistakes are generally the result of a product of faulty organizational cultures rather than solely brought about by the person involved. The concept takes a balanced approach between a blameless culture and a punitive culture. The current language of NH RSA 153-A:13 forces the hand of the commissioner to universally act in a punitive fashion, no matter the infraction. Changing the wording from “shall” to “may” gives the commissioner the flexibility necessary to follow the practices of a Just Culture, which encourages self-reporting and honesty within the EMS community when it comes to mistakes or violations of protocol for example. This in turn helps to identify systems issues which ultimately lead to improved and safer patient care.

Sincerely,

Robert Rix, MD, FACEP
Chair, State of NH EMS Medical Control Board
Medical Director, Capital Area EMS
Attending Physician, Concord Hospital Emergency Department

Mailing: 33 Hazen Drive, Concord, NH 03305
Location: 98 Smokey Bear Blvd, Concord, NH 03301

Mailing: 33 Hazen Drive, Concord, NH 03305
Location: 98 Smokey Bear Blvd, Concord, NH 03301



Division of Fire Standards and Training & Emergency Medical Services
98 Smokey Bear Boulevard, Concord, New Hampshire
Mailing Address: 33 Hazen Drive, Concord, New Hampshire 03305-0002

Business: (603) 223-4200 Fax: (603) 271-1091

Robert L. Quinn
Commissioner

Jeffrey R. Phillips
Assistant Director

20 April, 2021

RE: Senate Bill 133 Testimony

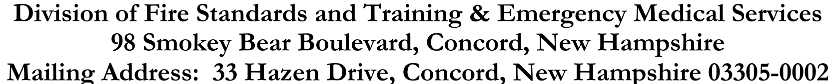
Thank you Madam Chairperson and members of the New Hampshire House of Representatives for allowing a few moments to speak on behalf of the Department of Safety. I first want to express my sincere gratitude for your continued service and commitment to the state of New Hampshire and our residents. The Department of Safety is in favor of the passing of Senate Bill 133 with an amendment to remove Section III. We feel strongly that the components of this Bill benefit the residents and visitors of the State by creating pathways for licensure as well modifications of oversight of said licensure as respectively outlined in the Bill text.

Section XI, specifically to the revocation of licensure for licensed emergency medical services (EMS) units and EMS vehicles, will assist the Commissioner of the Department of Safety in their regulatory duties of the EMS system. This adoption will provide them with options other than suspension or revocation of a license when an investigation warrants an actionable offense. This tool benefits the New Hampshire EMS system greatly by encouraging a just culture, similar to that of other healthcare disciplines.

Section III, which calls for the repealing the EMS personnel licensure interstate compact, would be removing a tool that New Hampshire has yet to benefit from. The compact was declared fully operational in March of 2020, in response to the COVID-19 pandemic. At this time there are twenty-one states participating in the compact which is an increase of six additional states since New Hampshire adopted it in July of 2018. To date this compact has not been used within borders of New Hampshire and thus has produced no instances where it has been proven to show no benefit to Granite Staters. On the contrary we have seen the compact used by New Hampshire EMS providers in other States.

More recently a fellow compact state, Colorado, called for National assistance in battling wildfires within its borders. The State of New Hampshire wildland firefighting team responded to this cry for help. As part of this team a local fire Chief was able to provide care for her teammates as well as residents of Colorado utilizing her privilege to practice care with no delay, all because of the EMS compact. If New Hampshire was not participating in the compact, Chief Lund would have not been able to provide care without the delays of obtaining an emergency license; which could have put her team at risk if an injury occurred.

Although New Hampshire has not directly benefited from the compact, to repeal it and subsequently take this tool out of the EMS system's toolbox is a step backwards. This compact extends a privilege to practice to EMS



Department of Safety

Division of Fire Standards and Training & Emergency Medical Services
98 Smokey Bear Boulevard, Concord, New Hampshire
Mailing Address: 33 Hazen Drive, Concord, New Hampshire 03305-0002

Business: (603) 223-4200 Fax: (603) 271-1091

Robert L. Quinn
Commissioner

Jeffrey R. Phillips
Assistant Director

providers only and does not bypass the requirement of departments and agencies wishing to provide EMS services in our state from being licensed as an EMS unit. This compact simple allows a mechanism for our appropriately licensed units to have access to an additional workforce if ever needed. Furthermore, within the originally adopted language safeguards were placed disallowing the use of providers under the privilege to practice (extended by the compact) as “regular and usual staff personnel”, per RSA 153-A:20 (XXIV).

In closing, the compact does no harm to the residents or the visitors of the state of New Hampshire. The compact enables our 5,640 licensed EMS providers to be part of a twenty-one-state initiative that extends a resource to one another. This comes at a time where there is a national recruitment and retention problem in public safety as well as on what we hope to be the curtails of the largest pandemics in history. We ask that you consider passing Senate Bill 133 with an amendment to remove Section III.

Justin Romanello
Chief, Bureau of EMS
DOS, Division of Fire Standards and Training & EMS

Archived: Tuesday, May 25, 2021 11:57:39 AM
From: Romanello, Justin
Sent: Thursday, April 22, 2021 7:43:39 AM
To: ~House Executive Departments and Administration
Subject: SB133 Testimony and Letter of Support
Importance: Normal
Attachments:
CB SB133 Letter.pdf ;

Dear members of the House of Representatives,

Please find an additional letter from the New Hampshire Medical and Trauma Services Coordinating Board voicing their concerns with the repeal of REPLICA and the support for Section X regarding amendments to adjust and add language giving the Commissioner of the Department of Safety more tools and flexibility in his/her duties of regulation of the New Hampshire EMS system.

I want to apologize for the errors in both this letter from the board and in my submitted testimony yesterday. I somehow was using an older and non-amended form of the Bill text which caused the Sections to be missed numbered.

Thank you for all that you do for our State and I look forward to attended the sub-committee meeting next week.

Justin

Justin Romanello
Bureau Chief
NH DOS, Division of Fire Standards and Training & EMS
Email: justin.s.romanello@dos.nh.gov

Office: 603-223-4211
Cell: 603-573-6307
Fax: 603-271-1091
http://www.nh.gov/ems

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From: Romanello, Justin
Sent: Tuesday, April 20, 2021 6:54 PM
To: houseexecutivedepartmentsandadministration@leg.state.nh.us
<houseexecutivedepartmentsandadministration@leg.state.nh.us>
Subject: SB133 Testimony and Letter of Support

Dear Sir/Ma'am,

Please find the attached document of my personal testimony that I will be presenting at tomorrow's session as well as a letter of support from the New Hampshire Medical Control Board.

Thank you,

Justin

Justin Romanello
Bureau Chief
NH DOS, Division of Fire Standards and Training & EMS
Email: justin.s.romanello@dos.nh.gov

Office: 603-223-4211
Cell: 603-573-6307
Fax: 603-271-1091
http://www.nh.gov/ems

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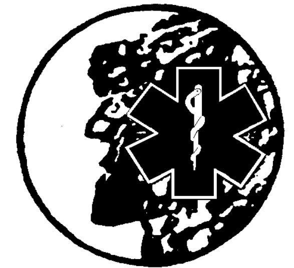

New Hampshire Association of Emergency Medical Technicians, Inc.

Post Office Box 2951
Concord, NH 03301-2951

http://www.NHAEMT.org

Senator Hennessy,

I am writing about SB 133. This bill has a hearing tomorrow before the ED&A committee. The section of this bill I am writing about is only the section dealing with the interstate Emergency Medical Services compact known as REPLICA. I believe this is section III. I would like you to consider keeping the interstate compact in force in New Hampshire and prevent its repeal. The NH membership in the interstate compact was passed by the legislature in 2018. The compact facilitates the use of emergency medical personnel, either Emergency Medical Technicians or Paramedics that are licensed in other states, in New Hampshire for a short term during a time of disaster or other crisis. In this year of the pandemic it should be obvious that in a disaster our ability to supplement the states resources with EMS providers that have been verified as competent, have passed a criminal background check, and who are accountable is a matter of vital public safety. New Hampshire is one of 22 states that are currently members of REPLICA. REPLICA does not cost the state anything.There are no funding requirements or provisions to be a member of the compact. The compact does not permit NH EMS licensed providers or providers from member states to work in a compact state without having to obtain a provider license from that state. Again, the compact is only used when a member state requests EMS personnel. The EMS compact serves as a force multiplier for signatory states during times of crises or disaster and should remain law by striking Part III of SB133.

Thank you for your consideration of this request.
Respectfully submitted,

Dave Tauber, BS, NRP, FP-C
Chief
Linwood Ambulance
A non-profit serving the towns of Lincoln and Woodstock NH since 1969

Vice President of the New Hampshire Association of EMTs
NHAEMT representative to the NH Emergency Medical and Trauma Services Coordinating Board

An Affiliate of the National Association of Emergency Medical Technicians
We are a 501(c)3 and donations are tax deductible to the amount allowed by law.

April 26th, 2021

Dear Committee Members,

I am opposed to the following language being proposed for Senate Bill 133

Amendment to SB 133-FN

Amend section 2 of the bill by inserting after Part XIII the following:

Part XIV

Establishing minimum qualifications for certification as a child care associate teacher.
1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after
subparagraph (m) the following new subparagraph:

(n) The following qualification for certification as an associate teacher: a minimum of 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of
training in child growth and development, the latter of which may be documented life experience.
2 Effective Date. This act shall take effect 60 days after its passage.

I am currently a participant in the following workgroups and task forces (Child Care Advisory Council, Child Care Staffing Crisis Task Force, Higher Education Round Table) and with my involvement in each of these groups I am fully aware of the high need of child care workers in our state. I do agree that COVID-19 has exacerbated this need AND ALSO believe that making the above proposed changes to the Associate Teacher qualifications is something that should not be done haphazardly. As you may know, child care and licensing regulations have been a topic of conversation for several years, not just during this pandemic. The qualifications that were put into place by the Child Care Licensing Bureau were well researched and thoughtfully included as part of our regulations that meet the basic needs to provide adequate care to the children in our community.

I encourage the committee to think about the children that will be in these child care classrooms, **7-9 hours a day**, the stressors that the child care classroom can have when you are providing group care to many children (typically all the same age in one space), and the level of education needed to adequately meet the needs of these children. Children deserve to have high quality classrooms to attend where the teachers are trained in a manner that meets the needs of group care and not being a mom of 2 or 3 children. There can be natural dispositions of adults that make them suitable for the job but specific training on topics such as Positive Behavior

Guidance, Curriculum, and Trauma-Informed Care are not topics that can just be navigated based on experience.

I sit on the aforementioned committees and task force groups because I am passionate about the field and want to provide as many opportunities as I can to help nurture and grow the field. I am currently working to put together an expediated entry-level certificate for students entering the field (a 9-credit certificate that already exists) and offer 3, 4-week courses to help provide more well-trained applicants to the field. I am hoping to be able to provide scholarships through Perkins funding to allow these students the opportunity to this at no cost. I am working with others in the field to find ways to attract new individuals into early childhood AND AGAIN I am sure you are aware that the funding to pay these individuals is lacking, at the very least. I believe it would be shameful to completely change these qualifications to put a band aid on a bigger bleeding issue in our field.

I suggest to this committee that instead of making this a permanent adjustment to the qualifications in our licensing regulations that you, instead, consider language that allows for this to be a temporary fix and gives the power to the licensing bureau to review with a working committee each year to see if it is improving the needs of the field or if we are at a place, at the designated time, to revert to the current qualifications. In other words, use this opportunity to make this an accommodation for the current situation but not something that will be changed permanently and then need to be "fought over" to go back to.

Thank you for your consideration,

Diana Menard

Diana Menard – Concerned Citizen in the Early Childhood field

PROFESSIONAL FIRE FIGHTERS

OF NEW HAMPSHIRE

House Executive Departments and Administration Committee
Legislative Office Building
33 N State Street
Concord, NH 03301

RE: Testimony in Support of SB 133, Part II: repealing the emergency medical services personnel licensure interstate compact.

Madame Chair and Honorable Members of the Committee:

My name is Brian Ryll and I serve as the President of the Professional Fire Fighters of New Hampshire and am a Captain for the Portsmouth Fire Department. Today I am providing testimony in support of SB 133, Part II *repealing the emergency medical services personnel licensure interstate compact*, otherwise known as 'REPLICA'.

The initial intent of the RFP for REPLICA was to allow federal resources to maintain a "home state" card, but operate in other states to fulfill their specific mission without seeking reciprocity. It was also intended to exclusively allow emergency resources to cross state lines to assist in emergency responses or large-scale emergency responses which had not been declared such by a governor. However, the scope of REPLICA extends the intent to include day-to-day EMS response, including non-emergency interfacility work. If this work were to base itself near our state's borders, this would effectively take work away from current positions funded by New Hampshire's cities and towns, and draw New Hampshire-expanded Medicaid dollars from our state which would result in a loss of revenue.

The current REPLICA model allows ambulances to cross state lines to pick up patients and transport them to other states. Unlike our Mutual Aid model, which is on a case-by-case basis through the 9-1-1 emergency system, REPLICA allows companies to come in from around the country on a routine basis and transport patients to participating compact states. By doing this, EMS personnel are working under the licensure and clinical oversight of their home state, and not New Hampshire. There should always be a reasonable expectation that when you or your family calls 9-1-1, the highest possible standard of care is received, and that standard of care is determined by New Hampshire's Medical Control Board. Under the REPLICA model, providers no longer operate under the same scope of practice, which could not only lead to inappropriate patient treatment, but also leads to confusion within the EMS system that could result in discipline, loss of licensure or termination of a provider.

Furthermore, with the current REPLICA model, we have taken away the ability for local cities and towns to manage their own mutual aid agreements, allowing for a means of self-deployment which adds confusion to an already disastrous situation. Municipalities should have the autonomy to oversee their individual public safety response based on their community's needs.

We believe REPLICA threatens the state's economy and the quality of care delivered to patients in New Hampshire. Allowing EMS providers to migrate into state intermittently creates a loss of taxable revenue, all translating to a weaker New Hampshire economy. It is clear that REPLICA is not a formula that works for New Hampshire. Since its passage in 2018, we have not used this model and it has added no value to emergency response for the State of New Hampshire.

PROFESSIONAL FIRE FIGHTERS
OF NEW HAMPSHIRE

Because of these reasons, I respectfully ask that this committee move to support SB 133, Part II: repealing the emergency medical services personnel licensure interstate compact.

Respectfully Submitted,

Brian Ryll
President
Professional Fire Fighters of New Hampshire

43 Centre Street, Concord, NH 03301 • Office: (603) 223-3304 • Fax: (603) 223-3310 • www.pffnh.org

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PROFESSIONAL FIRE FIGHTERS
OF NEW HAMPSHIRE

House Executive Departments and Administration Committee
Legislative Office Building
33 N State Street
Concord, NH 03301

RE: Testimony in Support of SB 133, Part X: relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

Dear Madame Chair and Honorable Members of the Committee:

My name is Brian Ryll and I serve as the President of the Professional Fire Fighters of New Hampshire and am a Captain for the Portsmouth Fire Department. The Professional Fire Fighters of New Hampshire is a state association representing 42 local unions, and approximately 2,000 active and retired professional fire fighters and paramedics across the Granite State. As the preeminent fire fighter organization in New Hampshire, we advocate for the health and safety of the brave men and women that protect the citizens of this great state. I am providing testimony in support of SB 133, Part X: *relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.*

This bill offers a simple solution to ensure the Commissioner of the Department of Safety has more discretion when acting upon the licensure for licensed emergency medical service units. Under current law the Commissioner "shall" suspend or revoke a license for a number of non-specific acts or offenses. This includes any situation where a unit or service self-reports a violation in an attempt to rectify the situation. Due to the complex nature of the emergency medical services industry it would be prudent to allow the Commissioner of Safety the flexibility to act on these matters using sound judgement and discretion rather than forced revocation or suspension of license.

As EMS providers in this state, we believe in the just-culture concept and we encourage a provider or a unit to report when a mistake is made. However, with the current language of RSA 153-A:13, there is the potential for a provider or a unit to avoid the reporting procedure for fear of revocation of their license.

SB 133, Part X simply makes a technical change to the current law that could improve the EMS system in New Hampshire, and we ask for the committee's full support.

Respectfully,

Brian Ryll
President
Professional Fire Fighters of New Hampshire

PROFESSIONAL FIRE FIGHTERS OF NEW HAMPSHIRE

House Executive Departments and Administration Committee
Legislative Office Building
33 N State Street
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Respectfully,

Brian Ryll
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Professional Fire Fighters of New Hampshire

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State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
7 Eagle Square, Suite 200
Concord, N.H. 03301-2412
Telephone 603-271-2152 · Fax 603-271-6202

LINDSEY B. COURTNEY
Executive Director

April 27, 2021

Hon. Carol McGuire
Chair, Executive Departments & Administration
LOB Room 306
33 North State Street
Concord, NH 03301

Re: Testimony regarding SB 133—adopting omnibus legislation relative to occupational licensure

Good afternoon, Madam Chair, members of the committee:

My name is Lindsey Courtney, Executive Director of the New Hampshire Office of Professional Licensure and Certification, the agency that administers fifty-four occupational licensing boards, councils, and commissions within the State of New Hampshire.

OPLC wishes to express its support of portions of this bill, specifically Part III (hearings at the board of nursing); Part V (adopting the audiology and speech-language pathology compact and the occupational therapy licensure compact); Part VII (concerning the authority of the office of professional licensure and certification for administration, rulemaking, and enforcement of investigations, hearings, and appeals); and, Part XI (schools for barbering, cosmetology, and esthetics). OPLC also wishes to comment upon Part XII (relative to telemedicine provided by out of state psychologists).

Part III removes the prohibition in RSA 326-B:38, VIII of public members of the board serving as the presiding officer over disciplinary hearings. The Board of Nursing is the only board of the fifty-four boards, councils, and commissions within the Office of Professional Licensure that does not permit the public member to preside over hearings. The Board of Nursing has requested this legislation to standardize requirements across the agency, and to permit all members of the board to serve the State in this capacity.

The presiding officer of disciplinary hearings controls the flow and conduct of the hearing, and rules on evidentiary motions. The presiding officer does not have authority to make decisions regarding disciplinary actions on behalf of the board. That authority remains with the board. A quorum of the board must be present to adjudicate cases; all board members have the authority to ask questions of witnesses. The presiding officer simply facilitates communications.

During last session, we heard testimony that some nurses were concerned about a non-nurse presiding over a hearing. However, I believe those concerns are based on the mistaken belief that the presiding officer has authority over the outcome of the proceedings. As noted, the presiding officer has no more authority over the outcome of the proceedings than other board members. OPLC supports this bill as it brings the Board of Nursing in line with the other boards within OPLC and permits all board members appointed by Governor and Council to serve the State in this capacity.

Part V adopts the audiology and speech-language pathology compact and the occupational therapy licensure compact. The compacts would facilitate the interstate practice of audiology and speech-language pathology and occupational therapy. As it is supported by members of the profession and would promote workforce opportunities within the state, while ensuring the public is protected, OPLC fully supports Part V of this bill.

Part VII concerns the authority of the office of professional licensure and certification. The bill would permit the agency to adopt rules regarding hearings and disciplinary proceedings. In order to effectively administer fifty-four boards, councils, and commissions, it is necessary that the agency has one set of rules that govern process for hearings and disciplinary hearings. At present, our two prosecutors must work within fifty-four sets of rules, which is incredibly inefficient. This bill is intended to remedy this.

The bill also codifies our present process within the agency. Over the last nine months, OPLC has been collaborating with the boards to adopt a streamlined complaint and investigation process. We have been able to implement this through standing orders issued by the majority of the boards. The bill would codify this process and permit OPLC to adopt rules regarding investigations, which would provide more efficient, better support for the boards, councils, and commissions within the agency.

Part XI clarifies the authority of the board of barbering, cosmetology, and esthetics to regulate programs within secondary schools. At present, the board does regulate such programs; the board's regulation permits high school students to obtain licensure through a high school program. However, it is unclear that it has the statutory authority to do so. Part XI clarifies the board's authority to permit high school students to continue to attend board-approved program sin high school and, as such, OPLC and the board fully support Part XI.

Part XI also changes RSA 313-A to permit the board to grant apprentice certificates as opposed to licensure. Licensure carries requirements that the agency capture social security numbers (due to federal child support requirements). In essence, by licensing apprentices in high school, the board must collect social security numbers, effectively preventing those students without social security numbers from participating in a high school education program. This conflicts with federal education law. This bill resolves that conflict.

Part XII creates a special license specifically for the provision of telemedicine services only by psychologists. OPLC understand the Board of Psychology has sought this specific statutory

provision as the existing licensure process is onerous and can be a barrier to promoting workforce. OPLC does not oppose this bill as the agency is supportive of the bill's objective. However, OPLC does not believe a new license (that would be established by this bill) is required to accomplish the bill's purpose.

At present, individuals with a New Hampshire psychology license are permitted to practice in New Hampshire, through in-person services or telehealth services. See RSA 329-B:16, I ("Persons licensed by the board shall be permitted to provide services through the use of telemedicine."). Generally, a person may only provide telehealth services if it is consistent with the standard of care; indeed, the standard of care for telehealth and in-person services must be the same. Assuming the standard of care is the same for both in-person and virtual services, there really is no basis for creating two classes of licensure simply based on the platform through which the service is rendered.

The current statute is seemingly straightforward in terms of requirements to obtain a psychologist license. The rules, however, are onerous and can pose a barrier to workforce. Rather than create a new licensing category based solely on the way services are delivered, OPLC believes the Board should exercise its existing statutory authority to modify its current rules.

Very truly yours,

Lindsey B. Courtney, JD
Executive Director
Office of Professional Licensure and Certification

MANPOWER AND
RESERVE AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
1500 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-1500

April 21, 2021

Representative Carol McGuire
Chair, House Executive Departments and Administration Committee

Remarks of
Christopher R. Arnold
Northeast Region Liaison
United States Department of Defense-State Liaison Office

Regarding: SB 133-FN, as amended by the Senate, AN ACT adopting omnibus legislation relative to occupational licensure; in OPPOSITION to Part II (Repealing the emergency medical services personnel licensure interstate compact); and in SUPPORT of Part V (Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact)

Testimony

Madame Chair and honorable committee members, the Department of Defense is grateful for the opportunity to provide testimony and express its strong opposition to the policy set forth in Part II of Senate Bill SB133, to repeal the EMS Compact. The Department asks you to seriously consider not repealing this compact and instead continue New Hampshire's reputation as a military friendly state.

At the same time, the Department expresses its support for the policies reflected in Part V of this bill. Subparts A and B of Part V of SB133 recognize the benefits of interstate compacts, by adopting the Audiology and Speech-Language Pathology Compact, or "ASLP-IC", and the Occupational Therapy Licensure Compact, or "OT Compact".

My name is Christopher Arnold. I am the northeast region liaison at the United States Department of Defense-State Liaison Office, operating under the direction of Under Secretary of Defense for Personnel and Readiness.

We represent the Department and work with state leaders across the country who are concerned for troops and their families' welfare by harmonizing state and federal law and regulation on policy problems of national significance. These are identified by the Office of the Secretary of Defense, the Military Departments, and the National Guard Bureau as areas where states can play a crucial role.

As our service members and their families move from state to state, obtaining licenses in order to pursue employment is critical. These compacts serve to relieve one of the many stressors of a military move. Paradoxically, SB133 recognizes the benefit of compacts by enacting the ASLP-IC and the OT Compact; while repealing the Emergency Medical Services Personnel Licensure Interstate Compact, also known as "REPLICA".

Licensure issues for both our transitioning military members and their spouses have been a priority for the Department for several years. The issue is so important, the Secretary of Defense has made taking care of Service members and their families a fourth line of effort in the National Defense Strategy.

The Secretaries of the Military Departments have made the importance of military spouse licensure explicitly clear as they consider the availability of license reciprocity when evaluating future basing or mission alternatives. This consideration was codified by Congress as a requirement in the 2020 National Defense Authorization Act.[1]

The secretaries must further consider "*whether the State in which an installation subject to a basing decision is or will be located ... has entered into reciprocity agreements to recognize and accept professional and occupational licensure and certification credentials granted by or in other States or allows for the transfer of such licenses and certifications granted by or in other States*."[2]

The FY2019 report from the Office of Local Defense Community Cooperation found the largest installations in the Granite State supported 6,337 jobs and generated $3.1 billion in defense spending, or, roughly 3.5% of State GDP, fourteenth overall in the United States.[3]

To address license portability for military spouses, states have turned to occupational licensure interstate compacts, which streamline relicensing between member States of a compact for all practitioners in an occupation, and provide specific support for military spouses of relocating active-duty personnel through provisions recognizing unique requirements of military life.

SB 133-FN, Part II (Repealing the emergency medical services personnel licensure interstate compact)

The Department perceives that Part II of Senate Bill SB133, which proposes to repeal REPLICA, negatively impacts military spouse licensure. If passed, Part II would make New Hampshire the first state to ever leave a licensing compact, undermining the Department's efforts nationwide.

A 2018 study by the Federal Trade Commission, "Options to Enhance Occupational License Portability," recognized there are two approaches to alleviating barriers to license portability. Namely, mutual recognition, which relates to occupational compacts, and expedited licensure, which encompasses exemption approaches.[4]

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[1] Notably, §2883(h) requires the Department and each of the military services to produce annual basing decision scorecards at the state and installation level considering military family readiness issues, including interstate portability of licensure credentials.
[2] Id. (b)
[3] *DOD Releases Report on Defense Spending by State in Fiscal Year 2019*. January 13, 2021. https://www.defense.gov/Newsroom/Releases/Release/Article/2470586/dod-releases-report-on-defense-spending-by-state-in-fiscal-year-2019/
[4] Karen A. Goldman. "Options to Enhance Occupational License Portability." Federal Trade Commission. September 2018. Retrieved from http://www.ftc.gov/policy/reports/policy-reports/commission-and-staff-reports

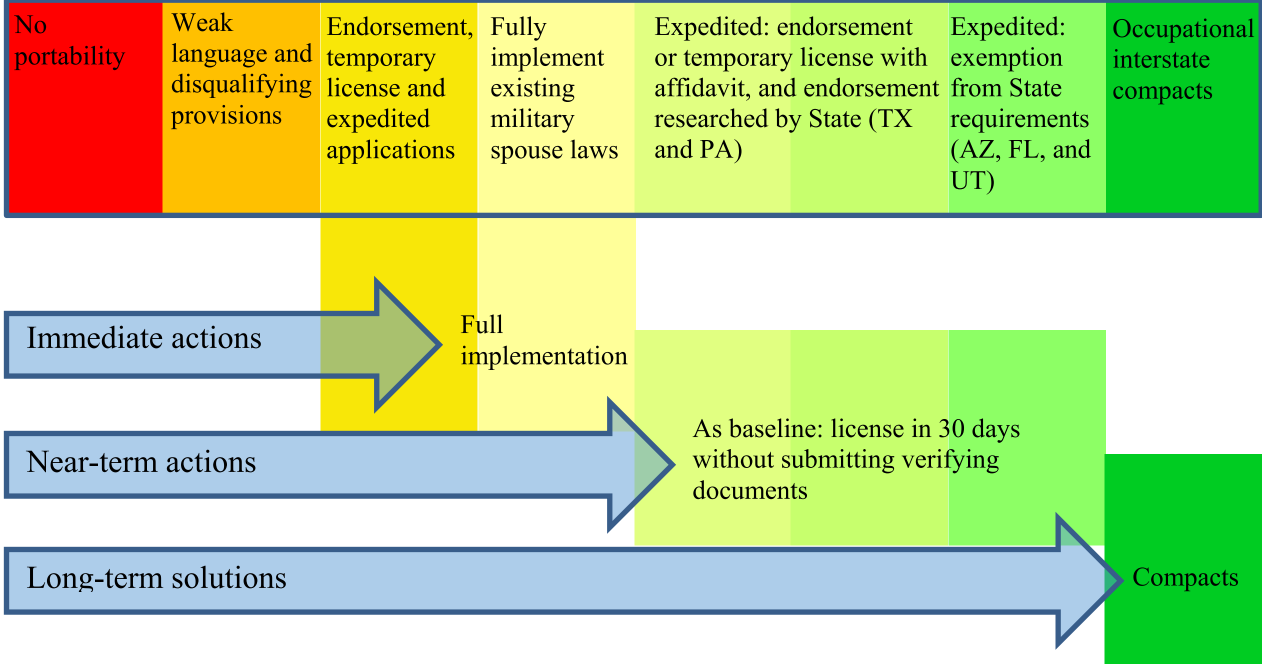
Occupational licensure compacts provide consistent rules for licensed members to work in other states. Common misinformation about compacts is that they either lower or raise the standards for the occupation, when in fact, compact states have the option to issue a "compact license" and also a "State-only license" to maintain their State's standards.

To date, twenty-two states have passed legislation to join the emergency medical services personnel licensure interstate compact and three states have legislation to join REPLICA pending. It would be a step in the wrong direction if New Hampshire repealed the emergency medical services personnel licensure interstate compact as proposed in SB133.

SB 133-FN, Part V (Adopting the Audiology and Speech-Language Pathology Compact and the Occupational Therapy Licensure Compact)

Occupational licensure has been an enduring problem for military spouses. Obtaining a license in a new State can be both time consuming and expensive, and military spouses often cannot adequately anticipate how to prepare for licensure in a new State due to the unpredictable nature of military moves. The short duration of military assignments, coupled with lengthy relicensing processes, can discourage military spouses from seeking relicensure, causing them to quit an occupation or causing military families to leave the military.

Complicating matters further, the term "reciprocity" is used differently among the States. The continuum of reciprocity related programs is represented graphically below. The continuum goes from red, representing little to no portability, to dark green, representing the DoD's optimum state of full reciprocity (licensing compacts). Available alternatives can be categorized as being more immediately attainable, achievable within the near-term, or obtainable in the long-term:



The ASLP-IC addresses licensing issues affecting our service members and their families and enhances opportunities of portable careers for military spouses by providing consistent rules which allow licensed members to work in other states through "privilege to practice policies", or more easily transfer their license to a new state.

Frequent moves and cumbersome licensing and certification requirements limit career options for military spouses. Enacting the ASLP-IC allows service members and military spouses to more easily maintain their profession when relocating.

The OT Compact similarly addresses such licensing issues. The purpose of the OT Compact is to facilitate interstate practice of occupational therapy with the goal of improving public access to occupational therapy services, while preserving the regulatory authority of states to protect public health and safety through the current system of state licensure.

Section 6 of the OT Compact allows an active duty service member, or their spouse, to designate a home state where the individual has a current license in good standing. This state then serves as the individual's home state for as long as the service member is on active duty, while adhering to the laws, rules and scope of practice in New Hampshire. Joining the OT Compact will allow military personnel and spouses to more easily maintain their certifications when relocating.

The coronavirus pandemic demonstrates that interstate licensure compacts can provide a permanent solution to leverage underutilized medical talent to meet labor shortages in high-need areas. We appreciate the opportunity to support the policies outlined in the ASLP-IC and the OT Compact.

Conclusion

The reasons to join these two compacts are the same reasons not to repeal the EMS Compact. Indeed, New Hampshire is one of only 8 states in the nation to have joined 4 or more major health compacts: REPLICA, the Interjurisdictional Compact for Psychology (PsyPACT); the Nurse Licensure Compact (NLC); and the Physical Therapy Licensure Compact (PTLC). Were the state to leave REPLICA, many New Hampshire licensed military spouses involuntarily stationed in other states would lose their eligibility to practice in those compact states.

Military spouses are a cross-section of the American population, although a greater percentage of them are in licensed occupations than their civilian counterparts,[5] and they are significantly more mobile.[6] States have committed to using interstate compacts, which establish common

[5] 34 percent of active duty spouses self-identified as needing a State issued license to work (2017 Survey of Active Duty (Active Component) Spouses, Tabulations of Responses; Office of People Analytics Report No. 2018-006, May 2018), compared to 30 percent of the civilian population (The Hamilton Project, Brookings Institute, https://www.hamiltonproject.org/charts/percent_of_occupations_requiring_a_license_by_state)

[6] "Military spouses are 10 times more likely to move across State lines than their civilian counterparts," "Supporting Our Military Families: Best Practices for Streamlining Occupational Licensing Across State Lines," U.S. Department of Treasury and U.S. Department of Defense, February 2012, page 7.

understanding of competency and its measurement within the occupation, to resolve the interstate issue of license portability.

Military spouses are more educated and trained than their civilian counterparts, yet on average, earn 25 percent less than their civilian counterparts.[7] Portable employment opportunities support military spouse career development. Compacts can provide seamless reciprocity for military spouses in an occupation. Barriers to the transfer and acceptance of certifications and licenses that occur when state rules differ can have a dramatic and negative effect on the financial well-being of military families.

Removing these barriers, creating reciprocity in licensing requirements, and facilitating placement opportunities can help a military family's financial stability, speed the assimilation of the family into its new location, and create a desirable new employee pool for a state.

Understanding that military spouses need assistance now, the Department advocates that States should pursue multiple approaches to reciprocity simultaneously, including near-term actions to at least attain a baseline of getting military spouses a license in 30 days based on minimal documentation; and long-term solutions for reciprocity through compacts.

How fast these actions and solutions can be approved and implemented is up to the States.

In closing, we are grateful for the tremendous efforts that New Hampshire has historically made to support our military members and their families. We appreciate the opportunity to provide testimony on this legislation. As always, as Northeast Region Liaison, I stand ready to answer whatever questions you may have.

Yours etc.,

CHRISTOPHER R. ARNOLD
Northeast Region Liaison
Defense-State Liaison Office

[7] Hiring Our Heroes. *Military Spouses in the Workplace. Understanding the Impacts of Spouse Unemployment on Military Recruitment, Retention and Readiness*. June 2017. Retrieved form https://www.uschamberfoundation.org/sites/default/files/Military%20Spouses%20in%20the%20Workplace.pdf

PART VI

Relative to the licensure and regulation of music therapists.

1 New Chapter; Music Therapists. Amend RSA by inserting after chapter 326-L the following new chapter:

CHAPTER 326-M

MUSIC THERAPISTS

326-M:1 Definitions. In this chapter and RSA 328-F:

I. "Board" means the music therapists governing board established in RSA 328-F.

II. "Board certified music therapist" means an individual who holds current board

certification from the Certification Board for Music Therapists.

III. "Executive director" means the executive director of the office of professional licensure

and certification.

IV. "Music therapist" means a person licensed to practice music therapy pursuant to this

chapter.

V. "Music therapy" means the clinical and evidence based use of music interventions to

accomplish individualized goals for people of all ages and ability levels within a therapeutic

relationship by a board certified music therapist. The music therapy interventions may include,

music improvisation, receptive music listening, song writing, lyric discussion, music and imagery,

singing, music performance, learning through music, music combined with other arts, music-assisted

relaxation, music-based patient education, electronic music technology, adapted music intervention

and movement to music. The practice of music therapy does not include the screening, diagnosis, or

assessment of any physical, mental, or communication disorder. This term may include:

(a) Acceptance of clients referred for music therapy by other health care or educational

professionals, family members, or caregivers.

(b) Assessment of clients to determine appropriate music therapy services.

(c) Development and implementation of individualized music therapy treatment plans

that identify goals, objectives, and strategies of music therapy that are appropriate for clients.

(d) Use of music therapy techniques such as improvisation, performance, receptive

music listening, song writing, lyric discussion, guided imagery with music, learning through music, and movement to music.
(e) Evaluation of a client's response to music therapy techniques and to the client's individualized music therapy treatment plan.
(f) Any necessary modification of the client's individualized music therapy treatment plan.
(g) Any necessary collaboration with the other health care professionals treating a client.
(h) Minimizing of barriers that may restrict a client's ability to receive or fully benefit from music therapy services.

326-M:2 Prohibition on Unlicensed Practice; Professional Identification.
I. No person without a license as a music therapist shall use the title "music therapist" or similar title or practice music therapy.
II. Nothing in this chapter shall be construed to prohibit or restrict the practice, services, or activities of the following:
(a) Any person licensed, certified, or regulated under the laws of this state in another profession or occupation or personnel supervised by a licensed professional in this state performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation, if that person does not represent himself or herself as a music therapist; or
(b) Any person whose training and national certification attests to the individual's preparation and ability to practice his or her certified profession or occupation, if that person does not represent himself or herself as a music therapist; or
(c) Any practice of music therapy as an integral part of a program of study for students enrolled in an accredited music therapy program, if the student does not represent himself or herself as a music therapist; or
(d) Any person who practices music therapy under the supervision of a licensed music therapist, if the person does not represent himself or herself as a music therapist.

III. Subject to Subsection (V) of this section, unless authorized to practice speech–language pathology under this title or unless otherwise provided for under this article, a person may not represent to the public by title, by description of services, methods, or procedures, or otherwise that the person:

(a) Is authorized to practice speech–language pathology in this State; or

(b) Evaluates, examines, instructs, or counsels individuals suffering from disorders or conditions that affect speech, language, communication, and swallowing.

IV. Subject to Subsection (V) of this section, unless authorized to practice speech–language pathology under RSA 326-F, a person may not use any word or term connoting professional proficiency in speech–language pathology, including but not limited to "communication disorders."

V. (a) Expect as provided in paragraph (b) of this subsection, an individual licensed under this title to engage in the practice of music therapy may not represent to the public that the individual is authorized to treat a communication disorder.

(b) This section may not be construed to prohibit an individual licensed under this title to engage in the practice of music therapy from representing to the public that the individual may work with a client who has a communication disorder to address communication skills.

326-M:3 Licensure of Music Therapists. In addition to requirements under RSA 328-F:

I. The board shall issue a license to an applicant for a music therapy license when such applicant has completed and submitted an application upon a form and in such manner as the executive director prescribes, accompanied by applicable fees, and evidence satisfactory to the board that:

(a) The applicant is in good standing based on a review of the applicant's music therapy licensure history in other jurisdictions, including a review of any alleged misconduct or neglect in the practice of music therapy on the part of the applicant, and a review of the criminal background check required under RSA 328-F:18-a.

(b) The applicant provides proof of passing the examination for board certification offered by the Certification Board for Music Therapists or any successor organization or provides proof that the applicant is currently a board certified music therapist.

II. The board shall issue a license to an applicant for a music therapist license when such applicant has completed and submitted an application upon a form and in such manner as the executive director prescribes, accompanied by applicable fees, and evidence satisfactory to the board that the applicant is licensed and in good standing as a music therapist in another jurisdiction where the qualifications required are equal to or greater than those required in this chapter at the date of

application.

326-M:4 Music Therapists Governing Board; Duties. In addition to the duties of a governing
board under RSA 328-F:
I. The board may facilitate the development of materials that the office of professional
licensure and certification may utilize to educate the public concerning music therapist licensure, the
benefits of music therapy, and utilization of music therapy by individuals and in facilities or
institutional settings.
II. The board may act as a facilitator of statewide dissemination of information between
music therapists, the American Music Therapy Association or any successor organization, the
Certification Board for Music Therapists or any successor organization, and the executive director.
III. The executive director shall seek the advice of the board for issues related to the
regulation of music therapists.

2 Allied Health Professionals; Definition; Governing Board. Amend RSA 328-F:2, II to read as
follows:
II. "Governing boards" means individual licensing boards of athletic trainers, occupational
therapy assistants, occupational therapists, recreational therapists, physical therapists, physical
therapist assistants, respiratory care practitioners, speech-language pathologists, [and] genetic
counselors, and music therapists.

3 New Paragraph; Allied Health Professionals; Music Therapists. Amend RSA 328-F:2 by
inserting after paragraph X the following new paragraph:
XI. "Music therapist" means music therapist as defined in RSA 326-M:1.

4 Governing Board; Establishment. Amend RSA 328-F:3, I to read as follows:
I. There shall be established governing boards of athletic trainers, occupational therapists,
recreational therapists, respiratory care practitioners, physical therapists, speech-language
pathologists, [and] genetic counselors, and music therapists.

5 New Paragraph; Music Therapists Governing Board; Appointment. Amend RSA 328-F:4 by inserting after paragraph X the following new paragraph:

XI. The music therapists governing board shall consist of 3 licensed music therapists, who have actively engaged in the practice of music therapy in this state for at least 2 years, one member who is a licensed health care provider who is not a music therapist, and one public member. Initial appointment of professional members by the governor and council shall be qualified persons practicing music therapy in this state. All subsequent appointments or reappointments shall require licensure.

6 Renewals; Reference to Music Therapists Added. Amend RSA 328-F:19, I to read as follows:

I. Initial licenses and renewals shall be valid for 2 years, except that timely and complete application for license renewal by eligible applicants shall continue the validity of the licenses being renewed until the governing board has acted on the renewal application. Licenses issued pursuant to RSA 328-A, RSA 326-G, [and] RSA 326-J, and RSA 326-M shall expire in even-numbered years and licenses issued pursuant to RSA 326-C, RSA 326-E, RSA 326-F, and RSA 326-K shall expire in odd-numbered years.

7 Office of Professional Licensure and Certification; New Classified Position; Appropriation.

I. One program assistant II position, labor grade 15, is hereby established as a classified position in the office of professional licensure and certification.

II. The amount necessary to pay for the position established in paragraph I and for the per diem and travel reimbursement as required under RSA 328-F:6 for the music therapy governing board established in this act is hereby appropriated to the executive director of the office of professional licensure and certification. Salaries and necessary expenses shall be a charge against the office of professional licensure and certification fund established in RSA 310-A:1-e.

8 Effective Date. Part VI of this act shall take effect July 1, 2021.

PART VI

Relative to the licensure and regulation of music therapists.

1 New Chapter; Music Therapists. Amend RSA by inserting after chapter 326-L the following new chapter:

CHAPTER 326-M

MUSIC THERAPISTS

326-M:1 Definitions. In this chapter and RSA 328-F:

I. "Board" means the music therapists governing board established in RSA 328-F.

II. "Board certified music therapist" means an individual who holds current board

certification from the Certification Board for Music Therapists.

III. "Executive director" means the executive director of the office of professional licensure

and certification.

IV. "Music therapist" means a person licensed to practice music therapy pursuant to this

chapter.

V. "Music therapy" means the clinical and evidence based use of music interventions to

accomplish individualized goals for people of all ages and ability levels within a therapeutic

relationship by a board certified music therapist. The music therapy interventions may include,

music improvisation, receptive music listening, song writing, lyric discussion, music and imagery,

singing, music performance, learning through music, music combined with other arts, music-assisted

relaxation, music-based patient education, electronic music technology, adapted music intervention

and movement to music. The practice of music therapy does not include the screening, diagnosis, or

assessment of any physical, mental, or communication disorder. This term may include:

(a) Acceptance of clients referred for music therapy by other health care or educational

professionals, family members, or caregivers.

(b) Assessment of clients to determine appropriate music therapy services.

(c) Development and implementation of individualized music therapy treatment plans

that identify goals, objectives, and strategies of music therapy that are appropriate for clients.

(d) Use of music therapy techniques such as improvisation, performance, receptive

music listening, song writing, lyric discussion, guided imagery with music, learning through music, and movement to music.

(e) Evaluation of a client's response to music therapy techniques and to the client's individualized music therapy treatment plan.

(f) Any necessary modification of the client's individualized music therapy treatment plan.

(g) Any necessary collaboration with the other health care professionals treating a client.

(h) Minimizing of barriers that may restrict a client's ability to receive or fully benefit from music therapy services.

326-M:2 Prohibition on Unlicensed Practice; Professional Identification.

I. No person without a license as a music therapist shall use the title "music therapist" or similar title or practice music therapy.

II. Nothing in this chapter shall be construed to prohibit or restrict the practice, services, or activities of the following:

(a) Any person licensed, certified, or regulated under the laws of this state in another profession or occupation or personnel supervised by a licensed professional in this state performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation, if that person does not represent himself or herself as a music therapist; or

(b) Any person whose training and national certification attests to the individual's preparation and ability to practice his or her certified profession or occupation, if that person does not represent himself or herself as a music therapist; or

(c) Any practice of music therapy as an integral part of a program of study for students enrolled in an accredited music therapy program, if the student does not represent himself or herself as a music therapist; or

(d) Any person who practices music therapy under the supervision of a licensed music therapist, if the person does not represent himself or herself as a music therapist.

III. Subject to Subsection (V) of this section, unless authorized to practice speech–language pathology under RSA 326-F or unless otherwise provided for under this article, a person may not represent to the public by title, by description of services, methods, or procedures, or otherwise that the person:

(a) Is authorized to practice speech–language pathology in this State; or

(b) Evaluates, examines, instructs, or counsels individuals suffering from disorders or conditions that affect speech, language, communication, and swallowing.

IV. Subject to Subsection (V) of this section, unless authorized to practice speech–language pathology under RSA 326-F, a person may not use any word or term connoting professional proficiency in speech–language pathology, including but not limited to “communication disorders.”

V. (a) Expect as provided in paragraph (b) of this subsection, an individual licensed under this title to engage in the practice of music therapy may not represent to the public that the individual is authorized to treat a communication disorder.

(b) This section may not be construed to prohibit an individual licensed under this title to engage in the practice of music therapy from representing to the public that the individual may work with a client who has a communication disorder to address communication skills.

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(b) The applicant provides proof of passing the examination for board certification offered by the Certification Board for Music Therapists or any successor organization or provides proof that the applicant is currently a board certified music therapist.

II. The board shall issue a license to an applicant for a music therapist license when such applicant has completed and submitted an application upon a form and in such manner as the executive director prescribes, accompanied by applicable fees, and evidence satisfactory to the board that the applicant is licensed and in good standing as a music therapist in another jurisdiction where the qualifications required are equal to or greater than those required in this chapter at the date of

application.

326-M:4 Music Therapists Governing Board; Duties. In addition to the duties of a governing board under RSA 328-F:

I. The board may facilitate the development of materials that the office of professional licensure and certification may utilize to educate the public concerning music therapist licensure, the benefits of music therapy, and utilization of music therapy by individuals and in facilities or institutional settings.

II. The board may act as a facilitator of statewide dissemination of information between music therapists, the American Music Therapy Association or any successor organization, the Certification Board for Music Therapists or any successor organization, and the executive director.

III. The executive director shall seek the advice of the board for issues related to the regulation of music therapists.

2 Allied Health Professionals; Definition; Governing Board. Amend RSA 328-F:2, II to read as follows:

II. "Governing boards" means individual licensing boards of athletic trainers, occupational therapy assistants, occupational therapists, recreational therapists, physical therapists, physical therapist assistants, respiratory care practitioners, speech-language pathologists, [and] genetic counselors, and music therapists.

3 New Paragraph; Allied Health Professionals; Music Therapists. Amend RSA 328-F:2 by inserting after paragraph X the following new paragraph:

XI. "Music therapist" means music therapist as defined in RSA 326-M:1.

4 Governing Board; Establishment. Amend RSA 328-F:3, I to read as follows:

I. There shall be established governing boards of athletic trainers, occupational therapists, recreational therapists, respiratory care practitioners, physical therapists, speech-language pathologists, [and] genetic counselors, and music therapists.

5 New Paragraph; Music Therapists Governing Board; Appointment. Amend RSA 328-F:4 by inserting after paragraph X the following new paragraph:

XI. The music therapists governing board shall consist of 3 licensed music therapists, who have actively engaged in the practice of music therapy in this state for at least 2 years, one member who is a licensed health care provider who is not a music therapist, and one public member. Initial appointment of professional members by the governor and council shall be qualified persons practicing music therapy in this state. All subsequent appointments or reappointments shall require licensure.

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8 Effective Date. Part VI of this act shall take effect July 1, 2021.

The Senate of the State of New Hampshire

107 North Main Street, Concord, N.H. 03301-4951

Senator Kevin Avard
Senate District 12
Kevin.avard@leg.state.nh.us
Office – 271-3077

Part VI of the omnibus legislation SB 133-FN is relative to occupational licensure of Board Certified Music Therapists in New Hampshire.

While many of you understand and value the power of music, you might not know that there are individuals in New Hampshire who are specifically educated and clinically trained to provide evidence-based, goal oriented music interventions to individuals. This profession, recognized by the National Institutes of Health, is called Music Therapy and the qualified professionals are board certified music therapists.

Although there are experts here today who will provide testimony relative to both the Music Therapy profession and the need for licensure to delineate what a qualified music therapist is, and is not, I would like to simply address the nuts and bolts of what music therapy is, and what the bill would do.

Music therapy is an allied health profession similar to physical, occupational, or speech therapy. A Board Certified Music Therapist utilizes music-based activities to address social, emotional, physical, communicative, and cognitive domains on an individualized basis. Research in music therapy supports its effectiveness in many areas such as: overall physical rehabilitation and facilitating movement, increasing people's motivation to become engaged in their treatment, providing emotional support for clients and their families, and providing an outlet for expression of feelings. Some things you might see in a music therapy session include songwriting and lyric analysis, instrument playing, music and movement, and/or improvisation. Music therapists work with all populations, including behavioral health, military populations, Autism Spectrum Disorder and other Developmental Disabilities, Alzheimer's Disease, persons in correctional and forensic facilities, in response to crisis and trauma, within medical settings, and in collaboration with music educators and other members of a client's treatment team.

This bill will modify RSA 328:F of the Allied Health Board to include licensed music therapists. The primary goal of Part VI of SB-133 is for NH to recognize the music therapy profession for the therapeutic benefits it provides, increase consumer access to services by allowing state and private health insurances to include this form of therapy in their allied health professionals list and ensure consumers are receiving services from a qualified professional.

Some history on this bill: Music Therapy licensure was introduced in the 2020 House legislative session, where very thorough discussions regarding the language of the bill occurred. During several subcommittee hearings, input from the American Music Therapy Association, American Speech-Language Hearing Association, and the Office of Professional Licensure and Certification was discussed and considered and the language of Part VI of SB-133 is the product of these discussions, ultimately passing through the New Hampshire House of Representatives on March 13, 2020.

I want to reiterate that music therapy presents consumers in New Hampshire with choices regarding treatment options available to them, where individuals have the freedom to choose the appropriate modality, depending upon their particular condition. In this way, music therapy has been proven to work in cases where other therapies do not, and these results are scientifically based – it's not merely someone playing a guitar or recorded music without goal-setting and purposeful expertise behind it. It is supporting a trained and qualified therapist in defining a treatment plan that leverages the power of music to meet patients where they are, to achieve specific goals against stubborn impediments as well as collaborating and consulting with the client's treatment team.

The final lines of the bill mention the costs associated with having to add a person who administers this program for the state. There would be an offset to that cost based upon the existing and future licensure fees, collected every two years, that would contribute to the cost of Music Therapy Licensure Administration. I believe an objection to this salary should be met with the understanding that the other salaries now paid, for other Allied Health professions, are no more worthy than Music Therapy.

Please feel free to reach out to me if you have any questions.

Thank you for your consideration.

New Hampshire Emergency Medical and Trauma Services Coordinating Board

April 20, 2021

New Hampshire House of Representatives
107 North Main Street
Concord, NH 03301

RE: SB133

Dear Members of the New Hampshire House of Representatives:

This letter is sent on the behalf of the New Hampshire Emergency Medical and Trauma Services Coordinating Board. In 2017, New Hampshire became the fifteenth state to enact the emergency medical services personnel licensure interstate compact (REPLICA) when SB370 was passed. Since 2017, six other states have also joined the compact for a total of twenty-one throughout the country. The compact facilitates the opportunity for assistance from other states where the criteria for mutual aid or the Emergency Management Assistance Compact (EMAC) has not been met. REPLICA is a critical tool that New Hampshire has yet to use in-state but our providers have used to assist other states in the wake of natural disaster.

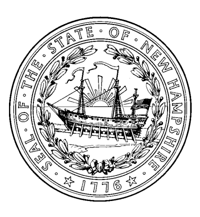
At our March 13th, 2021 the board discussed SB133 Sections III and X. Section III repeals the emergency medical services personnel licensure interstate compact (REPLICA). In 2017, this board supported the passing of the compact because of the benefits it would bring to New Hampshire. We have seen this with other industry compacts that are recognized in the state such as with nurses and other allied health professionals. As this is a personal license compact and only would affect individuals, there are safeguards in place based on agencies and vehicles still requiring a New Hampshire license and the oversight that comes with such. Section X allows the Commissioner of Safety to issue a letter of concern to licensed EMS providers. This allows the Commissioner to consider “just culture” aspects to what can be complicated cases of EMS providers who are found to have violated rules or laws.

Ultimately the board voted in an 8-2 motion to write the New Hampshire House of Representatives to voice our concerns with Section III and support of Section X of SB133. We hope you take our concerns and support in to consideration.

Sincerely,

Chad Miller
Vice Chair

Mailing: 33 Hazen Drive, Concord, NH 03305
Location: 98 Smokey Bear Blvd, Concord, NH 03301



Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

BUREAU OF PUBLIC HEALTH PROTECTION

29 HAZEN DRIVE, CONCORD, NH 03301
603-271-4524 1-800-852-3345 Ext. 4524
Fax: 603-271-8705 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

Testimony for SB 133-FN Adopting Omnibus Legislation Relative to Occupational Licensure
Part XIII Sanitary Production and Distribution of Food
House Executive Departments and Administration Committee
April 21, 2021

Good Morning Chair McGuire and Members of the Committee:

My name is Colleen Smith, and I am the Administrator of the Food Protection Section within the New Hampshire Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS).

I want to thank the committee for the opportunity to speak is support of Section XIII of SB133-FN regarding program rules within the DHHS for sanitary production and distribution of food.

The Department has worked closely with Senator Giuda on the bill as amended to address concerns with the Department's Food Protection Regulations, in particular the Certified Food Protection Manager requirement. This was a new requirement for food establishments that came into effect when the Department updated its administrative rules, He-P 2300 *The New Hampshire Rules for the Sanitary Production and Distribution of Food* to incorporate the United States Food and Drug Administration's (FDA) 2017 Food Code by reference in August 2019.

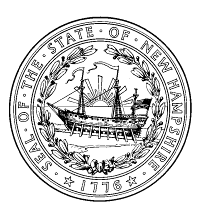
The bill, as amended, addresses a concern of hardship to small businesses and certain low risk food service establishments due to the requirement that a Certified Food Protection Manager must be present during all hours of operation. This bill allows flexibility for certain low risk businesses that have at least one Certified Food Protection Manager on staff such that, the Certified Food Protection Manager does not need to be present in instances when preparation is limited to reheating commercially prepared food, handling ready to eat food, or when the food establishment has five food employees or less on duty.

The Department has also started a rulemaking process to amend He-P 2300 to align with the changes proposed in SB133 with regard to Certified Food Protection Manager requirement. The final proposed rules are projected to be before the New Hampshire Joint Legislative Committee on Administrative Rules within the next few months.

A study by the Centers for Disease Control (CDC) suggests that the presence of a Certified Food Protection Manager reduces the risk for a foodborne outbreak for a food establishment and was a distinguishing factor between restaurants that experienced a foodborne illness outbreak and those that had not. The Department feels it is important to maintain the requirement for food establishments to have at least one Certified Food Protection Manager to ensure effective control of certain foodborne illness risk factors that impact the safety of the food they sell or serve.

I am happy to answer any questions that the Committee may have.

Colleen Smith, MS Administrator,
Food Protection Section
New Hampshire Division of Public Health Services,
Department of Health and Human Services
29 Hazen Drive Concord, NH 03301-6504
Phone: 603-271-4589
Email: colleen.smith@dhhs.nh.gov



Lori A. Shibinette
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I am happy to answer any questions that the Committee may have.

Colleen Smith, MS Administrator,
Food Protection Section
New Hampshire Division of Public Health Services,
Department of Health and Human Services
29 Hazen Drive Concord, NH 03301-6504
Phone: 603-271-4589
Email: colleen.smith@dhhs.nh.gov

April 26th, 2021

Dear Committee Members,

I am opposed to the following language being proposed for Senate Bill 133

Amendment to SB 133-FN

Amend section 2 of the bill by inserting after Part XIII the following:

Part XIV

Establishing minimum qualifications for certification as a child care associate teacher.
1 New Subparagraph; Child Day Care Licensing; Rulemaking; Continuing Education Requirements and Associate Teacher Qualifications. Amend RSA 170-E:11, I by inserting after
subparagraph (m) the following new subparagraph:

(n) The following qualification for certification as an associate teacher: a minimum of 1,000 hours of supervised child care experience in a licensed child care program and 30 hours of
training in child growth and development, the latter of which may be documented life experience.
2 Effective Date. This act shall take effect 60 days after its passage.

I am currently a participant in the following workgroups and task forces (Child Care Advisory Council, Child Care Staffing Crisis Task Force, Higher Education Round Table) and with my involvement in each of these groups I am fully aware of the high need of child care workers in our state. I do agree that COVID-19 has exacerbated this need AND ALSO believe that making the above proposed changes to the Associate Teacher qualifications is something that should not be done haphazardly. As you may know, child care and licensing regulations have been a topic of conversation for several years, not just during this pandemic. The qualifications that were put into place by the Child Care Licensing Bureau were well researched and thoughtfully included as part of our regulations that meet the basic needs to provide adequate care to the children in our community.

I encourage the committee to think about the children that will be in these child care classrooms, **7-9 hours a day**, the stressors that the child care classroom can have when you are providing group care to many children (typically all the same age in one space), and the level of education needed to adequately meet the needs of these children. Children deserve to have high quality classrooms to attend where the teachers are trained in a manner that meets the needs of group care and not being a mom of 2 or 3 children. There can be natural dispositions of adults that make them suitable for the job but specific training on topics such as Positive Behavior

Guidance, Curriculum, and Trauma-Informed Care are not topics that can just be navigated based on experience.

I sit on the aforementioned committees and task force groups because I am passionate about the field and want to provide as many opportunities as I can to help nurture and grow the field. I am currently working to put together an expediated entry-level certificate for students entering the field (a 9-credit certificate that already exists) and offer 3, 4-week courses to help provide more well-trained applicants to the field. I am hoping to be able to provide scholarships through Perkins funding to allow these students the opportunity to this at no cost. I am working with others in the field to find ways to attract new individuals into early childhood AND AGAIN I am sure you are aware that the funding to pay these individuals is lacking, at the very least. I believe it would be shameful to completely change these qualifications to put a band aid on a bigger bleeding issue in our field.

I suggest to this committee that instead of making this a permanent adjustment to the qualifications in our licensing regulations that you, instead, consider language that allows for this to be a temporary fix and gives the power to the licensing bureau to review with a working committee each year to see if it is improving the needs of the field or if we are at a place, at the designated time, to revert to the current qualifications. In other words, use this opportunity to make this an accommodation for the current situation but not something that will be changed permanently and then need to be "fought over" to go back to.

Thank you for your consideration,

Diana Menard

Diana Menard – Concerned Citizen in the Early Childhood field

Eric Schelberg, President - NH Paramedic Association
Town of Milford
SB133 Amended
Strikeout – Repealing emergency medical services personnel licensure interstate compact

Chairwoman Carol McGuire and members of the ED&A Committee,

The New Hampshire Paramedic Association (NHPA) respectfully requests the ED&A Committee to Amend SB133 to strikeout repealing the emergency medical services personnel licensure interstate compact.

This request is based on the following reasons. The purpose of the EMS licensure compact that was passed in 2018 is to protect the public through verification of competency, criminal background check and ensure accountability for patient care related activities in order to afford immediate legal recognition of EMS personnel when requested by other states that are members of the compact to perform EMS duties.

New Hampshire is one of twenty-one states with South Dakota pending to be the twenty-second state who are signatories to the EMS compact. The compact benefits these states in a time of crisis, increased prolonged EMS demand above and beyond normal day-to-day activities or during times of natural disaster wherein during the above noted situations, a state may place a request for EMS personnel assistance. Being a member of the compact recognizes the licensure of a NH EMS provider, or the state would recognize the EMS license of a provider from one of the compact states.

To practice medicine in NH including EMS personnel, a provider must be certified by a certification body, in the case of NH, the National Registry of EMTs and the provider must have a license approved by the NH Bureau of EMS.

There are no funding requirements or provisions to be a member of the compact.

The compact does not permit NH EMS licensed providers or providers from member states to work in a compact state without having to obtain a provider license from that state. Again, the compact is only used when a member state requests EMS personnel.

The EMS compact signatories agree to ensure EMS providers are competent and will take action against a provider's license if necessary after an investigation and due course.

The EMS compact serves as a force multiplier for signatory states during times of crisis or disaster and should remain law by striking SB133 repealing the emergency medical services personnel licensure interstate compact as amended.

Thank you for your consideration of this request.

Respectfully submitted

Eric Schelberg, President - NH Paramedic Association
Town of Milford
SB133 Amended
Strikeout – Repealing emergency medical services personnel licensure interstate compact

Chairwoman Carol McGuire and members of the ED&A Committee,

The New Hampshire Paramedic Association (NHPA) respectfully requests the ED&A Committee to Amend SB133 to strikeout repealing the emergency medical services personnel licensure interstate compact.

This request is based on the following reasons. The purpose of the EMS licensure compact that was passed in 2018 is to protect the public through verification of competency, criminal background check and ensure accountability for patient care related activities in order to afford immediate legal recognition of EMS personnel when requested by other states that are members of the compact to perform EMS duties.

New Hampshire is one of twenty-one states with South Dakota pending to be the twenty-second state who are signatories to the EMS compact. The compact benefits these states in a time of crisis, increased prolonged EMS demand above and beyond normal day-to-day activities or during times of natural disaster wherein during the above noted situations, a state may place a request for EMS personnel assistance. Being a member of the compact recognizes the licensure of a NH EMS provider, or the state would recognize the EMS license of a provider from one of the compact states.

To practice medicine in NH including EMS personnel, a provider must be certified by a certification body, in the case of NH, the National Registry of EMTs and the provider must have a license approved by the NH Bureau of EMS.

There are no funding requirements or provisions to be a member of the compact.

The compact does not permit NH EMS licensed providers or providers from member states to work in a compact state without having to obtain a provider license from that state. Again, the compact is only used when a member state requests EMS personnel.

The EMS compact signatories agree to ensure EMS providers are competent and will take action against a provider's license if necessary after an investigation and due course.

The EMS compact serves as a force multiplier for signatory states during times of crisis or disaster and should remain law by striking SB133 repealing the emergency medical services personnel licensure interstate compact as amended.

Thank you for your consideration of this request.

Respectfully submitted

New Hampshire Association of Emergency Medical Technicians, Inc.

Post Office Box 2951
Concord, NH 03301-2951

http://www.NHAEMT.org

April 21, 2021

Senator Hennessey and Committee members,

In 2018 REPLICA, The EMS Compact, set out to address EMS staffing and sharing of staff amongst states that were part of an established compact. This compact allowed for compact states to share vetted, qualified and able EMS staff during situations such as a natural disasters or, most recently, a global pandemic. New Hampshire is a small state and under certain circumstances, the need for additional EMS providers could arise where the resources of The Granite State are insufficient. Calling on other REPLICA compact states for assistance may be necessary in a time of disaster or public health emergency. Fears of REPLICA allowing "scab" staff to cross picket lines are simply untrue and lies, as proponents of the repeal would have you believe. REPLICA was not designed to address or battle union/department disagreements, it was designed and established to give states, like New Hampshire, with limited resources the ability to get help from already vetted and qualified EMS providers from other jurisdictions.

Other REPLICA states, "Utilize the National Registry exam at the EMT and Paramedic levels for initial licensure, Utilize FBI compliant background check with biometric data (e.g. fingerprints) within 5 years of Compact activation. (effective May 8, 2017), Have a process to receive, investigate, and resolve complaints; and share information with other Compact states via a Coordinated National Database, and lastly, have enacted the model REPLICA legislation. (Interstate Commission for EMS Personnel Practice, 2018)". This established process creates a network of qualified individuals that could be called upon in times of need to assist and aid the citizens and residents of The Granite State. Additionally, remaining a member state of REPLICA costs New Hampshire no money, eliminating this partnership makes no practical sense.

Please, I urge all of you not to tie the hands of our State EMS agency if the time were to ever come where we would need to call on other states for help. Please do not withdraw us from REPLICA.

Respectfully,

Jason Grey, BS, NRP, CCP-C, FP-C. IC
President
New Hampshire Association of Emergency Medical Technicians

Interstate Commission for EMS Personnel Practice. The Interstate Commission for EMS Personnel Practice. (2018). https://www.emscompact.gov/resources/.

PROFESSIONAL FIRE FIGHTERS
OF NEW HAMPSHIRE

House Executive Departments and Administration Committee
Legislative Office Building
33 N State Street
Concord, NH 03301

RE: Testimony in Support of SB 133, Part II: repealing the emergency medical services personnel licensure interstate compact.

Madame Chair and Honorable Members of the Committee:

My name is Brian Ryll and I serve as the President of the Professional Fire Fighters of New Hampshire and am a Captain for the Portsmouth Fire Department. Today I am providing testimony in support of SB 133, Part II *repealing the emergency medical services personnel licensure interstate compact*, otherwise known as 'REPLICA'.

The initial intent of the RFP for REPLICA was to allow federal resources to maintain a "home state" card, but operate in other states to fulfill their specific mission without seeking reciprocity. It was also intended to exclusively allow emergency resources to cross state lines to assist in emergency responses or large-scale emergency responses which had not been declared such by a governor. However, the scope of REPLICA extends the intent to include day-to-day EMS response, including non-emergency interfacility work. If this work were to base itself near our state's borders, this would effectively take work away from current positions funded by New Hampshire's cities and towns, and draw New Hampshire-expanded Medicaid dollars from our state which would result in a loss of revenue.

The current REPLICA model allows ambulances to cross state lines to pick up patients and transport them to other states. Unlike our Mutual Aid model, which is on a case-by-case basis through the 9-1-1 emergency system, REPLICA allows companies to come in from around the country on a routine basis and transport patients to participating compact states. By doing this, EMS personnel are working under the licensure and clinical oversight of their home state, and not New Hampshire. There should always be a reasonable expectation that when you or your family calls 9-1-1, the highest possible standard of care is received, and that standard of care is determined by New Hampshire's Medical Control Board. Under the REPLICA model, providers no longer operate under the same scope of practice, which could not only lead to inappropriate patient treatment, but also leads to confusion within the EMS system that could result in discipline, loss of licensure or termination of a provider.

Furthermore, with the current REPLICA model, we have taken away the ability for local cities and towns to manage their own mutual aid agreements, allowing for a means of self-deployment which adds confusion to an already disastrous situation. Municipalities should have the autonomy to oversee their individual public safety response based on their community's needs.

We believe REPLICA threatens the state's economy and the quality of care delivered to patients in New Hampshire. Allowing EMS providers to migrate into state intermittently creates a loss of taxable revenue, all translating to a weaker New Hampshire economy. It is clear that REPLICA is not a formula that works for New Hampshire. Since its passage in 2018, we have not used this model and it has added no value to emergency response for the State of New Hampshire.

Because of these reasons, I respectfully ask that this committee move to support SB 133, Part II: repealing the emergency medical services personnel licensure interstate compact.

Respectfully Submitted,

Brian Ryll
President
Professional Fire Fighters of New Hampshire

PROFESSIONAL FIRE FIGHTERS
OF NEW HAMPSHIRE

House Executive Departments and Administration Committee
Legislative Office Building
33 N State Street
Concord, NH 03301

RE: Testimony in Support of SB 133, Part X: relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.

Dear Madame Chair and Honorable Members of the Committee:

My name is Brian Ryll and I serve as the President of the Professional Fire Fighters of New Hampshire and am a Captain for the Portsmouth Fire Department. The Professional Fire Fighters of New Hampshire is a state association representing 42 local unions, and approximately 2,000 active and retired professional fire fighters and paramedics across the Granite State. As the preeminent fire fighter organization in New Hampshire, we advocate for the health and safety of the brave men and women that protect the citizens of this great state. I am providing testimony in support of SB 133, Part X: *relative to the revocation of licensure for licensed emergency medical service units and emergency medical service vehicles.*

This bill offers a simple solution to ensure the Commissioner of the Department of Safety has more discretion when acting upon the licensure for licensed emergency medical service units. Under current law the Commissioner "shall" suspend or revoke a license for a number of non-specific acts or offenses. This includes any situation where a unit or service self-reports a violation in an attempt to rectify the situation. Due to the complex nature of the emergency medical services industry it would be prudent to allow the Commissioner of Safety the flexibility to act on these matters using sound judgement and discretion rather than forced revocation or suspension of license.

As EMS providers in this state, we believe in the just-culture concept and we encourage a provider or a unit to report when a mistake is made. However, with the current language of RSA 153-A:13, there is the potential for a provider or a unit to avoid the reporting procedure for fear of revocation of their license.

SB 133, Part X simply makes a technical change to the current law that could improve the EMS system in New Hampshire, and we ask for the committee's full support.

Respectfully,

Brian Ryll
President
Professional Fire Fighters of New Hampshire

New Hampshire Health Care Association

April 27, 2021

MEMORANDUM

TO: Executive Departments & Administration Committee
FROM: Brendan Williams, President & CEO
RE: Temporary health partner legislation

Although the temporary health partner position embodied in Emergency Order #42 was borne out of a Mach 30, 2020 federal waiver issued by the U.S. Centers for Medicare & Medicaid Services (CMS),[1] there is no reason this position cannot exist absent that waiver.

This is because we never used it as a substitute for licensed staff. The CMS waiver allowed the use of such positions as a substitute for what we call licensed nursing assistants, but in other states are called nurse aides or certified nursing assistants.[2] We did not. We worked closely with the New Hampshire Nurses Association, Senator Tom Sherman, Representative Polly Campion, and others to navigate the sensitivities around authorizing this new position.

As Emergency Order #42 states: "Temporary health partners shall work under the supervision of an RN, APRN, or LPN, as is required of LNAs under RSA 326-B:14" and "[t]he position of temporary health partner shall not be considered a substitute for the licensure under RSA 326-B:14 but is intended to assist the work of licensed nursing assistants. The temporary health partner *shall not perform services independently*, and must be supervised by licensed nurses at all times."[3] (Emphasis added).

The position earned support from the National Governors Association (NGA) in a February brief entitled "Supporting A Trained Direct Care Workforce In Facility Settings During And After The Covid-19 Pandemic."[4] As the NGA noted, "[w]hile responding to urgent direct care staffing needs is a top priority for states in the short-term, it will be critical for states and employers to consider strategies for retaining this workforce when the waiver expires."

We believe that the approach that we would like to see taken in Part IX of SB 133 is consistent with the NGA guidance, and bipartisan policymaking in other states.[5] Similarly, to statutorily codify Emergency Order 42 in Part I of SB 155 is not inconsistent with any federal guidance or best practices.

Please feel free to contact me with any questions at bwilliams@nhhca.org.

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[1]*See* COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, U.S. CENTERS FOR MEDICARE & MEDICAID SERVICES (Mar. 30, 2020), https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf.
[2]*See id*. at pg. 10.
[3]*See* New Hampshire Emergency Order #42, Authorizing temporary health partners to assist in responding to the COVID-19 in long-term care facilities (May 11, 2020), https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/emergency-order-42.pdf.
[4]https://www.nga.org/wp-content/uploads/2021/02/Supporting_a_Trained_Direct_Care_Workforce.pdf.
[5]We would respectfully suggest that the words "by April 1, 2021" be removed from line 31, page 48, as it may inadvertently devalue the work of THPs after that date and limit their professional mobility.

Visit us at: www.nhhca.org
5 Sheep Davis Rd., Ste. B • Pembroke, NH 03275 • Phone (603) 226-4900

New Hampshire Speech-Language-Hearing Association
PO Box 1538 Concord NH 03302-1538 nhslha@gmail.com

The New Hampshire House ED & A Committee
Legislative Office Building
33 North State Street
Concord, NH 03301

Re: Interstate Compact SB 133 PART V

Date: May 5, 2021

Dear Chairperson McGuire,

At the hearing on SB 133 PART V (Interstate Compacts) on May 4, 2021, a question was raised about the support of the speech-language pathologists for this part of the bill.

I would like to emphasize that the NH Speech-Language-Hearing Association (NHSLHA) and the NH Speech-Language Pathology Board of Governors are strongly in favor of joining the Audiology Speech-Language Pathology Interstate Compact (A-SLP IC).

NHSLHA is affiliated with the national association for speech-language pathologists and audiologists, the American Speech-Language-Hearing Association (ASHA). Since ASHA has been working with other states on joining the A-SLP IC, they have been providing the information and testimony about the Compact.

In order to reduce repetitive testimony, NHSLHA has not registered to testify, but we have been monitoring the hearings and sending comments to Thomas Broderick who is representing the Office of Professional Licensure and Certification.

Please accept the following as testimony in support of joining the A-SLP IC.

Background Information:
NHSLHA represents speech-language pathologists and audiologists in NH. Audiologists are also represented by the NH Academy of Audiology.

The professional governing board for speech-language pathologists is the Speech-Language Pathology Board of Governors and the professional governing board for audiologists is the Board of Hearing Care Providers, both under the purview of the Office of Professional Licensure and Certification.

Trends
The Occupational Outlook Handbook projects a 25% growth in job opportunities for speech-language pathologists between 2019 and 2029. This will intensify the current shortage of speech-language pathologists, which is especially acute in school settings and areas with lower population.

Speech-language pathology is an exceptionally diverse field, covering the areas of swallowing, stuttering, autism, aphasia, delays in language development, cerebral palsy, brain injury, Parkinson's disease, Amyotrophic Lateral Sclerosis, Down Syndrome, cleft lip/palate, voice disorders, speech sound articulation, expressive and receptive language disorders as well as other rarer conditions.

With the advances in medical science, the infant mortality rate has dropped from 6.909 in 1,000 in live births in 2005 to 5.614 in 2021. This is great news for the families of these infants, but many of the babies will need on-going support to develop their full potential. The general school age population has decreased, but the number of individuals needing special services in schools has remained nearly the same from year to year. More and more children with severe disabilities are being placed in the public schools. As the incidence of severe disabilities increases, the need for licensed speech-language pathologists increases.

Benefits
Joining an Interstate Compact would allow NH employers to recruit SLPs from other states to fill vacancies and find specialists in the areas of low-incidence disabilities as well as bilingual speech-language pathologists. Drawing on the expertise of SLPs in member states would improve treatment outcomes for the neediest children.

NH is a small state with easy access to three other states. Individuals living in NH who work across the borders now often need to hold two or more licenses. Joining the A-SLP IC would allow them to keep their NH licenses and hold a compact license which would cover practice in other member states.

In addition, joining the A-SLP IC would benefit military spouses when relocating to bases in this area. There are several military bases within commuting distance of NH.

Summary
Speech-language pathologists in NH would benefit from joining the Audiology – Speech-Language Pathology Interstate Compact as would the individuals who need speech-language services.

Respectfully submitted,

Victoria Chesterley, MS, CCC-SLP

Victoria Chesterley, MS, CCC-SLP
NHSLHA VP of Governmental Affairs

New Hampshire Speech-Language-Hearing Association
PO Box 1538 Concord NH 03302-1538 nhslha@gmail.com

The New Hampshire House ED & A Committee
Legislative Office Building
33 North State Street
Concord, NH 03301

Re: Music Therapist Licensure SB 133 PART VI

Date: May 5, 2021

Dear Chairperson McGuire:

I am writing to let the ED & A Committee know that the New Hampshire Speech-Language-Hearing Association is completely in favor of the wording that the American Speech-Language-Hearing Association and the American Music Therapy Association have agreed to add to SB 133 PART VI.

This wording addresses our concerns and clarifies the roles of the SLP and the music therapist, allowing both disciplines to work together for the benefit of clients and patients.

Thank you for your attention to this matter.

Respectfully submitted,

Victoria Chesterley, MS, CCC-SLP

Victoria Chesterley, MS, CCC-SLP
NHSLHA co-VP of Governmental Affairs

Clay Odell
6 Longwood Lane
West Lebanon, NH 03784
clay.odell@outlook.com

April 21, 2021

Chairman Carol McGuire and Committee Members
Executive Departments and Administration Committee
NH House of Representatives
Concord, NH

Dear Chairman McGuire and Members of the ED&A Committee;

I am a member of the public, a resident of the City of Lebanon, a Firefighter/Paramedic for the Town of Newport and also a Paramedic/Registered Nurse for New London Hospital.

I would like to advise you of my concern about a part of SB 133. While there are many good parts of this omnibus bill, I would ask the ED&A Committee to amend the bill to strike out Section II regarding the repeal of the EMS multi-state licensing compact (REPLICA). The loss of multi-state licensing capability if REPLICA is repealed would be detrimental to myself and to many other EMS providers in NH.

Multi-state licensing compacts for healthcare professionals have proven to be very beneficial to both the provider as well as the public. In fact SB 133 seeks to ADD additional licensed professionals to their discipline's multi-state licensing compact. You will undoubtedly hear testimony from those professions as to why a multi-state licensing compact is good. I support multi-state licensing compacts and I was very pleased a couple of years ago when New Hampshire became an early adopter of my profession's compact.

The effort to repeal that compact now is very puzzling. There does not appear to be a valid reason for the repeal. An argument has been made that there are no other compact states close to New Hampshire. That is a short-sighted view that does not anticipate more states coming on board in the future. There are currently 21 states including New Hampshire that are members of the compact. I am confident there are more states to follow.

Arguments against the National EMS Compact have been refuted. There is no reason to repeal it. If a multi-state licensing compact is good for nurses, doctors, physical therapists, and a host of other healthcare disciplines, why would it be bad for EMS professionals?

Thank you for your consideration, and again I urge you to amend SB 133 to strike out Section II.

Sincerely,

Clay Odell, RP, RN

Testimony

SB 133
Testimony

…divided into 3 separate
saved
Testimony files

Testimony
3 of 3 files

Information Summary and Recommendations

Music Therapy Sunrise Review

December 2012

Publication Number 631-037

For more information or

Additional copies of this report contact:

Health Systems Quality Assurance

Office of the Assistant Secretary
Post Office Box 47850
Olympia, WA 98504-7850
360-236-4612

Mary Selecky
Secretary of Health

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THE SUNRISE REVIEW PROCESS

A sunrise review is an evaluation of a proposal to change the laws regulating health professions in Washington. The legislature's intent, as stated in Chapter 18.120 RCW, is to permit all qualified people 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. Changes to the scope of practice should benefit the public.

The Sunrise Act, RCW 18.120.010, says a health care profession should be regulated or scope of practice expanded 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.

If the legislature identifies a need and finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive alternative method of regulation, consistent with the public interest. Five types of regulation may be considered as set forth in RCW 18.120.010(3):

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 people 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 registered person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
4. *Certification*. A voluntary process by which the state grants recognition to a person who has met certain qualifications. Non-certified people may perform the same tasks, but may not use "certified" in the title.[1] 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 people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

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[1] Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement such as nursing assistant – certified, home care aides, and pharmacy technicians.

EXECUTIVE SUMMARY

Background and Proposal

The practice of music therapy is not regulated in Washington. A music therapist uses musical instruments and music making as therapeutic tools to rehabilitate a patient's normal living functions or improve quality of life through studying and promoting measurable change in the patient's behavior. Music therapists apply various music elements through live, improvised, adapted, individualized, or recorded music to address physical, emotional, cognitive, or social needs of the patient. They often work in collaboration with or by referral from a medical, mental health, occupational therapy, physical therapy, or other health care provider.

The Senate Health and Long-Term Care Committee requested a sunrise review of Senate Bill 6276, which would require any individual practicing music therapy or using the title of "music therapist" to be certified by the department. Senate Bill 6276 would require music therapists to complete a bachelor's degree program in music therapy and pass an examination based on core competencies of music therapy approved by the secretary prior to applying for a state credential.

The applicant has stated that regulation of music therapy is necessary to protect the public from misuse of terms and techniques; ensure competent practice; protect access to music therapy services by encouraging payment by third-party payers; recognize music therapy as a valid, research-based health care service; validate the profession in state, national, and international work settings; establish credentialing; and provide a method of addressing consumer complaints and ethics violations.

Recommendations

The department recognizes the therapeutic benefit of music to address the cognitive, emotional, physical, social, or functional needs of clients, and the value of music to comfort and aid those who are sick, injured, or dying. However, the department does not support the proposal to require state certification of music therapists.

The proposal does not meet the sunrise criteria because:

- The applicant has not identified a clear and easily recognizable threat to public health and safety from the unregulated practice of music therapy.
- The proposal does not articulate the public need for regulation or that regulation would ensure initial and continuing professional ability above the current requirements for nationally certified music therapists.
- The applicant has not demonstrated that the public cannot be effectively protected by other means in a more cost-beneficial manner.
- The proposal would place a heavy financial burden on the small pool of potential music therapy practitioners to cover the state's costs of regulating the profession.
- The proposal contains flaws that would prohibit the use of music-based therapy by other practitioners as well as Native American and other traditional healers may who use music to aid the sick, injured, or dying.

- The scope of practice in the proposal may prevent licensed health care professionals such as occupational therapists from using music therapy in their practice, and encroach on the scope of practice of other professions such as speech-language pathologists.

The department recognizes that the lack of a state credential may prevent music therapists from being employed in certain educational and state mental health facilities, or may prevent them from being compensated for services by insurance or some government programs. However, these potential barriers are not part of the sunrise review criteria.

SUMMARY OF INFORMATION

Background

Music therapists are skilled musicians who use music interventions to achieve therapeutic goals. They assess an individual's functioning through response to music; design music interventions and therapy sessions based on treatment goals, objectives, and the individual's needs; and evaluate and document treatment outcomes. The music therapist may be part of an interdisciplinary team including medical, mental health, occupational therapy, physical therapy, or educational professionals. A state credential is not required to practice music therapy.

Music therapists work in a variety of settings, including, but not limited to, hospitals and clinics, rehabilitative facilities, mental health centers, residential and day facilities for senior citizens or individuals with developmental disabilities, drug, alcohol, or correctional facilities, schools, or in private practice.

Bachelor's degrees in music therapy are available from 62 U.S. colleges and universities approved by the American Music Therapy Association (AMTA)[2] and accredited by the National Association of Schools of Music. The AMTA requires music therapy students to complete at least 1,200 hours of supervised clinical training and a six-month internship in a competency-based program. Music therapists who complete academic and clinical training are eligible to take a national exam offered by the Certification Board for Music Therapy (CBMT), and upon passage earn a Music Therapist-Board Certified (MT-BC) national certification.

Music therapists are not alone in providing therapeutic interventions through music. Music thanatologists, [3] therapeutic musicians, music practitioners, clinical musicians, therapeutic harp practitioners, healing musicians, guided music and imagery/Bonny method practitioners, and others provide comfort to the ill, injured or dying, typically by playing music in hospitals, psychiatric units, hospices, residential facilities and other settings. Each music modality has a training program and some are credentialed or accredited by national organizations. Native American healers, traditional healers, and other cross-cultural healers use music, song, and instruments to support a person's or family's physical, mental, or spiritual health in hospitals, hospice, and other health facilities. In addition, some musicians play for the sick and dying with no stated therapeutic goal other than the person's relaxation and enjoyment.

A key difference between music therapy and other music modalities is that a music therapist uses music or musical instruments to rehabilitate normal functions of living or improve the quality of life through studying the effect of music on clients and promoting measurable changes in behavior or function. Other modalities use live or recorded music to provide an environment conducive to the client's healing or transition to death. Training levels also differ. A nationally certified music therapist completes a bachelor's degree program that may include classes in abnormal psychology, cognitive and behavioral psychology, counseling techniques, and behavioral management. Training in other music modalities varies from no formal training to graduate level educational programs.

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[2] http://www.musictherapy.org/careers/. Searched by approved U.S. colleges and universities offering bachelor's degrees in music therapy. Accessed August 30, 2012.
[3] Music thanatologists provide palliative care by playing the harp or singing to patients who are in transition to death.

Proposal for Sunrise Review

Senate Bill 6276, which proposed creating a certified music therapy credential, was introduced in the 2012 regular legislative session and was forwarded to the department for a sunrise review by the Senate Health and Long-Term Care Committee. The bill:

- Establishes the scope of practice of a music therapist;
- Provides practice and title protection;
- Establishes the requirements to qualify for a music therapy credential;
- Exempts the practice of other professions performing services within their respective scope of practice;
- Grants the secretary of health authority to approve music therapy education programs and examinations, and to adopt fees; and
- Names the secretary as the disciplinary authority for music therapy.

Public Participation and Hearing

The department received the request from the legislature to conduct this sunrise review on April 3, 2012, and received the applicant report on June 1, 2012. We notified interested parties of the sunrise review on June 12, 2012, and gave them an opportunity to provide written comments. A public hearing was held on August 20, 2012 in Tumwater, and the department provided an additional opportunity for written public comments through August 30, 2012. Here is a summary of the written and oral testimony we received:

The applicant – Music Therapy of Washington – described music therapists as skilled musicians who use musical interventions to achieve therapeutic goals with a client. Interventions include music improvisation, songwriting, lyric analysis, singing, playing music, or music listening. Goals may include pain management, coping skills, enhanced memory, physical rehabilitation, reducing depression, or working with social, emotional, or spiritual wellbeing.

The applicant described the music therapy treatment process as first assessing the client's functioning through responses to music or instruments. The music therapist develops treatment goals and objectives, designs therapy sessions, and implements music therapy interventions. The therapist continually evaluates the client's responses and adjusts interventions, and documents outcomes. Music therapists may work with a client independently or participate in the client's treatment as a member of an interdisciplinary team. Music therapists may work in a variety of facilities or settings, including, but not limited to, hospitals, rehabilitative centers, outpatient clinics, residential facilities, in the client's home or the music therapist's office. The applicant said individuals of all ages and various abilities may benefit from music therapy, including infants, children on the autism spectrum, people with developmental disabilities, patients suffering from chronic pain, stroke, Parkinson's disease or brain injury,[4] individuals grieving or depressed, or those with Alzheimer's or other dementia disorders.

According to the applicant report and testimony at the sunrise hearing, regulation is needed to protect the public from harm due to misuse of terms and techniques of music therapy. The applicant stated there are a growing number of unqualified individuals in Washington claiming

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[4] See Appendix D, Applicant's power point at the sunrise public hearing August 20, 2012. Applicant noted that music therapy helped Arizona Rep. Gabriel Giffords regain partial speech function following her brain injury from a gunshot wound in January 2011.

to be music therapists who do not hold a music therapy degree or national certification. These individuals may misrepresent the music therapy profession, claim to be able to produce certain outcomes that are not evidence based, or may not have supervised clinical training to demonstrate competency and proficiency in the practice of music therapy.

The applicant described the degree requirements, supervised clinical experiences, and the internships music therapy students undergo before they may sit for the national examination offered by the CBMT.[5] The applicant compared the academic rigor of a music therapy program with that required for nurses. CBMT certified music therapists must complete 100 hours of continuing education every five years to maintain their Music Therapist-Board Certified credential.

The applicant contends that state certification of music therapists would decrease confusion for the public and facilities seeking qualified music therapy practitioners, as opposed to other practitioners who employ music as a therapeutic modality. However, when asked at the hearing how the public or a potential employer could access information about a music therapist's national certification, the applicant said one could easily go on the www.cbmt.org website and enter the therapist's name to verify his or her Music Therapist-Board Certified certification. This was tested during the sunrise review process and is accurate. Verification of a national certification took less than one minute using the CBMT website.

The applicant said state regulation of music therapy is needed to recognize it as a valid, research-based health care service to validate the prominence of music therapy in state, national, and international work settings; establish education and examination requirements and a scope of practice in law; and to establish a procedure for addressing complaints or ethical violations.

Further, the applicant stated that state certification may allow music therapists to work in public schools and state mental health facilities that require staff to be state-licensed, certified or registered. State certification may also allow music therapists to be reimbursed for services, such as assessment of infants or toddlers with possible developmental delays under the federal Individual with Disabilities Education Act[6], or listing as an "eligible provider" to contract for state reimbursement from the Health Care Authority (HCA). One mother who testified that music therapy helped her son with regressive autism regain language skills believed that state certification would help her get insurance to pay for music therapy treatments. However, it should be noted that state credentialing does not guarantee listing as an HCA-eligible provider – some Department of Health-credentialed professions, including East Asian medicine practitioners (listed by HCA as acupuncturists), naturopaths, and massage therapists, are specifically <u>not</u> eligible to be reimbursed as a HCA provider.[7]

The applicant described previous attempts to become regulated in Washington, including House Bill 3310 introduced in 2008[8]. However, the applicant incorrectly noted that a sunrise review was requested in 2008 but was denied because the department had not requested the review. The

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[5] http://www.cbmt.org/. Accessed April 24, 2012

[6] Federal Register Vol. 74, No. 188, 34 CFR Part 303. Department of Education – Early Intervention Program for Infants and Toddlers with Disabilities. "Qualified personnel" who may conduct an early intervention assessment of an infant or toddler must be state licensed, certified or registered.

[7] WAC 182-502-0002Eligible provider types and 182-502-0003 Non-eligible provider types.

[8] http://apps.leg.wa.gov/billinfo/summary.aspx?year=2007&bill=3310 . Accessed September 3, 2012

department cannot perform a sunrise review without the request of the House Health Care and Wellness Committee or Senate Health and Long-Term Care Committee as required by RCW 18.120.030.[9]

We received testimony and written support for the proposal from practicing music therapists, family members of individuals who received music therapy treatments, an music appreciation advocacy group, and several credentialed health professionals who have observed music therapists at work in hospitals, clinics, hospice, schools, and other treatment settings. These individuals described how music therapy improved clients' speech, cognition, mood, communication, anxiety, vital signs, or sense of wellbeing. They noted music therapy's effectiveness with various age groups and conditions. They did not indicate difficulty with patients accessing the services of a trained music therapist in most health care settings. However, two individuals provided examples of a public school district and Western State Hospital that they said would not employ a music therapist on staff due to lack of a state credential.

We also received and heard concerns from many practitioners who provide different forms of music-based therapy, including music thanatologists, therapeutic musicians, and clinical music practitioners. They said the scope of practice in the proposal would prevent them from assessing a client's needs, implementing music therapy plans, and evaluating outcomes. Some music practitioners were concerned that if the certified music therapists became eligible for payment by insurance or government programs as a result of the proposal, then hospitals and other facilities would stop using music practitioners who lack a state credential. At least one other music practitioner type stated that if music therapists become state certified they will ask the legislature for a separate certification. Other music-based practitioners noted that without regulation the public still has ample tools available to evaluate the qualifications of music therapists, that no significant harm had been shown from the lack of state regulation, and that the cost of regulating music therapists is underestimated.

We received comments from a psychologist, a speech-language pathologist, and an occupational therapist who were concerned that the proposal may prevent them from using music as a treatment modality, or could prevent Native American and others who use traditional songs, music or instruments from having access to people in health care facilities.

The Washington Occupational Therapy Association opposed the proposal and questioned the need to regulate music therapy. The association provided a comparison of the music therapy and occupational therapy scopes of practice and noted where there were apparent duplications or overlaps. The association suggested an amendment to Section 2 of SB 6276 that read: "No person may practice music therapy or represent oneself as a music therapist by use of any title unless certified as provided for in this chapter <u>or licensed as an occupational therapist as defined by RCW 18.59.020(3).</u>" The association questioned the cost of regulating music therapists versus its benefits, and whether the public's access to music therapy is currently restricted.[10]

The Washington Speech-Language-Hearing Association testified on its concerns about the proposed scope of practice, and whether music therapists are trained to support this scope.[11] It

[9] RCW 18.120.030 . "After July 24, 1983, if appropriate, applicant groups shall explain each of the following factors to the extent requested by the legislative committee of reference."
[10] See Appendix D, Public Hearing Summary.
[11] See Appendix D.

said speech-language pathologists are uniquely qualified to assess and treat communication disorders, and suggested that references to communication disorders in the scope of practice should be clarified, narrowed, or removed from the proposal. The American Speech-Language Association sent written comments with similar concerns.

Current Regulation and Practice

Music therapy is not regulated in Washington. There are several professions that use or may use music as a treatment modality or as an adjunct to treatment:

State-credentialed professions including, but not limited to:

- Psychologists
- Occupational therapists
- Speech-language pathologists
- Mental health counselors
- Marriage and family therapists
- Social workers
- Hypnotherapists
- Massage therapists

Non-state-credentialed professions:

- Music therapists
- Therapeutic musicians
- Music thanatologists
- Certified music practitioners
- Native American and other traditional healers
- Clinical musicians
- Therapeutic harp practitioners
- Healing musicians
- Guided music and imagery/Bonny method practitioners

There are no firm data on the number of potential certified music therapists. The applicant estimates that 45 music therapists in Washington have obtained a MT-CB credential and could qualify for state certification under SB 6276.[12]

National Certification

National certification for music therapists is available from the CBMT. Some music therapists may hold older designations as a registered music therapist (RMT), certified music therapist (CMT), or advanced certified music therapist (ACMT) issued by the American Association of Music Therapy or the National Association of Music Therapy. These two groups merged into the American Music Therapy Association (AMTA), and designees are listed on the National Music Therapy Registry. By 2020, AMTA will have phased out the AMT, CMT, and ACMT designations as well as the national registry. After this time, music therapists seeking national certification must obtain a MT-BC credential.

[12] See Appendix A, Applicant Report, submitted June 1, 2012.

There are national or international organizations that credential or accredit other music practitioners, including:

- Bedside harp (certified harp therapists)[13]
- Chalice of repose project (music thanatologists)[14]
- Clinical Musician's Home Study Course (advanced clinical musicians)[15]
- International Harp Therapy Program (certified therapeutic harp musicians)[16]
- International Healing Musician's Program (certified healing musicians)[17]
- Music for Healing and Transition Program (certified music practitioners)[18]
- National Standards Board for Therapeutic Musicians (which accredits the Clinical Musician Home Study Course, International Harp Therapy Program, and Music for Healing and Transition Program. They also list other music-based therapy programs as affiliates)[19]

Formal Education Options for Music Therapists

There are 62 accredited college or university programs in the U.S offering bachelor's degrees in music therapy, including Seattle Pacific University in Seattle and Marylhurst University in Marylhurst, Oregon. There are also other master's and doctoral programs in music therapy.

A bachelor's degree program approved by the American Music Therapy Association must offer 120 semester hours or equivalent. The curriculum must include 45 percent music foundations, 15 percent clinical foundations, 20 percent to 25 percent general education, 5 percent electives, and 15 percent music therapy. The 15 percent music therapy curriculum must include foundations and principles, assessment and evaluation, methods and techniques, psychology of music, music therapy research, influence of music on behavior, music therapy with various populations, and pre-internship and internship courses.[20]

Four-year tuition at American Music Therapy Association-approved schools we researched ranged from more than $28,350 at the University of North Dakota (state resident) to $108,500 at Anna Maria College, in Massachusetts (non-resident).[21]

Costs for Music Therapy National Certification

The Certification Board for Music Therapists (CBMT) exam currently costs $325, with retakes costing $275.[22] The online examination may be taken at sites around the country, including six locations in western Washington and four in eastern Washington.[23] Upon passage, the individual receives a MT-BC credential. Music therapists must complete 100 hours of continuing education every five years to maintain their MT-BC credential.

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[13] http://www.bedsideharp.com/. Accessed September 3, 2012.
[14] http://chaliceofrepose.org/music-thanatology/. Accessed September 3, 2012.
[15] http://www.harpforhealing.com/. Accessed September 3, 2012.
[16] http://www.harprealm.com/. Accessed September 3, 2012.
[17] http://www.healingmusician.com/. Accessed September 3, 2012.
[18] http://www.mhtp.org/. Accessed September 3, 2012.
[19] http://www.therapeuticmusician.com/. Accessed September 3, 2012.
[20] Standards for Education and Clinical Training, AMTA website, accessed April 24, 2012.
[21] Tuition costs obtained through random scan of AMTA-approved college web sites August 30, 2012.
[22] http://www.cbmt.org/examination/ . Accessed April 23, 2012.
[23] http://www.goamp.com/displayTCList.aspx?pExamID=3423. Accessed August 29, 2012.

Regulation of Music Therapy in Other States

Five states regulate music therapists.

Georgia enacted Senate Bill 414 creating a music therapy license in May 2012.[24] License applicants must complete an AMTA-approved bachelor's degree program in music therapy, complete 1,200 hours of clinical training, and provide proof of passing the CBMT exam. Licensees must complete 40 hours of continuing education every two years.

North Dakota passed laws licensing music therapists in 2011.[25] Music therapists must complete an educational program and examination approved by a new state Board of Integrated Health established to license health professions and act as the disciplinary authority. North Dakota licenses only music therapists holding a MT-CB credential or those listed on the National Music Therapy Registry as a RMT, CMT, or ACMT.

Nevada also enacted a music therapist licensure law in 2011.[26] A license applicant must have a bachelor's degree from an American Music Therapy Association-approved school and obtain a MT-CB credential prior to licensure. A licensed music therapist must complete 100 hours of continuing education every three years. The Nevada statute prohibits music therapists from providing psychological assessments, diagnosing any physical or mental disorders, and other medical diagnosis or treatment.

New York has recognized music therapy since 2005 as a subspecialty (as well as art, dance, drama, psychodrama and poetry therapies) under a *creative arts therapist* license.[27] A license applicant must complete a master's or doctoral level creative arts program, a state exam, and at least 1,500 hours of supervised experience, of which 1,000 hours must be directly with clients. New York allowed individuals who practiced creative arts therapy before January 1, 2006 to meet alternative licensure requirements.

Wisconsin registers music therapists who are certified, registered, or accredited by the CMBT, National Music Therapy Registry, American Music Therapy Association, or other state-approved body.[28] Wisconsin allows a music therapist to practice psychotherapy if he or she meets license requirements comparable to those for a clinical social worker, marriage and family therapist, or professional counselor.

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[24] Senate Bill 414, Georgia Assembly, http://apps.leg.wa.gov/billinfo/summary.aspx?year=2007&bill=3310. Accessed September 3, 2012.
[25] Senate Bill 2271, North Dakota Century Code 43-59-02, 43-59-03 http://www.legis.nd.gov/assembly/62-2011/documents/11-0700-01000.pdf . Accessed, April 23, 2012
[26] Senate Bill 190, Nevada Revised Statute, Title 54. http://www.leg.state.nv.us/Session/76th2011/Bills/SB/SB190_R2.pdf. Accessed, April 23, 2012.
[27] Subpart 79-11, Creative Arts Therapy, New York Regulations of the Education Commissioner, Office of the Professions http://www.op.nysed.gov/prof/mhp/subpart79-11.htm. Accessed April 24, 2012.
[28] Section 440.03(14) Wisconsin Legislative Statutes. https://docs.legis.wisconsin.gov/document/statutes/440.03(14)(a)1.a.. Access April 24, 2012.

Definition of the Problem and Why Regulation is Necessary

Potential for Harm

According to the applicant's report and testimony at the hearing, regulation is needed to protect the public from harm due to misuse of terms and techniques of music therapy. The applicant stated that there are a growing number of unqualified individuals in the state claiming to be music therapists who do not hold a music therapy degree or MT-BC national credential. The applicant asserted that individuals may misrepresent the music therapy profession, may represent themselves as being able to produce certain outcomes that are not evidence based, or may have a lack of supervised clinical training to demonstrate competency and proficiency in the practice of music therapy.

Without music therapy training, the applicant's said, a person might bring music to a treatment situation that the client may not be ready for. The person may not have the skills to determine when a client might need a particular type of music, or to know when a music therapy intervention was doing more harm than good, such as when music played too fast or too slow might "disregulate" a client with autism. The applicant provided some anecdotal incidents potential harm that could not be verified, including:

- A nurse in a long-term care facility claimed to provide music therapy by playing piano and holding sing-a-longs with facility residents.
- A person claiming to be a music therapist programmed classical music recordings at the bedside of a young patient in a coma. The patient showed signs of agitation, increased heart rate and decreased oxygen saturation. When a trained music therapist consulted the youth's parents and changed the selections to his favorite music, "gangster rap," the boy's heart and oxygen rates stabilized, and he relaxed and fell asleep.
- A music therapist let her MT-BC credential lapse but continued to present herself as board certified.

The applicant did not provide information about specific situations in Washington involving individuals who present themselves as music therapists, but noted that without state credentialing there is no regulating body to which the public can submit complaints. According to the applicant, the CBMT, credentials more than 5,400 music therapists nationwide, and receives between 12 and 36 complaints per year.[29]

Harm to the Public with Increased Regulation

The proposal would create a financial barrier for entry into the music therapy profession due to the small number of potential credential holders. RCW 43.70.250 requires that the cost of regulating a health profession be fully borne by the members of that profession.[30] Costs include processing credential applications (including confirming education, examination scores, and background checks), processing renewals, responding to inquiries, investigating complaints, taking enforcement action if needed, recordkeeping, and rule making. The department anticipates the number of music therapist disciplinary cases would likely be low. The applicant estimates there are about 45 potential music therapy credential holders in the state. Without historical data on music therapy to use to develop a cost comparison, the department looked at professions that have comparable credentialing requirements, low discipline rates, and a small number of

[29] See Appendix C, Applicant Report Follow Up.
[30] RCW 43.70.250

credential holders. Genetic counselors, for example, licensed under chapter 18.290 RCW and chapter 246-825 WAC, have about 65 license holders and their annual license fee is $300. The department's 2012 fiscal note for SB 6276 estimated credentialing fees for music therapists would be about $250 per year.[31]

The proposal will likely prevent other practitioners from using music as a therapeutic modality. Section 2 of SB 6276 prohibits people from applying elements of the practice of music therapy without certification as a music therapist. Occupational therapists, music thanatologists, therapeutic musicians, harp for healing practitioners, and others, state that they apply assessment, therapy implementation, and evaluative elements from the music therapist's scope of practice in their existing practice to aid the sick, injured or dying through playing music. Several credentialed health providers – mental health, rehabilitative therapy, massage therapy professionals, and others – also use music as a treatment modality or as an adjunct to therapy. The proposal may inhibit their use of music as a treatment tool. In addition, it may prohibit recreational musicians from playing for the sick and dying with no stated therapeutic goal other than the person's relaxation and enjoyment.

[31] SB 6276 Fiscal Note https://fortress.wa.gov/ofm/fnspublic/legsearch.asp?BillNumber=6276&SessionNumber=62.

REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act RCW 18.120.010(2) states that the scope of a profession's practice should be expanded 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.

First Criterion: Unregulated practice can harm or endanger health or safety.

The proposal does not meet this criterion.

The applicants provided anecdotal incidents or generalized examples of harm that even if verified would not rise to the level requiring state regulation. Clients and the public may be harmed more because the proposal bars access to practitioners other than music therapists who employ music to aid and comfort the sick, injured or dying.

Access to music therapy is reduced if schools, mental health facilities, or infant-toddler early intervention programs bar hiring or paying therapists who are not state-credentialed. These barriers are better addressed by working with local, state, or federal agencies to change practices, rules, or laws, but are not incidents of harm related to the actual practice of music therapy.

Second Criterion: The public needs and will benefit from assurance of professional ability.

The proposal does not meet this criterion.

As noted by the applicant, the public can easily access the professional qualifications of nationally certified music therapists on the CBMT website. The education and training requirements proposed in SB 6276 for initial certification are identical to those required for national certification.

Regulation is not needed to ensure the qualifications of music therapists. Qualifications for a national music therapist credential are already standardized, with minimum education requirements set by the AMTA and an examination based on core competencies of music therapy administered by the CBMT. Music therapists seeking to maintain a CBMT credential must pay the costs of obtaining a music therapy degree, CBMT testing and continuing education. State certification would add an estimated $250 or more per year to this cost without a corresponding increase in public benefit. The public might gain a small benefit from access to a music therapist's state credentialing and disciplinary history.

All practitioners of music-based therapy could benefit from increasing public awareness about the different therapy options available, training standards for each modality, practice applications and therapeutic benefits. This would reduce confusion and help clients, facilities and the general public make informed choices about which music practitioner best suits the client's needs. However, that is better accomplished through public education than creating state certification.

Third Criterion: Public protection cannot be met by other means in a more cost-beneficial manner.

The proposal does not meet this criterion.

The applicant has not shown a lack of public protection from the unregulated practice of music therapy. Anecdotal incidents of minor, temporary harm the applicant provided, even if verified, do not rise to a level of harm requiring state regulation. Most testimonials from clients, family members, and facilities indicated that clients, family members, and facilities have access to trained music therapists now. As noted at the sunrise hearing, the public, an employer or a facility could easily find a particular music therapist's qualifications and national certification status by going online to www.cbmt.org.

Qualifications for a national music therapy certification are already standardized and available from the CBMT. Adding the cost of state certification without increasing the quality or safety of the profession would be an unnecessary burden on music therapists. In addition, a CBMT certified music therapist must complete 100 hours of continuing education every five years. A continuing education requirement is not included in SB 6276. As a result, the proposed state certification would have arguably lower standards compared to what is required for a national certification.

DETAILED RECOMMENDATIONS TO THE LEGISLATURE

The department does not support the proposal to require state certification for music therapists. The department cannot support creating a barrier for the public to access music therapists, potentially preventing the practice of other music-based therapies, or restricting the practice of credentialed health professions who use music as a treatment modality, without documented evidence of "an overwhelming need for the state to protect the interests of the public by restricting entry into the profession."

Rationale:

- *The applicant has not demonstrated a clear and easily recognizable threat to public health and safety from the unregulated practice of music therapy.*
- *The proposal would place a burden of state certification, renewal and fees on music therapists in addition to their existing formal training, national certification, and fees without a corresponding increase in public protection.*
- *The standards for maintaining a national music therapist certification exceed the standards in the proposal. The proposal would add additional burdens and cost of state certification without providing increased guarantees of competency or patient safety.*
- *The proposal contains serious flaws that would make it difficult to implement. It may reduce public access to other licensed and unlicensed practitioners, Native American healers, and other traditional healers who use music as a therapeutic tool to aid the sick, injured, or dying. The music therapist scope of practice may overlap or encroach on the practice of other credentialed health professions that use music as a therapy modality or an adjunct to treatment, including but not limited to rehabilitative therapists, mental health professionals, and massage therapists.*

REBUTTALS TO DRAFT REPORT

Differences between music therapist and other music practitioners

The applicant (Washington Music Therapy Task Force) said that when describing how music therapists and other music practitioners are different, the report should include that music therapists are trained in areas of abnormal psychology, cognitive and behavioral psychology, counseling techniques, and behavioral management, whereas other disciplines may not have the same types of training. The applicant noted that the difference in training is where harm may occur.

Department response

The department revised the section describing the differences between music therapists and other music practitioners to note that a nationally accredited music therapist must complete a bachelor's degree program that includes training in psychology, counseling and behavioral management, and that other music practitioners complete non-degree training programs specific to their modality. However, the department did not make other changes to the recommendations based on this comment.

Characterization of the 2008 attempts to obtain credentialed profession status

The applicant said the correct description of the action of House Bill 3310 in 2008, with regard to not receiving a Sunrise Review for music therapy at that time, would be to say the review was denied because the Department of Health could not institute the process without the request of the House Health Care and Wellness Committee.

Department response

The department revised the summary section to reflect that a 2008 request to initiate a sunrise review was denied because the department could not perform the process without the request of the House Health Care and Wellness Committee or Senate Health and Long-Term Care Committee.

Concerns raised by other professions about the music therapy scope of practice in SB 6276

The applicant said concerns raised by occupational therapists and speech and language pathologist regarding overlaps between the scopes of practice for those professions concerning the use of music in therapy and the scope of practice in SB 6276, would have been addressed in the legislative process. The applicant also noted that while some other music practitioners wanted language in the bill to protect their ability to practice, those practitioners did not oppose state credentialing of music therapists.

Department response

The department did not make any changes to the recommendations based on this comment, because the department must make recommendations on the bill as referred from the legislature, not on potential amendments.

State credentialing lowering standards regarding continuing education

The applicant disagreed with the department's analysis that the lack of continuing education (CE) in SB 6276 would lower current standards for music therapists, since CE is required for a music therapist to maintain national certification. They said, "We were informed that (CE would be included) in the rule making process after the passage of the bill. If the state of Washington adopted the Certification Board for Music Therapists' (CBMT) certifying criteria, it would automatically mean that continuing education or re-examination would be required for state certification since it is required for national certification."

> **Department response**
>
> The department did not change any recommendation as a result of this comment, since the department does not have authority to require members of a profession to complete continuing education unless directed by law. SB 6276 did not contain a continuing education requirement, nor did the bill require maintaining a CBMT certification as a condition for maintaining a state credential.

State credentialing of music therapy should not wait for substantial injury

Curtis Thompson of the King County Veterans Program Advisory Board questioned whether a number clients or patients should suffer substantial injury before the state acts to limit or regulate a profession. He said, "Do we need to wait for and allow blatant and extensive human suffering before eventually regulating life-caring/sustaining/preserving 'professions?'"

> **Department response**
>
> The department did not change any recommendation as a result of this comment. The sunrise criteria in RCW 18.120.010(2), states that the department must find that "unregulated practice can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is easily recognizable…" The department found that the anecdotal and generalized incidents of harm provided by the applicants did not meet these criteria.

Music thanatology school sends appreciation for the sunrise process

Therese Schroeder-Sheker of the Chalice of Repose-Music Thanatology Task Force thanked the department for the opportunity to participate in the sunrise review process. She said, "We have been…awed by the strength, clarity, thoughtfulness, fairness and care extended to everyone, to all voices and ideas, and to many different professional constituencies."

> **Department response**
>
> The department did not change any recommendation as a result of this comment, since the commenter did not suggest changes in the report.

Occupational therapist opposed to the proposal

Susan Drake, a licensed occupational therapist, opposed state credentialing of music therapists, saying the scope of practice in SB 6276 would infringe on the scope of practice for other

professions, creating problems and confusion. She said, "Music is so broad and valuable a modality that it should be available to all. What is the 'misuse' of music, after all? I do not see any danger posed to the public by allowing all people to use music therapeutically."

Department response

The department did not change any recommendations as a result of this comment, since it is similar to comments by occupational therapists, a psychologist, and a speech and language pathology practitioner included in this report.

Appendix A

Applicant Report

Applicant Report Cover Sheet and Outline
Washington State Department of Health Sunrise Review

COVER SHEET

- **Legislative proposal being reviewed under the sunrise process (include bill number if available):**

  HB 2522: Legislation requiring certification of Washington music therapists

- **Name and title of profession the applicant seeks to credential/institute change in scope of practice:**

  Music therapy

- **Number of members in the organization:**

  Music Therapy Association of Washington: 24

  American Music Therapy Association: represents over 5,000 music therapists, corporate members and related associations world wide

  Certification Board for Music Therapists: does not have members but instead has over 5,400 certificants who have met board-certification criteria

- **Approximate number of individuals practicing in Washington:** 45

- **Name(s) and address(es) of national organization(s) with which the state organization is affiliated:**

  Applicant's organization: Certification Board for Music Therapists

  Contact person: Dena Register, PhD, MT-BC, Regulatory Affairs Associate

  Address: 506 E. Lancaster Ave., Suite 102, Downingtown, PA 19335

  Telephone number: 800-765-2268 **Email address:** dregister@cbmt.org

  Applicant's organization: American Music Therapy Association

  Contact person: Judy Simpson, MT-BC, Director of Government Relations

  Address: 8455 Colesville Road, Suite 1000, Silver Spring, MD 20910

  Telephone number: 301-589-3300x105 **Email address:** Simpson@musictherapy.org

- Name(s) of other state organizations representing the profession:

  Applicant's organization: Music Therapy Association of Washington

Contact person: Nancy Houghton, President

Address: 10989 Rolling Bay Walk NE; Bainbridge, WA 98110

Telephone number: (206) 371-5312 **Email address:** nhhoughton@msn.com

Applicant's organization: Washington State Music Therapy Task Force – a joint project with the Certification Board for Music Therapists and the American Music Therapy Association

Contact person: Patti Catalano

Address: 3715 204th CT NE; Sammamish, WA 98074

Telephone number: (425) 444-6893 **Email address:** pattic@musicworksnw.org

OUTLINE OF FACTORS TO BE ADDRESSED

Please refer to RCW 18.120.030 (attached) for more detail. Concise, narrative answers are encouraged. Please explain the following:

(1) Define the problem and why regulation is necessary:

Music therapists in Washington are seeking state certification in order to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect access to music therapy services. State certification of music therapists would:

- Recognize music therapy as a valid, research-based health care service, on par with other therapy disciplines serving an equally wide range of clinical populations (e.g. speech-language pathology, occupational therapy).
- Validate the prominence of music therapy in state, national and international work settings for serving consumers of health- and education-related services.
- Establish educational and clinical training requirements for music therapists.
- Establish examination and continuing education requirements for music therapists.
- Establish music therapy scope of practice.
- Establish an ethics review procedure for complaints and potential ethical violations.

We also seek to gain:

- The inclusion of music therapy in state-wide legislation that protects consumers of music therapy;
- The ability for Washington residents and businesses to easily determine qualified music therapy practitioners;
- The ability for facilities interested in providing music therapy services to comply with state regulations in contracting with or employing certified music therapists.

Many existing state regulations require that education and healthcare providers hold official Washington state certification. Since music therapy is not certified by the state, qualified music therapists are frequently restricted from providing services within these settings. As a result, Washington state residents have difficulty accessing music therapy services within educational and healthcare facilities. Communication with state education and healthcare agencies emphasize that service provision procedures require official state recognition for Washington citizens to access services.

(2) The efforts made to address the problem:

Washington music therapists have been working since September 2007 to address the need for state recognition of the music therapy profession to protect the public and insure competent practice. Efforts thus far have included the introduction of music therapy licensure legislation (spring 2008), the introduction of music therapy certification legislation (winter 2012), the submission of a Sunrise Review application (summer 2008), and multiple meetings with state legislators and state agency officials. A detailed description of these efforts follows:

Meetings with staff from several education and health state offices were held in September 2007 to discuss the benefits of music therapy services, qualification of providers, and access to services within the structure of Washington programs. Departments included Early

Learning, Mental Health, DDD Waiver, Special Education Operations, and Aging and Disability Services. The common thread throughout all discussions in order for Washington residents to access music therapy services was the need for official state recognition of the profession, with possible acceptance of the existing board certification for music therapists.

Music therapy licensure legislation was introduced in January 2008 by Representative Darneille. Rep. Darneille, in turn, requested a Sunrise Review be completed. AMTA and CBMT attempted to submit a Sunrise Review to the Department of Health in July of 2008, but the review was not accepted because it had not been officially requested by the Department.

In March 2011, meetings were held with several state legislators to discuss the benefits of music therapy services, the difficulties Washington residents have accessing music therapy services, and the options for getting music therapy recognized by the state. The common thread, again, was that in order for Washington residents to access music therapy services and to be protected from unqualified individuals, official state recognition through a licensure program is needed. Although not included in the final budget bill, support from these Hill Day visits did result in the listing of music therapy services for individuals with developmental disabilities in proposed budget legislation.

Contacts made with legislators during the March 2011 visits resulted in several legislators expressing an interest in helping music therapists look at ways to achieve state recognition within the state of Washington. Rep. Darneille expressed willingness to sponsor a bill. In June 2011, Sen. Steve Conway (Vice Chair of the Health and Long Term Care Committee and of the 29th Legislative District) set up a meeting with state music therapists, Kathy Buchli (Counsel to the Health and Longterm Care Committee), and Brian Peyton (Director, Policy, Legislative & Constituent Relations, Department of Health, Washington State). Music therapists provided information for the state officials regarding music therapy and the need for state recognition. State officials and Sen. Conway shared information regarding the levels of state recognition and the process of the Sunrise Review.

A second meeting was scheduled in Olympia in which Ms. Buchli would share her review of other state's bills regarding music therapy state recognition as well as Washington State regulatory language that would affect the process. On July 19th, 2011, Sen. Conway, Kathy Buchli, and Brian Peyton met with music therapists and recommended meeting with Sen. Karen Keiser of the 33rd Legislative District (Chair of the Health and Long Term Care Committee) and Rep. Eileen Cody of the 34th Legislative District (Chair of the Health and Wellness Committee) to get their recommendations for the process. On July 26th, 2011, music therapists met with Sen. Conway, Sen. Keiser, Rep. Cody, Kathy Buchli and Brian Peyton. At that time it was recommended by Sen. Keiser and Rep. Cody that music therapists request a bill to establish a music therapy registry.

In August 2011, music therapists polled their colleagues in Washington State and respondents indicated support for pursuing state registration. In September 2011, music therapists contacted Kathy Buchli and informed her of the decision to pursue registry. In November 2011, Ms. Buchli sent a draft of a bill that reflected much of the language of the original licensure bill. Information was exchanged regarding updated language and in December 2011, Veronica Warnock, Session Counsel for the Health and Long Term Care committee, was assigned the music therapy draft and submitted bill language to music

therapists that reflected a change in status to a certification bill. In early January 2012, music therapists had a conference call with Ms. Warnock who indicated that if the draft could be agreed upon, the bill could be submitted for the 2012 Legislative Session. The following week the bill language was finalized and Brooke McKasson, music therapist from Tacoma, went to Olympia to gain signatures and support for the bill. SB 6276 was sponsored by Senators Conway, Keiser and Pridemore and it received its first reading on Jan. 16. It was referred to the Health and Long Term Care Committee and received a public hearing in the Senate Committee on Health and Long Term Care on February 1, 2012. A companion bill was sought from the House and HB 2522 was sponsored by Representatives Darneille, Van De Wege and Goodman. It was decided by Sen. Keiser that the bill should receive a Sunrise Review and Sen. Keiser made the request of the Department of Health in April 2012. The Department of Health notified the Washington State Music Therapy Task Force and requested a Sunrise Review report to be submitted by June 1, 2012.

(3) The alternatives considered:

Alternatives considered include title protection, state registration, or state licensure.

(4) The benefit to the public if regulation is granted:

Residents would be assured that individuals providing music therapy services are qualified clinicians who have met the education, clinical training, and national board certification examination requirements for the profession. Access to medically, behaviorally, or educationally necessary music therapy services would be improved, as residents would be able to locate qualified providers recognized by the state. Facilities interested in providing music therapy services would be able to comply with state regulations in contracting with or employing state recognized music therapists. Communication with state education and healthcare agencies emphasize that service provision procedures require official state recognition through a state certification or state license for Washington citizens to access services. To address these concerns, we are interested in the creation of a state certification for music therapists in the state of Washington.

(5) The extent to which regulation might harm the public:

There is no foreseeable harm to the public as a result of regulating this profession.

(6) The maintenance of standards:

This proposal would require the same national education, clinical training, examination, and recertification requirements currently in place to hold the MT-BC credential.

At the completion of academic and clinical training, students are eligible to take the national examination administered by CBMT, an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies. After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC). To demonstrate continued competence and to maintain this credential, music therapists are required to complete 100 hours of continuing music therapy education, or to re-take and pass the CBMT examination within every five-year recertification cycle.

All music therapists receive education and training in how to comply with state and federal and facility regulations and accreditation.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice.

Music therapists actively apply various music elements through live, improvised, adapted, individualized, or recorded music to address physical, emotional, cognitive, and social needs of individuals of all ages. After assessing the strengths and needs of each client, qualified music therapists develop a treatment plan with goals and objectives and then provide the indicated treatment. Music therapists structure the use of both instrumental and vocal music strategies to facilitate changes that are non-musical in nature. Like other members of a rehabilitation team, music therapists collaborate with related professionals in providing interventions that meet the needs, capabilities, and interests of each patient.

Music therapy interventions can be designed to facilitate movement, increase motivation, promote wellness, manage stress, alleviate pain, enhance memory, provide emotional support, create an outlet for expression, improve communication, and provide unique opportunities for interaction. As members of the interdisciplinary team, music therapists frequently address similar treatment goals as other allied health therapists, such as occupational therapy, physical therapy, and speech therapy. What distinguishes music therapy from these other therapies, however, is the use of music as the therapeutic tool. The music therapy treatment plan is designed to help the client attain and maintain a maximum level of functioning using interactive music therapy strategies.

Music therapists work with children and adults with developmental disabilities, speech and hearing impairments, physical disabilities, psychiatric disorders, neurological impairments, and general medical illnesses, among others. Although music therapists work with over 40 different patient populations, a significant number of music therapists provide services for persons with autism and other developmental and learning disabilities, Alzheimer's disease, mental health needs, medical illnesses, and physical disabilities.

Music therapists work in many different settings including general and psychiatric hospitals, mental health agencies, physical rehabilitation centers, nursing homes, public and private schools, substance abuse programs, forensic facilities, hospice programs, and day care facilities. Typically, full-time therapists work a standard 40-hour workweek. Some therapists prefer part-time work and choose to develop contracts with specific agencies, providing music therapy services for an hourly or contractual fee. In addition, a growing number of clinicians are choosing to start private practices in music therapy to benefit from opportunities provided through self-employment.

American Music Therapy Association (AMTA)
8455 Colesville Road, Suite 1000
Silver Spring, MD 20910
T: 301-589-3300
F: 301-589-5175
www.musictherapy.org

AMTA represents over 5,000 music therapists, corporate members, and related associations worldwide. AMTA's roots date back to organizations founded in 1950 and 1971. Those two organizations merged in 1998 to ensure the progressive development of the therapeutic use of music in rehabilitation, special education, medical, and community settings. AMTA is committed to the advancement of education, training, professional standards, and research in support of the music therapy profession. The mission of the organization is to advance public knowledge of music therapy benefits and increase access to quality music therapy services. Currently, AMTA establishes criteria for the education and clinical training of music therapists. Members of AMTA adhere to a Code of Ethics and Standards of Practice in their delivery of music therapy services.

Certification Board for Music Therapists
506 East Lancaster Ave., Suite 102
Downingtown, PA 19335
T: 1-800-765-2268
F: 610-269-9232
www.cbmt.org

The Certification Board for Music Therapists (CBMT) is an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). The CBMT defines the body of knowledge that represents competent practice in the profession of music therapy, creates and administers a program to evaluate initial and continuing competence of this knowledge, and issues the credential of MT-BC to individuals that demonstrate the required level of competence. The NCCA accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer. Approximately 5,400 music therapists hold the MT-BC credential and, because of its success, CBMT is regarded as a leader in the credentialing field.

Music Therapy Association of Washington
President: Nancy Houghton
E: nhhoughton@msn.com
www.musictherapywa.org

The music therapists in the state have formed the Music Therapy Association of Washington. This state network maintains a public website, communicates periodically through email, and hosts periodic educational workshops, primarily in the Seattle area. In addition, there is a **Washington State Music Therapy Task Force** that works in cooperation with AMTA and CBMT to advance advocacy and state recognition efforts of the music therapy profession and MT-BC credential required for competent practice.
Task Force contact: Patti Catalano
E: pattic@musicworksnw.org
T: (425)444-6893

There are approximately 45 eligible music therapists within the state. This number represents all levels of practice.

In late 2010 the American Music Therapy Association received a $400,000 legacy gift from the Eleanor and Raymond Wilson Charitable Trust. **The Wilson Trust Music Therapy Project** aims to increase access to quality music therapy services to those in need primarily targeting the greater Puget Sound region. Other areas of Washington may benefit depending on the structure of partnerships and service recognition. This donation is intended to serve as a catalyst to "jump start" a host of music therapy programs and services. The contribution will be structured in a way to maximize the investment, develop partnerships, grow music therapy services, and promote sustainability.

(8) The expected costs of regulation:

This proposal is requesting state acceptance of the existing national board certification examination developed and administered by CBMT. No costs would be incurred by the state for development or administration of a new or separate exam. It is anticipated that administrative costs to process applications would be covered by the application and renewal fees.

(9) List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:

Music therapists are qualified to complete the following tasks independently, and when applicable, in conjunction with an interdisciplinary treatment team:

Music Therapy Assessment and Treatment Planning;
Music Therapy Treatment Implementation and Termination; and
Ongoing Evaluation and Documentation of Music Therapy Treatment.

For a complete listing of all items included within each of these categories, please refer to the CBMT Scope of Practice (attached).

Although work functions and procedures vary by clinical setting and job title, we estimate that most music therapists spend 60% of their time in direct service and 40% on administrative responsibilities (i.e., documentation, program development, research, continuing education, treatment team meetings, etc.).

RCW 18.120.030Applicants for regulation -- Information.

After July 24, 1983, if appropriate, applicant groups shall explain each of the following factors to the extent requested by the legislative committees of reference:

(1) A definition of the problem and why regulation is necessary:

Music therapists in Washington are seeking state certification in order to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect access to music therapy services. State certification of music therapists would:

- Recognize music therapy as a valid, research-based health care service, on par with other therapy disciplines serving an equally wide range of clinical populations (e.g. speech-language pathology, occupational therapy).
- Validate the prominence of music therapy in state, national and international work settings for serving consumers of health- and education-related services.
- Establish educational and clinical training requirements for music therapists.
- Establish examination and continuing education requirements for music therapists.
- Establish music therapy scope of practice.
- Establish an ethics review procedure for complaints and potential ethical violations.

We also seek to gain:

The inclusion of music therapy in state-wide legislation that protects consumers of music therapy;

The ability for Washington residents and businesses to easily determine qualified music therapy practitioners;

The ability for facilities interested in providing music therapy services to comply with state regulations in contracting with or employing certified music therapists.

Many existing state regulations require that education and healthcare providers hold official Washington state certification. Since music therapy is not certified by the state, qualified music therapists are frequently restricted from providing services within these settings. As a result, Washington state residents have difficulty accessing music therapy services within educational and healthcare facilities. Communication with state education and healthcare agencies emphasize that service provision procedures require official state recognition for Washington citizens to access services.

(a) The nature of the potential harm to the public if the business profession is not regulated, and the extent to which there is a threat to public health and safety;

There are a growing number of unqualified individuals in the state claiming to be music therapists who do not hold a music therapy degree from an accredited institution or carry the national credential of Music Therapist-Board Certified (MT-BC). This potential harm to the public includes misrepresentation of the music therapy profession, as these individuals hold themselves out to the public as being able to produce outcomes that are not based upon evidence-based practice; and, these individuals show a substantial lack of supervised clinical training and feedback to promote and ensure ethical practice.

The current lack of music therapy certification in the state leaves Washington residents at-risk for negative social, emotional and economic consequences due to the inability of an untrained individual having no experience or understanding of the assessment, treatment planning, implementation and documentation processes. For example, a nurse at a long-term

care facility claimed to do “music therapy” by playing the piano for sing-a-longs for the residents. While qualified to address a number of physical issues, she is not trained to select or manipulate particular musical elements to elicit specific desired responses nor is she trained to handle the social or emotional responses that those individuals may have in response to musical stimuli. Financial implications for constituents include untrained individuals charging a variety of fees with the inability to document measurable outcomes as a result of scientifically based treatment.

Music therapists often work with vulnerable populations (e.g. persons with intellectual or emotional disabilities, or persons coping with physical, mental, or terminal illness). Therefore, it is imperative to regulate this profession within the state in order to safeguard members of the public who may be less able to protect themselves. A person claiming to be a music therapist, but who does not have the appropriate academic and clinical could potentially cause significant health and/or safety risks.

The potential for harm could be recognized when a non-qualified individual claiming to be a music therapist does not comply with federal and state statutes and regulations, (i.e., HIPAA regulations) safeguarding client privacy. Additionally, potential for harm exists if a non-qualified individual provides inappropriate applications of music therapy interventions that could cause physical or emotional harm, or if the individual participated in unethical practice that could be harmful to the public and consumers in general. For example, a qualified music therapist working in the Neonatal Intensive Care Unit is trained to administer both live and recorded music interventions to assist both the infant and family. This training includes understanding of acoustical principles (effected by the playing of music in an isolette), appropriate levels of sound (i.e. decibel levels) and amount of time exposed to music. Additionally music therapists are trained to read behavioral and empirical (i.e., vital signs) cues of the infant that indicate infant distress. Without state certification of music therapists, it is difficult to identify music therapists who were in compliance with state regulations, which is essential for public protection.

(b) The extent to which consumers need and will benefit from a method of regulation identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession; and

Consumers will benefit from formal state recognition of music therapy, as state recognition will improve access to services provided by qualified professionals. Many existing state regulations require that education and healthcare providers hold an official Washington state license or certification. Since this type of recognition is not established for music therapy, qualified board certified music therapists are frequently restricted from providing services within these settings. As a result, Washington state residents have difficulty accessing music therapy services within educational and healthcare facilities. Typical employers can include hospitals, public and private schools, nursing homes, mental health facilities, rehabilitation treatment centers, correctional facilities, hospice programs, and community day centers. Communication with state education and healthcare agencies emphasize that service provision procedures require official state recognition through a state license or certification for Washington citizens to access services. To address these concerns, we are interested in the creation of a state certification for music therapists in the state of Washington.

(c) The extent of autonomy a practitioner has, as indicated by:

Board certified music therapists are qualified to complete the following tasks independently, and when applicable, in conjunction with an interdisciplinary treatment team:

Music Therapy Assessment and Treatment Planning;
Music Therapy Treatment Implementation and Termination; and
Ongoing Evaluation and Documentation of Music Therapy Treatment.

*For a complete listing of all items included within each of these categories, please refer to the CBMT Scope of Practice (**attached**).*

(i) The extent to which the health profession calls for independent judgment and the extent of skill or experience required in making the independent judgment; and

Currently, a music therapist is bound to the allowable actions, judgments, and procedures outlined in the profession's Standards of Clinical Practice **(attached)** and Code of Ethics **(attached)**, and the national credential examination's Scope of Practice **(attached)** and Code of Professional Practice **(attached)**.

All music therapists are qualified to conduct music therapy assessments, develop and implement music therapy treatment plans, evaluate and document response to music therapy interventions, and contribute to multidisciplinary treatment team reports and meetings.

(ii) The extent to which practitioners are supervised;

Some music therapists work independently in private practice and some are employed in an educational or healthcare setting. Access to, and requirements for, supervision vary depending upon the clinical setting and facility policies and procedures. It is common practice for physicians to order music therapy in medical settings or when making a referral to a self-employed music therapist. Other settings and situations allow for referrals from a wide variety of practitioners.

For example, when employed by a healthcare facility, Therapy Service Department Directors may supervise music therapists, and peers often include physical therapists, occupational therapists, and speech/language pathologists. In educational settings, music therapists are usually supervised by Special Education Administrative Directors with peers in related services as listed above. For clinicians in private practice, supervision opportunities are available through state, regional, and national conferences.

(2) The efforts made to address the problem:

Washington music therapists have been working since September 2007 to address the lack of recognition of the music therapy profession. Efforts thus far have included the introduction of music therapy licensure legislation (spring 2008), the introduction of music therapy certification legislation (winter 2012), the submission of a Sunrise Review application (summer 2008), and multiple meetings with state legislators and state agency officials. A detailed description of these efforts follows:

Meetings with staff from several education and health state offices were held in September 2007 to discuss the benefits of music therapy services, qualification of providers, and access to services within the structure of Washington programs. Departments included Early

Learning, Mental Health, DDD Waiver, Special Education Operations, and Aging and Disability Services. The common thread throughout all discussions in order for Washington residents to access music therapy services was the need for official state recognition of the profession, with possible acceptance of the existing board certification for music therapists.

Music therapy licensure legislation was introduced in January 2008 by Representative Darneille. Rep. Darneille, in turn, requested a Sunrise Review be completed. AMTA and CBMT attempted to submit a Sunrise Review to the Department of Health in July of 2008, but the review was not accepted because it had not been officially requested by the Department.

In March 2011, meetings were held with several state legislators to discuss the benefits of music therapy services, the difficulties Washington residents have accessing music therapy services, and the options for getting music therapy recognized by the state. The common thread, again, was that in order for Washington residents to access music therapy services and to be protected from unqualified individuals, official state recognition through a licensure program is needed. Although not included in the final budget bill, support from these Hill Day visits did result in the listing of music therapy services for individuals with developmental disabilities in proposed budget legislation.

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In August 2011, music therapists polled their colleagues in Washington State and respondents indicated support for pursuing state registration. In September 2011, music therapists contacted Kathy Buchli and informed her of the decision to pursue registry. In November 2011, Ms. Buchli sent a draft of a bill that reflected much of the language of the original licensure bill. Information was exchanged regarding updated language and in December 2011, Veronica Warnock, Session Counsel for the Health and Long Term Care committee, was assigned the music therapy draft and submitted bill language to music therapists that reflected a change in status to a certification bill. In early January 2012, music

therapists had a conference call with Ms. Warnock who indicated that if the draft could be agreed upon, the bill could be submitted for the 2012 Legislative Session. The following week the bill language was finalized and Brooke McKasson, music therapist from Tacoma, went to Olympia to gain signatures and support for the bill. SB 6276 was sponsored by Senators Conway, Keiser and Pridemore and it received its first reading on Jan. 16. It was referred to the Health and Long Term Care Committee and received a public hearing in the Senate Committee on Health and Long Term Care on February 1, 2012. A companion bill was sought from the House and HB 2522 was sponsored by Representatives Darneille, Van De Wege and Goodman. It was decided by Sen. Keiser that the bill should receive a Sunrise Review and Sen. Keiser made the request of the Department of Health in April 2012. The Department of Health notified the Washington State Music Therapy Task Force and requested a Sunrise Review report to be submitted by June 1, 2012.

(a) Voluntary efforts, if any, by members of the profession to:
(i) Establish a code of ethics; or
(ii) Help resolve disputes between practitioners and consumers; and

Music therapists in Washington follow the American Music Therapy Association (AMTA) Standards of Clinical Practice **(attached)** and Code of Ethics **(attached)**, as these documents describe therapist responsibilities and relationships with clients and other professionals involved in client treatment. In addition, any person representing himself or herself as a board certified music therapist shall practice within the Scope of Practice and adhere to the CBMT Code of Professional Practice (attached). Any complaints made by the public against a board certified music therapist should be brought to the attention of CBMT for investigation and possible disciplinary action as defined by the CBMT Code of Professional Practice.

(b) Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem;

No existing laws address the issue of protecting the public from unqualified individuals misrepresenting themselves as music therapists. Public access to music therapy services by qualified professionals in health and education settings is not able to be addressed under current statutes or regulations.

(3) The alternatives considered:

Alternatives considered include title protection, state registration, or state licensure.

(a) Regulation of business employers or practitioners rather than employee practitioners;

Regulating business employers and other practitioners would not be in the best interest of protecting the public as these entities do not have the knowledge to determine the standard of care or clinical competency that state certification would provide.

(b) Regulation of the program or service rather than the individual practitioners;

Regulation of programs and services would not insure consumer protection to the extent required in healthcare and educational settings. Since music therapists maintain individual board certification, each individual practitioner is required to meet national education,

clinical training, and credentialing requirements regardless of the type of program in which they work. We are asking the state to formally recognize these existing national requirements for each individual practitioner.

(c) Registration of all practitioners;

The concern with registration is that this option does not insure the greatest level of protection for the public. In addition, healthcare and educational settings typically require state certification or licensure. It is our understanding that individuals on a state registry would not be obligated to verify continuing education requirements. Therefore, this method of recognition would not adequately protect the public.

(d) Certification of all practitioners;

A state certification would provide the necessary recourse for consumers and employers to verify competent clinicians, understand the scope of practice, and report unethical behavior and practice.

(e) Other alternatives;

Title protection was another alternative that was investigated. Unfortunately, title protection alone does not provide the level of quality assurance necessary to protect the public and often creates confusion due to the wide variety of populations music therapists serve.

(f) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest; and

The alternatives listed above do not adequately provide the level of public protection that is required in the healthcare and educational settings in which music therapists provide services. In addition, meetings with state agency officials and state legislators indicate that state certification may be the only way for Washington residents to safely and successfully access music therapy services.

(g) Why licensing would serve to protect the public interest;

The public needs additional assurance through certification of music therapists so that they are protected from the misuse of terms and techniques by unqualified individuals and to insure competent practice. Washington citizens would be assured that individuals providing music therapy services are qualified clinicians who have met the education, clinical training, and examination requirements for the profession. Certification will prevent the incidence of unqualified individuals having access to clients' confidential information and potentially compromising clients' health and wellness issues.

(4) The benefit to the public if regulation is granted:

Residents would be assured that individuals providing music therapy services are qualified clinicians who have met the education, clinical training, and national board certification examination requirements for the profession. Access to medically, behaviorally, or educationally necessary music therapy services would be improved, as residents would be able to locate qualified providers recognized by the state. Facilities interested in providing

music therapy services would be able to comply with state regulations in contracting with or employing state recognized music therapists. Communication with state education and healthcare agencies emphasize that service provision procedures require official state recognition through a state certification or state license for Washington citizens to access services. To address these concerns, we are interested in the creation of a state certification for music therapists in the state of Washington.

(a) The extent to which the incidence of specific problems present in the unregulated health profession can reasonably be expected to be reduced by regulation;

State recognition in the form of certification would effectively decrease confusion for those seeking services, as consumers would be able to locate qualified providers through the state. There are a large number of non-credentialed individuals claiming to practice music therapy who could cause harm as they do not have the necessary education and clinical training to assess, develop and implement interventions as outlined in the CBMT Scope of Practice for board certified music therapists **(attached)**. This is confusing to the general public and these individuals do not always represent themselves accurately. State certification would assist potential employers in identifying music therapists who have met the state required education, clinical training, and board certification.

(b) Whether the public can identify qualified practitioners;

Certification by the state that recognizes the standards currently in place for the profession of music therapy would provide the public with a well-defined, easily accessed method of determining qualified practitioners.

(c) The extent to which the public can be confident that qualified practitioners are competent:

All board certified music therapists receive education and training in how to comply with state and federal and facility regulations and accreditation. They are able to conduct assessments, draft and incorporate goals and objectives into treatment plans, specify procedures and define expected treatment outcomes, evaluate and make appropriate modifications and accommodations, and document this process utilizing standard tools. The CBMT Scope of Practice **(attached)** ensures that MT-BCs are able to optimize program plans of other disciplines and establish principles of normal growth and development. They are trained to meet priority needs of clients during crisis intervention, comply with infection control requirements, and incorporate medical precautions.

(i) Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners; and how fees would be levied and collected to cover the expenses of administering and operating the regulatory system;

We are proposing that the music therapy certification program be administered by the Department of Health. Since the number of music therapy practitioners is relatively small in comparison with other health professions, there could be a five member Advisory Council comprised of three music therapists, one physician, and one public member that reports to a larger existing board within the Department that regulates related healthcare professions. This Advisory Council would assist with the development of regulations and could serve as a resource for any questions the Department receives in the administration of the certification. Members of the Music Therapy Advisory Council would serve without compensation. In addition, the Department could utilize existing professional documents such as the AMTA Code of Ethics **(attached)**, the CBMT Scope of Practice **(attached)**, and the CBMT Code of Professional Practice **(attached)** in the development of regulations.

The Department would collect the applications, review for completeness, contact CBMT for verification, process payments, and issue the certifications.

Additional information related to this issue is provided below in response to Question 6(b)(ii).

(ii) If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date;

We are not seeking a grandfather clause as a part of this proposal.

(iii) The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions;

This proposal would require the same education, clinical training, and board certification exam standards currently in place to obtain the MT-BC credential in the United States.

(iv) Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions; and

The Department would be authorized to enter into reciprocity agreements with other jurisdictions as the profession of music therapy requires the same education, clinical training and board certification standards to obtain the MT-BC credential in the United States. There are currently three states which have recently passed music therapy licensure legislation. All three states, Nevada, North Dakota, and Georgia require the MT-BC credential for licensure applicants.

(v) The nature and duration of any training including, but not limited to, whether the training includes a substantial amount of supervised field experience; whether training programs exist in this state; if there will be an experience requirement; whether the experience must be acquired under a registered, certificated, or licensed practitioner; whether there are alternative routes of entry or methods of meeting the prerequisite qualifications; whether all applicants will be required to pass an examination; and, if an examination is required, by whom it will be developed and how the costs of development will be met;

Those who wish to become music therapists must earn a bachelor's degree (based on 120 semester hours or its equivalent) or higher in music therapy from one of over 70 AMTA

approved colleges and universities. These programs require academic coursework and 1,200 hours of clinical training, including a supervised internship. The academic institution takes primary responsibility for providing students with the entire continuum of clinical training experiences with a representative range of client populations in diverse settings. Qualified supervision of clinical training is required and coordinated or verified by the academic institution. An academic institution, AMTA, or both may approve internship programs. Clinical supervisors must meet minimum requirements outlined by AMTA Education and Clinical Training Guidelines **(attached)**. In exceptional cases, a student may have an on-site supervisor or facility coordinator who may not be a music therapist but holds a professional, clinical credential (e.g., OT, nurse, special educator, etc.). Under these circumstances, the student must have a credentialed music therapist as a supervisor under the auspices of the university.

In the state of Washington, Seattle Pacific University has an AMTA approved music therapy program, which offers a bachelors degree in music therapy. Whidbey General Hospital offers an AMTA National Roster Internship Program.

At the completion of academic and clinical training, students are eligible to take the national examination administered by CBMT, an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies. After successful completion of the CBMT examination, graduates are issued the credential necessary for professional practice, Music Therapist-Board Certified (MT-BC). To demonstrate continued competence and to maintain this credential, music therapists are required to complete 100 hours of continuing music therapy education, or to re-take and pass the CBMT examination within every five-year recertification cycle.

We are proposing that all individuals who have successfully completed an AMTA-approved music therapy education program, clinical training requirements, and passed the CBMT board certification exam will be eligible to apply for the state music therapy certification. We are not proposing alternate routes of meeting these prerequisite requirements.

Since this proposal is requesting state recognition of the existing national board certification examination developed and administered by CBMT, no costs would be incurred by the state for development or administration of a new or separate exam.

(vi) What additional training programs are anticipated to be necessary to assure training accessible statewide; the anticipated time required to establish the additional training programs; the types of institutions capable of providing the training; a description of how training programs will meet the needs of the expected work force, including reentry workers, minorities, placebound students, and others;

At this time, no additional training programs have been proposed. The music therapy bachelor's degree curriculum at Seattle Pacific University is currently serving as the AMTA-approved academic program in the state. Other colleges and universities interested in offering an AMTA-approved music therapy degree program are directed to contact the AMTA National Office to request music therapy degree information.

The time required to establish new degree programs varies significantly due to individual school procedures, but program proposals typically receive association approval and begin accepting students within three years from initial inquiry.

The AMTA Standards for Education and Clinical Training **(attached)** provide a detailed description regarding training program requirements. The following information is a brief overview of the information from the Standards related to Question (4)(c)(vi).

Only regionally accredited, degree-granting institutions awarding at least the bachelor's degree may offer an academic program in music therapy eligible for program approval by the Association.

Only academic institutions accredited or affirmed by National Association of Schools of Music (NASM) are eligible to apply for AMTA approval. Schools that are eligible for NASM membership must be accredited by NASM. Schools that are ineligible for NASM accreditation must seek affirmation by NASM through the alternative review process.

All music therapy programs in branch campuses or extension programs must meet all NASM Standards for Branch Campuses and External Programs.

All programs approved by the Association that offer distance learning programs must meet NASM Standards for Distance Learning and the AMTA Guidelines for Distance Learning.

The Association encourages diversity among institutions and programs and respects the operational integrity within academic and clinical training programs.

Institutions are encouraged to be innovative both in education delivery and financially.

The American Music Therapy Association, Inc., aims to establish and maintain competency-based standards for all three levels of education (bachelor's, master's, and doctoral), with guidelines for the various curricular structures appropriate to different degrees, as defined by the National Association of Schools of Music (NASM). Using this competency-based system, the Association formulates competency objectives or learning outcomes for the various degree programs, based on what knowledge, skills, and abilities are needed by music therapists to work in various capacities in the field.

In implementing these standards, the Association shares the beliefs that education and clinical training are not separate processes, but reflect a continuum of music therapy education; that education and clinical training must be competency based at all levels; that education and clinical training must be student centered; and that education and clinical training must exist in a perspective of continuous change to remain current.

(d) Assurance of the public that practitioners have maintained their competence:

Competence would be maintained through strict documentation of existing CBMT requirements, which includes clearly defined continuing education, adherence to the CBMT Code of Professional Practice **(attached)** or re-examination and completion of remedial coursework.

(i) Whether the registration, certification, or licensure will carry an expiration date; and

Certification would be renewed once every 5 years.

(ii) Whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement;

Certified individuals must provide proof of continuous board certification for the previous state certification cycle. In addition, certified individuals must present documentation of successful completion of 100 Continuing Music Therapy Education (CMTE) units during the 5-year cycle. To assist with maintaining the state certification, there are multiple state, regional, and national offerings that serve as continuing education opportunities for board certified music therapists. Many courses are provided through live, interactive workshops, but there are also audio and web conference presentations, online courses, and self-directed specialized trainings available nationwide to meet the needs of all board certified music therapists.

(5) The extent to which regulation might harm the public:

There is no foreseeable harm to the public as a result of regulating this profession.

(a) The extent to which regulation will restrict entry into the health profession:

With board certification being a nationally recognized credential currently required of all music therapists, this state certification would not restrict entry into the profession. Nationally board certified music therapists who migrate from other states would be eligible to apply for the Washington certification as they would have met the requirements for practice.

(i) Whether the proposed standards are more restrictive than necessary to insure safe and effective performance; and

These standards meet the same high quality standards required of related healthcare professions and healthcare and education accrediting agencies and are not more restrictive than necessary to protect the public.

(ii) Whether the proposed legislation requires registered, certificated, or licensed practitioners in other jurisdictions who migrate to this state to qualify in the same manner as state applicants for registration, certification, and licensure when the other jurisdiction has substantially equivalent requirements for registration, certification, or licensure as those in this state; and

Board certified music therapists moving to Washington from other states will be eligible to apply for the Washington music therapy certification without having to meet any additional requirements. Since this proposal is based on acceptance of the existing national music therapy board certification credential, all music therapists holding that credential, regardless of state of residence, will meet the requirements and be eligible for this certification.

(b) Whether there are similar professions to that of the applicant group which should be included in, or portions of the applicant group which should be excluded from, the proposed legislation;

No other professions need to be included in this proposed certification as it is specifically designed to recognize board certified music therapists.

(6) The maintenance of standards:

This proposal would require the same national education, clinical training, and exam requirements currently in place to obtain the MT-BC credential.

CBMT currently develops, maintains, and updates a Scope of Practice **(attached)** for the profession of music therapy. Every five years a practice analysis is completed in cooperation with a team of experts in the field, surveyed certificants, and CBMT's testing firm, Applied Measurement Professionals (AMP). It is from this process that the current SOP is developed which details the tasks necessary to practice competently to ensure consumer protection. The five content outline areas, essentially performance domains, encompass the certificants' scope of practice.

Additionally, the AMTA provides the standards for academic and clinical training of prospective music therapists, on which eligibility to sit for the CBMT Board Certification Examination is based. These are based on the AMTA Professional Competencies, which provide a definition of the current entry-level skills of a music therapist who has completed either a bachelor's degree or its equivalent in music therapy. All AMTA-approved bachelor's degree training programs incorporate these competencies in their music therapy curriculum. These competencies are periodically revised to reflect the growth of the professional knowledge base as music therapy clinical and research activities expand.

(a) Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics; and

National standards and professional requirements established by the American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT) provide the necessary documents for creating formal recognition of the profession at the state level. These documents include:

AMTA	**CBMT**
Standards for Education and Clinical Training	Scope of Practice
Code of Ethics	Code of Professional Practice
Standards of Clinical Practice	
Professional Competencies	
Advanced Competencies	
Levels of Practice	

(b) How the proposed legislation will assure quality:

We are seeking recognition of an existing national examination-based credential in order to protect the public from misuse of terms and techniques and to insure competent practice. Many of the system responsibilities required for implementation and enforcement of the certification could be completed in coordination with CBMT.

Any person representing himself or herself as a board certified music therapist shall practice within the CBMT Scope of Practice **(attached)** and adhere to the CBMT Code of Professional Practice **(attached)**. Any complaints made by the public against the Board

Certified Music Therapist should be brought to the attention of the Department of Health for investigation and possible disciplinary action.

(i) The extent to which a code of ethics, if any, will be adopted; and

We recommend that music therapists recognized by the state of Washington abide by the existing CBMT Code of Professional Practice **(attached)**, which is a requirement of all board certified music therapists. In addition, music therapists in Washington who are members of the American Music Therapy Association (AMTA) should also follow the AMTA Code of Ethics **(attached)** and Standards of Clinical Practice **(attached.)**

(ii) The grounds for suspension or revocation of registration, certification, or licensure;

We are proposing that the state utilize procedures similar to that of the Certification Board for Music Therapists (CBMT) as grounds for suspension or revocation of state certification. Applicable portions of the CBMT Code of Professional Practice are included below

1. Obtaining or attempting to obtain certification or recertification by a false or misleading statement or failure to make a required statement; fraud or deceit in an application, reapplication, representation of event/s, or any other communication to the CBMT.
2. Misrepresentation of the CBMT certification or certification status.
3. Failure to provide any written information required by the CBMT.
4. Habitual use of alcohol or any other drug/substance, or any physical or mental condition which impairs competent and objective professional performance.
5. Failure to maintain confidentiality as required by law.
6. Gross or repeated negligence or malpractice in professional practice, including sexual relationships with clients, and sexual, physical, social, or financial exploitation.
7. Limitation or sanction (including but not limited to revocation or suspension by a regulatory board or professional organization) relating to music therapy practice, public health or safety, or music therapy certification or recertification.
8. The conviction of, plea of guilty or plea of nolo contendere to a felony or misdemeanor related to music therapy practice or health/mental health related issues as listed in the section on criminal convictions in Section II of this document.
9. Failure to timely update information to CBMT.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice; and

Music therapists actively apply various music elements through live, improvised, adapted, individualized, or recorded music to address physical, emotional, cognitive, and social needs of individuals of all ages. After assessing the strengths and needs of each client, qualified music therapists develop a treatment plan with goals and objectives and then provide the indicated treatment. Music therapists structure the use of both instrumental and vocal music strategies to facilitate changes that are non-musical in nature. Like other members of a

rehabilitation team, music therapists collaborate with related professionals in providing interventions that meet the needs, capabilities, and interests of each patient.

Music therapy interventions can be designed to facilitate movement, increase motivation, promote wellness, manage stress, alleviate pain, enhance memory, provide emotional support, create an outlet for expression, improve communication, and provide unique opportunities for interaction. As members of the interdisciplinary team, music therapists frequently address similar treatment goals as other allied health therapists, such as occupational therapy, physical therapy, and speech therapy. What distinguishes music therapy from these other therapies, however, is the use of music as the therapeutic tool. The music therapy treatment plan is designed to help the client attain and maintain a maximum level of functioning using interactive music therapy strategies.

Music therapists work with children and adults with developmental disabilities, speech and hearing impairments, physical disabilities, psychiatric disorders, neurological impairments, and general medical illnesses, among others. Although music therapists work with over 40 different patient populations, a significant number of music therapists provide services for persons with autism and other developmental and learning disabilities, Alzheimer's disease, mental health needs, medical illnesses, and physical disabilities.

Music therapists work in many different settings including general and psychiatric hospitals, mental health agencies, physical rehabilitation centers, nursing homes, public and private schools, substance abuse programs, forensic facilities, hospice programs, and day care facilities. Typically, full-time therapists work a standard 40-hour workweek. Some therapists prefer part-time work and choose to develop contracts with specific agencies, providing music therapy services for an hourly or contractual fee. In addition, a growing number of clinicians are choosing to start private practices in music therapy to benefit from opportunities provided through self-employment.

American Music Therapy Association (AMTA)
8455 Colesville Road, Suite 1000
Silver Spring, MD 20910
T: 301-589-3300
F: 301-589-5175
www.musictherapy.org

AMTA represents over 5,000 music therapists, corporate members, and related associations worldwide. AMTA's roots date back to organizations founded in 1950 and 1971. Those two organizations merged in 1998 to ensure the progressive development of the therapeutic use of music in rehabilitation, special education, medical, and community settings. AMTA is committed to the advancement of education, training, professional standards, and research in support of the music therapy profession. The mission of the organization is to advance public knowledge of music therapy benefits and increase access to quality music therapy services. Currently, AMTA establishes criteria for the education and clinical training of music therapists. Members of AMTA adhere to a Code of Ethics and Standards of Practice in their delivery of music therapy services.

Certification Board for Music Therapists
506 East Lancaster Ave., Suite 102
Downingtown, PA 19335

T: 1-800-765-2268
F: 610-269-9232
www.cbmt.org

The Certification Board for Music Therapists (CBMT) is an independent, non-profit certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). The CBMT defines the body of knowledge that represents competent practice in the profession of music therapy, creates and administers a program to evaluate initial and continuing competence of this knowledge, and issues the credential of MT-BC to individuals that demonstrate the required level of competence. The NCCA accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer. Approximately 5,400 music therapists hold the MT-BC credential and, because of its success, CBMT is regarded as a leader in the credentialing field.

Music Therapy Association of Washington
President: Nancy Houghton
E: nhhoughton@msn.com
www.musictherapywa.org

The music therapists in the state have formed the Music Therapy Association of Washington. This state network maintains a public website, communicates periodically through email, and hosts periodic educational workshops, primarily in the Seattle area. In addition, there is a **Washington State Music Therapy Task Force** that works in cooperation with AMTA and CBMT to advance advocacy and state recognition efforts of the music therapy profession and MT-BC credential required for competent practice.
Task Force Contact: Patti Catalano
E: pattic@musicworksnw.org
T: (425) 444-6893

There are approximately 45 eligible music therapists within the state. This number represents all levels of practice.

In late 2010 the American Music Therapy Association received a $400,000 legacy gift from the Eleanor and Raymond Wilson Charitable Trust. **The Wilson Trust Music Therapy Project** aims to increase access to quality music therapy services to those in need primarily targeting the greater Puget Sound region. Other areas of Washington may benefit depending on the structure of partnerships and service recognition. This donation is intended to serve as a catalyst to "jump start" a host of music therapy programs and services. The contribution will be structured in a way to maximize the investment, develop partnerships, grow music therapy services, and promote sustainability.

(8) The expected costs of regulation:

This proposal is requesting state acceptance of the existing national board certification examination developed and administered by CBMT. No costs would be incurred by the state for development or administration of a new or separate exam. It is anticipated that administrative costs to process applications would be covered by the application and renewal fees.

(a) The impact registration, certification, or licensure will have on the costs of the services to the public; and

The impact of certification on the costs of services to the public would be minimal, if at all, as fees for certification would likely not be significant enough to warrant raising therapy rates. Adding certification for music therapists creates the potential for increased access to services, additional employment opportunities, and support of students studying in the music therapy program at Seattle Pacific University. All of these factors are considered to have a positive impact for residents of the state, as access to quality services will increase as the profession is officially recognized.

(b) The cost to the state and to the general public of implementing the proposed legislation.

Cost to the state and the general public would likely be minimal, as it would not require the creation of an entire board. Because of the small number of MT-BCs currently working in the state, this certification could be managed with a part-time staff liaison that utilizes the information from CBMT in order to process licensure. Additionally, certification could positively impact the costs of services for Washington residents. There is a potential for decreased out-of-pocket expenses for those receiving services as facilities confidently identify and employ therapists who have met the state requirements for professional practice. There could be improved reimbursement for music therapy services by private and federal third-party payers, thereby decreasing the costs assumed by the state.

(c) The cost to the state and the members of the group proposed for regulation for the required education, including projected tuition and expenses and expected increases in training programs, staffing, and enrollments at state training institutions.

There are no anticipated additional costs to the state with the creation of state certification regarding education and clinical training programs. The costs to member of the profession for education and clinical training will remain the same. The only new cost to members will be the application and certification fees.

American Music Therapy Association

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AMTA Advanced Competencies

Preamble

The American Music Therapy Association has established competency-based standards for ensuring the quality of education and clinical training in the field of music therapy. As the clinical and research activities of music therapy provide new information, the competency requirements need to be reevaluated regularly to ensure consistency with current trends and needs of the profession and to reflect the growth of the knowledge base of the profession. The Association updates these competencies based on what knowledge, skills, and abilities are needed to perform the various levels and types of responsibilities to practice at both a professional level and an advanced level.

In November 2005 the AMTA Assembly of Delegates adopted the *Advisory on Levels of Practice in Music Therapy.* The Advisory, which was developed by the Education and Training Advisory Board, distinguishes two Levels of Practice within the music therapy profession:

> Professional Level of Practice: based on the AMTA *Professional Competencies* acquired with a baccalaureate degree in music therapy or its equivalent, which leads to entrance into the profession and Board Certification in Music Therapy.
>
> Advanced Level of Practice: based on the AMTA *Advanced Competencies*, which is defined as the practice of music therapy wherein the music therapist applies and integrates a comprehensive synthesis of theories, research, treatment knowledge, musicianship, clinical skills, and personal awareness to address client needs. A music therapist at an Advanced Level of Practice has at least a bachelor's degree or its equivalent in music therapy, a current professional designation or credential in music therapy (i.e., ACMT, CMT, MT-BC, or RMT), professional experience, and further education and/or training (e.g., receiving clinical supervision, a graduate degree, and/or advanced training). It is anticipated that in the future music therapists at the Advanced Level of Practice will hold at least a master's degree in music therapy that includes advanced clinical education. The advanced music therapist demonstrates comprehensive understanding of foundations and principles of music, music therapy, treatment, and management in clinical, educational, research, and/or administrative settings.

Following the adoption of the *Advisory on Levels of Practice in Music Therapy*, AMTA appointed a Task Force on Advanced Competencies, which was charged with developing competencies for the Advanced Level of Practice as outlined in the Advisory. The Advisory describes four domains for the Advanced Level of Practice: Professional Growth, Musical Development, Personal Growth and Development, and Integrative Clinical Experience. The general headings and subheadings of the proposed Advanced Competencies have been reorganized to provide a better understanding of the context of these competencies, not only within the music therapy profession, but also beyond it for other constituencies. It is acknowledged that the advanced music therapist may not demonstrate competence in each of the areas of the *Advanced Competencies*, but would instead demonstrate acquisition of the majority of these competencies, with most, if not all, in the area(s) of his/her practice (e.g., clinical, supervisory, academic, research).

The *Advanced Competencies* provide guidelines for academia, both in regards to qualifications for university/college faculty and in setting standards for master's degree programs in music therapy. The AMTA *Standards for Education and Clinical Training* specify standards for academic faculty employed full-time at a college or university with primary responsibilities for teaching music therapy and/or directing a music therapy program at the undergraduate or graduate level. Such qualifications for faculty require a music therapist practicing at an Advanced Level of Practice. The AMTA *Standards for Master's Degrees* state that "the purpose of the master's degree programs in music therapy is to impart advanced competencies, as specified in the AMTA *Advanced Competencies.* These degree

programs provide breadth and depth beyond the AMTA *Professional Competencies* required for entrance into the music therapy profession." The *Advanced Competencies* will also serve to guide the development of standards for the doctoral degree in music therapy, which shall focus on advanced competence in research, theory development, clinical practice, supervision, college teaching, and/or clinical administration.

The *Advanced Competencies* also provide guidelines for the Advanced Level of Practice in clinical, supervisory, administrative and research settings, as well as in government relations work dealing with such issues as state licensures and employment practices. Music therapists with master's degrees and other professional requirements are being granted state licensures in the creative arts therapies (music therapy) and related disciplines in some states.

The initial version of the *Advanced Competencies* was adopted by the AMTA Assembly of Delegates in 2007 and was viewed as a work in progress. Following feedback from a number of sources, including the National Association of Schools of Music (NASM), a revised version is being submitted in 2009 for AMTA approval.

In conclusion, the *Advanced Competencies* serve as a vision for the further growth and development of the profession in issues related to advanced education and training, and more specifically, the relationship of these competencies to advanced degrees, education and training requirements, levels of practice, professional titles and designations, and various state licensures, based on current and future trends.

AMTA Advanced Competencies

I. PROFESSIONAL PRACTICE

A. Theory

1.1 Apply comprehensive knowledge of the foundations and principles of music therapy practice.

1.2 Synthesize comprehensive knowledge of current theories and deduce their implications for music therapy practice and/or research.

1.3 Differentiate the theoretical or treatment orientations of current models of music therapy.

1.4 Identify theoretical constructs underlying various clinical practices and research approaches.

1.5 Understand emerging models and trends in music therapy.

1.6 Apply current literature in music therapy and related fields relevant to one's area(s) of expertise.

B. Clinical Practice

2. 0 Clinical Supervision

2.1 Establish and maintain effective supervisory relationships.

2.2 Promote the professional growth, self-awareness, and musical development of the supervisee.

2.3 Apply theories of supervision and research findings to music therapy supervision.

2.4 Design and implement methods of observing and evaluating supervisees that have positive effects on music therapy students and professionals at various levels of advancement and at different stages in the supervisory process.

2.5 Analyze the supervisee's music therapy sessions in terms of both the effects of specific musical, verbal, and nonverbal interventions and the musical and interpersonal dynamics and processes of the client(s)-therapist relationship.

2.6 Use music to facilitate the supervisory process.

2.7 Apply knowledge of norms and practices of other cultures to the supervisory process.

2.8 Evaluate the effectiveness of various approaches and techniques of supervision.

2.9 Evaluate the effects of one's own personality, supervisory style, and limitations on the supervisee and the supervisory process and seek consultation when appropriate.

3. 0 Clinical Administration

3.1 Adhere to laws and occupational regulations governing the provision of education and health services, particularly with regard to music therapy.

3.2 Adhere to accreditation requirements for clinical agencies, particularly with regard to music therapy.

3.3 Employ music therapy reimbursement and financing options.

3.4 Develop effective staffing patterns for the provision of music therapy services.

3.5 Develop effective recruiting and interviewing strategies for student and professional applicants.

3.6 Develop policies and procedures for staff evaluation and supervision.

3.7 Utilize management strategies to establish and maintain effective relationships and a high level of motivation among staff.

3.8 Integrate music therapy staff and programs into the agency's service delivery systems.

3.9 Design methods for evaluating music therapy programs and service delivery.

4.0 Advanced Clinical Skills

4.1 Apply comprehensive knowledge of current methods of music therapy assessment, treatment, and evaluation.

4.2 Utilize comprehensive knowledge of human growth and development, musical development, diagnostic classifications, etiology, symptomatology, and prognosis in formulating treatment plans.

4.3 Understand the contraindications of music therapy for client populations served.

4.4 Understand the dynamics and processes of therapy from a variety of theoretical perspectives.

4.5 Utilize the dynamics and processes of various theoretical models in individual, dyadic, family, and group music therapy.

4.6 Design or adapt assessment and evaluation procedures for various client populations.

4.7 Utilize advanced music therapy methods (e.g., listening, improvising, performing, composing) within one or more theoretical frameworks to assess and evaluate clients' strengths, needs, and progress.

4.8 Design treatment programs for emerging client populations.

4.9 Employ one or more models of music therapy requiring advanced training.

4.10 Utilize advanced verbal and nonverbal interpersonal skills within a music therapy context.

4.11 Assume the responsibilities of a primary therapist.

4.12 Relate clinical phenomena in music therapy to the broader treatment context.

4.13 Respond to the dynamics of musical and interpersonal relationships that emerge at different stages in the therapy process.

4.14 Fulfill the clinical roles and responsibilities of a music therapist within a total treatment milieu and in private practice.

4.15 Apply advanced skills in co-facilitating treatment with professionals from other disciplines.

4.16 Demonstrate comprehensive knowledge of client rights.

4.17 Understand the differential uses of the creative arts therapies and the roles of art, dance/movement, drama, psychodrama, and poetry therapy in relation to music therapy.

4.18 Apply creative processes within music therapy.

4.19 Employ imagery and ritual in music therapy.

4.20 Understand and respond to potential physical and psychological risks to client health and safety.

C. College/University Teaching

5.1 Design academic curricula, courses, and clinical training programs in music therapy consistent with current theories, research, competencies, and standards, including those for national accreditation and program approval.

5.2 Utilize current educational resources in music therapy (e.g., equipment, audio-visual aids, materials, technology).

5.3 Draw from a breadth and depth of knowledge of clinical practice in teaching music therapy.

5.4 Establish and maintain effective student-teacher relationships.

5.5 Communicate with other faculty, departments, and administration regarding the music therapy program and its educational philosophy.

5.6 Develop standards and procedures for admission and retention that support educational objectives consistent with the policies of the institution.

5.7 Utilize various methods of teaching (e.g., lecture, demonstration, role-playing, group discussion, collaborative learning).

5.8 Supervise and mentor students in clinical training, supervision, teaching, and research.

5.9 Advise and counsel students with regard to academic and professional matters.

5.10 Design and apply means of evaluating student competence, both internal (e.g., proficiency exams) and external (e.g., evaluations from clinical training supervisors).

5.11 Utilize internal, external, and self-evaluations to monitor the effectiveness of academic courses and programs in meeting educational objectives.

D. Research

6.1 Perform comprehensive literature searches using various indices to identify gaps in knowledge.

6.2 Translate theories, issues, and problems in clinical practice, supervision, administration, and higher education into meaningful research hypotheses or guiding questions.

6.3 Apply quantitative and qualitative research designs according to their indicated uses.

6.4 Conduct advanced research using one or more research approaches (e.g., historical, philosophical, qualitative, quantitative.)

6.5 Acknowledge one's biases and personal limitations related to research.

6.6 Write grant proposals for funding research.

6.7 Conduct research according to ethical principles for protection of human participants, including informed consent, assessment of risk and benefit, and participant selection.

6.8 Collect and analyze data using appropriate procedures to avoid or minimize potential confounds.

6.9 Collaborate with others in conducting research.

6.10 Use various methods of data analysis.

6.11 Interpret and disseminate research results consistent with established standards of inquiry.

6.12 Evaluate scholarly and student research regarding research questions or problems, methods, procedures, data collection, analysis, and conclusions.

II. PROFESSIONAL DEVELOPMENT

A. Musical and Artistic Development

7.1 Reproduce, notate, and transcribe musical responses of clients.

7.2 Compose music, including songs, in various styles to meet specific therapeutic objectives.

7.3 Provide spontaneous musical support for client improvisation.

7.4 Improvise in a variety of musical styles.

7.5 Utilize a wide variety of improvisatory techniques for therapeutic purposes.

7.6 Design music listening programs for therapeutic purposes.

7.7 Use different methods of musical analysis for client assessment and evaluation.

7.8 Adapt and select musical material for different musical cultures and sub-cultures.

7.9 Apply advanced skills in the clinical use of at least two of the following: keyboard, voice, guitar and/or percussion.

7.10 Utilize extensive and varied repertoire of popular, folk, and traditional songs.

B. Personal Development and Professional Role

8.1 Utilize self awareness and insight to deepen the client's process in music therapy.

8.2 Identify and address one's personal issues.

8.3 Apply the principles of effective leadership.

8.4 Use personal reflection (e.g., journaling, artistic involvement, meditation, other spiritual pursuits).

8.5 Recognize limitations in competence and seek consultation.

8.6 Practice strategies for self care.

8.7 Selectively modify music therapy approaches based on knowledge of the roles and meanings of music in various cultures.

8.8 Work with culturally diverse populations, applying knowledge of how culture influences issues regarding identity formation, concepts of health and pathology, and understanding of the role of therapy.

8.9 Understand how music therapy is practiced in other cultures.

8.10 Apply current technology to music therapy practice.

8.11 Adhere to the AMTA Code of Ethics and Standards of Clinical Practice using best professional judgment in all areas of professional conduct.

Endnotes

The Task Force gratefully acknowledges the previous work of Kenneth Bruscia (1986) in identifying "Advanced Competencies in Music Therapy." The ideas Bruscia expressed served as a basis for these competencies.

Members of the Task force on Advanced Competencies were Jane Creagan, Michele Forinash (Chair), Gary Johnson, Cathy McKinney, Christine Neugebauer, Paul Nolan, Marilyn Sandness, and Elizabeth Schwartz.

Reference

Bruscia, K. (1986). Advanced competencies in music therapy. *Music Therapy, 6A,* 57-67.

Glossary

advanced level of practice - the practice of music therapy wherein the therapist, applying the integration of in-depth theories, research, treatment knowledge, musicianship, clinical skills, and personal awareness, assumes a central role using process-oriented or outcome-oriented music therapy methods to address a broad spectrum of client needs.

advanced training - learning of a comprehensive approach to, or model of, music therapy intended for broad and in-depth clinical application. The training occurs over an extended period of time; includes both didactic instruction and extensive, supervised clinical application; and results in the acquisition of a number of advanced competencies. Advanced training typically requires the master's degree as a prerequisite or co-requisite of the training program. Examples include, but are not limited to, Analytic Music Therapy, Bonny Method of Guided Imagery and Music, Nordoff Robbins Music Therapy.

construct – a working hypothesis or concept.1

dynamics - forces that interplay in the mind as a manifestation of purposeful intentions working concurrently or in mutual opposition. These forces can include the patterns of actions and reactions within the music, therapist and client triangle, as well as within groups.2

knowledge - facts or ideas acquired by study, investigation, observation, or experience.4

model - a. comprehensive approach to assessment, treatment, and evaluation which includes theoretical principles, clinical implications and contraindications, goals, methodological guidelines and specifications, and the use of procedural sequences and techniques.5

musical responses – the musical actions or reactions of a person in response to external or internal stimuli and the physiological, affective, motor, cognitive, or communicative responses to musical stimuli.

primary therapist - whether in an individual private practice or working within a team approach, the person who facilitates the therapeutic work of the highest importance.

process - a sequence of conscious and unconscious events leading to some change or alteration in the state of a dynamic system that includes the client, the music, and the music therapist.[6]

supervision - usually referred to as clinical, or music therapy, supervision. This educational relationship consists of an on-going consultation with another health care professional about the supervisee's emerging role or continued growth as a clinician. Clinical supervision provides support for the supervisee for the purpose of development as a music therapist.

understanding – knowledge of or familiarity with a particular thing; skill in dealing with or handling something.[7] Perception and comprehension of the nature and significance of.[8]

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[1] Merriam-Webster. (2006-2007). *Merriam-Webster's online dictionary.* Retrieved January 31, 2007, from http://www.m-w.com/cgi-bin/dictionary

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[4] Adapted from Merriam-Webster. (2006-2007). *Merriam-Webster's online dictionary.* Retrieved January 31, 2007, from http://www.m-w.com/cgi-bin/dictionary

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[6] Adapted from Colman, A. M. (2006). A dictionary of psychology. In *Oxford Reference Online*. Retrieved September 29, 2006 from http://www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t87.e6674

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[8] understanding. (n.d.). *The American Heritage® Dictionary of the English Language, Fourth Edition*. Retrieved January 31, 2007, from Dictionary.com website: http://dictionary.reference.com/browse/understanding

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AMTA CODE OF ETHICS

(Revised 11/09)

Preamble

The members of the American Music Therapy Association, Inc., hereby recognize and publicly accept the proposition that the fundamental purposes of the profession are the progressive development of the use of music to accomplish therapeutic aims and the advancement of training, education, and research in music therapy. Music therapy is an allied health profession and clinical process, facilitated by a music therapist, in which music is used within a therapeutic relationship to address physical, psychological, cognitive, social, spiritual, or palliative care needs of individuals or groups. Our objectives are to determine and utilize music therapy approaches that effectively aid in the restoration, maintenance, and improvement in mental and physical health. To that end, we believe in the dignity and worth of every person. We promote the use of music in therapy, establish and maintain high standards in public service, and require of ourselves the utmost in ethical conduct.

This Code of Ethics is applicable to all those holding the MT-BC credential or a professional designation of the National Music Therapy Registry and professional membership in the American Music Therapy Association. This Code of Ethics is also applicable to music therapy students and interns under clinical supervision. We shall not use our professional positions or relationships, nor permit ourselves or our services to be used by others for purposes inconsistent with the principles set forth in this document. Upholding our right to freedom of inquiry and communication, we accept the responsibilities inherent in such freedom: competency, objectivity, consistency, integrity, and continual concern for the best interests of society and our profession. Therefore, we collectively and individually affirm the following declarations of professional conduct.

1.0 Professional Competence and Responsibilities

1.1 The MT will perform only those duties for which he/she has been adequately trained, not engaging outside his/her area of competence.

1.2 The MT will state his/her qualifications, titles, and professional affiliation(s) accurately.

1.3 The MT will participate in continuing education activities to maintain and improve his/her knowledge and skills.

1.4 The MT will assist the public in identifying competent and qualified music therapists and will discourage the misuse and incompetent practice of music therapy.

1.5 The MT is aware of personal limitations, problems, and values that might interfere with his/her professional work and, at an early stage, will take whatever action is necessary (i.e., seeking professional help, limiting or discontinuing work with clients, etc.) to ensure that services to clients are not affected by these limitations and problems.

1.6 The MT respects the rights of others to hold values, attitudes, and opinions that differ from his/her own.

1.7 The MT does not engage in sexual harassment.

1.8 The MT accords sexual harassment grievants and respondents dignity and respect, and does not base decisions solely upon their having made, or having been the subject of, sexual harassment charges.

1.9 The MT practices with integrity, honesty, fairness, and respect for others.

1.10 The MT delegates to his/her employees, students, or co-workers only those responsibilities that such persons can reasonably be expected to perform competently on the basis of their training and experience. The MT takes reasonable steps to see that such persons perform services competently; and, if institutional policies prevent fulfillment of this obligation, the MT attempts to correct the situation to the extent feasible.

2.0 General Standards

2.1 The MT will strive for the highest standards in his/her work, offering the highest quality of services to clients/students.

2.2 The MT will use procedures that conform with his/her interpretation of the Standards of Clinical Practice of the American Music Therapy Association, Inc.

2.3 Moral and Legal Standards

2.3.1 The MT respects the social and moral expectations of the community in which he/she works. The MT is aware that standards of behavior are a personal matter as they are for other citizens, except as they may concern the fulfillment of professional duties or influence the public attitude and trust towards the profession.

2.3.2 The MT refuses to participate in activities that are illegal or inhumane, that violate the civil rights of others, or that discriminate against individuals based upon race, ethnicity, language, religion, marital status, gender, sexual orientation, age, ability, socioeconomic status, or political affiliation. In addition, the MT works to eliminate the effect on his or her work of biases based upon these factors.

3.0 Relationships with Clients/Students/Research Subjects

3.1 The welfare of the client will be of utmost importance to the MT.

3.2 The MT will protect the rights of the individuals with whom he/she works. These rights will include, but are not limited to the following:

- right to safety;
- right to dignity;
- legal and civil rights;
- right to treatment;
- right to self-determination;
- right to respect; and
- right to participate in treatment decisions.

3.3 The MT will not discriminate in relationships with clients/students/research subjects because of race, ethnicity, language, religion, marital status, gender, sexual orientation, age, ability, socioeconomic status or political affiliation.

3.4 The MT will not exploit clients/students/research subjects sexually, physically, financially or emotionally.

3.5 The MT will not enter into dual relationships with clients/students/research subjects and will avoid those situations that interfere with professional judgment or objectivity (e.g., those involving competitive and/or conflicting interests) in their relationships.

3.6 The MT will exert caution in predicting the results of services offered, although a reasonable statement of prognosis and/or progress may be made. The MT will make only those claims to clients concerning the efficacy of services that would be willingly submitted for professional scrutiny through peer review, publication in a professional journal, or documentation in the client's record.

3.7 The MT will offer music therapy services only in the context of a professional relationship and in a setting which insures safety and protection for both client and therapist. The MT will avoid deception in representations of music therapy to the public.

3.8 The MT will inform the client and/or guardian as to the purpose, nature, and effects of assessment and treatment.

3.9 The MT will use every available resource to serve the client best.

3.10 The MT will utilize the profession's Standards of Clinical Practice as a guideline in accepting or declining referrals or requests for services, as well as in terminating or referring clients when the client no longer benefits from the therapeutic relationship.

3.11 In those emerging areas of practice for which generally recognized standards are not yet defined, the MT will nevertheless utilize cautious judgment and will take reasonable steps to ensure the competence of his/her work, as well as to protect clients, students, and research subjects from harm.

3.12 Confidentiality

3.12.1 The MT protects the confidentiality of information obtained in the course of practice, supervision, teaching, and/or research.

3.12.2 In compliance with federal, state and local regulations and organizational policies and procedures, confidential information may be revealed under circumstances which include but are not limited to:

a. when, under careful deliberation, it is decided that society, the client, or other individuals appear to be in imminent danger. In this situation, information may be shared only with the appropriate authorities, professionals or others. The client is made aware of this when possible and if reasonable.

b. when other professionals within a facility or agency are directly related with the case or situation.

c. when the client consents to the releasing of confidential information.

d. when compelled by a court or administrative order or subpoena, provided such order or subpoena is valid and served in accordance with applicable law.

3.12.3 The MT informs clients of the limits of confidentiality prior to beginning treatment.

3.12.4 The MT disguises the identity of the client in the presentation of case materials for research and teaching. Client or guardian consent is obtained, with full disclosure of the intended use of the material.

3.12.5 All forms of individually identifiable client information, including, but not limited to verbal, written, audio, video and digital will be acquired with the informed client or guardian consent and will be maintained in a confidential manner by the MT. Also, adequate security will be exercised in the preservation and ultimate disposition of these records.

3.12.6 Information obtained in the course of evaluating services, consulting, supervision, peer review, and quality assurance procedures will be kept confidential.

4.0 Relationships with Colleagues

4.1 The MT acts with integrity in regard to colleagues in music therapy and other professions and will cooperate with them whenever appropriate.

4.2 The MT will not offer professional services to a person receiving music therapy from another music therapist except by agreement with that therapist or after termination of the client's relationship with that therapist.

4.3 The MT will attempt to establish harmonious relations with members from other professions and professional organizations and will not damage the professional reputation or practice of others.
4.4 The MT will share with other members of the treatment team information concerning evaluative and therapeutic goals and procedures used.

5.0 Relationship with Employers
5.1 The MT will observe the regulations, policies, and procedures of employers with the exception of those that are in violation of this code of ethics.
5.2 The MT will inform employers of conditions that may limit the effectiveness of the services being rendered.
5.3 When representing the employer or agency, the MT will differentiate personal views from those of the profession, the employer, and the agency.
5.4 The MT will provide services in an ethical manner and will protect the property, integrity, and reputation of the employing agency.
5.5 The MT will utilize the agency's facilities and resources only as authorized.
5.6 The MT will not use his/her position to obtain clients for private practice, unless authorized to do so by the employing agency.

6.0 Responsibility to Community/Public
6.1 The MT will strive to increase public awareness of music therapy.
6.2 The MT engaged in a private practice or business will abide by federal, state and local regulations relevant to self-employment including but not limited to professional liability, registering and maintaining a business, tax codes and liability, confidentiality and reimbursement.

7.0 Responsibility to the Profession/Association
7.1 The MT respects the rights, rules, and reputation of his/her professional association.
7.2 The MT will distinguish personal from professional views when acting on behalf of his/her association. The MT will represent the association only with appropriate authorization.
7.3 The MT will strive to increase the level of knowledge, skills, and research within the profession.
7.4 The MT will refrain from the misuse of an official position within the association.
7.5 The MT will exercise integrity and confidentiality when carrying out his/her official duties in the association.

8.0 Research
8.1 The MT establishes a precise agreement with research subjects prior to their participation in the study. In this agreement, the responsibilities and rights of all parties are explained, and written consent is obtained. The MT explains all aspects of the research that might influence the subject's willingness to participate, including all possible risks and benefits. The MT will avoid any deception in research.
8.2 Participation of subjects in music therapy research will be voluntary. To ensure ethical research practices, appropriate authorization will be obtained from the subjects involved (or specified and/or legal guardians) and the facility's Institutional Review Board or other

similar consulting agency. The subject is free to refuse to participate or to withdraw from the research at any time without penalty or loss of services.

8.3 The MT is ultimately responsible for protecting the welfare of the research subjects, both during and after the study, in the event of after effects, and will take all precautions to avoid injurious psychological, physical, or social effects to the subjects.

8.4 The MT will store data, including written, audio, video, digital, or artistic media, in a secure location accessible to the researcher and authorized members of the research team. The researcher and authorized members of the research team will determine a set period of time after completion of the study by which all research data must be shredded or erased. The researcher or the research team may apply for a waiver allowing creation of a database given informed consent of participants.

8.5 The MT will be competent in his/her research efforts, being cognizant of his/her limits.

8.6 The MT will present his/her findings without distortion and in a manner that will not be misleading.

8.7 Publication Credit

8.7.1 Credit is assigned only to those who have contributed to a publication, in proportion to their contribution.

8.7.2 Major contributions of a professional nature made by several persons to a common project will be recognized by joint authorship.

8.7.3 Minor contributions such as editing or advising, will be recognized in footnotes or in an introductory statement.

8.7.4 Acknowledgment through specific citations will be made for unpublished as well as published material that has directly influenced the research or writing.

8.7.5 The MT who compiles and edits for publication the contribution of others will publish the symposium or report under the title of the committee or symposium, with the therapist's name appearing as chairperson or editor among those of the other contributors or committee members.

9.0 Fees and Commercial Activities

9.1 The MT accepts remuneration only for services actually rendered by himself or herself or under his or her supervision and only in accordance with professional standards that safeguard the best interest of clients and the profession.

9.2 The MT will not take financial advantage of a client. The MT will take into account the client's ability to pay. Financial considerations are secondary to the client's welfare.

9.3 Private fees may not be accepted or charged for services when the MT receives remuneration for these services by the agency.

9.4 No gratuities, gifts or favors should be accepted from clients that could interfere with the MT's decisions or judgments.

9.5 Referral sources may not receive a commission fee, or privilege for making referrals (fee-splitting).

9.6 The MT will not engage in commercial activities that conflict with responsibilities to clients or colleagues.

9.7 The materials or products dispensed to clients should be in the client's best interest, with the client's having the freedom of choice. The MT will not profit from the sale of equipment/materials to clients. Charges for any materials will be separate from the bill for services.

10.0 Announcing Services

10.1 The MT will adhere to professional rather than commercial standards in making known his or her availability for professional services. The MT will offer music therapy services only in a manner that neither discredits the profession nor decreases the trust of the public in the profession.

10.2 The MT will not solicit clients of other MT's.

10.3 The MT will make every effort to ensure that public information materials are accurate and complete in reference to professional services and facilities.

10.4 The MT will avoid the following in announcing services: misleading or deceptive advertising, misrepresentation of specialty, guarantees or false expectations, and the use of the Association's logo.

10.5 The MT will differentiate between private practice and private music studio in announcing services.

10.6 The following materials may be used in announcing services (all of which must be dignified in appearance and content): announcement cards, brochures, letterhead, business cards and the internet. The MT may include the following on these materials: name, title, degrees, schools, dates, certification, location, hours, contact information, and an indication of the nature of the services offered.

10.7 Announcing services through the mail (to other professionals), a listing in the telephone directory, or the internet (i.e., email, website) are acceptable. No advertisement or announcement will be rendered in a manner that will be untruthful and/or deceive the public.

11.0 Education (Teaching, Supervision, Administration)

11.1 The MT involved in teaching establishes a program combining academic, research, clinical, and ethical aspects of practice. The program will include a wide range of methods and exposure to and application of current literature.

11.2 The MT involved in education and/or supervision will use his/her skill to help others acquire the knowledge and skills necessary to perform with high standards of professional competence.

11.3 Theory and methods will be consistent with recent advances in music therapy and related health fields. The MT involved in education will teach new techniques or areas of study only after first undertaking appropriate training, supervision, study, and/or consultation from persons who are competent in those areas or techniques.

11.4 The MT involved in the education of students and internship training will ensure that clinical work performed by students is rendered under adequate supervision by other music therapists, other professionals, and/or the MT educator.

11.5 The MT involved in education and/or supervision will evaluate the competencies of students as required by good educational practices and will identify those students whose limitations impede performance as a competent music therapist. The MT will recommend only those students for internship or membership whom he/she feels will perform as competent music therapists and who meet the academic, clinical, and ethical expectations of the American Music Therapy Association, Inc.

11.6 The MT involved in the education of students and internship training will serve as an exemplary role model in regard to ethical conduct and the enforcement of the Code of Ethics.

11.7 The MT involved in education and training will ensure that students and interns operate under the same ethical standards that govern professionals.

12.0 Implementation

12.1 *Confronting Ethical Issues*

- 12.1.1 MT's have an obligation to be familiar with this Code of Ethics.
- 12.1.2 When a MT is uncertain whether a particular situation or course of action would violate this Code of Ethics, the MT should consult with a member of the Ethics Board.
- 12.1.3 A MT will not disobey this code, even when asked to do so by his/her employer.
- 12.1.4 The MT has an obligation to report ethical violations of this Code by other MT's to the Ethics Board.
- 12.1.5 The MT does not report or encourage reporting of ethics grievances that are frivolous and are intended to harm the respondent rather than to protect the public and preserve the integrity of the field of music therapy.
- 12.1.6 The MT cooperates in ethics investigations, proceedings, and hearings. Failure to cooperate is, itself, an ethics violation.
- 12.1.7 Grievances may be reported by any individual or group who has witnessed an apparent ethical violation by a Music Therapist.
- 12.1.8 Neither the Chair nor any other member of the Ethics Board will take part in the informal or formal resolution procedures if s/he has a conflict of interest.

12.2 *Informal Resolution of Ethical Violations*

- 12.2.1 Upon observing or becoming aware of alleged violations of this Code of Ethics by an MT (hereinafter referred to as the respondent), the observer will consult first with the respondent involved and discuss possible actions to correct the alleged violation when such consultation is appropriate for the resolution of the ethical violation. The MT should document these efforts at informal resolution. In some instances, the individual consultation between the observer and the respondent may be either inappropriate or not feasible. In such instances (which may include, but are not limited to: sexual harassment, fear of physical retaliation, and imminent threats to the observer's employment), the observer should file a formal grievance with an explanation of the reason why individual consultation was not appropriate or feasible.

12.3 *Formal Resolution of Ethical Violations*

- 12.3.1 If an apparent ethical violation is not appropriate for informal resolution or is not resolved through consultation, the observer (herein referred to as the grievant) will submit a written report (herein referred to as the grievance) describing the alleged violation(s) to a member of the Ethics Board. The written report will consist of the following: (a) a signed, dated summary, not longer than one page, of the principle allegations (hereinafter referred to as the charge) against the respondent; (b) a thorough explanation of the alleged violation(s); (c) a summary of informal resolution attempts, when such have been made; and (d) collaborative documentation, including signed statements by witnesses, if available.
- 12.3.2 The grievance must be made within one year of the last instance of the alleged violation(s) of this code.
- 12.3.3 Upon receipt of the grievance by the member of the Ethics, the member in consultation with the Ethics Chairperson and the Executive Director of AMTA

will advise the MT respondent, in writing and within 45 days, that an ethics grievance has been made against him/her. Included in this notification will be a copy of the signed charge. The Ethics Board member will invite the respondent to submit a written defense within 60 days, including corroborative documentation and/or signed statements by witnesses, if available.

12.3.4 The Ethics Chairperson, or his/her designee from the Ethics Board, will conduct an initial inquiry into the grievance to confirm (a) the seriousness of the charge and (b) the possibility of resolution of the issue without a formal hearing.

12.3.5 After the initial inquiry, the Ethics Chairperson or designee may, at his or her discretion, negotiate a resolution to the grievance that will be presented in writing to the grievant and the respondent. If both parties agree to this resolution, they will sign and abide by the terms therein stated.

12.3.6 The initial inquiry by the Ethics Chairperson or designee, and negotiated attempts at a resolution, will be conducted within 45 days following receipt of the respondent's defense.

12.3.7 If agreement to a negotiated resolution is not reached, or if 45 days have passed following receipt of the respondent's defense, the Ethics Chairperson will initiate the formal procedure. At that time the Ethics Chairperson will inform in writing the Ethics Board, the Executive Director of AMTA, the President of AMTA, the grievant, and the respondent that the formal hearing procedure has begun and appoint a chair for the hearing panel.

12.4 *Group Grievances*

12.4.1 If the Ethics Chairperson or designee receives more than one grievance related in a substantive way against the same party, the chair or designee may choose to combine the grievances into a single grievance, as long as there is no objection to such combination by the individual grievants. In this instance, the procedure heretofore established will remain the same.

12.4.2 If two or more individuals report a grievance against the same party, they may report a group grievance. This will be handled as a single grievance, following established procedures.

12.4.3 An employing agency may charge a MT with a violation of this Code of Ethics in the same manner as an individual grievant does so. The employing agency will appoint a representative to function in the role of grievant.

12.5 *Corrective Actions*

12.5.1 If the individual takes no corrective action within the designated time-limit, the panel chair will reconvene the hearing panel to determine recommended sanctions to the Board of Directors for action. Possible sanctions may include, but are not limited to:

(a) permanent or time-specific withdrawal of an individual's membership in the Association;

(b) rehabilitative activity, such as personal therapy;

(c) a binding agreement by the respondent to conform his/her practice, education/training methods, or research methods to AMTA rules and guidelines;

(d) a written reprimand;

(e) recommendation to the National Music Therapy Registry or the Certification Board for Music Therapists (as appropriate) for the withdrawal of professional designation or credential. The MT may appeal the decision of the Ethics Board to the Judicial Review Board.

AMERICAN MUSIC THERAPY ASSOCIATION

LEVELS OF PRACTICE IN MUSIC THERAPY

ADOPTED NOVEMBER 18, 2005
AMENDED NOVEMBER 22, 2008

History and Rationale for Delineating Levels of Practice in Music Therapy

When the Commission on Education and Clinical Training made its recommendations to the Association, some of the recommendations in its 2000 report to the Assembly of Delegates were not adopted in the *Standards for Education and Clinical Training* and were appended to that document as "Issues for Future Consideration." The Commission also recommended changes in the organizational structure, to include committees on Program Approval and Internship Roster, as well as an Overview Committee. The Overview Committee was to be charged with internal and external monitoring of standards, considering competency requirements, examining trends and needs, giving advice concerning the Association's role and responsiveness in the areas of education and training, and acting as liaison to the Certification Board for Music Therapists (CBMT) and other outside agencies. The 2001 report of the Implementation Task Force supported the changes in the organizational structure recommended by the Commission.

In 2001 the Assembly of Delegates charged a Task Force on Organizational Restructuring to develop this new structure. In 2002, the Assembly adopted the proposed new organizational structure, which included an Education and Training Advisory Board. This board was created to serve as a visionary body to advise, inform, and make recommendations to the American Music Therapy Association (AMTA) on issues related to music therapy education and training. It was charged to analyze policy issues that focus on standards and professional competencies for advanced levels of education and training; and more specifically, the relationship of these standards and competencies to advanced degrees, education and training requirements, levels of practice, professional titles and designations, and various state licensures.

In carrying out these charges, the Education and Training Advisory Board was to address the "Issues for Future Consideration." Prior to its first meeting in November 2003, the Advisory Board reviewed a comprehensive packet of published literature, AMTA documents, and AMTA internal reports related to music therapy education and training from 1960 to the present. At the meeting, the Advisory Board discussed the literature and then focused on the prioritization of tasks. The Advisory Board determined that it was necessary to delineate levels of practice in music therapy in order to provide the foundation for the development of advanced competencies. From its inception, the Advisory Board worked according to one fundamental principle: that no recommendation would be forwarded to the Association unless it was unanimous.

After much discussion, the Advisory Board agreed that defining levels of practice in music therapy was a top priority for the profession as well as a foundation for other high priority tasks. Each Advisory Board member then researched and wrote a paper from her/his respective area of expertise related to this topic.

Differential levels of music therapy clinical practice have been described for decades in the music therapy literature (Bruscia, 1989, 1998; Gfeller & Thaut, 1999; Maranto, 1993; Scartelli, 1989; Standley, 1989; Wheeler, 1983). Suggested levels have been based on types of goals, depth and extent of services, and/or independence of the music therapist. Gfeller and Thaut, Scartelli, and Standley related levels of practice

to educational preparation. The Commission on Education and Clinical Training (AMTA, 1999) similarly suggested that while the Bachelor's degree is designed to impart Professional Competencies for music therapy practice, the Master's degree could prepare the music therapist to work at a more advanced level, "depending on the clinical components of the degree program" while the doctoral degree would not only provide competence in research, teaching, and supervision, but also advanced competency in a "specialization area in music therapy."

The clinical music therapy literature describes several music therapy models that require substantial training and expertise beyond the AMTA Professional Competencies. These models include Analytical Music Therapy (AMT; Priestly, 1994), the Bonny Method of Guided Imagery and Music (BMGIM; Grocke & Bruscia, 2002), and Nordoff-Robbins Music Therapy (NRMT; Nordoff & Robbins, 1977). Several authors have described other treatment approaches that represent advanced or highly specialized clinical practice (e.g., Austin, 2001; Gfeller, 2001) or advanced areas of practice such as supervision (e.g., Forinash, 2001) and education and training (e.g., Wheeler, 2003; Wigram, Pedersen, & Bonde, 2002). Still others have modeled a level of practice beyond the Professional Competencies by developing methods of assessment (e.g., Coleman & Brunk, 1999; Wigram, 2000) or by proposing theories of music therapy (e.g., Kenny, 1989; Thaut, 2000).

The urgency of the need for AMTA to define levels of music therapy practice has increased with recent legislative and regulatory actions in several states that have specified how and under what circumstances music therapists may practice. By defining levels of music therapy practice, AMTA will be prepared proactively to partner with state legislatures and regulatory bodies in the development of occupational regulations that affect music therapy services.

Defining levels of practice in music therapy serves as the foundation toward achieving the following objectives for the Association:

1. Identify advanced competencies, both global and in areas of specialization, along with analysis of existing professional competencies
2. Develop education and clinical standards for graduate degree programs
3. Support the Academic Program Approval Committee in reviewing AMTA approved academic programs that are reapplying for AMTA program approval, as well as new programs applying for initial approval
4. Provide information for government relations work dealing with state licensures and employment practices (e.g., job descriptions, salaries, populations, scope of practice).
5. Support efforts in seeking reimbursement and financing of MT services
6. Support public relations efforts in professional recognition and perception of music therapy by other professions and the public
7. Support efforts in continuing education by providing a framework for defining what constitutes specialized trainings, advanced trainings, and other types of continuing education opportunities
8. Provide a basis for developing advanced professional designations and/or credentials
9. Support research efforts in music therapy
10. Stimulate continued growth of music therapists and the profession

In November 2004 the Advisory Board began its deliberations on defining levels of practice, which continued through a mid-year retreat in July 2005. Following the retreat, the Advisory Board issued the following Advisory on Levels of Practice for consideration by the AMTA Board of Directors, Assembly of Delegates, Regions, and membership.

Preamble

This Advisory distinguishes two Levels of Practice within the music therapy profession. In presenting a framework for these Levels of Practice, the Advisory Board has described characteristics, preparation, and skills within four domains for each of two levels of practice. For the advanced level, types of experiences that may lead to an advanced level of practice also are offered.

In making a distinction between professional practice and advanced professional practice, the Advisory Board recognizes that music therapy practice exists on a developmental continuum. This continuum represents both breadth and depth in levels of practice and may be viewed from the perspective of a "gestalt," where the whole is greater than the sum of its parts. Considering this developmental continuum, the Advisory Board felt that Abraham Maslow's (1971) principles of human development closely matched our perception of the field and its members; that is, professional music therapists are always in a process of "becoming." Moreover, the Advisory Board acknowledges that a music therapist may practice at an advanced level in a specific role or with a specific population; however, the level of practice may shift when the therapist takes on a distinctly different role or serves a different population , e.g., from clinician to supervisor or from developmental disabilities to mental health.

In deliberating about levels of practice, the Advisory Board debated what to label the level of practice needed to enter the profession as a practitioner. At the present time, AMTA has a document entitled "Professional Competencies" and CBMT grants a "professional" credential. For now, the Advisory Board has chosen to use the term "professional" to remain consistent with current terminology; however, the terminology may be subject to change in response to internal and external influences.

Professional Level of Practice

A music therapist at the Professional Level of Practice has a Bachelor's degree or its equivalent in music therapy and a current professional designation or credential in music therapy (i.e., ACMT, CMT, MT-BC, or RMT). At this level, the therapist has the ability to assume a supportive role in treating clients, collaborating within an interdisciplinary team to contribute to the client's overall treatment plan.

Central to the Professional Level of Practice are the characteristics of the music therapist practicing at this level. This section presents characteristics of the professional music therapist and how these contribute to professional practice.

Professional Growth

Professional growth includes the development of knowledge, skills, and abilities through education, supervision, and other professional experiences. At this level, the music therapist pursues continuing education, receives supervision, participates in a supervisory relationship, demonstrates understanding of his/her role within the organizational structure of the treatment setting, and actively seeks continued development within that structure. The therapist practices within the scope of professional preparation.

Musical Development

Musical development is the acquisition of music knowledge, aesthetic sensitivity, and skills relevant to music therapy, and the application of those skills to clinical practice. At this level, the music therapist uses music and music experiences to elicit musical and extramusical responses from clients and to support progress toward treatment goals.

Personal Development of the Therapist

Personal development involves becoming self-aware and actively seeking to further develop the self. At this level, the music therapist observes and is aware of her/his own feelings, behaviors, and limitations in order to respond therapeutically to client behaviors. S/he may actively seek personally challenging and enriching experiences in order to facilitate personal growth.

Clinical Experience

Clinical experience involves provision of music therapy services within the context of a treatment team. At this level, the music therapist utilizes music therapy techniques to meet clients musically and clinically. The music therapist demonstrates basic knowledge of assessment, treatment, documentation, and evaluation; communicates empathy and establishes therapeutic relationships; and demonstrates understanding of ethical principles and current standards of practice.

Advanced Level of Practice

Advanced Level of Practice is the practice of music therapy wherein the music therapist applies and integrates a comprehensive synthesis of theories, research, treatment knowledge, musicianship, clinical skills, and personal awareness to address client needs. A music therapist at an Advanced Level of Practice has at least a Bachelor's degree or its equivalent in music therapy, a current professional designation or credential in music therapy (i.e., ACMT, CMT, MT-BC, or RMT), professional experience, and further education and/or training (e.g., receiving clinical supervision, a graduate degree, and/or advanced training). It is anticipated that in the future music therapists at the Advanced Level of Practice will hold at least a Master's degree in music therapy that includes advanced clinical education. The advanced music therapist demonstrates comprehensive understanding of foundations and principles of music, music therapy, treatment, and management in clinical, educational, research, and/or administrative settings.

Central to the Advanced Level of Practice are the characteristics of the music therapist practicing at this level. This section presents characteristics of the advanced music therapist and how these contribute to advanced practice.

Professional Growth

Professional growth includes the development of music therapy-related knowledge, skills, and abilities through education, supervision, and other professional experiences. Education includes formal coursework, graduate degree programs, and continuing education directly related to and integrated into music therapy practice. Supervision includes observation and feedback, case consultation, and/or mentorship of music therapy practice provided by a clinical supervisor, an advanced colleague, or a graduate educator. The advanced music therapist understands major theories of clinical supervision, provides supervision, and serves as a clinical model for the supervisee. Other professional growth experiences include informal, professionally related activities, such as teaching at conferences and institutes. The advanced music therapist understands issues involved in standards, policies and procedures for clinical practice, clinical supervision, clinical administration, college/university teaching, and research. Listed below are possible ways to enhance professional growth.

Educational options include but are not limited to

- Completion of graduate degree program
- Completion of institute-based advanced training (AMT, BMGIM, NRMT)
- Graduate level courses
- Completion of continuing education credits through conferences, workshops/institutes
- Remaining current with the music therapy literature and integrating it into teaching, supervision, research and clinical practice

Supervision options include but are not limited to

- Consultation
- On-the job clinical supervision
- Contracting for private clinical supervision
- Peer supervision
- Clinically oriented in-services
- Supervised clinical experiences as part of a graduate degree program

Other professional growth options include but are not limited to

- Participation in professional committees and task forces

- Government and public relations activities on behalf of music therapy
- Publishing scholarly articles, books, monographs, etc.
- Teaching music therapy
- Professional presentations about music therapy
- Supervision of music therapy interns
- Volunteering with an unfamiliar population

Musical Development

Musical development is the broadening and deepening of both the music therapist's relationship to music and her/his musicianship relevant to music therapy, and the integration of both into clinical practice. The advanced music therapist designs and conducts music experiences that are primarily process-oriented. S/he applies complex and spontaneous manipulation of multiple musical elements to facilitate and work with client responses.

Ways in which music therapists may develop musically include but are not limited to

- Actively working to broaden repertoire in response to clinical need
- Taking lessons to broaden and deepen musical skills and musicality
- Active involvement in music outside of the clinical setting (e.g., composing; attending concerts; listening to music; moving to music; or making music in bands, orchestras, choirs, houses of worship, community theaters)
- Reflecting on the way music affects people and communities emotionally, cognitively, interpersonally, spiritually, and physically
- Familiarizing oneself with various genre of music and their cultural contexts (e.g., multicultural, multi-denominational, hip-hop/rap, country/western) while recognizing one’s own cultural limitations
- Expanding skill using various forms, structures and techniques (e.g., improvisation, jazz, drumming, music technology, movement, additional styles)

Personal Growth and Development

Personal growth is the deepening awareness and actualization of the self. The advanced music therapist is aware of the role of the self and its effect on both the client and the therapeutic process. The advanced music therapist is aware of the role of self in relation to one’s own personal issues, which may affect the client and therapeutic process. The advanced music therapist integrates knowledge with empathy and is aware of resources and limitations, both personal and situational.

Ways in which music therapists may grow personally include but are not limited to

- Personal music therapy (e.g., AMT, BMGIM)
- Personal therapy (e.g., counseling, other arts therapies, psychotherapy)
- Involving oneself in new personal challenges and self-growth experiences (e.g., travel to or study of different cultures, dance classes, retreats)
- Personal growth groups (e.g., dream work, support groups, 12-step groups)
- Engagement in challenging life experiences that enhance understanding of the human condition
- Living a lifestyle that includes expression, reflection, and self-awareness (e.g., journaling, arts, meditation, other spiritual pursuits)

Integrative Clinical Experience

Integrative clinical experience is professional practice in music therapy of sufficient duration and depth to gain a comprehensive understanding of the clinical process of the client and the therapist's impact on that process. Through such experiences the music therapist moves beyond didactic knowledge to integrate rationale, theories, treatment methods, and use of self to enhance client growth and development. Based on a comprehensive understanding and integration of theories and practices in assessment, treatment, evaluation, and termination, the advanced music therapist takes a central and independent role in client treatment plans.

Given a growth motivation and a conducive work environment, clinical experiences that lead to this integration include professional activities such as

- Treatment and analysis of client progress over time
- Providing music therapy interventions within a clinically based research protocol
- Interaction with treatment team members and milieu
- Sufficient experience with many clients to recognize patterns
- Reflecting on and interpreting the clinically relevant actions of both client and self
- Partnering with the client in therapeutic process
- Collaboration and sharing with colleagues and mentors
- Assimilating relevant literature into clinical practice
- Research activities that further enhance the treatment process

Summary

This document represents an initial framework of Levels of Practice in Music Therapy. The Advisory Board envisions that Advanced Competencies will emerge from the Advanced Level of Practice and recommends that a Task Force now be appointed to develop those Competencies. The Advisory Board recognizes that the Advanced Level of Practice actually encompasses more than one level. In the future, the multiple layers within the advanced level will need to be clarified further as they emerge. The Advisory Board urges the Association to be proactive in delineating and disseminating Levels of Practice to external regulatory bodies before they define them for us.

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AMTA PROFESSIONAL COMPETENCIES

Preamble to AMTA *Professional Competencies*

The American Music Therapy Association has established competency-based standards for ensuring the quality of education and clinical training in the field of music therapy. As the clinical and research activities of music therapy provide new information, the competency requirements need to be reevaluated regularly to ensure consistency with current trends and needs of the profession and to reflect the growth of the knowledge base of the profession. The Association updates these competencies based on what knowledge, skills, and abilities are needed to perform the various levels and types of responsibilities to practice at a professional level.

In November 2005 the AMTA Assembly of Delegates adopted the *Advisory on Levels of Practice in Music Therapy.* This Advisory, which was developed by the Education and Training Advisory Board, distinguishes two Levels of Practice within the music therapy profession: Professional Level of Practice and Advanced Level of Practice. This Advisory describes the Professional Level of Practice as follows:

> A music therapist at the Professional Level of Practice has a Bachelor's degree or its equivalent in music therapy and a current professional designation or credential in music therapy (i.e., ACMT, CMT, MT-BC, or RMT). At this level, the therapist has the ability to assume a supportive role in treating clients, collaborating within an interdisciplinary team to contribute to the client's overall treatment plan.

The AMTA *Professional Competencies* are based on music therapy competencies authored for the former American Association for Music Therapy (AAMT) by Bruscia, Hesser, and Boxhill (1981). The former National Association for Music Therapy (NAMT) in turn adapted these competencies as the *NAMT Professional Competencies* revised in 1996. In its final report the Commission on Education and Clinical Training recommended the use of these competencies, and this recommendation was approved by the AMTA Assembly of Delegates in November 1999. The AMTA *Professional Competencies* has had several minor revisions since its adoption in 1999.

AMTA Professional Competencies

A. MUSIC FOUNDATIONS

1. Music Theory and History

1.1 Recognize standard works in the literature.
1.2 Identify the elemental, structural, and stylistic characteristics of music from various periods and cultures.
1.3 Sight-sing melodies of both diatonic and chromatic makeup.
1.4 Take aural dictation of melodies, rhythms, and chord progressions.
1.5 Transpose simple compositions.

2. Composition and Arranging Skills

2.1 Compose songs with simple accompaniment.
2.2 Adapt, arrange, transpose, and simplify music compositions for small vocal and non-symphonic instrumental ensembles.

3. Major Performance Medium Skills

3.1 Perform appropriate undergraduate repertoire; demonstrate musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice.
3.2 Perform in small and large ensembles.

4. Keyboard Skills

4.1 Accompany self and ensembles proficiently.
4.2 Play basic chord progressions (I-IV-V-I) in several keys.
4.3 Sight-read simple compositions and song accompaniments.
4.4 Play a basic repertoire of traditional, folk, and popular songs with or without printed music.
4.5 Harmonize and transpose simple compositions.

5. Guitar Skills

5.1 Accompany self and ensembles proficiently.
5.2 Employ simple strumming and finger picking techniques.
5.3 Tune guitar using standard and other tunings.
5.4 Perform a basic repertoire of traditional, folk, and popular songs with or without printed music.
5.5 Harmonize and transpose simple compositions in several keys.

6. Voice Skills

6.1 Lead group singing by voice.
6.2 Communicate vocally with adequate volume (loudness).
6.3 Sing a basic repertoire of traditional, folk, and popular songs in tune with a pleasing quality.

7. Percussion Skills

7.1 Accompany self and ensembles proficiently.
7.2 Utilize basic techniques on several standard and ethnic instruments.
7.3 Lead rhythm-based ensembles proficiently.

8. Non-symphonic Instrumental Skills

8.1 Care for and maintain non-symphonic and ethnic instruments.
8.2 Play autoharp or equivalent with same competence specified for guitar.
8.3 Utilize electronic musical instruments.

9. Improvisation Skills

9.1 Improvise on percussion instruments.
9.2 Develop original melodies, simple accompaniments, and short pieces extemporaneously in a variety of moods and styles, vocally and instrumentally.
9.3 Improvise in small ensembles.

10. Conducting Skills

10.1 Conduct basic patterns with technical accuracy.
10.2 Conduct small and large vocal and instrumental ensembles.

11. Movement Skills

11.1 Direct structured and improvisatory movement experiences.
11.2 Move in structural rhythmic and improvisatory manners for expressive purposes.
11.3 Move expressively and with interpretation to music within rhythmic structure.

B. CLINICAL FOUNDATIONS

12. Exceptionality

12.1 Demonstrate basic knowledge of the potentials, limitations, and problems of exceptional individuals.
12.2 Demonstrate basic knowledge of the causes and symptoms of major exceptionalities, and basic terminology used in diagnosis and classification.
12.3 Demonstrate basic knowledge of typical and atypical human systems and development (e.g. anatomical, physiological, psychological, social.)

13. Principles of Therapy

13.1 Demonstrate basic knowledge of the dynamics and processes of a therapist-client relationship.
13.2 Demonstrate basic knowledge of the dynamics and processes of therapy groups.
13.3 Demonstrate basic knowledge of accepted methods of major therapeutic approaches.

14. The Therapeutic Relationship

14.1 Recognize the impact of one's own feelings, attitudes, and actions on the client and the therapy process.
14.2 Establish and maintain interpersonal relationships with clients that are conducive to therapy.
14.3 Use oneself effectively in the therapist role in both individual and group therapy, e.g. appropriate self-disclosure, authenticity, empathy, etc. toward affecting desired behavioral outcomes.
14.4 Utilize the dynamics and processes of groups to achieve therapeutic goals
14.5 Demonstrate awareness of one’s cultural heritage and socio-economic background and how these influence the perception of the therapeutic process.

C. MUSIC THERAPY

15. Foundations and Principles

15.1 Demonstrate basic knowledge of existing music therapy methods, techniques, materials, and equipment with their appropriate applications.
15.2 Demonstrate basic knowledge of principles, and methods of music therapy assessment and their appropriate application.
15.3 Demonstrate basic knowledge of the principles and methods for evaluating the effects of music therapy.
15.4 Demonstrate basic knowledge of the purpose, intent, and function of music therapy for various client populations.
15.5 Demonstrate basic knowledge of the psychological and physiological aspects of musical behavior and experience (i.e. music and affect; influence of music on behavior; physiological responses to music; perception and cognition of music; psychomotor components of music behavior; music learning and development; preference; creativity).
15.6 Demonstrate basic knowledge of philosophical, psychological, physiological, and sociological bases for the use of music as therapy.
15.7 Demonstrate basic knowledge of the use of current technologies in music therapy assessment, treatment, and evaluation.

16. Client Assessment

- 16.1 Communicate assessment findings and recommendations in written and verbal forms.
- 16.2 Observe and record accurately the client's responses to assessment.
- 16.3 Identify the client's appropriate and inappropriate behaviors.
- 16.4 Select and implement effective culturally based methods for assessing the client's assets, and problems through music.
- 16.5 Select and implement effective culturally based methods for assessing the client's musical preferences and level of musical functioning or development.
- 16.6 Identify the client's therapeutic needs through an analysis and interpretation of music therapy and related assessment data.
- 16.7 Demonstrate knowledge of professional Standards of Clinical Practice regarding assessment.

17. Treatment Planning

- 17.1 Select or create music therapy experiences that meet the client's objectives.
- 17.2 Formulate goals and objectives for individuals and group therapy based upon assessment findings.
- 17.3 Identify the client's primary treatment needs in music therapy.
- 17.4 Provide preliminary estimates of frequency and duration of treatment.
- 17.5 Select and adapt music consistent with strengths and needs of the client.
- 17.6 Formulate music therapy strategies for individuals and groups based upon the goals and objectives adopted.
- 17.7 Select and adapt musical instruments and equipment consistent with strengths and needs of the client.
- 17.8 Organize and arrange the music therapy setting to facilitate the client's therapeutic involvement.
- 17.9 Plan and sequence music therapy sessions.
- 17.10 Determine the client's appropriate music therapy group and/or individual placement.
- 17.11 Coordinate treatment plan with other professionals.
- 17.12 Demonstrate knowledge of professional Standards of Clinical Practice regarding planning.

18. Therapy Implementation

- 18.1 Recognize, interpret, and respond appropriately to significant events in music therapy sessions as they occur.
- 18.2 Provide music therapy experiences to
  - 18.2.1 Change nonmusical behavior;
  - 18.2.2 Assist the client's development of social skills;
  - 18.2.3 Improve the client's sense of self and self with others;
  - 18.2.4 Elicit social interactions from the client;
  - 18.2.5 Promote client decision making;
  - 18.2.6 Assist the client in increasing on task behavior;
  - 18.2.7 Elicit affective responses from the client;

18.2.8 Encourage creative responses from the client;
18.2.9 Improve the client’s orientation to person, place, and time;
18.2.10 Enhance client’s cognitive/intellectual development;
18.2.11 Develop or rehabilitate the client’s motor skills;
18.2.12 Offer sensory stimulation that allows the client to use visual, auditory, or tactile cues;
18.2.13 Promote relaxation and/or stress reduction in the client.

18.3 Provide verbal and nonverbal directions and cues necessary for successful client participation.
18.4 Provide models for appropriate social behavior in group music therapy.
18.5 Utilize therapeutic verbal skills in music therapy sessions.
18.6 Communicate to the client's expectations of their behavior.
18.7 Provide feedback on, reflect, rephrase, and translate the client's communications.
18.8 Assist the client to communicate more effectively.
18.9 Sequence and pace music experiences within a session according to the client's needs and situational factors.
18.10 Conduct or facilitate group and individual music therapy.
18.11 Implement music therapy program according to treatment plan.
18.12 Promote a sense of group cohesiveness and/or a feeling of group membership.
18.13 Create a physical environment (e.g. arrangement of space, furniture, equipment, and instruments) that is conducive to effective therapy.
18.14 Develop and maintain a repertoire of music for age, culture, and stylistic differences.
18.15 Recognize and respond appropriately to effects of the client's medications.
18.16 Establish closure of music therapy sessions.
18.17 Establish closure of treatment issues.
18.18 Demonstrate knowledge of professional Standards of Clinical Practice regarding implementation.

19. Therapy Evaluation

19.1 Recognize and respond appropriately to situations in which there are clear and present dangers to the client and/or others.
19.2 Modify treatment approaches based on the client's response to therapy.
19.3 Recognize significant changes and patterns in the client's response to therapy.
19.4 Revise treatment plan as needed.
19.5 Establish and work within realistic time frames for evaluating the effects of therapy.
19.6 Review treatment plan periodically within guidelines set by agency.
19.7 Design and implement methods for evaluating and measuring client progress and the effectiveness of therapeutic strategies.
19.8 Demonstrate knowledge of professional Standards of Clinical Practice regarding evaluation.

20. Documentation

- 20.1 Produce documentation that accurately reflect client outcomes and meet the requirements of internal and external legal, regulatory, and reimbursement bodies.
- 20.2 Document clinical data.
- 20.3 Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner.
- 20.4 Communicate orally with the client, parents, significant others, and team members regarding the client's progress and various aspects of the client's music therapy program.
- 20.5 Document and revise the treatment plan and document changes to the treatment plan.
- 20.6 Develop and use data-gathering techniques during all phases of the clinical process including assessment, treatment, and evaluation.
- 20.7 Demonstrate knowledge of professional Standards of Clinical Practice regarding documentation.

21. Termination/Discharge Planning

- 21.1 Inform and prepare the client for approaching termination from music therapy.
- 21.2 Establish closure of music therapy services by time of termination/discharge.
- 21.3 Determine termination of the client from music therapy.
- 21.4 Integrate music therapy termination plan with plans for the client's discharge from the facility.
- 21.5 Assess potential benefits/detriments of termination of music therapy.
- 21.6 Develop music therapy termination plan.
- 21.7 Demonstrate knowledge of professional Standards of Clinical Practice regarding termination.

22. Professional Role/Ethics

- 22.1 Interpret and adhere to the AMTA Code of Ethics.
- 22.2 Adhere to professional Standards of Clinical Practice.
- 22.3 Demonstrate dependability: follow through with all tasks regarding education and professional training.
- 22.4 Accept criticism/feedback with willingness and follow through in a productive manner.
- 22.5 Resolve conflicts in a positive and constructive manner.
- 22.6 Meet deadlines without prompting.
- 22.7 Express thoughts and personal feelings in a consistently constructive manner.
- 22.8 Demonstrate critical self-awareness of strengths and weaknesses.
- 22.9 Demonstrate knowledge of and respect for diverse cultural backgrounds.
- 22.10 Treat all persons with dignity and respect, regardless of differences in race, religion, ethnicity, sexual orientation, or gender.
- 22.11 Demonstrate skill in working with culturally diverse populations.
- 22.12 Apply laws and regulations regarding the human rights of the clients.
- 22.13 Respond to legislative issues affecting music therapy.

22.14 Demonstrate basic knowledge of professional music therapy organizations and how these organizations influence clinical practice.
22.15 Demonstrate basic knowledge of music therapy service reimbursement and financing sources (e.g., Medicare, Medicaid, Private Health Insurance, State and Local Health and/or Education Agencies, Grants).

23. Interdisciplinary Collaboration

23.1 Demonstrate a basic understanding of the roles and develop working relationships with other disciplines in the client's treatment program.
23.2 Communicate to other departments and staff the rationale for music therapy services and the role of the music therapist.
23.3 Define the role of music therapy in the client's total treatment program.
23.4 Collaborate with team members in designing and implementing interdisciplinary treatment programs.

24. Supervision and Administration

24.1 Participate in and benefit from supervision.
24.2 Manage and maintain music therapy equipment and supplies.
24.3 Perform administrative duties usually required of clinicians (e.g. scheduling therapy, programmatic budgeting, maintaining record files).
24.4 Write proposals to create and/or establish new music therapy programs.

25. Research Methods

25.1 Interpret information in the professional research literature.
25.2 Demonstrate basic knowledge of the purpose of historical, quantitative, and qualitative research.
25.3 Perform a data-based literature search.
25.4 Apply selected research findings to clinical practice.

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STANDARDS FOR EDUCATION AND CLINICAL TRAINING

Adopted 2000
Revised 2010

AMTA STANDARDS FOR EDUCATION AND CLINICAL TRAINING

Preamble

The American Music Therapy Association, Inc., aims to establish and maintain competency-based standards for all three levels of education (bachelor's, master's, and doctoral), with guidelines for the various curricular structures appropriate to different degrees, as defined by the National Association of Schools of Music (NASM). Using this competency-based system, the Association formulates competency objectives or learning outcomes for the various degree programs, based on what knowledge, skills, and abilities are needed by music therapists to work in various capacities in the field. Academic institutions should take primary responsibility for designing, providing, and overseeing the full range of learning experiences needed by students to acquire these competencies, including the necessary clinical training.

A bachelor's degree program should be designed to impart professional level competencies as specified in the *AMTA Professional Competencies,* while also meeting the curricular design outlined by NASM. Since education and clinical training form an integrated continuum for student learning at the professional level, academic institutions should take responsibility not only for academic components of the degree, but also for the full range of clinical training experiences needed by students to achieve competency objectives for the degree. This would include developing and overseeing student placements for both pre-internship and internship training.

A master's degree program should be designed to impart selected and specified advanced competencies, drawn from the *AMTA Advanced Competencies*, which would provide breadth and depth beyond the *AMTA Professional Competencies* that are required for entrance into the music therapy profession. At this level the degree should address the practice of music therapy wherein the music therapist applies and integrates a comprehensive synthesis of theories, research, treatment knowledge, musicianship, clinical skills, and personal awareness to address client needs. The curricular design would be appropriate to the degree title, per agreement between AMTA and NASM.

The doctoral degree should be designed to impart advanced competence in research, theory development, clinical practice, supervision, college teaching, and/or clinical administration, depending upon the title and purpose of the program. AMTA will work with NASM in the delineation of the doctoral degree in music therapy.

Academic institutions and internship sites should take primary responsibility for assuring the quality of their programs, jointly and/or separately. This is accomplished by regular, competency-based evaluations of their programs and graduates by faculty, supervisors, and/or students. The Association will assure the quality of education and clinical training through its approval standards and review procedures. The Association encourages diversity among institutions and programs and respects the operational integrity within academic and clinical training programs.

In implementing these standards, the Association shares the beliefs that education and clinical training are not separate processes, but reflect a continuum of music therapy education; that education and clinical training must be competency based at all levels; that education and clinical training must be student centered; and that education and clinical training must exist in a perspective of continuous change to remain current. The Association also believes in the importance of music as central to music therapy and that music study must be at the core of education and clinical training.

The Association's standards are based on a vision of the future for music therapy education and clinical training. In establishing and maintaining these standards, it has a responsibility related to education and clinical training in relationship to the outside world that includes clients, professionals of other disciplines, and settings. The Association's relationships with the outside world include the identification of levels of professional practice and training, interface with professionals of other disciplines and with their professional associations, involvement with regulatory entities, and alliances in the private sector. The Association works from a philosophy of inclusiveness that embraces a wide range of approaches and a broad base of therapeutic models including uses of music for persons with disabilities and disease, as well as those who desire music therapy for health, wellness, and prevention. The Association must therefore give academic institutions and clinical training programs the flexibility they need to simultaneously meet student needs, market needs, client needs, and quality standards.

The Association believes it can maintain high quality in education and clinical training while it provides for maximum flexibility in the ways professional standards and competencies are implemented. It also believes that standards can be implemented in ways that prevent overregulation and micromanagement. Quality assurance for education and clinical training must be accomplished at the local level, managed by the academic faculty at the academic institutions and the music therapy supervisors at clinical training sites rather than solely by the Association. The Association shall use these competency-based standards as the basis for evaluating academic and clinical training programs and awarding its approval.

These standards must be viewed along with the Association's *Professional Competencies, Advanced Competencies, Standards of Clinical Practice, Advisory on Levels of Practice in Music Therapy, Code of Ethics, Policies and Procedures for Academic Program Approval,* and *National Roster Internship Guidelines.* In addition, academic programs in music therapy should refer to the NASM *Handbook* for general standards and competencies common to all professional baccalaureate and graduate degree programs in music, as well as specific baccalaureate and graduate degree programs in music therapy. Academic institutions and clinical training programs have the responsibility for determining how their programs will impart the required professional and/or advanced competencies to students (i.e., through which courses, requirements, clinical training experiences, etc.). The standards have been designed to allow institutions and programs to meet this responsibility in ways that are consistent with their own philosophies, objectives, and resources. All AMTA-approved academic and clinical training programs will strive to attain these standards.

AMTA STANDARDS FOR EDUCATION AND CLINICAL TRAINING

1.0 GENERAL STANDARDS FOR ACADEMIC INSTITUTIONS

1.1 Only regionally accredited, degree-granting institutions awarding at least the bachelor's degree may offer an academic program in music therapy eligible for program approval by the Association.

1.2 The Association will grant academic program approval only when every music therapy curricular program of the applicant institution (including graduate work, if offered) meets the standards of the Association. *Note: This policy excludes doctoral degree programs in music therapy until such time as AMTA and NASM have worked together to delineate the doctoral degree in music therapy.*

1.3 The administrative section of the academic institution housing the music therapy unit shall have a clearly defined organizational structure, with administrative officers who involve music therapy faculty at the appropriate level of decision making and who provide the necessary support systems for effective implementation of the program.

1.4 The music therapy unit shall be administratively organized in a way that enables students to complete the program and accomplish its educational objectives within the designated time frame.

1.5 The academic institution shall have the space, equipment, library, technology, and instrument resources necessary to support degree objectives.

1.6 The rationale and objectives of each music therapy degree program offered by the academic institution shall be clearly defined, responsive to significant trends and needs in the profession, and consistent with clinical and ethical standards of practice.

1.7 The degree title shall be consistent with educational objectives and curricular requirements of the program.

1.8 The music therapy unit shall have criteria and procedures for admission that reflect the abilities and qualities needed by the student to accomplish degree objectives. The unit shall also have criteria and procedures for determining advanced standing and transfer credit.

1.9 The music therapy unit shall have criteria and procedures for determining student retention, and specifying conditions for dismissal. These shall reflect the level of competence expected of students at various stages during and upon completion of the program.

1.10 The music therapy unit shall take primary responsibility for academic advisement and career counseling of all music therapy majors.

1.11 The music therapy unit shall conduct periodic evaluation of its programs and graduates according to competency objectives of each degree program. The results of these evaluations shall be used as the basis of program development, quality control, and change.

1.12 All music therapy programs in branch campuses or extension programs must meet all NASM Standards for Branch Campuses and External Programs.

1.13 All programs approved by the Association that offer distance learning programs must meet NASM Standards for Distance Learning and the AMTA Guidelines for Distance Learning.

2.0 STANDARDS FOR COMPETENCY-BASED EDUCATION

2.1 The Association shall establish and maintain competency-based standards for ensuring the quality of education and clinical training in the field. Specifically:

2.1.1 The Association shall establish educational objectives for academic and clinical training programs that are outcome specific. That is, the standards shall specify learning outcomes, or the various areas of knowledge, skills, and abilities that graduates will acquire as a result of the program.

2.1.2 The Association shall formulate and update these competency objectives based on what knowledge, skills, and abilities are needed by graduates to perform the various levels and types of responsibilities of a professional music therapist. As such, the standards must continually reflect current practices in both treatment and prevention, illness and wellness; embrace diverse models, orientations and applications of music therapy; address consumer needs; and stimulate growth of the discipline and profession.

2.1.3 The Association shall use these competency-based standards as the basis for evaluating academic and clinical training programs and awarding its approval.

2.2 The Association shall establish curricular structures for academic programs based on competency objectives and title of the degree. A curricular structure gives credit distributions for broad areas of study that must be included in each degree type (e.g., for the M.M. degree, 40% in music therapy, 30% in music, 30% in electives). These curricular structures shall be consistent with those outlined by NASM.

2.3 Academic institutions shall design degree programs in music therapy according to the competency objectives required or recommended by AMTA and the appropriate curricular structure.

2.4 Internship programs shall be designed according to competency objectives delineated by the Association, and in relation to the competency objectives addressed by affiliate academic institutions.

2.5 The academic institution and internship program shall evaluate students of its programs according to the competency requirements established by AMTA, and shall use the evaluation in determining each student's readiness for graduation.

3.0 STANDARDS FOR BACHELOR'S DEGREES

3.1 Academic Component

3.1.1 The bachelor's degree in music therapy (and equivalency programs) shall be designed to impart professional competencies in three main areas: musical foundations, clinical foundations, and music therapy foundations and principles, as specified in the *AMTA Professional Competencies*. A program of academic coursework and clinical training that gives students who have degrees outside of music therapy the equivalent of a bachelor's degree in music therapy may be

offered post-baccalaureate. For equivalency programs combined with the master's degree, all AMTA Standards for Master's Degrees must be met.

3.1.2 In compliance with NASM Standards, the bachelor's degree in music therapy shall be divided into areas of study as follows (based on 120 semester hours or its equivalent). *Please note that the following outline of content areas listed below is not intended to designate course titles.*

Musical Foundations (45%)
Music Theory
Composition and Arranging
Music History and Literature
Applied Music Major
Ensembles
Conducting
Functional Piano, Guitar, Percussion, and Voice
Improvisation

Clinical Foundations (15%)
Exceptionality and Psychopathology
Normal Human Development
Principles of Therapy
The Therapeutic Relationship

Music Therapy (15%)
Foundations and Principles
Assessment and Evaluation
Methods and Techniques
Pre-Internship and Internship Courses
Psychology of Music
Music Therapy Research
Influence of Music on Behavior
Music Therapy with Various Populations

General Education (20-25%)
English, Math, Social Sciences, Arts,
Humanities, Physical Sciences, etc.

Electives (5%)

3.1.3 The academic institution shall take primary responsibility for the education and clinical training of its students at the professional level. This involves: offering the necessary academic courses to achieve required competency objectives, organizing and overseeing the student's clinical training, integrating the student's academic and clinical learning experiences according to developmental sequences, and evaluating student competence at various stages of the program.

3.1.4 The music therapy unit shall evaluate each student's competence level in the required areas prior to completion of degree or equivalency requirements.

3.2 Clinical Training Component

3.2.1 The academic institution shall take primary responsibility for providing students with the entire continuum of clinical training experiences with a representative range of client populations in diverse settings. Toward that end, the academic institution shall establish and maintain training and internship agreements with a sufficient number and diversity of field agencies that have the client population,

supervisory personnel, and program resources needed to train interns and/or provide pre-internship clinical training experiences. Qualified supervision of clinical training is required and coordinated or verified by the academic institution.

3.2.2 The academic institution shall design its own clinical training program, including types of pre-internship and internship requirements, the number of hours for each placement, the variety of client types involved, and whether internship sites will be approved by the Association, the academic institution, or both. These pre-internship and internship experiences shall be designed, like academic components of the program, to enable students to acquire specific professional level competencies. At least three different populations should be included in pre-internship training. The academic institution shall describe the design of its clinical training program in the application for approval or re-approval by the Association.

NOTE: Academic course hours that include role-playing or instructing students in music skills, session planning, documentation, and related skills for hypothetical clinical sessions in music therapy may not be utilized as clinical training hours.

3.2.3 Internship, here defined as the culminating, in-depth supervised clinical training at the professional level, may be designed in different ways: part or full time, in one or more settings, for varying periods or time frames, and near or distant from the academic institution. Internships are always under continuous, qualified supervision by a credentialed music therapist. (See Qualification Standards for definition of internship supervisor.) Each internship shall be designed or selected to meet the individual needs of the student. This requires joint planning by the academic faculty, the internship supervisor, and the student, as well as continuous communication throughout the student's placement.

3.2.4 Internship programs may be approved by an academic institution, the Association, or both. Academic institutions will maintain information about affiliated internship programs that they have selected and approved for their own students, and the Association will maintain a national roster of all AMTA-approved internship sites open to any student from any academic institution. Internship sites may choose to establish both university-affiliated internship(s) and a national roster internship program so long as the internship site stays within the standards set by the National Roster Internship Guidelines. The internship supervisor shall make final acceptance decisions regarding applicants for their internship, regardless of whether the internship has been approved by the academic institution or the Association.

3.2.5 University-affiliated internship programs must meet all AMTA standards of the Clinical Training Component and Qualifications for Clinical Supervisors in this document, as well as AMTA Guidelines for Distance Learning (if applicable). These programs will be reviewed in conjunction with academic program approval or re-approval by the Association. University-affiliated internships must be designed so that the music therapy intern spends at least half of the internship hours at one or more placements under the direct supervision of a credentialed music therapist who regularly provides professional music therapy services at that placement(s). For any portion of the internship when there cannot be a music therapist on site, the student must have a credentialed music therapist providing direct supervision under the auspices of the university. Direct supervision includes observation of the intern’s clinical work with feedback provided to the intern.

3.2.6 The academic institution shall develop an individualized training plan with each student for completion of all facets of clinical training based on the AMTA competencies, student's needs, student's competencies, and life circumstances. The various clinical training supervisors will work in partnership with the academic faculty to develop the student's competencies and to meet the individualized training plan. It is recommended that this training plan for clinical training shall include specification of placements, minimum hours in each aspect of clinical training including both pre-internship and internship experiences, and the roles and responsibilities of the student, the qualified on-site supervisor, and the academic faculty. A written internship agreement will also be made between the student, internship supervisor, and the academic faculty to describe the student's level of performance at the initiation of the internship. The academic faculty will assume responsibility for the initiation of the internship agreement with the intern and the internship director. The internship agreement shall include

- The academic institution's evaluation of the student's level of achievement on each of the AMTA Professional Competencies based on information gathered from music therapy faculty, recent supervisors, written evaluations of clinical work, and the student.
- The number of clinical training hours the student has completed ($\geq$ 180) and the minimum number of hours required for internship ($\geq$ 900) to a total of $\geq$ 1200).
- The starting and estimated ending dates of the internship. For national roster sites, these are provided by the internship director.
- Any academic requirements the student must fulfill for the University during internship. The signature of the internship director on the internship agreement signifies that these requirements may be reasonably completed over and above the site's requirements of the intern.

All parties will participate in the formulation of the agreement which should be completed by the end of the first week of the internship. The agreement will carry the signatures of the academic faculty involved in assessing student competence, the internship director, and the student.

The internship agreement may also include other pertinent information, such as the length of the internship; the student's work schedule; the supervision plan; role and responsibilities of each party; and health, liability, and insurance issues. The content and format of each internship agreement may vary according to the situation and parties involved. This internship agreement is required for both the university affiliated and AMTA national roster internship programs. These individualized training plans and internship agreements are separate and distinct from any affiliation agreements or other legal documents that delineate the terms of the relationship between the university and the clinical training site(s).

3.2.7 The internship program shall have its own competency-based evaluation system to determine whether each intern has attained required AMTA competencies. The internship program shall also solicit intern site evaluations for quality assurance purposes. These evaluations shall be forwarded to the intern's academic institution.

3.2.8 Every student must complete a minimum of 1200 hours of clinical training, with at least 15% (180 hours) in pre-internship experiences and at least 75% (900 hours) in

internship experiences. Clinical training is defined as the entire continuum of supervised field experiences, including observing, assisting, co-leading, leading, and assuming full responsibility for program planning and music therapy treatment implementation with clients. It is recommended that hours of clinical training include both direct client contact and other activities that relate directly to clinical sessions in music therapy. Such experiences also may include time in group and individual supervision of client sessions, session planning, and documentation for clients.

Academic institutions may opt to require more than the minimum total number of hours, and internship programs may opt to require more hours than the referring or affiliate academic institution. In addition, when a student is unable to demonstrate required professional level competencies, additional hours of internship may be required of the student by the academic institution in consultation with the internship supervisor.

3.2.9 The internship must be satisfactorily completed before the conferral of any music therapy degree or completion of a non-degree equivalency program. The student must have received a grade of C- or better in all music therapy courses in order to be eligible for internship. The academic institution has the ultimate responsibility to determine whether these requirements have been successfully met.

3.2.10 Existing internship sites already approved by the Association shall maintain their approval status pending adherence to the National Roster Internship Guidelines.

4.0 STANDARDS FOR MASTER'S DEGREES

The purpose of the master's degree programs in music therapy is to impart advanced competencies, as specified in the *AMTA Advanced Competencies.* These degree programs provide breadth and depth beyond the *AMTA Professional Competencies* required for entrance into the music therapy profession.

4.1 Curricular Standards

Each graduate student in a master's degree program is expected to gain in-depth knowledge and competence in both of the following areas. These areas may be addressed in either separate or combined coursework as deemed appropriate.

4.1.1 Music Therapy Theory (e.g., principles, foundations, current theories of music therapy practice, supervision, education, implications for research);

4.1.2 Advanced Clinical Skills: In-depth understanding of the clinical and supervisory roles and responsibilities of a music therapist. Advanced clinical skills are acquired through a supervised clinical component, defined as one or more music therapy fieldwork experiences that focus on clients and require post-internship, graduate training.

NB: All master's degrees in music therapy must include a supervised clinical component beyond the completion of the 1200 hours of clinical training required for acquisition of the *AMTA Professional Competencies* and concurrently with or following completion of graduate music therapy courses. It is strongly advised that the student receive direct supervision under the auspices of the University in either on-site or consultative form. Such supervision must be provided by a music therapist who has acquired advanced clinical competencies.

In addition, each graduate student in a master's degree program is expected to gain in-depth knowledge and competence in one or more of the following areas:

4.1.3 Research (e.g., quantitative and qualitative research designs and their application to music therapy practice, supervision, administration, higher education);

4.1.4 Musical Development and Personal Growth (e.g., leadership skills, self-awareness, music skills, improvisation skills in various musical styles, music technology);

4.1.5 Clinical Administration (e.g., laws and regulations governing the provision of education and health services, the roles of a clinical administrator in institutions and clinical settings).

4.2 Curricular Structures

4.2.1 Practice-Oriented Degrees. These degrees focus on the preparation of music therapists for advanced clinical practice.

4.2.2 Research-Oriented Degrees. These degrees focus on the preparation of scholars and researchers in music therapy, preparing graduates for doctoral study.

4.2.3 Degrees Combining Research and Practice Orientations. These degrees focus on the simultaneous development of the ability to produce research findings and utilize, combine, or integrate these findings within the practice of music therapy.

4.2.4 Graduate education requires the provision of certain kinds of experiences that go beyond those typically provided in undergraduate programs. These include opportunities for active participation in small seminars and tutorials and ongoing consultation with faculty prior to and during preparation of a final project over an extended period of time.

4.2.5 A culminating project such as a thesis, clinical paper, or demonstration project is required.

4.2.6 Master's degree programs include requirements and opportunities for studies that relate directly to the educational objectives of the degree program, including supportive studies in music and related fields.

4.2.7 Within master's degree programs, academic institutions are encouraged to develop graduate level specialization areas and courses on advanced topics based on faculty expertise and other resources available at the institution. Therefore, the curriculum and the requirements of each program must be tailored to the resources available, the mission of the institution, and the contribution they aspire to make to the profession of music therapy.

4.2.8 At least one-half of the credits required for the master's degree must be in courses intended for graduate students only. A single course that carries both an undergraduate and a graduate designation is not considered a course intended for graduate students only. To obtain graduate credit, students enrolled in a single course that carries a separate undergraduate and graduate designation or number must complete specific published requirements that are at a graduate level. Distinctions between undergraduate and graduate expectations must be delineated for such courses in the course syllabi. Only courses taken after undergraduate courses that are prerequisite to a given graduate program may receive graduate credit in that program.

4.2.9 Students entering the master's degree without the bachelor's degree in music therapy and/or the MT-BC credential must take a minimum of 30 semester hours or

45 quarter hours graduate credits toward advanced competence in addition to and beyond any courses needed to demonstrate *AMTA Professional Competencies*.

4.2.10 A master's degree in music therapy must include a minimum of 12 semester hours or 18 quarter hours of graduate credits in music therapy in addition to and beyond any courses needed to demonstrate the *AMTA Professional Competencies*. These courses must be intended for graduate students only and should not carry designations for both graduate and undergraduate students.

4.3 Degree Formats and Titles

4.3.1 Master of Music degree places advanced music therapy studies within a musical context: 40% music therapy, 30% music, and 30% electives in related areas. The studies in music may include coursework in diverse areas (e.g., performance, ethnomusicology, advanced musicianship, and analysis). The electives consist of supportive studies in related areas that bear directly on the specific educational objectives of the degree program.

4.3.2 Master of Music Therapy degree places advanced music therapy studies within a disciplinary context of theory, research, and practice in music therapy: 50% music therapy and 50% electives. The electives consist of supportive studies in related areas that bear directly on the specific educational objectives of the degree program.

4.3.3 Master of Arts or Master of Music Education degree places advanced music therapy studies within the context of creative arts therapy, expressive therapies, psychology, counseling, social sciences, education, arts, and/or humanities: 40% music therapy, 30% specialization field, and 30% electives. The electives consist of supportive studies that bear directly on the specific educational objectives of the degree program.

4.3.4 Master of Science degree places advanced music therapy studies within the context of medicine, allied health, and the physical sciences: 40% music therapy, 30% science specialization, and 30% electives. The electives consist of supportive studies that bear directly on the specific educational objectives of the degree program.

4.3.5 Master's degrees in music therapy may be designed additionally to prepare certified professionals for state licensure.

5.0 STANDARD FOR DOCTORAL DEGREES

The doctoral degree shall impart advanced competence in research, theory development, clinical practice, supervision, college teaching, and/or clinical administration, depending on the title and purpose of the program. Requirements for the doctoral degree must remain flexible to ensure growth and development of the profession. The academic and clinical components of each doctoral degree must be formulated by the institution according to student need and demand, emerging needs of the profession, faculty expertise, educational mission of the institution, and the resources available. Admission of candidates for doctoral degrees in music therapy should require at least three years of full-time clinical experience in music therapy or its equivalent in part-time work. Doctoral students who have less than five years full-time clinical experience in music therapy or the equivalent in part-time experience should be encouraged to acquire additional experience during the course of the doctoral program. AMTA and NASM will work together in the delineation of the doctoral degree in music therapy.

6.0 STANDARDS FOR QUALIFICATIONS AND STAFFING

The following are minimal qualification standards to be used by academic institutions when hiring faculty, selecting clinical supervisors, making placements, and approving their own internship programs, and by the Association in endorsing internship programs for the national roster. These standards shall be upheld by the Association through its initial and periodic reviews of academic institutions and internship programs on the national roster, rather than through authorization of individual faculty and supervisors.

6.1 Academic Faculty

6.1.1 *Undergraduate Faculty:* An individual employed full-time at a college or university with primary responsibilities for teaching music therapy and/or directing a music therapy program at the undergraduate level.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a master's degree in music therapy or related area, with a minimum of 12 semester hours or the equivalent of graduate credits in music therapy beyond the undergraduate equivalency requirements;
- Has at least three years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her teaching responsibilities;
- Demonstrates the following: mastery of all professional level and applicable advanced competencies in music therapy; effectiveness as a music therapy clinician in at least one area of practice; the ability to teach and clinically supervise undergraduate students; and the ability to organize and administer an undergraduate music therapy program.

6.1.2 *Graduate Faculty:* An individual employed full-time at a college or university with primary responsibilities for teaching music therapy and/or directing music therapy programs at the master's and/or doctoral level.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a master's degree in music therapy or related area, with a minimum of 12 semester hours or the equivalent of graduate credits in music therapy beyond the undergraduate equivalency requirements. A doctorate is preferred.
- Has at least five years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her teaching responsibilities;
- Demonstrates the following: mastery of all professional level and applicable advanced competencies in music therapy; effectiveness as a music therapy clinician in at least one area of practice; the ability to teach and clinically supervise graduate students; ability to guide graduate research; and the ability to organize and administer a graduate music therapy program.

6.1.3 *Adjunct Faculty:* An individual employed by a college or university to teach specific courses in music therapy on a part-time basis.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a bachelor's degree in music therapy or its equivalent;

- Has at least two years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her teaching responsibilities
- Demonstrates specific competencies appropriate to the teaching assignment.

6.2 Clinical Supervisors

6.2.1 *Pre-internship Supervisor:* An individual who has a clinical practice in music therapy (either private or facility-based) and supervises students in introductory music therapy clinical training (variously called fieldwork, practicum, pre-clinical, etc.).

- Holds an appropriate professional credential or designation in music therapy;
- Holds a bachelor's degree in music therapy or its equivalent;
- Has at least one year of full-time clinical experience in music therapy or its equivalent in part-time work;
- Pursues continuing education relevant to his/her clinical and supervisory responsibilities;
- Demonstrates the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of pre-internship students, and professional level skills in supervision.

NOTE: In an exceptional case, a student may have an on-site supervisor or facility coordinator who may not be a music therapist but holds a professional, clinical credential (e.g., OT, nurse, special educator, etc.). Under these circumstances, the student must have a credentialed music therapist as a supervisor under the auspices of the university.

6.2.2 *Internship Supervisor:* An individual who has a clinical practice in music therapy (either private or institutional) and supervises students in the final field experiences required for the music therapy degree or equivalency program.

- Holds an appropriate professional credential or designation in music therapy;
- Holds a bachelor's degree in music therapy or its equivalent;
- Has at least two years of full-time clinical experience in music therapy or its equivalent in part-time work;
- Has sufficient experience working in the internship setting as defined in the *National Roster Internship Guidelines* or by the university program.
- Pursues continuing education relevant to his/her clinical and supervisory responsibilities;
- Demonstrates the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of internship students, and established skills in supervision.

6.3 Staffing

6.3.1 Academic institutions shall have a minimum of one full-time faculty position in music therapy for each degree program offered. If an equivalency program is offered in an institution without a degree program in music therapy, the institution shall have a minimum of one full-time faculty position in music therapy. Additional full or part-time faculty may be required depending upon student enrollment in each degree program and teaching loads.

7.0 STANDARDS FOR QUALITY ASSURANCE

7.1 Differential Roles

7.1.1 The academic institution and internship site shall take primary responsibility for assuring the quality of their programs, jointly and/or separately. This shall be accomplished by regular, competency-based evaluations of its programs and graduates, by faculty, supervisors, and/or students. Each academic institution and internship program shall develop its own system of evaluation, and shall use the results as the basis for program development, quality assurance, and program change.

7.1.2 AMTA shall assure the quality of education and clinical training by: a) establishing and maintaining standards of excellence for education and clinical training in the field; and b) using these standards as evaluative criteria for granting its approval to academic institutions and internship programs.

7.1.3 AMTA shall consider academic institutions and/or internship programs for approval upon initial application and review, and every ten years thereafter in conjunction with the NASM accreditation/affirmation review.

7.2 National Association of Schools of Music (NASM)

7.2.1 Only academic institutions accredited or affirmed by NASM are eligible to apply for AMTA approval. Schools that are eligible for NASM membership must be accredited by NASM. Schools that are ineligible for NASM accreditation must seek affirmation by NASM through the alternative review process.

7.3 Grandfathering

7.3.1 All academic institutions previously approved by AAMT and NAMT shall maintain their approval status with AMTA during the transition from previous standards to the standards set forth herein. AMTA-approved academic programs in institutions that did not offer degrees or majors in music and that did not hold NASM accreditation or affirmation at the time the AMTA standards were originally adopted are eligible to re-apply for AMTA approval according to the standards without seeking NASM accreditation or affirmation. AMTA-approved academic programs in institutions that did offer degrees or majors in music at the time the AMTA standards were originally adopted but do not currently hold NASM accreditation or affirmation must apply for NASM accreditation or affirmation in order to maintain AMTA approval.

8.0 Guidelines for Distance Learning

Rationale: Technology is rapidly becoming integrated into all aspects of our daily lives. The utilization of technology in education in university teaching is a natural step. With this in mind, it is imperative that the American Music Therapy Association (AMTA) formulate guidelines for distance learning in education. Technology beyond the posting of syllabi, course outlines, and use

as a communication device, is currently being used in 50% of music therapy undergraduate and 58% of graduate programs in the United States (Keith & Vega, 2006). Of those undergraduate training programs, 45% of these programs use face-to-face instruction and use technology only for discussions and online assignments. American Music Therapy Association receives a significant number of requests from prospective music therapy candidates who are unable to move geographically to institutions with AMTA approved music therapy programs. The AMTA Academic Program Approval Committee has received applications for new program approval for distance learning programs and is therefore in need of standards and guidelines for its program approval process. Institutions are encouraged to be innovative both in education delivery and financially. It is recognized that with the rapid changes in technology, these standards and guidelines will require flexibility and will be in a continued state of development.

8.1 Definition:

The National Association of Schools of Music (NASM) defines distance learning as learning that "involves programs of study delivered entirely or partially away from regular face-to-face interactions between teachers and students in classrooms, tutorials, laboratories, and rehearsals associated with course work, degrees, and programs on the campus. . . . Programs in which more than 40% of their requirements are fulfilled through distance learning will be designated as distance learning programs. . . .
The distance aspect of these programs may be conducted through a variety of means, including teaching and learning through electronic systems. . . ."

8.2 Standards Applications

The American Music Therapy Association requires that all AMTA approved music therapy programs meet the NASM standards for distance learning: "Distance learning programs must meet all NASM operational and curricular standards for programs of their type and content. This means that the functions and competencies required by applicable standards are met even when distance learning mechanisms predominate in the total delivery system." (NASM) The American Music Therapy Association also requires that baccalaureate, equivalency, and master's degree programs in music therapy meet AMTA Standards for Education and Clinical Training when such programs meet the above criteria for distance learning. All new distance learning programs that meet the above criteria must apply for AMTA academic program approval even if the existing degree/equivalency program already has AMTA program approval.

8.3 General Standards

There are several NASM standards that must be fully addressed before a music therapy program initiates a distance learning format. They include the following:

8.3.1 Financial and Technical Support. "The institution must provide financial and technical support commensurate with the purpose, size, scope, and content of its distance learning programs." (NASM)

8.3.2 Student Evaluations "Specific student evaluation points shall be established throughout the time period of each course or program." (NASM)

8.3.3 Student Technical Competence and Equipment Requirements. "The institution must determine and publish for each distance learning program or course (a) requirements for technical competence and (b) any technical equipment requirements. The institution must have means for assessing the extent to which prospective students meet these requirements before they are

accepted or enrolled. The institution shall publish information regarding the availability of academic and technical support services." (NASM)

8.3.4 Distance Learning vs. Traditional Learning. "When an identical program, or a program with an identical title, is offered through distance learning as well as on campus, the institution must be able to demonstrate functional equivalency in all aspects of each program. Mechanisms must be established to assure equal quality among delivery systems." (NASM)

8.3.5 Student Instructions, Expectations, and Evaluation. "Instructions to students, expectations for achievement, and evaluation criteria must be clearly stated and readily available to all involved in a particular distance learning program. Students must be fully informed of means for asking questions and otherwise communicating with instructors and students as required." (NASM)

8.4 Guidelines for Music Therapy Programs

8.4.1 Hours of Face-to-Face Instruction

Distance learning programs should specify how much face-to-face instruction will occur per course, if any. Such courses are often referred to as "hybrid courses" (also known as blended or mixed mode courses) in which a significant portion of the learning activities have been moved online. Faculty need to be knowledgeable about modules and course management systems specific to their college/university, different file types, browsers, broadcasting systems, etc., and continue to keep updated with new technology.

8.4.2 Office Hours

The course instructor may fulfill office hours either by posting virtual office hours or by instituting a policy of responding to student needs within a 48 hour time frame.

8.4.3 Support Services

The methods and technological requirements for online learning should be published (e.g., Discussion Board on Blackboard, webinars, Skype, etc.). It is suggested that each course of study devote time to teaching the use of technology in the program. The program shall publish information regarding the availability of academic and technical support services. Any online courses outside of music therapy that are available for support should also be indicated. Provisions for using library resources should be published.

8.4.4 Admission

Admission will be in compliance with each university's admission policies and procedures for music therapy programs.

8.4.5 Residency Requirement and Transfer Credits

If the university has a "residency requirement," such a requirement will be honored by the music therapy programs. Furthermore, music therapy core courses and clinical training from AMTA approved institutions will be eligible for transfer as determined by the university's policies and evaluation of student competencies. The number of credit hours that can be taken at another educational institution and in what areas should be indicated to the student at the time of admission.

8.4.6 Music Therapy Courses

Music therapy programs must meet the curricular structures as outlined in the

AMTA Standards for Education and Clinical Training. Academic faculty should determine what learning should be done in residence as opposed to online and how this must be implemented. Course syllabi should clearly provide the course outline and assignments to indicate what each course entails, including the technological requirements and the online course management systems. Means of evaluation of the student's work at periodic times throughout the course must be provided in the syllabi. Course syllabi should indicate the AMTA Professional Competencies and/or Advanced Competencies (whichever if applicable) that will be addressed in the course(s) and how these competencies will be evaluated using distance learning methods.

8.4.7 Academic Faculty

Academic faculty teaching music therapy courses must meet AMTA standards for academic faculty. These guidelines for distance learning apply to all baccalaureate, equivalency, and master's degree programs in music therapy. Administering an online program and teaching online courses will require a significant amount of time over and beyond the credits awarded for the course. Load issues and overload issues should be taken into account when designing the program and distributed in a fair and equitable way to the music therapy faculty.

8.4.8 Music Competencies

Each student's music competencies in performance and functional music skills will be evaluated prior to acceptance into a distance learning program and upon completion of the program will meet AMTA standards stated in the Professional Competencies and/or Advanced Competencies (whichever is applicable to the degree/equivalency programs). This includes competencies in functional keyboard, guitar, voice, percussion, and improvisation. Music competencies may be evaluated through face-to-face auditions, web-based conferencing juries, or through videotaping. Credit for functional music skills may be acquired either at the college/university offering the program or transferred in from other academic institutions. Requirements for meeting any deficiencies in these areas must be specified in a plan for the student's remediation and continued evaluation. Methods of evaluating musical proficiencies long distance must be specified.

8.4.9 Clinical Training

The pre-internship and internship learning experiences for students should meet all AMTA standards for clinical training. Pre-internship field experiences may be established through distance learning. There should be legal contracts and/or affiliation agreements for these distance learning relationships which specify the roles and responsibilities of the academic faculty, pre-internship supervisors, internship supervisors, and the student. The music therapy faculty/staff at the academic program site (full-time or adjunct) should provide training and supervision for the on-site pre-internship and (if applicable) university affiliated internship clinical training supervisors and serve as a liaison between the academic program and the pre-internship/internship clinical training program(s). All clinical training supervisors must meet the AMTA "Standards for Qualifications and Staffing" for Pre-internship Supervisor and Internship Supervisor (whichever is applicable), including that of holding an appropriate professional credential or designation in music therapy (e.g., MT-BC; ACMT; CMT; RMT).

8.4.10 Online Supervision

Online supervision may be provided for the clinical supervisors along with site

visits by the academic faculty. Supervision for the student's clinical training experiences includes individual supervision of the student by the qualified music therapist at the host site, as well as supervision by the academic faculty. Feedback of the student's clinical work can be provided to academic faculty through such means as audio-visual media and other forms of technology and telecommunications to evaluate the student's clinical competencies. Please note that the issues related to client confidentiality must be addressed.

8.4.11 Group Supervision
Group supervision may also be provided through online discussion boards such as those found in Blackboard and/or live-time webinars with faculty and students. Please note that the issues related to client confidentiality must be addressed.

8.4.12 Related Coursework
The music therapy program should state explicitly whether courses that are required outside of the music therapy program (e.g., psychology, statistics or other research courses) are also available in distance-learning format.

Keith, D. & Vega, V. P. (2006) A survey of online courses in music therapy. Unpublished manuscript.

GLOSSARY OF SELECTED TERMS

AAMT: The American Association for Music Therapy was one of the two former organizations that merged to form the American Music Therapy Association.

Academic Institution: A college or university offering music therapy degree program(s).

Academic Faculty: The full-time, part-time and adjunct teaching professionals in an academic institution that have responsibility for instruction, research, and service as per academic institution policies. Academic faculty members have responsibility for the music therapy academic program(s).

Accreditation (NASM): The process whereby a private, governmentally authorized agency grants public recognition to an academic institution that meets standards of quality for higher education in a particular field, as determined through initial and subsequent periodic reviews. In the field of music, the National Association of Schools of Music (NASM) is the only authorized accrediting agency empowered to accredit academic institutions offering music degrees in any area in the United States. Thus, NASM accreditation (or "NASM membership") signifies that *all* the music degrees offered by an academic institution have been evaluated by NASM and found to be consistent with national standards. *Please note the following differences between NASM accreditation, NASM affirmation, and AMTA approval:* NASM *accredits* an academic institution based on the quality of all of its music degree programs; NASM *affirms* an institution ineligible for NASM accreditation, based on the adequacy of its music resources for music therapy programs; AMTA *approves* an academic institution based on the quality of its music therapy programs only. See respective definitions.

ACMT: "Advanced Certified Music Therapist" is a designation formerly given by the American Association for Music Therapy.

Affirmation (NASM): NASM offers an alternative review process for music therapy programs that are ineligible to apply for NASM accreditation (e.g., in an institution in a foreign country). The alternative review process leads to a statement of affirmation from NASM assuring that the institution and its music programs provide a context for and qualitative outcome by the music

therapy program consistent with NASM standards. Academic institutions that meet NASM standards and receive such affirmation are not "accredited" members of NASM. *Please see under "Accreditation (NASM)" for an explanation of the differences between NASM accreditation, NASM affirmation, and AMTA approval.*

AMTA: The American Music Therapy Association is the organization formed by the unification of AAMT and NAMT.

Appropriate Music Therapy Credential or Designation: Appropriate music therapy credentials or designations include three designations that were issued by the former Associations—RMT or Registered Music Therapist, CMT or Certified Music Therapist, and ACMT or Advanced Certification in Music Therapy; and the MT-BC or Music Therapist-Board Certified, which is the professional credential in music therapy granted in the United States. An appropriate music therapy credential or designation could also include a professional designation or credential from a country other than the United States.

Approval of Academic Institutions: Approval is a process whereby the professional association in music therapy grants public recognition to an academic institution for its degree (and/or equivalency) programs in music therapy. Approval is granted when the degree program meets the Association's standards of quality, as determined through initial and periodic review by the Association. *Please see under "Accreditation (NASM)" for an explanation of the differences between NASM accreditation, NASM affirmation, and AMTA approval.*

Approval of Internship Sites: Internship approval by AMTA is the process by which AMTA determines that an internship site meets its standards of quality and grants public recognition to that fact. The Association maintains a national roster of approved internship sites for use by approved academic institutions and their students. Academic institutions also may approve and individually affiliate with internship sites. These university-affiliated internship programs will be reviewed in conjunction with academic program approval or re-approval by the Association.

Approval Review Process: The entire sequence of procedures established by AMTA for the evaluation of an academic institution or internship site. The "review" typically involves application by the academic institution or internship site using established forms, a process of evaluation by designated committees within the Association according to the standards and criteria for approval established by the association, and procedures for communication and appeal.

Board Certification: The credential of Music Therapist-Board Certified (MT-BC) is initially obtained by successful passage of the national board certification examination designed and administered by the Certification Board for Music Therapists (CBMT). Each certificant must re-certify every five years. Re-certification may be accomplished either through re-examination or through accrual of appropriate continuing education as specified by CBMT.

CBMT: The Certification Board for Music Therapists.

Clinical Training: Clinical training is the entire continuum of supervised field experiences, including observing, assisting, co-leading, leading, and assuming full responsibility for program planning and music therapy treatment implementation with clients. This continuum includes all experiences formerly called observations, fieldwork, field experience, practicum, pre-clinical experience, and internship. For the sake of clarity, clinical training has been conceived as having two main components: pre-internship and internship. Pre-internship training consists of all the various practical field experiences taken by a student in conjunction with music therapy coursework as pre-requisites for internship placement. This may include experiences formerly called observations, practica, fieldwork, pre-clinical placements, etc. The internship is the culminating, in-depth supervised clinical training experience in a degree program in music therapy (or its equivalent) that leads to the achievement of the professional competency objectives.

CMT: "Certified Music Therapist" is a designation formerly given by the American Association for Music Therapy.

Competency-Based Education in Music Therapy: An approach to higher education and clinical training which has the following components: 1) the specification of student competencies or learning outcomes that serve as educational objectives for the program; 2) the distribution of these competency objectives into a developmentally sequenced curriculum of instruction, study, and/or practical training, 3) the design of specific courses and practical or field experiences to meet designated competency objectives, and 4) methods of quality assurance based on student competence upon completion of the program. The inventory entitled the *AMTA Professional Competencies* lists the professional competencies and the *AMTA Advanced Competencies* lists the advanced competencies.

Credential: *Please see "Appropriate Music Therapy Credential or Designation."*

Equivalency Program: A program of academic coursework and clinical training that gives students who have degrees outside of music therapy the equivalent of a bachelor's degree in music therapy. Like the bachelor's degree, an equivalency program is designed to impart professional level competencies in music therapy and to prepare the student to begin professional practice. Usually, the equivalency program consists of all core music therapy courses at the undergraduate level, all clinical training requirements, plus any pertinent courses in other fields (e.g., abnormal psychology). In those academic institutions offering a bachelor's degree, the student usually earns undergraduate credit for these equivalency courses, while in some that only offer the master's degree, students earn graduate credit for the same courses. It should be noted that an equivalency program is always regarded as professional level, regardless of the level of credit awarded for the coursework.

Internship: The culminating, in-depth supervised clinical training experience in a professional level degree program (or its equivalent) in music therapy.

Music Therapy Unit: The academic department, section, division, or subdivision within a college or university that takes administrative and programmatic responsibility for the music therapy degree(s) offered (e.g., a department of music therapy, a music therapy section within the department of music education, a music therapy program within the division of arts).

MT-BC: Music Therapist-Board Certified. Also see Board Certification.

NAMT: The National Association for Music Therapy was one of the two former organizations that merged to form the American Music Therapy Association.

NASM: The National Association of Schools of Music is the sole agency designated by the government to accredit music schools in the USA. (Refer to "Accreditation.")

Pre-internship: Pre-internship training is constituted by clinical training experiences conducted in conjunction with academic work in music therapy that are prerequisites for internship placement. This may include experiences formerly called observations, practica, fieldwork, pre-clinical placements, etc. Pre-internship experiences include both direct client contact and other activities that relate directly to clinical sessions in music therapy.

Professional Designation: *Please see "Appropriate Music Therapy Credential or Designation."*

RMT: Registered Music Therapist is a designation formerly given by the National Association for Music Therapy.

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STANDARDS OF CLINICAL PRACTICE

Preamble

Definition
Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program.

Further Clarification:

- *"Clinical & evidence-based":* There is an integral relationship between music therapy research and clinical practice.
- *"Music interventions":* The process is "purpose-driven" within a productive use of musical experience based on the AMTA Standards of Clinical Practice.
- *"Individualized goals within a therapeutic relationship":* This process includes assessment, treatment planning, therapeutic intervention, and evaluation of each client.
- *"Credentialed professional":* Each credential or professional designation (i.e., MT-BC, RMT, CMT) requires a set of professional competencies to be fulfilled and maintained according to established professional standards.
- *"Approved music therapy program":* A degreed program with AMTA approval and NASM accreditation.

Music therapy services are rendered by credentialed *Music Therapists, clinicians who are professional members of the American Music Therapy Association Inc. (AMTA). Although music therapy services exist in diversified settings, there is a core of common procedures and considerations stated formally as standards of general practice for all Music Therapists. Additional standards that are germane for particular clientele are delineated herein for ten areas of music therapy service: 1) addictive disorders, 2) consultant, 3) developmental disabilities, 4) educational settings, 5) geriatric settings, 6) medical settings, 7) mental health, 8) physical disabilities, 9) private practice, and 10) wellness practice. These ten areas reflect current music therapy services, but should not be interpreted as strict limits that would prevent development of new areas for music therapy.

Concomitant with the AMTA Code of Ethics, these Standards of Clinical Practice are designed to assist practicing Music Therapists and their employers in their endeavor to provide quality services. The Music Therapist will utilize *best professional judgment in the execution of these standards. The AMTA's Standards of Clinical Practice Committee is charged with periodic revision to keep these standards current with advances in the field.

* Starred (*) items are listed in the Explanatory Notes located at the end of the document.

Introduction

Standards of Clinical Practice for music therapy are defined as rules for measuring the quality of services. These standards are established through the authority of the American Music Therapy Association, Inc. This document first outlines general standards which should apply to all music therapy practice. Following these General Standards are specific standards for each of the ten areas of music therapy service. These serve as further delineations of the General Standards and are linked

closely to them. This close relationship is reflected in the numbering system used throughout this document. For example, section 4.0 regarding implementation in the General Standards ends with standard 4.7. The standards on implementation in Mental Health begin with 4.8 and supplement the General Standards with others that are specific to mental health settings. **Thus, the reader should read the General Standards first, and have them in hand when reading the specific standards.**

GENERAL STANDARDS

In delivery of music therapy services, Music Therapists follow a general procedure that includes 1. referral and acceptance, 2.*assessment, 3. program planning, 4. implementation, 5. documentation and 6. termination. Standards for each of these procedural steps are outlined herein and all Music Therapists should adhere to them in their delivery of services. Exceptions must be approved in writing by the Standards of Clinical Practice Committee. Decisions affecting the quality of services should be based on the best professional judgment of the Music Therapist with regard to client ratio and caseload, as well as the frequency, length, and duration of sessions. The Music Therapist will allocate time needed to execute responsibilities such as administration, in-service, and services relating to client care in order to provide quality, direct client service.

The recipient of music therapy services may be called by a variety of terms, depending on the setting in which therapy is rendered--e.g., client, consumer, patient, resident, or student. Such diversity of terminology is reflected in this document.

1.0 Standard I - Referral and Acceptance

A client will be accepted for music therapy in accordance with specific criteria.

1.1 A client may be a candidate for music therapy when a psychological, educational, social, or physiological need might be ameliorated or prevented by such services.

1.2 A client may be referred for an initial music therapy assessment by:

1.2.1 a Music Therapist

1.2.2 members of other disciplines or agencies

1.2.3 self

1.2.4 parents, guardians, advocates, or designated representatives

1.3 The final decision to accept a client for music therapy services, either direct or consultative, will be made by a Music Therapist and, when applicable, will be in conjunction with the interdisciplinary team. *Screening may be used as a part of this process.

2.0 Standard II - Assessment

A client will be assessed by a Music Therapist at the onset of music therapy services.

2.1 The music therapy assessment will include the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client’s needs and strengths. The assessment will also determine the client’s responses to music, music skills, and musical preferences.

2.2 The music therapy assessment will explore the client’s culture. This can include but is not limited to race, ethnicity, language, religion/spirituality, social class, family experiences, sexual orientation, gender identity, and social organizations.

2.3 All music therapy assessment methods will be appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing. Information may also be obtained from different disciplines or sources such as the past and present medical and social history in accordance with HIPAA permission regulation.

2.4 All interpretations of test results will be based on *appropriate norms or criterion referenced data.

2.5 The music therapy assessment procedures and results will become a part of the client's file.

2.6 The results, conclusions, and implications of the music therapy assessment will become the basis for the client's music therapy program and will be communicated to others involved with provision of services to the client. When appropriate, the results will be communicated to the client.

2.7 When assessment indicates the client's need for other services, the Music Therapist will make an appropriate referral.

3.0 Standard III - Program Planning

The Music Therapist will prepare a written individualized program plan based upon the music therapy assessment, the client's prognosis, and applicable information from other disciplines and sources. The client will participate in program plan development when appropriate. The music therapy program plan will be designed to:

3.1 Help the client attain and maintain the maximum level of functioning.

3.2 Comply with federal, state, and facility regulations.

3.3 Delineate the type, frequency, and duration of music therapy involvement.

3.4 Contain *goals that focus on assessed needs and strengths of the client.

3.5 Contain *objectives which are operationally defined for achieving the stated goals within estimated time frames.

3.6 Specify procedures, including music and music materials, for attaining the objectives.

3.6.1 The Music Therapist will include music, instruments, and musical elements, from the client's culture as appropriate.

3.7 Provide for periodic *evaluation and appropriate modifications as needed.

3.8 Optimize, according to the *best professional judgment of the Music Therapist:

3.8.1 The program plans of other disciplines.

3.8.2 Established principles of normal growth and development.

3.9 Change to meet the priority needs of the client during crisis intervention.

3.10 Comply with infection control procedures.

3.11 Incorporate medical precautions as necessary.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the written program plan and will:

4.1 Strive for the highest level and quality of music involvement consistent with the functioning level of the client.
- 4.1.1 The Music Therapist's provision of music will reflect his or her best abilities as a musician.
- 4.1.2 Appropriate musical instruments and materials, as well as the best possible sound reproduction equipment should be used in music therapy services.
- 4.1.3 The Music Therapist will make every effort to ensure safe and quality client care.

4.2 Use methodology that is consistent with recent advances in health, safety and infection control practices.

4.3 Maintain close communication with other individuals involved with the client.

4.4 Record the schedule and procedures used in music therapy programming.

4.5 Evaluate the client's responses periodically to determine progress toward the goals and objectives.

4.6 Incorporate the results of such evaluations in subsequent programming.

4.7 Consider the psychological effects of therapeutic separation as termination of services approaches.

5.0 Standard V - Documentation

The Music Therapist will document the client's referral to music therapy, assessment, placement, program plan, and ongoing progress in music therapy in a manner consistent with federal, state, and facility regulations.

5.1 The Music Therapist will periodically document the client's level of functioning with regard to the goals and objectives.

5.2 The documentation of progress will describe significant intervention techniques and the client's responses to them.

5.3 In all documentation relating to music therapy services, the Music Therapist will:
- 5.3.1 Write in an objective, professional style based on observable client responses.
- 5.3.2 Include the date, signature, and professional status of the therapist.
- 5.3.3 Place such documentation in the client's file and maintain its confidentiality unless proper authorization for release is obtained.

5.4 Upon obtaining written client permission, the Music Therapist will document and disseminate information to key service providers to ensure consistency of services.

5.5 The Music Therapist will document referrals made to other sources and will include plans for music therapy services as appropriate.

5.6 The documentation of all referrals will include date of referral, source of referral, and services requested.

6.0 Standard VI - Termination of Services

The Music Therapist will terminate music therapy services when the client has attained stated goals and objectives, fails to benefit from services, can no longer be scheduled, or is discharged. At the time of termination, consideration will be given for scheduling periodic reevaluation to determine the need for follow-up services. The Music Therapist will prepare the music therapy termination plan in accordance with federal, state, and facility regulations. The termination plan will:

6.1 Further optimize the goals of the individualized music therapy program plan.

6.2 Coordinate with the individualized program plans of other services received by the client.

6.3 Allow sufficient time for approval, coordination, and effective implementation whenever possible.

6.4 Summarize the client's progress and functioning level at the time of termination.

7.0 Standard VII - Continuing Education

7.1 It is the responsibility of the Music Therapist to maintain knowledge of current developments in research, theory, and techniques in music therapy related areas.

7.2 The Music Therapist will be familiar with current federal, state, and local laws pertaining to issues of client rights and confidentiality.

7.3 The Music Therapist will contribute to the education of others regarding the use and benefits of music therapy.

8.0 Standard VII – Supervision

8.1 It is the responsibility of the Music Therapist to seek and participate in supervision on a regular basis.

8.1.1 Types of supervision may include but are not limited to direct observation, peer review, verbal feedback, group supervision, individual supervision, and music based supervision.

8.1.2 The Music Therapist may seek supervision from music therapists as well as other professionals including but not limited to psychologists, psychiatrists, social workers, art therapists, dance/movement therapists, drama therapists, physical therapists, occupational therapists, speech language pathologists, physicians, and nurses.

8.2 It is the responsibility of the Music Therapist providing supervision to maintain knowledge of current developments in research, theory, and techniques in music therapy supervision and supervision in general.

8.2.1 The Music Therapist providing supervision will be familiar with current federal, state, and local laws as well as the AMTA Code of Ethics as they pertain to supervision and confidentiality within supervision.

8.2.2 The Music Therapist providing supervision is required to will adhere to all AMTA Standards of Clinical Practice and will assure that the Music Therapist supervisee has read and agrees to adhere to the AMTA Standards of Clinical Practice. The Music Therapist providing supervision shall hold the supervisee accountable for adhering to the AMTA Standards of Clinical Practice.

8.2.3 The Music Therapist providing supervision will complete any necessary documentation pertaining to supervision accurately, completely, and in a timely manner.

8.2.4 The Music Therapist providing supervision will keep all supervision content confidential. All records will be kept for at least five years after the final supervision session.

ADDICTIVE DISORDERS

These Standards of Clinical Practice are designed specifically for the Music Therapist working with clientele who have addictive disorders. The Music Therapist will adhere to the General Standards of Clinical Practice, as well as the specific standards for clients with addictive disorders described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy with clientele who have addictive disorders is the specialized use of music to restore, maintain, and improve mental, physical, and social-emotional functioning.

1.0 Standard I - Referral and Acceptance

1.2.5 Members of a treatment team

2.0 Standard II - Assessment

2.8 The music therapy assessment will include current diagnosis and history and will be performed in a manner congruent with the client's level of functioning to address the following areas:

2.8.1 Emotional status
2.8.2 Motor development (fine, gross, perceptual-motor)
2.8.3 Developmental level
2.8.4 Independent functioning and adaptive needs
2.8.5 Sensory acuity and perception
2.8.6 Attending behaviors
2.8.7 Sensory processing, planning, and task execution
2.8.8 Substance use or abuse
2.8.9 Vocational status
2.8.10 Reality orientation

2.8.11 Educational background
2.8.12 Coping skills
2.8.13 Infection control precautions
2.8.14 Medical regime and possible side effects.
2.8.15 Mental status
2.8.16 Pain tolerance and threshold level
2.8.17 Spatial and body concepts
2.8.18 Long and short term memory
2.8.19 Client's use of music

4.0 Standard IV - Implementation

4.8 Include family member participation in the treatment plan when appropriate.

4.9 Disclose information to the patient and the patient's family consistent with the physician's judgment and discretion in accordance with regulations when appropriate.

4.10 Disclose information consistent with the treatment team's recommendations in accordance with federal, state, and local confidentiality regulations.

6.0 Standard VI - Termination of Services

6.5 At the time of termination of services, document an evaluation of the client's functional abilities in the following areas: physiological, affective, sensory, communicative, social-emotional, and cognitive functioning.

7.0 Standard VII - Continuing Education

7.1.1 The Music Therapist will maintain knowledge of current developments in research, theory, and techniques concerning addictive disorders and related areas.
7.1.2 Related areas may include, but need not be limited to, family systems theory and 12 step programs, such as Alcoholics Anonymous, Narcotics Anonymous and Adult Children of Alcoholics.

CONSULTANT

These Standards of Clinical Practice are designed specifically for the Music Therapist working as a consultant in various settings such as educational, psychiatric, medical, and rehabilitation facilities and with professionals of other disciplines. The Music Therapist consultant will adhere to the General Standards of Clinical Practice as well as the specific standards for consultative music therapy services described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

The music therapy consultant may provide services to other professionals in music therapy and related disciplines and to others directly involved with the client. The consultant may also provide resource information regarding music therapy techniques and materials or may design music therapy programs for clientele in various settings.

1.0 Standard I - Referral and Acceptance

1.4 The Music Therapist consultant will establish a written contract which details the services and responsibilities of both the consultee and the consultant.

1.5 The Music Therapist consultant will adopt a fee schedule that is fair and appropriate for professional services rendered.

DEVELOPMENTAL DISABILITIES

These Standards of Clinical Practice are designed specifically for the Music Therapist working with clientele who have, or are at risk for developmental disabilities. The Music Therapist will adhere to the General Standards of Clinical Practice as well as the specific standards for clients with developmental disabilities described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music Therapy with clientele who have, or are at risk for developmental disabilities is the specialized use of music to improve or maintain functioning in one or more of the following areas: motor, physiological, social/emotional, sensory, communicative, or cognitive functioning.

2.0 Standard II - Assessment

2.8 The music therapy assessment will include current diagnosis and history and will be performed in a manner congruent with the client's adaptive functioning and developmental levels to address the following areas:

2.8.1 Motor functioning
2.8.2 Sensory processing, planning, and task execution
2.8.3 Emotional status
2.8.4 Coping skills
2.8.5 Infection control procedures
2.8.6 Attending behaviors
2.8.7 Interpersonal relationships

7.0 Standard VII - Continuing Education

7.1.1 Related areas may include, but need not be limited to, psychopharmacology, neurology, psychology, physiology, special education, early childhood education and early intervention.

EDUCATIONAL SETTINGS

These Standards of Clinical Practice are designed specifically for the Music Therapist working in educational settings. The Music Therapist will adhere to the General Standards of Clinical Practice as well as the specific standards for educational settings described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy in publicly-funded educational settings for students with disabilities may be defined as the use of music as a medium for assisting the students in meeting defined educational goals and objectives. In providing this service, the Music Therapist works closely with all members of the treatment team. Music therapy in other educational settings may also encompass a broader range of therapeutic goals.

2.0 Standard II - Assessment

2.2.1 The Music Therapist should be a member of the team which writes the student's *individual plan.

2.8 The music therapy assessment should be individualized according to the student's level of functioning.

4.0 Standard IV - Implementation

The Music Therapist will deliver services according to the individual plan.

4.8 Evaluation must be made in terms of goals and objectives stated in the student's individual plan.

7.0 Standard VII – Continuing Education

7.1.1 Related areas may include, but need not be limited to psychopharmacology, neurology, psychology, physiology, special education, early childhood education and early intervention.

GERIATRIC SETTINGS

These Standards of Clinical Practice are designed specifically for the Music Therapist working in settings with geriatric clients. The Music Therapist will adhere to the General Standards of Clinical Practice and the specific standards for geriatric settings described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy with clientele in geriatric settings may be defined as the specialized use of music with emphasis on the development, restoration or maintenance of each individual at the highest possible level of functioning.

2.0 Standard II - Assessment

2.8 The music therapy assessment will include current diagnosis and history and will be performed in a manner congruent with the client's level of functioning to address the following areas:

2.8.1 Motor skills.
2.8.2. Reality orientation
2.8.3 Emotional status
2.8.4 Spatial and body concepts
2.8.5 Long and short term memory
2.8.6 Attending behaviors
2.8.7 Infection control precautions
2.8.8 Sensory acuity and perception
2.8.9 Independent functioning and adaptive needs
2.8.10 Coping skills.

7.0 Standard VII - Continuing Education

7.1.1 Related areas may include, but need not be limited to, sensory processing, planning, and task execution; sensitivity training, specific diagnoses, and issues involved in death and dying, grief, loss, and spirituality.

MEDICAL SETTINGS

These Standards of Clinical Practice are designed specifically for the Music Therapist working in medical settings. The Music Therapist will adhere to the General Standards of Clinical Practice and the specific standards for medical settings described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy for clientele in medical settings is the specialized use of music in sites which may include, but need not be limited to, those designated as medical-surgical, pediatric, palliative care, obstetrics, rehabilitation, and wellness care.

1.0 Standard I - Referral and Acceptance

1.3.1 Note: Some medical settings may require a physician's order for music therapy services.

2.0 Standard II - Assessment

2.8 The music therapy assessment will include current diagnosis and history and will be performed in a manner congruent with the client's level of functioning to address the following areas:

2.8.1 Emotional/psychosocial
2.8.2 Coping skills
2.8.3 Infection control precautions
2.8.4 Activity status, pre-operative and post-operative
2.8.5 Attitude toward surgery and/or medical procedures
2.8.6 Cardiac precautions
2.8.7 Impact of surgery and/or loss of body function on self-image
2.8.8 Medical equipment precautions
2.8.9 Medical regime and possible side effects
2.8.10 Mental status
2.8.11 Pain tolerance and threshold levels
2.8.12 Postural restrictions
2.8.13 Scheduling requirements, coordination with other medical treatments

2.8.14 Support during medical procedures

4.0 Standard V - Implementation

4.8 Include family member participation in the treatment plan when appropriate.

4.9 Disclose information to patient and family members consistent with the physician's judgment and discretion and in accordance with hospital regulations.

5.0 Standard V - Documentation

5.3.4 The documentation of the referral will include confirmation of physician orders when applicable.

5.3.5 The Music Therapist will complete a discharge summary based on the treatment team's protocol.

5.6.1 The Music Therapist will provide written documentation of music therapy services for patients based on the treatment team's protocol.

6.0 Standard VI - Termination of Services

6.5 Include consultation with the attending physician and/or other treatment team members regarding termination of music therapy services when appropriate.

7.0 Standard VII - Continuing Education

7.1.1 Related areas may include, but need not be limited to, basic medical terminology, pharmacology, and issues involved in death, dying, trauma, grief and loss, and spirituality.

7.1.2 Some form of personal counseling for the Music Therapist is recommended.

MENTAL HEALTH

These Standards of Clinical Practice are designed for the Music Therapist working with clientele who require mental health services. The Music Therapist will adhere to the General Standards of

Clinical Practice as well as the specific standards described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.
Music therapy with clientele who require mental health services is the specialized use of music to restore, maintain, and improve the following areas of functioning: cognitive, psychological, social/emotional, affective, communicative, and physiological functioning.

1.0 Standard I - Referral and Acceptance

1.2.5 Members of a treatment team

2.0 Standard II - Assessment

2.8 The music therapy assessment will include current diagnosis and history and will be performed in a manner congruent with the client's level of functioning to address the following areas:

2.8.1 Motor functioning
2.8.2 Sensory processing, planning, and task execution
2.8.3 Substance use or abuse
2.8.4 Reality orientation
2.8.5 Emotional status
2.8.6 Vocational status
2.8.7 Educational background
2.8.8 Client's use of music
2.8.9 Developmental level
2.8.l0 Coping skills
2.8.11 Infection control precautions

7.0 Standard VII - Continuing Education

7.1.1 Related areas may include, but need not be limited to, mental health disorders, specific areas of dysfunction, diagnostic knowledge, psychotherapy, treatment approaches including music, leisure education, administrative skills, and psychopharmacology.
7.1.2 Some form of *personal counseling for the Music Therapist is recommended.

PHYSICAL DISABILITIES

These Standards of Clinical Practice are designed specifically for the Music Therapist working with clients who have physical disabilities. The Music Therapist will adhere to the General Standards of Clinical Practice as well as the specific standards for clients with physical disabilities described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy with clients who have physical disabilities is the specialized use of music to help attain and maintain maximum levels of functioning in the areas of physical, cognitive, communicative, and social/emotional health.

1.0 Standard I - Referral and Acceptance

1.4 Music therapy may be indicated when an individual's well-being is affected by congenital factors, trauma, injury, chronic illness, or other health-related conditions.

2.0 Standard II - Assessment

2.8 The music therapy assessment will include current diagnosis and history and will be performed in a manner congruent with the client's level of functioning to address the following areas:

2.8.1 Motor skills
2.8.2 Sensory processing, planning, and task execution
2.8.3 Emotional status
2.8.4 Vocational status
2.8.5 Coping skills
2.8.6 Infection control precautions
2.8.7 Activity status
2.8.8 Impact of surgery &/or loss of body function on self-image
2.8.9 Medical regime & possible side effects
2.8.10 Mental status
2.8.11 Postural restrictions

2.8.12 Spatial & body concepts
2.8.13 Sensory acuity & perception
2.8.14 Independent functioning & adaptive needs
2.8.15 Pain tolerance and pain level

3.0 Standard III - Program Planning

3.11 Comply with established principles in areas such as facilitation, positioning, sensory stimulation, and sensorimotor integration.

6.0 Standard VI - Termination of Services

6.5 Include a description of methods, procedures, and materials used, such as adaptive devices and behavioral techniques.

PRIVATE PRACTICE

These Standards of Clinical Practice are designed specifically for the Music Therapist working in private practice. The Music Therapist will adhere to the General Standards of Clinical Practice and the specific standards for private practice described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

1.0 Standard I - Referral and Acceptance

The Music Therapist responds to a referral or request for services and accepts or declines a case at his or her own professional discretion.

1.4 The Music Therapist will provide acknowledgment to the referral source.
1.5 Prior to or at the onset of service delivery, the Music Therapist will enter into a mutually acceptable service contract with the client or their designated representative. The contract will include:
1.5.1 Frequency of sessions
1.5.2 Length of each session
1.5.3 Projected length of music therapy services
1.5.4 Terms of payment for services
1.6 The Music Therapist will adopt a fee schedule which is fair and appropriate for professional services rendered.

2.0 Standard II - Assessment

2.8 The music therapy assessment will include the client's current diagnosis and history and will be performed in a manner congruent with the client's level of functioning to address areas pertinent to each specific client in treatment.

5.0 Standard V - Documentation

5.6 Periodic evaluation will be sent to the referral source when appropriate.

5.7 The Music Therapist will document:

5.7.1 Each session with the client

5.7.2 The client's payment for services

7.0 Standard VII - Continuing Education

7.1.1 The Music Therapist in private practice will maintain knowledge of current developments in research, theory, and techniques concerning the specific clients receiving music therapy services.

WELLNESS

These Standards of Clinical Practice are designed specifically for the Music Therapist working with individuals seeking *personal growth. The Music Therapist will adhere to the General Standards of Clinical Practice and the specific standards for wellness described herein. The Music Therapist will also adhere to the standards of other applicable music therapy service areas.

Music therapy in wellness involves the specialized use of music to enhance quality of life, maximize well being and potential, and increase self-awareness in individuals seeking music therapy services.

1.0 Standard I - Referral and Acceptance

The Music Therapist responds to a request for services and accepts or declines at his or her own professional discretion.

1.4 The Music Therapist and client will agree upon services to be rendered prior to or at the onset of delivery. The agreement will include:

1.4.1 Frequency of sessions

1.4.2 Length of each session

1.4.3 Projected length of music therapy services

1.4.4 Terms of payment for services

1.5 The Music Therapist will adopt a fee schedule which is fair and appropriate for professional services rendered.

2.0 Standard II - Assessment

Assessment in this practice area is process oriented and is negotiated by the Music Therapist and the client.

3.0 Standard III - Program Planning

The Music Therapist will prepare a program plan based on the agreement for services.

4.0 Standard IV - Implementation

Communication with others will be contingent upon client consent when appropriate.

5.0 Standard V - Documentation

The Music Therapist will document in a manner consistent with client agreement.

EXPLANATORY NOTES

Appropriate norms or criterion-referenced data - Standardized tests, whose interpretations are based on data derived from "normal" populations, are generally not beneficial for program planning. Such tests should be used with caution. Criterion-referenced assessments, designed with the client's

level of functioning in mind, are usually more helpful in determining both the strengths and weaknesses of the client.

Assessment - The process of determining the client's present level of functioning. Screening may be incorporated into this process.

Best professional judgment - The Music Therapist's use of current knowledge that exists in music therapy and related fields in making decisions regarding the provision of music therapy services.

Developmental disabilities - Refers to one or more conditions of childhood or adolescence which interfere with normal development and or adaptive functioning (e.g., autism, mental retardation, sensory/motor/physical/cognitive impairments). Defined (PL 95-682) as chronic mental or physical impairment manifested before age 22. Results in substantial functional limitations in three or more areas of life activities: self care; learning; mobility; self direction; economic sufficiency; receptive and expressive language; capacity for independent living. Requires lifelong individually planned services.

Evaluation - The review of a client's status in reference to the program plan goals, with consideration given to the appropriateness and/or necessary modification of the plan.

Goal - A projected outcome of a treatment plan. Goals are often stated in broad terms, as opposed to objectives which are stated more specifically.

Individual plan - A program of therapeutic or educational intervention, e.g. IEP (Individual Educational Plan/ITP (Individual Treatment Plan)/IFSP(Individualized Family Service Plan) (/ISP (Individual Service Plan) /IHP (Individual Habilitative Plan), which focuses on the specific needs and strengths of the individual client.

Music Therapist - Professional Music Therapists who hold the professional credential MT-BC or the professional designation RMT (Registered Music Therapist), CMT (Certified Music Therapist) or ACMT (Advanced Certified Music Therapist). Further information on credentials and designations is available from the Certification Board for Music Therapists (CBMT) or the National Music Therapy Registry (NMTR)

Objective - One of a series of progressive accomplishments leading toward goal attainment; may include conditions under which the expected outcome occurs.

Personal Counseling - Opportunities for personal growth, awareness, and self-care. Seeking these opportunities plays an important role in the therapist’s ability to provide ongoing quality service.

Personal Growth - Seeking to maintain or enhance quality of life.

Safety – Avoidance of harm through structuring care processes, supplies, equipment and the environment to reduce/eliminate client and staff injuries, infection, and care errors. A safe auditory environment includes protecting clients from continued exposure to loud sounds. For example, continued exposure to sound levels above 85 dB TWA (Time Weighted Average) for more than 8 hours can result in hearing loss (2002) Occupational Safety and Health Centers for Disease Control and Prevention (http://www.cdc.gov/niosh/98-126a.html accessed: 8-1-02).

Screening – An intake procedure wherein the music therapist meets with the client to determine whether or not formal assessment and treatment are indicated.

Spirituality & Cultural Background - An interrelationship among a client's musical experiences, personal belief system, and cultural background, which may be influenced by the client's geographical origin, language, religion, family experiences, and other environmental factors.

Please feel free to reproduce these Standards of Clinical Practice. **However, the standards for specific areas of music therapy services are not to be reproduced separately.**
Adopted: Nov. 11, 1982. Revised: Nov. 21, 1987; Nov. 18, 1988; Nov. 21, 1992; Apr. 17, 1998; November 18, 1999, Nov. 1, 2002, Nov. 21, 2003, Nov. 20, 2004, Nov. 20, 2005., Nov. 14, 2009

CBMT
The Certification Board for Music Therapists

The Certification Board for Music Therapists

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CBMT Scope of Practice

From Practice Analysis Study, 2008

Effective April 1, 2010

I. Assessment and Treatment Planning: 40 items

A. Assessment

1. Observe client in music or non-music settings.
2. Obtain client information from available resources (e.g., documentation, client, other professionals, family members).
3. Within the following domains (e.g., perceptual, sensory, physical, affective, cognitive, communicative, social, and spiritual), identify the client's:
   a) functioning level.
   b) strengths.
   c) areas of need.
4. Identify client's:
   a) active symptoms.
   b) behaviors.
   c) cultural and spiritual background, when indicated.
   d) issues related to family dynamics and interpersonal relationships.
   e) learning styles.
   f) manifestations of affective state.
   g) music background, skills.
   h) preferences.
   i) stressors related to present status.
5. Document intake and assessment information.
6. Evaluate the appropriateness of a referral.
7. Identify the effects of medical and psychotropic drugs.
8. Review and select music therapy assessment instruments and procedures.
9. Adapt existing music therapy assessment instruments and procedures.
10. Develop new music therapy assessment instruments and procedures.
11. Create an assessment environment or space conducive to the assessment protocol and/or client's needs.
12. Engage client in music experiences to obtain assessment data.
13. Identify how the client responds to different types of music experiences (e.g., improvising, recreating, composing, and listening) and their variations.
14. Identify how the client responds to different styles of music.
15. Identify how the client responds to the different elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics).

B. Interpret Assessment Information and Communicate Results

1. Evaluate reliability and presence of bias in information from available resources.
2. Identify factors which may impact accuracy of information gathered during assessment (e.g., precipitating events, medications, health considerations).
3. Draw conclusions and make recommendations based on analysis and synthesis of assessment findings.
4. Acknowledge therapist's bias and limitations in interpreting assessment information (e.g., cultural differences, clinical orientation).
5. Communicate assessment findings and recommendations in oral, written, or other forms (e.g., video, audio).

C. Treatment Planning

1. Involve client in the treatment planning process, when appropriate.
2. Consult the following in the treatment planning process:
   a) clinical and research literature and other resources.
   b) client's family, caregivers, or personal network, when appropriate.
   c) other professionals, when appropriate.
3. Coordinate treatment with other professionals and/or family, caregivers, and personal network when appropriate.
4. Evaluate how music therapy fits within the overall therapeutic program.
5. Consider length of treatment when establishing client goals and objectives.
6. Establish client goals and objectives.
7. Select or design a data collection system.
8. Create environment or space conducive to client engagement.
9. Consider client's age, culture, music background, and preferences when designing music therapy experiences.
10. Create music therapy experiences that address client goals and objectives.
11. Select and adapt musical instruments and equipment consistent with treatment needs.
12. Select and prepare non-music materials consistent with music therapy goals and clients' learning styles (e.g., adaptive devices, visual aids).
13. Plan music therapy sessions of appropriate duration and frequency.
14. Structure and organize music therapy experiences within each session to create therapeutic contour (e.g., transitions, pacing, sequencing, energy level, intensity).
15. Design programs to reinforce goals and objectives for implementation outside the music therapy setting.
16. Document treatment plan.

II. Treatment Implementation and Termination: 60 items

A. Implementation

1. Develop a therapeutic relationship by:
   a) building trust and rapport.
   b) being fully present and authentic.
   c) providing a safe and contained environment.
   d) establishing boundaries and communicating expectations.
   e) providing ongoing acknowledgement and reflection.
   f) recognizing and managing aspects of one's own feelings

and behaviors that affect the therapeutic process.
g) recognizing and working with transference and countertransference dynamics.

2. Provide music therapy experiences to address client's:
   a) ability to empathize.
   b) ability to use music independently for self-care (e.g., relaxation, anxiety management, redirection from addiction).
   c) adjustment to life changes or temporary or permanent changes in ability.
   d) aesthetic sensitivity and quality of life.
   e) agitation.
   f) anticipatory grief.
   g) emotions.
   h) executive functions (e.g., decision making, problem solving).
   i) focus and maintenance of attention.
   j) generalization of skills to other settings.
   k) grief and loss.
   l) group cohesion and/or a feeling of group membership.
   m) impulse control.
   n) interactive response.
   o) initiation and self-motivation.
   p) language, speech, and communication skills.
   q) memories.
   r) motor skills.
   s) musical and other creative responses.
   t) neurological and cognitive function.
   u) nonverbal expression.
   v) on-task behavior.
   w) participation/engagement.
   x) physical and psychological pain.
   y) physiological symptoms.
   z) reality orientation.
   aa) responsibility for self.
   ab) self-awareness and insight.
   ac) self-esteem.
   ad) sense of self with others.
   ae) sensorimotor skills.
   af) sensory perception.
   ag) social skills and interactions.
   ah) spirituality.
   ai) spontaneous communication/interactions.
   aj) support systems.
   ak) verbal and/or vocal responses.
3. Utilize the following music therapy treatment approaches and models to inform clinical practice:
   a) behavioral.
   b) developmental.
   c) improvisational.
   d) medical.
   e) music and imagery.
   f) neurological.
4. Integrate the following theoretical orientations into music therapy practice:
   a) behavioral.
   b) cognitive.
   c) holistic.
   d) humanistic/existential.
   e) psychodynamic.
   f) transpersonal.
5. To achieve therapeutic goals:
   a) apply the elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics).
   b) apply a variety of scales, modes, and harmonic progressions.
   c) arrange, transpose, or adapt music.
   d) compose vocal and instrumental music.
   e) employ active listening.
   f) provide visual, auditory, or tactile cues.
   g) use creativity and flexibility in meeting client's changing needs.
   h) improvise instrumentally and vocally.
   i) integrate movement with music.
   j) provide verbal and nonverbal guidance.
   k) provide guidance to caregivers and staff to sustain and support the client's therapeutic progress.
   l) mediate problems among clients within the session.
   m) identify and respond to significant events.
   n) use song and lyric analysis.
   o) utilize imagery.
   p) employ music relaxation and/or stress reduction techniques.
   q) use music to communicate with client.
   r) apply standard and alternate tunings.
   s) apply receptive music methods.
   t) sight-read.
   u) exercise leadership and/or group management skills.
   v) utilize a varied music repertoire (e.g., blues, classical, folk, jazz, pop) from a variety of cultures and sub-cultures.
   w) employ functional skills with:
      1) voice.
      2) keyboard.
      3) guitar.
      4) percussion instruments.
   x) select adaptive materials and equipment.
   y) share musical experience and expression with clients.
   z) empathize with client's music experience.
   aa) observe client reactions.

B. Safety

1. Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
2. Recognize the potential harm of music experiences and use them with care.
3. Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
4. Observe infection control protocols (e.g., universal precautions, disinfecting instruments).
5. Recognize the client populations and health conditions for which music experiences are contraindicated and adapt treatment as indicated.
6. Comply with safety protocols with regard to transport and physical support of clients.

C. Termination and Closure

1. Assess potential benefits and detriments of termination.
2. Determine exit criteria.
3. Inform and prepare client.
4. Coordinate termination with a client's overall treatment.
5. Provide a client with transitional support and recommendations.
6. Help client work through feelings about termination.
7. Address client needs during staffing changes (e.g., therapist leaves job, job transfer, leave of absence).

III. Ongoing Documentation and Evaluation of Treatment: 15 items

A. Documentation

1. Develop and use data-gathering techniques and forms.
2. Record client responses, progress, and outcomes.

3. Employ language appropriate to population and facility.
4. Document music therapy termination and follow-up plans.
5. Provide periodic treatment summaries.
6. Adhere to internal and external legal, regulatory, and reimbursement requirements.
7. Provide written documentation that demonstrates evidence-based outcomes related to addressed goals/interventions.

B. Evaluation

1. Identify information that is relevant to client's treatment process.
2. Differentiate between empirical information and therapist's interpretation.
3. Acknowledge therapist's bias and limitations in interpreting information (e.g., cultural differences, clinical orientation).
4. Continually review and revise treatment plan, and modify treatment approaches accordingly.
5. Analyze all available data to determine effectiveness of therapy.
6. Consult with other music therapists.
7. Consult with other non-music therapy professionals.
8. Communicate with client or client's family, caregivers, or personal network.
9. Make recommendations and referrals as indicated.
10. Compare the elements, forms, and structures of music to the client's and to the therapist's subjective experience and/or reactions to them.

IV. Professional Development and Responsibilities: 15 items

A. Professional Development

1. Assess areas for professional growth and set goals.
2. Review current research and literature in music therapy and related disciplines.
3. Participate in continuing education.
4. Engage in collaborative work with colleagues.
5. Seek out and utilize supervision and/or consultation.
6. Expand music skills.
7. Develop and enhance technology skills.
8. Conduct or assist in music therapy research.
9. Participate in music therapy research.

B. Professional Responsibilities

1. Document all treatment and non-treatment related communications.
2. Maintain and expand music repertoire.
3. Respond to public inquiries about music therapy.
4. Conduct information sharing sessions, such as in-service workshops, for professionals and/or the community.
5. Communicate with colleagues regarding professional issues.
6. Work within a facility's organizational structure, policies, and procedures.
7. Maintain client confidentiality within HIPAA privacy rules.
8. Supervise staff, volunteers, practicum students, or interns.
9. Adhere to the CBMT Code of Professional Practice.
10. Fulfill legal responsibilities associated with professional role (e.g., mandated reporting, release of information).
11. Practice within scope of education, training, and abilities.
12. Acquire and maintain equipment and supplies.
13. Engage in business management tasks (e.g., marketing, payroll, contracts, taxes, insurance).
14. Prepare and maintain a music therapy program budget.
15. Prepare accountability documentation for facility administration and/or local,state, and federal agencies.
16. Maintain assigned caseload files (e.g., electronic, digital, audio, video, hard copies) in an orderly manner.
17. Serve as a representative, spokesperson, ambassador, or advocate for the profession of music therapy.

The CBMT Scope of Practice was developed from the results of the 2008 Practice Analysis Study. The CBMT Scope of Practice defines the body of knowledge that represents competent practice in the profession of music therapy and identifies what an MT-BC may do in practice. Continuing Music Therapy Education credits must relate to an area identified in the CBMT Scope of Practice. This new Scope of Practice will first be utilized as the source of reference for recertification requirements and test specifications on April 1, 2010.

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CBMT Code of Professional Practice

PREAMBLE

The CBMT is a nonprofit organization which provides board certification and recertification for music therapists to practice music therapy. The members of the Board of Directors comprise a diverse group of experts in music therapy. The Board is national in scope and blends both academicians and clinicians for the purpose of establishing rigorous standards which have a basis in a real world practice, and enforcing those standards for the protection of consumers of music therapy services and the public.

The CBMT recognizes that music therapy is not best delivered by any one sub-specialty, or single approach. For this reason, the CBMT represents a comprehensive focus. Certification is offered to therapists from a wide variety of practice areas, who meet high standards to the Practice of Music Therapy. To the extent that standards are rigorously adhered to, it is the aim of the CBMT to be inclusive, and not to be restrictive to any sub-specialty.

Maintenance of board certification will require adherence to the CBMT's Code of Professional Practice. Individuals who fail to meet these requirements may have their certification suspended or revoked. The CBMT does not guarantee the job performance of any individual.

I. COMPLIANCE WITH CODE OF PROFESSIONAL PRACTICE

As a condition of eligibility for and continued maintenance of any CBMT certification, each certificant agrees to the following:

A. Compliance with CBMT Standards, Policies and Procedures
No individual is eligible to apply for or maintain certification unless in compliance with all the CBMT standards, policies and procedures. Each individual bears the burden for showing and maintaining compliance at all times. The CBMT may deny, revoke, or otherwise act upon certification or recertification when an individual is not in compliance with all the CBMT standards, policies, and procedures. Nothing provided herein shall preclude administrative requests by the CBMT for additional information to supplement or complete any application for certification or recertification.

B. Notification
The individual shall notify the CBMT within sixty (60) days of occurrence of any change in name, address, telephone number, and any other facts bearing on eligibility or certification (including but not limited to: filing of any criminal charge, indictment, or litigation; conviction; plea of guilty; plea of nolo contendere; or disciplinary action by a licensing board or professional organization). A certificant shall not make and shall correct immediately any statement concerning the certificant's status which is or becomes inaccurate, untrue, or misleading.

All references to 'days' in the CBMT standards, policies and procedures shall mean calendar days. Communications required by the CBMT must be transmitted by certified mail, return receipt requested, or other verifiable methods of delivery when specified. The certificant agrees to provide the CBMT with confirmation of compliance with the CBMT requirements as requested by the CBMT.

C. Property of the CBMT
The examinations and certificates of the CBMT, the name Certification Board for Music Therapists, and abbreviations relating thereto are all the exclusive property of the CBMT and may not be used in any way without the express prior written consent of the CBMT. In case of suspension, limitation, revocation, or resignation from the CBMT or as otherwise requested by the CBMT, the individual shall immediately relinquish, refrain from using, and correct at the individual's expense any outdated or otherwise inaccurate use of any certificate, logo, emblem, and the CBMT name and related abbreviations. If the individual refuses to relinquish immediately, refrain from using and correct at his or her expense any misuse or misleading use of any of the above items when requested, the individual agrees that the CBMT shall be entitled to obtain all relief permitted by law.

II. APPLICATION AND CERTIFICATION STANDARDS

In order to protect consumers of music therapy services and the public from harm and to insure the validity of the MT-BC credential for the professional and public good, CBMT may revoke or otherwise take action with regard to the application or certification of a certificant in the case of:

A. Ineligibility for certification, regardless of when the ineligibility is discovered;

B. Failure to pay fees required by the CBMT;

C. Unauthorized possession of, use of, or access to the CBMT examinations, certificates, and logos of the CBMT, the name 'Certification Board for Music Therapists', and abbreviations relating thereto, and any other CBMT documents and materials;

D. Obtaining or attempting to obtain certification or recertification by a false or misleading statement or failure to make a required statement; fraud or deceit in an application, reapplication, representation of event/s, or any other communication to the CBMT;

E. Misrepresentation of the CBMT certification or certification status;

F. Failure to provide any written information required by the CBMT;

G. Failure to maintain confidentiality as required by law;

H. Gross or repeated negligence or malpractice in professional practice, including sexual relationships with clients, and sexual, physical, social, or financial exploitation;

I. Limitation or sanction (including but not limited to revocation or suspension by a regulatory board or professional organization) relating to music therapy practice, public health or safety, or music therapy certification or recertification;

J. The conviction of, plea of guilty or plea of nolo contendere to a felony or misdemeanor related to music therapy practice or public health and safety;

K. Failure to timely update information to CBMT; or

L. Other violation of a CBMT standard, policy or procedure as outlined in the CBMT Candidate Handbook, Recertification Manual, or other materials provided to certificants.

III. ESTABLISHMENT OF SPECIAL DISCIPLINARY REVIEW AND DISCIPLINARY HEARING COMMITTEES

A. Upon the recommendation by the Chair, the CBMT Board of Directors may elect by a majority vote (i) a Disciplinary Review Committee and (ii) a Disciplinary Hearing Committee, to consider alleged violations of any CBMT disciplinary standards set forth in Section III.1-12 above or any other CBMT standard, policy, or procedure.

B. Each of these Committees shall be composed of three members drawn from CBMT certificants.

C. A committee member's term of office on the committee shall run for three years and may be renewed.

D. A committee member may serve on only one committee and may not serve on any matter in which his or her impartiality or the presence of actual or apparent conflict of interest might reasonably be questioned.

E. At all times during the CBMT's handling of the matter, the CBMT must exist as an impartial review body. If at any time during the CBMT's review of a matter, any member of the CBMT Disciplinary Review Committee, Disciplinary Hearing Committee, or Board of Directors identifies a situation where his or her judgment may be biased or impartiality may be compromised, (including employment with a competing organization), the member is required to report such matter to the Executive Director immediately. The Executive Director and Board Chair shall confer to determine whether a conflict exists, and if so, shall replace the member.

F. Committee action shall be determined by majority vote.

G. When a committee member is unavailable to serve due to resignation, disqualification, or other circumstance, the Chair of CBMT shall designate another individual to serve as an interim member.

IV. REVIEW AND APPEAL PROCEDURES

A. Submission of Allegations

i. Allegations of a violation of a CBMT disciplinary standard or other CBMT standard, policy or procedure are to be referred to the Executive Director for disposition. Persons concerned with possible violation of CBMT's rules should identify the persons alleged to be involved and the facts concerning the alleged conduct in as much detail and specificity as possible with available documentation in a written statement addressed to the Executive Director. The statement should identify by name, address and telephone number the person making the information known to the CBMT and others who may have knowledge of the facts and circumstances concerning the alleged conduct. Additional information relating to the content or form of the information may be requested.

ii. The Executive Director shall make a determination of the substance of the allegations within sixty (60) days and after consultation with counsel.

iii. If the Executive Director determines that the allegations are frivolous or fail to state a violation of CBMT's standards, the Executive Director shall take no further action and so apprise the Board and the complainant (if any).

iv. If the Executive Director determines that good cause may exist to question compliance with CBMT's standards, the Executive Director shall transmit the allegations to the Disciplinary Review Committee.

B. Procedures of the Disciplinary Review Committee

i. The Disciplinary Review Committee shall investigate the allegations after receipt of the documentation from the Executive Director. If the majority of the Committee determines after such investigation that the allegations and facts are inadequate to sustain a finding of a violation of CBMT disciplinary standards, no further adverse action shall be taken. The Board and the complainant (if any) shall be so apprised.

ii. If the Committee finds by majority vote that good cause exists to question whether a violation of a CBMT disciplinary standard has occurred, the Committee shall transmit a statement of allegations to the certificant by certified mail, return receipt requested, setting forth:

a. The applicable standard;

b. Of facts constituting the alleged violation of the standard;

c. That the certificant may proceed to request: (i) review of written submission by the Disciplinary Hearing Committee; (ii) a telephone conference of the Disciplinary Hearing Committee; or (iii) an in-person hearing (at least held annually proximate to the annual meeting of the CBMT) for the disposition of the allegations, with the certificant bearing his or her own expenses for such matter;

d. That the certificant shall have fifteen (15) days after receipt of such statement to notify the Executive Director if he or she disputes the allegations, has comments on available sanctions, and/or requests a written review, telephone conference hearing, or in-person hearing on the record;

e. That, in the event of an oral hearing in person or by phone, the certificant may appear in person with or without the assistance of counsel, may examine and cross-examine any witness under oath, and produce evidence on his or her behalf;

f. That the truth of allegations or failure to respond may result in sanctions including possible revocation of certification; and

g. That if the certificant does not dispute the allegations or request a review hearing, the certificant consents that the Committee may render a decision and apply available sanctions. (Available sanctions are set out in Section V, below.)

iii. The Disciplinary Review Committee may offer the individual the opportunity to negotiate a specific sanction in lieu of proceeding with a written review or hearing. The individual may ask the Disciplinary Review Committee to modify its offer, and the Committee may do so in its sole discretion. Any agreed-upon sanction must be documented in writing and signed by CBMT and the individual. If the individual is unwilling to accept the Disciplinary Review Committee's offer, the requested review or hearing will proceed as provided below.

C. Procedures of the Disciplinary Hearing Committee

i. Written Review. If the individual requests a review by written briefing, the Disciplinary Review Committee will forward the allegations and response of the individual to the Disciplinary Hearing Committee. Written briefing may be submitted within thirty (30) days following receipt of the written review request by the Disciplinary Hearing Committee. The Disciplinary Hearing Committee will render a decision based on the record below and written briefs (if any) without an oral hearing.

ii. Oral Hearing. If the individual requests a hearing:

a. The Disciplinary Review Committee will:

(1) forward the allegations and response of the certificant to the Disciplinary Hearing Committee; and

(2) designate one of its members to present the allegations and any substantiating evidence, examine and cross-examine witness(es) and otherwise present the matter during any hearing of the Disciplinary Hearing Committee.

b. The Disciplinary Hearing Committee shall then:

(1) schedule a telephone or in-person hearing as directed by the certificant;

(2) send by certified mail, return receipt requested, a Notice of Hearing to the certificant. The Notice of Hearing will include a statement of the time and place selected by the Disciplinary Hearing Committee. The certificant may request a modification of the date of the hearing for good cause. Failure to respond to the Notice of Hearing or failure to appear without good cause will be deemed to be the individual's consent for the Disciplinary Hearing Committee to administer any sanction which it considers appropriate.

c. The Disciplinary Hearing Committee shall maintain a verbatim audio and/or video tape or written transcript of any telephone conference or in-person hearing.

d. The CBMT and the certificant may consult with and be represented by counsel, make opening statements, present documents and testimony, examine and cross-examine witnesses under oath, make closing statements, and present written briefs as scheduled by a Disciplinary Hearing Committee.

e. The Disciplinary Hearing Committee shall determine all matters relating to the hearing or review. The hearing or review and related matters shall be determined on the record by majority vote.

f. Formal rules of evidence shall not apply. Relevant evidence may be admitted. Disputed questions of admissibility shall be determined by majority vote of the Disciplinary Hearing Committee.

iii. In all written reviews and oral hearings:

a. The Disciplinary Hearing Committee may accept, reject, or modify the recommendation of the Disciplinary Review Committee, either with respect to the determination of a violation or the recommended sanction.

b. Proof shall be by preponderance of the evidence.

c. Whenever mental or physical disability is alleged, the certificant may be required to undergo a physical or mental examination at the expense of the certificant. The report of such an examination shall become part of the evidence considered.

d. The Disciplinary Hearing Committee shall issue a written decision following the hearing or review and any briefing. The decision shall contain factual findings, legal conclusions, and any sanctions applied. The decision of the Disciplinary Hearing Committee shall be mailed promptly by certified mail, return receipt requested, to the certificant. If the decision rendered by the Disciplinary Hearing Committee is that the allegations are not supported, no further action on them shall occur.

D. Appeal Procedures

i. If the decision rendered by the Disciplinary Hearing Committee is not favorable to the certificant, the certificant may appeal the decision to the CBMT Board of Directors by submitting a written appeal statement within thirty (30) days following receipt of the decision of the Disciplinary Hearing Committee. CBMT may file a written response to the statement of the certificant.

ii. The CBMT Board of Directors by majority vote shall render a decision on the appeal without oral hearing, although written briefing may be submitted by the certificant and CBMT.

iii. The decision of the CBMT Board of Directors shall be rendered in writing following receipt and review of any briefing. The decision shall contain factual findings, legal conclusions, and any sanctions applied and shall be final. The decision shall be transmitted to the certificant by certified mail, return receipt requested.

iv. A Director may not: (a) review a matter at the appeal stage if he/she heard the matter as a member of the Disciplinary Hearing Committee; (b) review any matter in which his/her impartiality might reasonably be questioned, or (c) review any matter which presents an actual, apparent, or potential conflict of interest.

v. In all reviews:

a. The Board of Directors may affirm or overrule and remand the determination of the Disciplinary Hearing Committee.

b. In order to overturn a decision of the Disciplinary Hearing Committee, the individual must demonstrate that the Committee's decision was arbitrary or capricious [e.g., was inappropriate because of: (a) material errors of fact, or (b) failure of the Disciplinary Review Committee or the Disciplinary Hearing Committee to conform to published criteria, policies, or procedures]. Proof is by preponderance of the evidence.

V. SANCTIONS

A. Sanctions for violation of any CBMT standard set forth herein or any other CBMT standard, policy, or procedure may include one or more of:

i. Mandatory remediation through specific education, treatment, and/or supervision;

ii. Written reprimand to be maintained in certificant's permanent file;

iii. Suspension of board certification with the right to re-apply after a specified date;

iv. Probation;

v. Non-renewal of certification;

vi. Revocation of certification; and

vii. Other corrective action.

B. The sanction must reasonably relate to the nature and severity of the violation, focusing on reformation of the conduct of the individual and deterrence of similar conduct by others. The sanction decision may also take into account aggravating circumstances, prior disciplinary history, and mitigating circumstances. No single sanction will be appropriate in all situations.

VI. SUMMARY PROCEDURE

Whenever the Executive Director determines that there is cause to believe that a threat of immediate and irreparable harm to the public exists, the Executive Director shall forward the allegations to the CBMT Board. The Board shall review the matter immediately, and provide telephonic or other expedited notice and review procedure to the certificant. Following such notice and opportunity by the individual to be heard, if the Board determines that a threat of immediate and irreparable injury to the public exists, certification may be suspended for up to ninety (90) days pending a full review as provided herein.

VII. PERIOD OF INELIGIBILITY FOLLOWING REVOCATION

If certification is revoked based on noncompliance with the Code of Professional Practice, then the individual is automatically ineligible to apply for certification or re-certification for the periods of time listed below:

A. In the event of a felony conviction directly related to music therapy practice or public health and/or safety, no earlier than seven (7) years from the exhaustion of appeals or release from confinement (if any), or the end of probation, whichever is later:

B. In any other event, no earlier than five (5) years from the final decision of revocation. After these periods of time, eligibility will be considered as set forth in CBMT's Eligibility Review and Appeal Policy.

After these periods of time, eligibility will be considered as set forth in CBMT's Eligibility Review and Appeal Policy.

VIII. CONTINUING JURISDICTION

CBMT retains jurisdiction to review and issue decisions regarding any matter which occurred prior to the termination, expiration, or relinquishment of certification.

Adopted: February 8, 1997
Effective date: January 1, 1998
Revised: February 7, 1998
Revised: February 8, 2001
Revised: October 4, 2011

Appendix B

Request from Legislature

and Proposed Bill

Washington State Senate

Olympia Office:
PO Box 40433
Olympia, WA 98504-0433

Senator Karen Keiser
33rd Legislative District

(360) 786-7664
TTY: 1-800-635-9993
Toll-Free Hotline: 1-800-562-600
E-mail: karen.keiser@leg.wa.go

April 2, 2012

Mary Selecky, Secretary
Washington State Department of Health
PO Box 47890
Olympia, WA 98504

Dear Secretary Selecky-

I write to day to ask the Department of Health to conduct a Sunrise Review under RCW 48.47 regarding certification of Music Therapists. Attached you will find a copy of the legislative proposal concerning this issue.

Music therapy helps individuals advance physically and cognitively. Those who have a limited ability to communicate can develop, regain, or retain speech through music therapy. Music therapy based programs help keep older adults who struggle with memory loss, dementia, and other physical and cognitive illnesses at home longer, which delays the need for in-patient care and reduces the burden on state resources.

Music therapists are not currently certified in Washington State. Certification may make a difference by increasing access to those who would benefit from music therapy, ensuring that practicing music therapists have adequate education, help consumers identify qualified music therapists and assist in ensuring that people see a qualified board-certified music therapist.

In the last session legislation was introduced to address certification. I believe further review of the appropriateness such certification is warranted and It is with that in mind that I am requesting this review and would be available to help you in whatever way you may need.

Patti Catalano represents the applicant group and can be reached at Pattic@musicworksnw.org and 425-644-0988.

Sincerely,

Senator Karen Keiser, Chair
Senate Health and Long Term Care Committee
33rd Legislative District

SENATE BILL 6276

State of Washington 62nd Legislature 2012 Regular Session

By Senators Conway, Keiser, and Pridemore

Read first time 01/16/12. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to certification of music therapists; amending RCW
2 18.130.040 and 18.120.020; and adding a new chapter to Title 18 RCW.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

4 NEW SECTION. **Sec. 1.** The definitions in this section apply
5 throughout this chapter unless the context clearly requires otherwise.
6 (1) "Department" means the department of health.
7 (2) "Music therapist" means a person certified to practice music
8 therapy under this chapter.
9 (3) "Music therapy" means:
10 (a) The assessment of a client's emotional well-being, physical
11 health, social functioning, communication abilities, and cognitive
12 skills through responses to musical stimuli;
13 (b) The development and implementation of treatment plans, based on
14 a client's assessed needs, using music interventions including music
15 improvisation, receptive music listening, song writing, lyric
16 discussion, music and imagery, music performance, learning through
17 music, and movement to music; and
18 (c) The evaluation and documentation of the client's response to
19 treatment.

1 (4) "Secretary" means the secretary of the department or the
2 secretary's designee.

3 NEW SECTION. **Sec. 2.** No person may practice music therapy or
4 represent oneself as a music therapist by use of any title unless
5 certified as provided for in this chapter.

6 NEW SECTION. **Sec. 3.** (1) An applicant applying for certification
7 as a certified music therapist shall file a written application on a
8 form or forms provided by the secretary setting forth under affidavit
9 such information as the secretary may require, and proof that the
10 candidate has met the following qualifications:
11 (a) Successful completion of a bachelor's degree or higher from an
12 academic program in music therapy; and
13 (b) Successful completion of examination based on core competencies
14 of music therapy administered by a public or private agency or
15 institution recognized by the secretary as qualified to administer the
16 examination.
17 (2) The secretary shall establish by rule what constitutes adequate
18 proof of meeting the criteria.
19 (3) Applicants are subject to the grounds for denial of a
20 certification under chapter 18.130 RCW.

21 NEW SECTION. **Sec. 4.** Nothing in this chapter may be construed to
22 prohibit or restrict the practice by an individual who is:
23 (1) Licensed, certified, or registered under the laws of this state
24 and performing services within the authorized scope of practice;
25 (2) Employed by the government of the United States while engaged
26 in the performance of duties prescribed by the laws of the United
27 States; or
28 (3) A regular student in an educational program approved by the
29 secretary, and whose performance of services is pursuant to a regular
30 course of instruction or assignments from an instructor and under the
31 general supervision of the instructor.

32 NEW SECTION. **Sec. 5.** In addition to any other authority, the
33 secretary has the authority to:

1 (1) Adopt rules under chapter 34.05 RCW necessary to implement this
2 chapter;
3 (2) Establish all certification and renewal fees in accordance with
4 RCW 43.70.250;
5 (3) Establish forms and procedures necessary to administer this
6 chapter;
7 (4) Determine minimum education requirements and evaluate and
8 designate those educational programs from which graduation will be
9 accepted as proof of eligibility to take a qualifying examination for
10 applicants for certification;
11 (5) Certify applicants who have met the requirements for
12 certification and to deny certification to applicants who do not meet
13 the requirements of this chapter, except that proceedings concerning
14 the denial of certification based upon unprofessional conduct or
15 impairment is governed by the uniform disciplinary act, chapter 18.130
16 RCW;
17 (6) Determine which states have credentialing requirements
18 equivalent to those of this state and issue certificates to individuals
19 credentialed in those states without examination;
20 (7) Hire clerical, administrative, investigative, and other staff
21 as needed to implement this chapter; and
22 (8) Maintain the official department record of all applicants and
23 certified individuals.

24 <u>NEW SECTION.</u> **Sec. 6.** Applications for certification must be
25 submitted on forms provided by the secretary. The secretary may
26 require any information and documentation that reasonably relates to
27 the need to determine whether the applicant meets the criteria for
28 certification provided for in this chapter and chapter 18.130 RCW.
29 Each applicant must pay a fee determined by the secretary under RCW
30 43.70.250. The fee must accompany the application.

31 <u>NEW SECTION.</u> **Sec. 7.** The secretary must establish by rule the
32 procedural requirements and fees for renewal of a certification.
33 Failure to renew invalidates the certification and all privileges
34 granted by the certification.

1 NEW SECTION. **Sec. 8.** The uniform disciplinary act, chapter 18.130
2 RCW, governs unlicensed practice, the issuance and denial of a license,
3 and the discipline of persons licensed under this chapter. The
4 secretary is the disciplining authority under this chapter.

5 **Sec. 9.** RCW 18.130.040 and 2011 c 41 s 11 are each amended to read
6 as follows:
7 (1) This chapter applies only to the secretary and the boards and
8 commissions having jurisdiction in relation to the professions licensed
9 under the chapters specified in this section. This chapter does not
10 apply to any business or profession not licensed under the chapters
11 specified in this section.
12 (2)(a) The secretary has authority under this chapter in relation
13 to the following professions:
14 (i) Dispensing opticians licensed and designated apprentices under
15 chapter 18.34 RCW;
16 (ii) Midwives licensed under chapter 18.50 RCW;
17 (iii) Ocularists licensed under chapter 18.55 RCW;
18 (iv) Massage operators and businesses licensed under chapter 18.108
19 RCW;
20 (v) Dental hygienists licensed under chapter 18.29 RCW;
21 (vi) East Asian medicine practitioners licensed under chapter 18.06
22 RCW;
23 (vii) Radiologic technologists certified and X-ray technicians
24 registered under chapter 18.84 RCW;
25 (viii) Respiratory care practitioners licensed under chapter 18.89
26 RCW;
27 (ix) Hypnotherapists and agency affiliated counselors registered
28 and advisors and counselors certified under chapter 18.19 RCW;
29 (x) Persons licensed as mental health counselors, mental health
30 counselor associates, marriage and family therapists, marriage and
31 family therapist associates, social workers, social work associates--
32 advanced, and social work associates--independent clinical under
33 chapter 18.225 RCW;
34 (xi) Persons registered as nursing pool operators under chapter
35 18.52C RCW;
36 (xii) Nursing assistants registered or certified under chapter
37 18.88A RCW;

(xiii) Health care assistants certified under chapter 18.135 RCW;

(xiv) Dietitians and nutritionists certified under chapter 18.138 RCW;

(xv) Chemical dependency professionals and chemical dependency professional trainees certified under chapter 18.205 RCW;

(xvi) Sex offender treatment providers and certified affiliate sex offender treatment providers certified under chapter 18.155 RCW;

(xvii) Persons licensed and certified under chapter 18.73 RCW or RCW 18.71.205;

(xviii) Denturists licensed under chapter 18.30 RCW;

(xix) Orthotists and prosthetists licensed under chapter 18.200 RCW;

(xx) Surgical technologists registered under chapter 18.215 RCW;

(xxi) Recreational therapists ((~~[under chapter 18.230 RCW]~~)) under chapter 18.230 RCW;

(xxii) Animal massage practitioners certified under chapter 18.240 RCW;

(xxiii) Athletic trainers licensed under chapter 18.250 RCW;

(xxiv) Home care aides certified under chapter 18.88B RCW; ((~~and~~))

(xxv) Genetic counselors licensed under chapter 18.290 RCW; and

(xxvi) Music therapists certified under chapter 18.--- RCW (the new chapter created in section 11 of this act).

(b) The boards and commissions having authority under this chapter are as follows:

(i) The podiatric medical board as established in chapter 18.22 RCW;

(ii) The chiropractic quality assurance commission as established in chapter 18.25 RCW;

(iii) The dental quality assurance commission as established in chapter 18.32 RCW governing licenses issued under chapter 18.32 RCW and licenses and registrations issued under chapter 18.260 RCW;

(iv) The board of hearing and speech as established in chapter 18.35 RCW;

(v) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;

(vi) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

1 (vii) The board of osteopathic medicine and surgery as established
2 in chapter 18.57 RCW governing licenses issued under chapters 18.57 and
3 18.57A RCW;
4 (viii) The board of pharmacy as established in chapter 18.64 RCW
5 governing licenses issued under chapters 18.64 and 18.64A RCW;
6 (ix) The medical quality assurance commission as established in
7 chapter 18.71 RCW governing licenses and registrations issued under
8 chapters 18.71 and 18.71A RCW;
9 (x) The board of physical therapy as established in chapter 18.74
10 RCW;
11 (xi) The board of occupational therapy practice as established in
12 chapter 18.59 RCW;
13 (xii) The nursing care quality assurance commission as established
14 in chapter 18.79 RCW governing licenses and registrations issued under
15 that chapter;
16 (xiii) The examining board of psychology and its disciplinary
17 committee as established in chapter 18.83 RCW;
18 (xiv) The veterinary board of governors as established in chapter
19 18.92 RCW; and
20 (xv) The board of naturopathy established in chapter 18.36A RCW.
21 (3) In addition to the authority to discipline license holders, the
22 disciplining authority has the authority to grant or deny licenses.
23 The disciplining authority may also grant a license subject to
24 conditions.
25 (4) All disciplining authorities shall adopt procedures to ensure
26 substantially consistent application of this chapter, the Uniform
27 Disciplinary Act, among the disciplining authorities listed in
28 subsection (2) of this section.

29 **Sec. 10.** RCW 18.120.020 and 2010 c 286 s 14 are each amended to
30 read as follows:
31 The definitions in this section apply throughout this chapter
32 unless the context clearly requires otherwise.
33 (1) "Applicant group" includes any health professional group or
34 organization, any individual, or any other interested party which
35 proposes that any health professional group not presently regulated be
36 regulated or which proposes to substantially increase the scope of
37 practice of the profession.

(2) "Certificate" and "certification" mean a voluntary process by which a statutory regulatory entity grants recognition to an individual who (a) has met certain prerequisite qualifications specified by that regulatory entity, and (b) may assume or use "certified" in the title or designation to perform prescribed health professional tasks.

(3) "Grandfather clause" means a provision in a regulatory statute applicable to practitioners actively engaged in the regulated health profession prior to the effective date of the regulatory statute which exempts the practitioners from meeting the prerequisite qualifications set forth in the regulatory statute to perform prescribed occupational tasks.

(4) "Health professions" means and includes the following health and health-related licensed or regulated professions and occupations: Podiatric medicine and surgery under chapter 18.22 RCW; chiropractic under chapter 18.25 RCW; dental hygiene under chapter 18.29 RCW; dentistry under chapter 18.32 RCW; denturism under chapter 18.30 RCW; dispensing opticians under chapter 18.34 RCW; hearing instruments under chapter 18.35 RCW; naturopaths under chapter 18.36A RCW; embalming and funeral directing under chapter 18.39 RCW; midwifery under chapter 18.50 RCW; nursing home administration under chapter 18.52 RCW; optometry under chapters 18.53 and 18.54 RCW; ocularists under chapter 18.55 RCW; osteopathic medicine and surgery under chapters 18.57 and 18.57A RCW; pharmacy under chapters 18.64 and 18.64A RCW; medicine under chapters 18.71 and 18.71A RCW; emergency medicine under chapter 18.73 RCW; physical therapy under chapter 18.74 RCW; practical nurses under chapter 18.79 RCW; psychologists under chapter 18.83 RCW; registered nurses under chapter 18.79 RCW; occupational therapists licensed under chapter 18.59 RCW; respiratory care practitioners licensed under chapter 18.89 RCW; veterinarians and veterinary technicians under chapter 18.92 RCW; health care assistants under chapter 18.135 RCW; massage practitioners under chapter 18.108 RCW; East Asian medicine practitioners licensed under chapter 18.06 RCW; persons registered under chapter 18.19 RCW; persons licensed as mental health counselors, marriage and family therapists, and social workers under chapter 18.225 RCW; dietitians and nutritionists certified by chapter 18.138 RCW; radiologic technicians under chapter 18.84 RCW; ((~~and~~)) nursing assistants registered or certified under chapter 18.88A

1 RCW; and music therapists certified under chapter 18.--- RCW (the new
2 chapter created in section 11 of this act).

3 (5) "Inspection" means the periodic examination of practitioners by
4 a state agency in order to ascertain whether the practitioners'
5 occupation is being carried out in a fashion consistent with the public
6 health, safety, and welfare.

7 (6) "Legislative committees of reference" means the standing
8 legislative committees designated by the respective rules committees of
9 the senate and house of representatives to consider proposed
10 legislation to regulate health professions not previously regulated.

11 (7) "License," "licensing," and "licensure" mean permission to
12 engage in a health profession which would otherwise be unlawful in the
13 state in the absence of the permission. A license is granted to those
14 individuals who meet prerequisite qualifications to perform prescribed
15 health professional tasks and for the use of a particular title.

16 (8) "Professional license" means an individual, nontransferable
17 authorization to carry on a health activity based on qualifications
18 which include: (a) Graduation from an accredited or approved program,
19 and (b) acceptable performance on a qualifying examination or series of
20 examinations.

21 (9) "Practitioner" means an individual who (a) has achieved
22 knowledge and skill by practice, and (b) is actively engaged in a
23 specified health profession.

24 (10) "Public member" means an individual who is not, and never was,
25 a member of the health profession being regulated or the spouse of a
26 member, or an individual who does not have and never has had a material
27 financial interest in either the rendering of the health professional
28 service being regulated or an activity directly related to the
29 profession being regulated.

30 (11) "Registration" means the formal notification which, prior to
31 rendering services, a practitioner shall submit to a state agency
32 setting forth the name and address of the practitioner; the location,
33 nature and operation of the health activity to be practiced; and, if
34 required by the regulatory entity, a description of the service to be
35 provided.

36 (12) "Regulatory entity" means any board, commission, agency,
37 division, or other unit or subunit of state government which regulates

1 one or more professions, occupations, industries, businesses, or other
2 endeavors in this state.

3 (13) "State agency" includes every state office, department, board,
4 commission, regulatory entity, and agency of the state, and, where
5 provided by law, programs and activities involving less than the full
6 responsibility of a state agency.

7 NEW SECTION. **Sec. 11.** Sections 1 through 8 of this act constitute
8 a new chapter in Title 18 RCW.

--- **END** ---

Appendix C

Applicant Follow Up

Music Therapist Certification Sunrise Review
Follow Up Questions to Applicant Report
June 19, 2012

1. **Do music therapists diagnose conditions?**

It is not within a music therapist's scope of practice to diagnose conditions. Music therapists are trained to interpret the results of and develop a music therapy treatment planning strategy for clients based on the following types of music therapy assessment processes:

(from the Certification Board for Music Therapist's (CBMT) Scope of Practice)

I. Assessment and Treatment Planning

A. Assessment

1. Observe client in music or non-music settings.
2. Obtain client information from available resources (e.g., documentation, client, other professionals, family members).
3. Within the following domains (e.g., perceptual, sensory, physical, affective, cognitive, communicative, social, and spiritual), identify the client's:
  a) functioning level.
  b) strengths.
  c) areas of need.
4. Identify client's:
  a) active symptoms.
  b) behaviors.
  c) cultural and spiritual background, when indicated.
  d) issues related to family dynamics and interpersonal relationships.
  e) learning styles.
  f) manifestations of affective state. music background, skills. preferences.
  g) stressors related to present status.
5. Document intake and assessment information.
6. Evaluate the appropriateness of a referral.
7. Identify the effects of medical and psychotropic drugs. Review and select music therapy assessment instruments and procedures.
8. Adapt existing music therapy assessment instruments and procedures.
9. Develop new music therapy assessment instruments and procedures.
10. Create an assessment environment or space conducive to the assessment protocol and/or client's needs.
11. Engage client in music experiences to obtain assessment data.
12. Identify how the client responds to different types of music experiences (e.g., improvising, recreating, composing, and listening) and their variations.
13. Identify how the client responds to different styles of music. Identify how the client responds to the different elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics).
14. Identify how the client responds to different styles of music.
15. Identify how the client responds to the different elements of music (e.g., tempo, pitch, timbre, melody, harmony, rhythm, meter, dynamics).

There is no part of the music therapy assessment process that involves diagnosing conditions.

2. Are clients of music therapy typically referred from other providers, who have already made a diagnosis and identified a need for this type of treatment?

Clients are typically referred for music therapy services by other service providers, parents or loved ones, or through self-referral. This distinction is most often determined by the clinical setting. For example, in schools, referrals usually come from the interdisciplinary team: parents; classroom teachers; and other professionals involved in that child's education. Clients have direct access to music therapists in private practice, sometimes with a referral and sometimes without.

Generally speaking, a referred client has already received a diagnosis or is in the process of being diagnosed by a professional that is trained to diagnose.

3. Are music therapists trained to recognize when a client should be referred to a mental health counselor or other professional?

Yes, a music therapist is trained to recognize when a client should be referred to another service provider, whether it be a mental health counselor, an occupational therapist, a physical therapist, or other appropriate professional. This is indicated within our Scope of Practice:

(from the CBMT's Scope of Practice)

III. Ongoing Documentation and Evaluation of Treatment

B. Evaluation

5. Analyze all available data to determine effectiveness of therapy.
9. Make recommendations and referrals as indicated.

IV. Professional Development and Responsibilities

B. Professional Responsibilities

11. Practice within scope of education, training, and abilities.

4. Are music therapists trained to recognize suicidal ideation in clients so they can refer them to the appropriate health care provider?

Yes, music therapists are trained to recognize and report to the appropriate providers when a client exhibits signs indicating harm to self or others.

5. Do music therapists receive clinical training in diagnosing conditions or illnesses?

Music therapists are not trained to diagnose conditions or illnesses. According to the education and clinical training standards outlined by the American Music Therapy Association (AMTA), a music therapy training program is designed to impart entry-level competencies in three main areas: musical foundations, clinical foundations, and music therapy foundations and principles:

Musical Foundations
Music Theory

Composition and Arranging
Music History and Literature Applied Music Major
Ensembles
Conducting
Functional Piano, Guitar, and Voice

Clinical Foundations
Exceptionality and Psychopathology Normal Human Development Principles of Therapy
The Therapeutic Relationship

Music Therapy
Foundations and Principles Assessment and Evaluation
Methods and Techniques Pre-Internship and Internship Courses Psychology of Music
Music Therapy Research
Influence of Music on Behavior
Music Therapy with Various Populations

General Education
English, Math, Social Sciences, Arts,
Humanities, Physical Sciences, etc.

Electives

There is no part of the music therapy training program that involves learning how to diagnose conditions.

6. **Please tell us more about working with vulnerable populations. For instance, how often do music therapists work independently with mentally challenged or mentally ill clients? Are the music therapists working in collaboration with the other providers? (See 10)**

Music therapists work across the lifespan with a variety of client groups including both healthcare and education settings. Many of these client groups can be considered vulnerable populations (e.g. persons with intellectual or emotional disabilities, or persons coping with physical, mental, or terminal illness):

Developmental Disabilities
Including, but not limited to, Down Syndrome, Autism Spectrum Disorders, Rett Syndrome, Fragile X Syndrome, Cerebral Palsy

Acute or Chronic Illnesses or Pain
Including, but not limited to, HIV/AIDS, cancer, Multiple Sclerosis, burns, surgeries

Impairments or Injuries due to Aging or Accidents
Including, but not limited to, stroke, Alzheimer's disease or other dementias, Traumatic Brain Injury, Parkinson's.

Hearing, Visual, or Speech Impairments
Multiple Impairments

Terminal Illnesses

Hospice and palliative care

Learning Disabilities
Including, but not limited to, math, language, or motor difficulties

Mental Illnesses
Including, but not limited to, Post-Traumatic Stress Disorder, schizophrenia, Bipolar Disorder, depression, emotional/behavioral disorders, substance abuse

Health and Wellness Issues
Including, but not limited to, cardiac care and well seniors

Humans respond to music, and music used systematically by a qualified music therapist has the ability to elicit a number of responses (physical, social, emotional, behavioral) regardless of age or ability level. Music therapists work both independently and frequently collaborate with related professions. It is very common for music therapists to provide co-treatment with other allied health professions, such as physical therapy, occupational therapy, speech language pathology, social work, and mental health counselors. According to a national survey by Register (2003), more than 90% of MT-BCs indicated that they collaborate with other related education or heath professionals. The opportunity to collaborate and co-treat is often dependent on the clinical setting. Behavioral health settings promote collaboration between music therapists and psychologists, social workers, and mental health counselors. Most healthcare settings provide opportunities for music therapists to interact as treatment team members in collaboration with nursing staff and physicians. Education settings allow collaboration with teachers, special educators, administrators, and other related service providers. The complementary nature in which music therapists provide services in healthcare and education settings offers the potential to enhance the services and outcomes for clients and their families.

7. **In section (1)(a), to what extent does the example on pages 9-10 of the application, or similar instances, represent a threat or harm to public health or safety?**

As indicated in section (1)(a) of our application, there are a growing number of unqualified individuals claiming to be music therapists who do not hold a music therapy degree from an accredited institution or carry the national credential of Music Therapist-Board Certified (MT-BC). This potential harm to the public includes misrepresentation of the music therapy profession, as these individuals hold themselves out to the public as being able to produce outcomes that are not based upon evidence-based practice; and, these individuals show a substantial lack of supervised clinical training and feedback to promote and ensure ethical practice.

The threat of harm can be characterized as either a medical nature or a mental health nature. This first example relates to medical harm and involves an individual misrepresenting him- or herself as a music therapist who does not have the necessary training to produce outcomes based on evidence-based, safe, and ethical practice:

> *I (a music therapist) was working in a major children's hospital when one of the PICU doctors called me in to consult on a case. There was a young teenager who ran his snowmobile into a tree and suffered a traumatic brain injury. He was in a stage of coma where he was extremely agitated. His parents consulted with someone who claimed to be a music therapist, but was not. That person programmed music for them to play at their child's bedside to help him relax. The result of that music was increased agitation, increased heart*

rate (to dangerous levels), and decreased oxygen saturation rates. This necessitated increased sedation medication which can have negative side effects.

Luckily, our doctors knew to call in the qualified staff (me) to consult on the case. They were playing some beautiful Mozart concerto when I came in. The child was in restraints and writhing on his bed. When I asked the mother if her son liked classical music and if that would have been his music of choice to relax to prior to the accident, she replied, "Oh no. He hates classical music!" I asked them to turn the music off, but his agitation continued. I asked what music he would relax to and his parents refused to tell me because they were ashamed. Once I explained that we could deal with his poor musical taste after recovery and explained why we would be using music purposefully and cited some research, they were on board. His sister revealed that he liked to relax to gangster rap. His mother said that this was unimaginable to her, and frankly to me too, but for this child, that is what would work. So, after conducting further assessment, I set up a music listening program specifically for him. As soon as I started playing the music that would work to help him relax, he let out a huge sigh and visibly relaxed. His heart rate lowered to normal in less than three minutes and his oxygen saturation rate went from 82% to 96% and remained stable. He was able then to relax and fall asleep without further sedation medication, allowing his body and brain to focus on healing.

The second example highlights the potential mental health harm that can happen when someone does not have the necessary supervised music therapy clinical training and feedback. Please note that the music therapist was working as part of an interdisciplinary mental health team:

While working with a seriously ill patient who was suffering from the same condition that killed her father, my (music therapy) intern at the time had an interesting experience. That patient had a particularly difficult week and truly deserved a break. The (treatment) team thought that she also needed to refocus on those things that bring her happiness. So, the intern brought in the book and song "Sunshine on my Shoulders" by John Denver. About half way through the song, the patient broke down into uncontrollable sobbing. As it turns out, that is the song that her father used to sing to her every night.

Luckily, a music therapist is trained and able to deal with instances such as this and it actually turned out for the best as she had not grieved the loss of her father. It ended up being a cathartic experience for that patient. If it had been a music volunteer or someone else with out proper training, that patient would not have been able to come to catharsis, rather they would have been left in a state of despair. Later that day, the psychologist called me thanking me for helping this patient begin her grief process.

8. **Please provide information and numbers of actual complaints about unqualified individuals purporting to provide music therapy services? If any such complaints allege harm to a client/patient, please describe the alleged harm.**

To our knowledge there have been no official complaints made in the state of Washington regarding unqualified individuals purporting to provide music therapy services. This is in large part due to there being no mechanism in the state at this time for reporting or tracking such complaints.

Reports from the public indicate that there are individuals falsely claiming to be music therapists without evidence of the nationally recognized education, clinical training, or board certification

determined by the American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT). These members of the public report receiving unprofessional, invasive, and poor quality treatment and interventions from these unqualified individuals. In addition, several musicians and music educators across the state identify themselves both verbally and in writing as “Music Therapists”. These individuals have offered to provide “music therapy” yet have no education or clinical training in the profession. For example, a nurse at a long-term care facility claimed to do “music therapy” by playing the piano for sing-a-longs for the residents. Furthermore, there are also people who misrepresent themselves as a board certified music therapist when they do not hold the credential. For example, there is a man in California who was arrested for nursing home fraud. He was a board certified music therapist at one time and continues to advertise that he is board certified. There is another instance of a woman who was board certified, let her certification lapse, then forged her original certificate to make it look current for her employer.

These types of misrepresentation issues are tracked and responded to by the AMTA and CBMT, generally in the form of a letter of support outlining a music therapist’s education, clinical training, and board certification requirements. According to the CBMT, the number of these types of issues has increased over the past 9 years from approximately 12 complaints a year to approximately 36 complaints a year. Furthermore, the types of complaints filed against MT-BCs over the past 10 years include:

Sexual Offender (3)
Fraudulent records: Medicaid or Medicare, or forged contracts with facilities (4)
Fraudulent certificate (1)
Employer/Employee issues, not submitting required paperwork, unfair work practices, ethics issues (3)
Inappropriate boundaries: with professor/student, therapist/client (5)
Working outside Scope of Practice (2)

We can assume, though, that the actual number of instances is greater given that the public in general does not realize they can report these types of issues to AMTA and CBMT. Furthermore, although the public can report these cases to AMTA and CBMT, these organizations do not have jurisdiction to take any further action than to send a letter of support. Unfortunately, this does not always go far enough to protect the public.

9. **Please cite the federal or Washington state rules (Washington Administrative Code) or laws that require healthcare providers to hold state certification for state residents to access the provider’s services, and the settings to which these rules/statutes are applicable.**

State

Chapter 246-12 WAC
Administrative procedures and requirements for credentialed health care providers

246-12-001—Purpose and scope.
The rules in this chapter are intended to ensure consistent application of administrative procedures and requirements for licensure, certification and registration of health care practitioners credentialed under the Uniform Disciplinary Act (RCW 18.130.040), except those credentialed under chapter 18.73 RCW (emergency medical services). Within the rules there are several references to additional requirements which may be unique to a profession.

Examples are the renewal cycle, fees, continuing education or competency requirements. Refer to individual profession's laws and rules for further guidance and information. Health profession laws and rules are available in public libraries and in publications by the department of health.

Chapter 182-502 WAC
Administration of medical programs — providers

182-502-0002—Eligible provider types.
The following healthcare professionals, healthcare entities, suppliers or contractors of service may request enrollment with the Washington state department of social and health services to provide covered healthcare services to eligible clients. For the purposes of this chapter, healthcare services includes treatment, equipment, related supplies and drugs.

Chapter 48.44 RCW
Health care services

48.44.015—Registration by health care service contractors required — Penalty.
(1) A person may not in this state, by mail or otherwise, act as or hold himself or herself out to be a health care service contractor, as defined in RCW
48.44.010 without first being registered with the commissioner.

Chapter 18.130 RCW
Regulation of health professions—uniform disciplinary act

18.130.010—Intent

It is the intent of the legislature to strengthen and consolidate disciplinary and licensure procedures for the licensed health and health-related professions and businesses by providing a uniform disciplinary act with standardized procedures for the licensure of health care professionals and the enforcement of laws the purpose of which is to assure the public of the adequacy of professional competence and conduct in the healing arts.
It is also the intent of the legislature that all health and health-related professions newly credentialed by the state come under the Uniform Disciplinary Act.

Further, the legislature declares that the addition of public members on all health care commissions and boards can give both the state and the public, which it has a statutory responsibility to protect, assurances of accountability and confidence in the various practices of health care

Federal

Individuals with Disabilities Education Act, Part C, Section 303.31 regarding qualified personnel who are eligible to provide early intervention services:

"Qualified personnel means personnel who have met State approved or recognized certification, licensing, registration, or other comparable requirements that apply to the areas in which the individuals are conducting evaluations or assessments or providing early intervention services."
(Federal Register, September 28, 2011, p. 60251)

Individuals with Disabilities Education Act, Part B, Section 300.156 regarding related services personnel qualifications:

"(a) *General.* The SEA must establish and maintain qualifications to ensure that personnel necessary to carry out the purposes of this part are appropriately and adequately prepared and trained, including that those personnel have the content knowledge and skills to serve children with disabilities.
(b) *Related services personnel and paraprofessionals.* The qualifications under paragraph (a) of this section must include qualifications for related services personnel and paraprofessionals that—

> (1) Are consistent with any State approved or State-recognized certification, licensing, registration, or other comparable requirements that apply to the professional discipline in which those personnel are providing special education or related services; and
> (2) Ensure that related services personnel who deliver services in their discipline or profession—
>
> > (i) Meet the requirements of paragraph (b)(1) of this section; and
> > (ii) Have not had certification or licensure requirements waived on an emergency, temporary, or provisional basis;"

(Federal Register, August 14, 2006, p. 46772)

Medicare and Medicaid Programs; Programs of All-Inclusive Care for the Elderly (PACE) Section 460.64 Personnel qualifications for staff with direct participant contact:

"(a) *General qualification requirements.* Each member of the PACE organization's staff that has direct participant contact, (employee or contractor) must meet the following conditions:
(1) Be legally authorized (for example, currently licensed, registered or certified if applicable) to practice in the State in which he or she performs the function or action;

(Federal Register, December 8, 2006, pgs. 71334 and 71335)

US Code: TITLE 42 - CHAPTER 7 - SUBCHAPTER XIX –
Section 1396r. Requirements for nursing facilities

(d)(4)(A): A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1320a-3 of this title) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

10. To what extent do music therapists typically provide services independently compared to providing services in coordination with a licensed mental health, a medical professional, or as part of an interdisciplinary health team.

Music therapists frequently collaborate with other allied health professionals, including mental health and medical professionals, as part of an interdisciplinary health or education team. For example, Akiko Ketron, MT-BC, collaborates with physicians, psychiatrists, nurses, social workers, and other therapists in her work at the Regional Behavioral Health Center at Auburn Regional Medical Center. Together, this multidisciplinary team works at provide care for older adults with emotional or cognitive health issues.

Washington State Music Therapy Task Force
Sunrise Review for Certification for Music Therapists, SB 6276
Comments and Responses to the Sunrise Review Hearing and Initial Public Comment Period
August 30, 2012

We appreciate this opportunity to respond to comments, testimony, and questions revealed in the initial public comment period as well as the Sunrise Review Hearing for SB 6276 – Certification for Music Therapists.

Music Therapy Data Collection and Assessments: Music therapy assessments take many different forms and may include different elements depending on the therapeutic setting. All music therapy assessments include a review of client history, origin of disabilities, medical or psychosocial issues, current therapeutic strategies and existing goals, and are largely composed of a comparison between client responses during music and during regular activities that do not normally include music.

Music therapy in a mental health institution, for example, will involve an assessment of a client's mood and behavior as contrasted in a music setting and a non-music setting. Music therapy in a setting with geriatric patients with dementia will involve an assessment of the client's attention span, relatedness, eye contact, mood and behavior as contrasted in a music setting and a non-music setting.

Music therapy in the public schools is partially governed by federal guidelines, as it is considered a related service. The evaluator looks for significant or unique differences in client performance when music based prompts are used, on specific objectives as described in the student's Individual Education Plan. Peer interaction, interactions with teachers, expressive and receptive communication, and ability to focus and follow directions may all be part of a music therapy assessment.

Music therapists are required to demonstrate competency in the following areas related to data collection and assessment:

Client Assessment:

16.1 Communicate assessment findings and recommendations in written and verbal forms.

16.2 Observe and record accurately the client's responses to assessment.

16.3 Identify the client's appropriate and inappropriate behaviors.

16.4 Select and implement effective culturally based methods for assessing the client's assets, and problems through music.

16.5 Select and implement effective culturally based methods for assessing the client's musical preferences and level of musical functioning or development.

16.6 Identify the client's therapeutic needs through an analysis and interpretation of music therapy and related assessment data.

16.7 Demonstrate knowledge of professional Standards of Clinical Practice regarding assessment.

Treatment Planning:

17.1 Select or create music therapy experiences that meet the client's objectives.

17.2 Formulate goals and objectives for individuals and group therapy based upon assessment findings.

17.3 Identify the client's primary treatment needs in music therapy.

17.4 Provide preliminary estimates of frequency and duration of treatment.

17.5 Select and adapt music consistent with strengths and needs of the client.

17.6 Formulate music therapy strategies for individuals and groups based upon the goals and objectives adopted.

17.7 Select and adapt musical instruments and equipment consistent with strengths and needs of the client.

17.8 Organize and arrange the music therapy setting to facilitate the client's therapeutic involvement.

17.9 Plan and sequence music therapy sessions.

17.10 Determine the client's appropriate music therapy group and/or individual placement.

17.11 Coordinate treatment plan with other professionals.

17.12 Demonstrate knowledge of professional Standards of Clinical Practice regarding planning.

Documentation:

20.1 Produce documentation that accurately reflect client outcomes and meet the requirements of internal and external legal, regulatory, and reimbursement bodies.

20.2 Document clinical data.

20.3 Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner.

20.4 Communicate orally with the client, parents, significant others, and team members regarding the client's progress and various aspects of the client's music therapy program.

20.5 Document and revise the treatment plan and document changes to the treatment plan.

20.6 Develop and use data-gathering techniques during all phases of the clinical process including assessment, treatment, and evaluation.

20.7 Demonstrate knowledge of professional Standards of Clinical Practice regarding documentation.

Music Therapy and Peer Reviewed Research: Evidenced-based practice is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care (Sackett, 2002). Music and music therapy research is available through many peer reviewed journals, including the *Journal of Music Therapy, The New York Academy of Sciences Annals, Perceptual and Motor Skills, Neuroscience Letters, and NeuroImage* . Such research publishes both the distinctive nature of using music alone as an intervention in health care, as well as music with combined therapies including but not limited to occupational therapy, speech/language pathology, physical therapy, and psychotherapy. Published peer reviewed research in music therapy spans over 60 years in the United States. In the most recent 20 years, an explosion of research activity blossomed along several important lines of work. Music therapists conduct research drawing upon a range of methods and research designs. Ultimately, the design of research is driven by the nature of the research question and the aims of the study.

There are several recent Cochrane Reviews regarding music therapy interventions among patients with medical issues.

RECENT PUBLISHED COCHRANE REVIEWS INCLUDE:

- Music for stress and anxiety reduction in coronary heart disease patients (Bradt & Dileo) (published 2009)
- Music therapy for end-of-life care (Bradt & Dileo) (published 2009)
- Music therapy for acquired brain injury (published, 2010) (Bradt, Magee, Dileo, Wheeler, McGilloway)
- Music interventions for mechanically ventilated patients (Bradt, Dileo, & Grocke) (published 2010)

UPCOMING REVIEWS INCLUDE:

- Music interventions for improving psychological and physical outcomes in cancer patients (Bradt, Dileo, Grocke & Magill) (published 2011)
- Music for pre-operative anxiety (Dileo & Bradt) (in progress)

RESULTS ACCORDING TO OUTCOME

- Heart rate: Music consistently lowers heart rate in cardiology, cancer and mechanically ventilated patients
- Respiratory rate: Music lowers respiratory rate in cardiology, cancer and mechanically ventilated patients although effects are variable.
- Systolic and Diastolic Blood Pressure: Music consistently reduces systolic and diastolic blood pressure in cardiology and cancer patients
- Anxiety: Music significantly and consistently lowers anxiety in MI patients and mechanically ventilated patients, inconsistently in cancer patients
- Pain: Music can have small to moderate effects on pain in cardiology and cancer patients, but this is not always consistent.
- Mood: Music significantly and consistently improves mood in cancer patients
- Quality of Life: Music therapy significantly and consistently improves quality of life in oncology and terminally ill patients.
- Gait: Significant and consistent favorable effects are observed for a specific music therapy intervention (Rhythmic Auditory Stimulation or RAS) on gait velocity, cadence, stride length, and stride symmetry.
- Global state: Music therapy, as an addition to standard care, helps people with schizophrenia to improve their global state and may also improve mental state and functioning if a sufficient number of music therapy sessions are provided.
- Communication: Music therapy interventions are favorable in helping children with autistic spectrum disorder improve their communication skills.

Music Therapy and Practice Restriction:

Example #1
From the Washington Administrative Code regarding service providers for psychiatric and inpatient treatment facilities. Relevant sections are **bolded**.

WAC 388-865-0229

Inpatient services.

The regional support network must develop and implement age and culturally competent services that are consistent with chapters 71.24, 71.05, and 71.34 RCW. The regional support network must: Ensure that all service providers or its subcontractors that provide evaluation and treatment services are **currently certified by the mental health division and licensed by the department of health**; Consumers listed:

(a) State psychiatric hospitals:

(i) Western state hospital;

(ii) Eastern state hospital;

(iii) Child study and treatment center.

(b) Community hospitals;

(c) Residential inpatient evaluation and treatment facilities licensed by the department of health as adult residential rehabilitation centers; and

(d) Children's long-term inpatient program.

How these regulations impacted Washington resident Jim Couture, MA, MT-BC: "In 2007 I applied for an advertised Music Therapy position at Western State Hospital. But since this was a therapist position it required state certification or registration. I had been on the state hiring list since 2003 as a Recreation Specialist and had also applied for Recreation Therapist (unsuccessfully without CTRS). But the only position recognized by the state in 2007 on the application was CTRS. I was unable to apply because the state did not recognize / register / certify MT-BCs. Melissa Gunter-Green, MT-BC had made the request to hire a music therapist but did not realize one could not be hired without recognition. Here is the AMTA announcement:

Posted 1/17/07
Job title: Music Therapist Board Certified
Hours: Full-time (40 hr)
Salary: Negotiable
Facility: Western State Hospital (Lakewood, WA)
Qualifications: MT-BC
Population: Inpatient psychiatric adults
Starting date: February 2007
Description of position: Western State Hospital is a 1000 bed inpatient psychiatric hospital who serves patients court ordered for treatment. The Director of Rehab would supervise all rehab staff hospital wide and be a key person in active treatment. Contact information: Western State

Hospital, 9601 Steilacoom Blvd SW Lakewood, WA 98498 253-582-8900 Dr. Andrew Phillips or Melissa Gunter-Green, MT-BC"

Example #2

Washington resident Wendy Zieve, MT-BC, was restricted from participating at a School Services Fair to promote music therapy and advertise her business because state regulations did not include Music Therapy as a provider in school settings, even though it is considered a related service under the Federal Individuals with Disabilities Education Act (IDEA) Legislation. This policy had an effect not only on Wendy's business and livelihood, but also in effect denied access to music therapy services to children with special needs who might have benefitted greatly from this treatment option.

Examples of Misrepresentation of Music Therapy:

Submitted by Jim Couture, MT-BC, articles found in the local newspaper:

1. Songwriting Works article that describes the process as "music therapy." The designation comes from the reporter, not the facilitators. I have worked with this group and they do fine work, though it does overlap with techniques we as music therapists would also use. The article also describes how they have been working on a "Tool Kit" to use music in the home between older adults and caregivers, something beyond even their scope of songwriting. The use of the term music therapy is misleading to the public in this context.

2. An announcement of a public talk, with $5 cost, about music therapy and psycho-acoustics with CDs available. A Google search reveals this person to be a harp therapist and KinderMusik educator who is a music therapy student. If that is true, it is still misleading to the public as advertised.

3. "Music Therapy" turns up as a category at the Mind Body Spirit Directory for Washington website http://www.bodymindspiritdirectory.org/WA which includes a link to http://soundings.com , a "new age" recording company in Bellingham, WA. Another misleading category.

Submitted by Patti Catalano, MT-BC, after completing a music therapy Google search for Washington State:

4. "**Welcome to Waves Music Therapy**, an independent company based in Seattle, Washington, offering the very best in music therapy!

Music heals! We use brainwave entrainment, featuring monaural tones, to safely and gently guide your brain into various brain states. Through ***'frequency following***' your brain waves naturally align to the tones in our programs, giving you a stronger, more focused state of mind.

Music therapy is an inexpensive yet effective therapy for many disorders including: Seasonal Affective Disorder (SAD), Attention Deficit Disorder (ADD), chronic pain, fibromyalgia and sleep disorders. Brain wave therapy can also reduce stress, headaches, migraines, insomnia and irritability. Our therapies promote relaxation, concentration, creativity and top performance. Professional audio engineer and musician, Katy Kavanaugh, is the creator of Waves Music Therapy. Her research in audio, led her to discover the positive benefits of music therapy. With her extensive audio background, Katy has created high quality music therapies encompassing a wide range of benefits. She hopes everyone will enjoy the effects of brain wave therapy and her custom programs." Although this company calls themselves a music therapy company, they are not trained to offer music therapy.

5. On the Autism Support Network website, it states: "Musical Therapy for Autism Seattle WA - Musical therapy for autism helps autistic patients with social skills, language comprehension and more. See below for local music therapists in Seattle that give access to therapy which has effects such as non-communicative speech reduction and echolalia reduction as well as advice and content on art therapy for autism and how to find music therapists for autism." None of the companies listed on the page actually offered music therapy.

Responses to Washington Occupational Therapy Association's (WOTA) Testimony and Questions: We appreciate the work that WOTA's legislative committee and lobbyist have been doing with us to learn from each other as well as work on amended language that protects the scope of practice of the Occupational Therapist in Washington State. We look forward to continued dialogue with WOTA as well as through our national associations. To that end, a clarification is in order. The language printed in the August 20, 2012 testimony of WOTA for the Sunrise Review Hearing of SB6276/HB2522 Certification of Music Therapists was not the amended language approved by the applicant group and WOTA representatives. It was suggested language submitted by the occupational therapists in January 2012, but was not acceptable to music therapists because it in essence allowed occupational therapists to call themselves music therapists.

The Senate Hearing in which the bill was heard took place on February 1, 2012, not January 23, 2012 as indicated on the testimony. The Music Therapy Task Force was approached by Mark Gjurasic on January 27 with a request for more information regarding the bill. Immediately prior to the February 1, 2012 testimony given by the music therapists, WOTA representative Rose Racicot and the American Music Therapy Association's Director of Government Relations Judy Simpson gave verbal approval to Patti Catalano of the Washington State Music Therapy Task Force to amend the suggested language. The amended language with additional hand written words acceptable to all parties was submitted at the Senate Hearing, is in the file for SB6276 Testimony, and a scanned copy is attached. Ms. Racicot communicated approval of this amended

language to Mr. Gjurasic. This language would not only protect occupational therapists but would also protect other allied health professionals as well.

Similarities Between the Scope of Practice of Music Therapy and Occupational Therapy

Music therapists frequently address similar treatment goals as other allied health therapists, such as occupational therapists. These types of service overlaps reinforce the treatment goals addressed and could hasten the therapeutic benefit to the patient. Collaboration with and between healthcare professionals support best outcomes and will serve in the best interest of Washington residents. What makes music therapy unique and distinguishes it from other therapies is the use of music as the therapeutic tool. The music therapy treatment plan is designed to help the client attain and maintain a maximum level of functioning using interactive music therapy strategies.

Furthermore, a major trend in healthcare is consumer choice. Consumers need and want choices in their healthcare treatment options. Certifying music therapists would provide Washington state residents access to another type of service that can enhance their treatment plan. When clients are given the choice, collaboration with and between professionals support best outcomes.

If these similarities are drawn between our two professions' scope of practice, and the Department of Health has seen fit to regulate Occupational Therapy for the health and safety of Washingtonians, then it could be argued that Music Therapy should also be regulated. Within these situations, vulnerable clients can be harmed if the therapist is untrained and uncertified and not held accountable for their actions.

WOTA's questions/comments from the Sunrise Review Hearing on August 20, 2012 *are as follows:*

1. *How does the proposed scope of practice for Music Therapists in the Sunrise Review application reconcile with their national AMTA documents of professional competencies, code of ethics and standards of practice, which are much broader in nature? WOTA is concerned that the broad scope of practice wording may be misinterpreted.*

Misinterpreted by whom? The music therapy scope of practice outlined in the applicant's Sunrise Review application is in line with our national educational, clinical training, and scope of practice standards identified by the American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT). The Washington State Music Therapy Task Force has worked closely with representatives from AMTA and CBMT to insure that the high quality standards for board certified music therapists are maintained in this state certification.

2. *The therapy concepts outlined in the proposed Music Therapy certification bill sound very similar to concepts that are in our Occupational Therapy profession. For example, both professions may use music as a therapeutic modality with students with autism and use the term Sensory Integration as a description for therapeutic practices.*

As mentioned above in the "Similarities Between the Scope of Practice of Music Therapy and Occupational Therapy" section, music therapists do frequently address similar treatment goals as other allied health therapists. The same can be said for similarities in treatment goals between speech/language pathologists, occupational therapists, physical therapists, and other specialists who work with populations in need of multiple therapy services. Since this bill is not designed to protect the use of music but rather protect the term "music therapy," it does not limit the use of music by other professions.

Therapy concepts overlap in many professions, but the implementation of each concept and the combination of concepts is unique to each profession's education, clinical training, and scope of practice. For example, several professions address communication-related goals, but the theoretical framework underlying them and the interventions used to address them will be different for the occupational therapist, the music therapist, and the speech-language pathologist. These types of service overlaps reinforce the treatment goals addressed and could hasten the therapeutic benefit to the client. Collaboration with and between healthcare professionals support best outcomes and will serve in the best interest of Washington residents. Many referrals for music therapy services are made because other members of the treatment team have exhausted their options for helping the client. Music therapists have a great deal of success reaching those clients for whom other treatments have been unsuccessful or limited. Having music therapy as a treatment options aligns with the consumer's need for and desire for choices in their healthcare treatment options.

3. *How would patient care be affected by the certification of Music Therapists?*

Patient care can only be improved if Washington creates state certification of music therapy. It will improve access to music therapy services and will mandate that these services be of high quality and be performed by qualified professionals.

4. *What is the cost of this regulation versus the benefits? Will this be confusing to clients who already receive OT services which may overlap with Music Therapy goals?*

We anticipate that the benefit to the public will outweigh the costs, if there are any. We anticipate that the impact of state certification on the costs of services to the public would be minimal. Adding state certification for music therapists creates the potential for increased access to services, additional employment opportunities, and support of students studying in the music therapy program at Seattle Pacific University. All of these factors are considered to have a positive impact for residents of the state, as access to quality services will increase as the profession is officially recognized.

If working with the understanding that client choice and access to services is of paramount importance, then any confusion between an overlap in services is a moot point. As mentioned earlier, service overlaps can reinforce the lessons imparted to the clients and could hasten the adoption of the therapeutic benefit. Furthermore, any potential confusion should be clarified by the individual therapist—occupational, music, or otherwise—whose professional responsibility involves describing their treatment goals, interventions, theoretical framework, and outcomes in a way that is understood by the client.

5. *How is access to Music Therapy currently restricted?*

Please see the above section labeled: Music Therapy and Practice Restriction as well as Examples of Misrepresentation of Music Therapy

Response to Speech/Language Pathology (SLP) claims regarding Communication Disorders:

The Music Therapy Scope of Practice addresses communication differently than SLPs and does not infringe on the SLP Scope of Practice. Since music is a non-verbal form of communication,

it would be impossible for music therapists to not address communication within client treatment. To state speech-language pathologists are the only professionals able to address client communication is not true and would restrict multiple groups of professionals in the state (e.g. occupational therapists) that deal with client communication in treatment. Just as music therapists do not own music, no one profession owns communication. Board certified music therapists (MT-BCs) typically collaborate and/or consult with SLPs in order to design a treatment plan that is appropriate for the client. It is also very common for music therapists to receive referrals from speech-language pathologists who feel that a client is unable to make adequate progress in speech therapy alone.

Jim Couture, MA, MT-BC has a certificate in vocal pedagogy that involves techniques for assessing and remediating vocal singing difficulties. Training included vocal anatomy, phonetics and various techniques as well as issues of the aging voice. One the three instructors was an expert PhD speech therapist. These are skills a music therapist with a special interest in the voice would have.

He has collaborated many times with SLPs in the hospital setting. His role as a music therapist was to assist speech therapy clients with Parkinson's, traumatic brain injury and geriatric issues to achieve goals set by the speech therapist. As such he was an adjunct therapist working with clients who responded well to music interventions that involved vocal exercises such as singing, diction and melodic intonation, all designed to assist clients to improve the quality of their speech communication. A typical example would be assisting a client who cannot speak fluidly, but who is able to learn to sing words and phrases as a form of communication.

Respectfully Submitted,

Washington State Music Therapy Task Force

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Carlene Brown, PhD, MT-BC, Associate Professor & Chair, Music Department Director, Music Therapy Program, Seattle Pacific University
Brooke McKasson, MT-BC, Tacoma, WA
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Contact information: pattic@musicworksnw.org

Language proposed regarding changes for occupational therapists from CBMT and AMTA legislative advisors:

Below please find recommended amendment language we hope you will consider for SB 6276. We believe this more accurately reflects the intent of our practices, while not restricting OTs or other related professionals from using music. We believe this language will protect OTs as they implement "non-music therapy" methods, such as AIT, Listening Therapy, and Interactive Metronome.

This language could be added in Section 4 as Numbers 1 and 2, with existing language from Numbers 2 and 3 being re-numbered as 3 and 4.

Nothing in this chapter may be construed to prohibit or restrict the practice, services, or activities of the following:

1) Any person licensed in another profession or personnel supervised by a licensed professional in this State performing work incidental to the practice of his or her profession or occupation, if that person does not represent himself or herself as a certified music therapist.

, including the use of music,

2) Any person whose training and national certification attests to the individual's preparation and ability to practice his or her profession, if that person does not represent himself or herself as a certified music therapist.

1/31/2012

Appendix D

Public Hearing Summary

And Participant List

Music Therapist Sunrise Hearing
August 20, 2012
Summary

Kristi Weeks opened the hearing at 9:00 AM. She introduced herself as Director of Legal Services and Legislative Liaison at the Department of Health, and also introduced Andy Fernando, Legislative and Rules Supervisor and Sherry Thomas, coordinator of the sunrise review process.

She next introduced the hearing panel, who will help to ensure we have all the information we need to make a sound recommendation.

- Miranda Bayne, Staff Attorney in our Health Systems Quality Assurance Division.
- Micah Matthews, Research and Education Manager for the Washington State Medical Commission.
- Peter Beaton, Economist in our Policy, Legislative and Constituent Relations Office.

Ms. Weeks stated today's hearing is for the proponents to make their presentation, and for opponents and other interested parties to comment on the proposal. Panel members and department staff will ask questions during the proponents' presentation and public testimony. She added that the recommendations in our report will be based in part on this hearing. The report is expected to go to the Secretary of Health for approval in October.

Ms. Weeks asked participants to please keep in mind during their presentations and testimony that the sunrise process has statutory criteria they should try to stick to as much as possible. This is not a legislative hearing, so political arguments or other factors outside the criteria will not help or hurt the proposal under review. It is the legislature's job to take those into account; they have specifically asked the department to look at certain criteria. It will be Ms. Weeks' job to try to keep the hearing within the time limits as well as the limits of the review.

Ms. Weeks explained the department typically holds two or three of these hearings each year, and we have been able to identify some strategies for holding a productive hearing:

- This hearing is being recorded and testimony will be shared with interested parties. Because it is important the recording is clear for future listeners, she asked that participants follow these two rules:
    1. Use the microphone when speaking. This includes panel members.

2. Please do not call out information from the audience. The person at the podium should not solicit information from colleagues in the audience.

- She reminded participants if their points have already been made by previous speakers, they do not need to repeat their testimony. Indicating agreement with previous speakers will get their positions on record.

Introduction of Applicant(s)

Ms. Weeks then asked the applicants to come up to present their proposal. She reminded them there is a 30 minute limit we provided them so there is sufficient time for panel questions and for others to testify. She stated the department has received a lot of information from various sources about the value of music therapy, so value is not as issue. She asked the applicants to please use their time to focus on the sunrise criteria that are in the law and how the proposal addresses those criteria.

Patti Catalano

Ms. Catalano presented first for the applicants. The applicants' PowerPoint is attached at the end of this hearing summary. She stated they will be presenting what music therapy is, what makes them unique, and why they should be certified.

Ms. Catalano is the music therapy program manager at Music Northwest in Bellevue. She was joined by Dr. Carlene Brown from Seattle Pacific University, Director of Music Therapy and Chair of the music department. Her research interests are in the use of music to control pain, which is a specialty of hers. She is a reviewer on the topic of music for pain relief for the International Cochrane Pain and Palliative Care Group. And Wendy Woolsey, who is also a board certified music therapist in Washington. Her specialty is Parkinson's, working with post-adoption services, and communicative disorders. She is also on the adjunct faculty of Seattle Pacific University.

She stated they are aware music is used by many professionals, and is a universal language owned by no one. They want to look at how music therapy is defined in this state. Wendy Woolsey came up to present.

Ms. Woolsey began with what music therapy is. It is the clinical and evidence-based use of music interventions to accomplish non-musical individualized goals used within a therapeutic relationship. That relationship is with a music professional that has completed an approved music therapy program and has been certified by the Certification Board for Music Therapists (CBMT). Music therapists are first and foremost highly skilled musicians who use music interventions to achieve therapeutic goals. Interventions include music improvisation, song writing, lyric analysis, the singing and playing of music, as well as music listening with individualized therapeutic goals. Goals include pain management, improving coping skills, enhancing memory, working on social, emotional and spiritual well-being, physical rehabilitation, depression, etc.

The role of a music therapist is to first assess functioning through musical responses, which includes music and instrument preferences. From the assessment, they develop treatment plans with goals and objectives, design the therapy session for individuals and groups based on their needs, and implement

music therapy interventions. They are constantly evaluating responses to treatments and adjusting their implementation as they go. They document client outcomes and participate as a member of the interdisciplinary team.

They do this in a variety of settings such as rehabilitative facilities, medical hospitals, outpatient clinics, private practice, etc. (See Slide 6 of the PowerPoint for complete list.) Ms. Woolsey explained who can benefit from music therapy, people of all ages and all abilities, from infants in the intensive care unit to preschoolers to kids with autism and other developmental disabilities to teenagers to people with neurological disabilities. Music therapists work with kids who have been adopted and are working on issues of loss at detachment. They work with older adults with Alzheimer's and other forms of dementia and those with psychiatric disorders. They also work with those in correctional facilities, and with grief and loss. There are parents of children who have been helped by music therapy who will testify later.

She then passed it to Dr. Carlene Brown. Dr. Brown introduced herself as associate professor and chair of the music department of Seattle Pacific University. She is also the director of the music therapy program, which was accredited in August of 2009. She spoke about education and training of music therapists. She explained music therapists are trained at the undergraduate and graduate levels through a comprehensive, rigorous curriculum from the program approved by the American Music Therapy Association (AMTA) and accredited by the National Association of Schools of Music (NASM). They also complete a minimum of 1,200 hours of supervised clinical training that includes a six-month internship in a competency based program.

Upon completion of academic and clinical training, graduates are eligible to sit for the certification exam to earn the Board Certified Music Therapist (MT-BC) credential. They are required to complete 100 hours of continuing education in every five-year cycle to maintain the MT-BC credential. The bottom line is that a music therapy student is first and foremost a musician. They have four years to gain competency on a professional level on what it means to be a musician. They study music extensively during those four years, including music history, theory, etc. and understand the elements of music and how to manipulate it, what it means to work with melody or rhythm, dynamics or tone, tempo. The rigor is first, being a musician. Their minimum competency level requires three instruments, sometimes four.

Students have about 140 competencies before they leave SPU. First is around being a musician, and the second is around clinical foundation. They take a number of classes in anatomy and physiology, several in psychology such as cognitive or developmental psychology, abnormal and adolescent psychology. They must also have communications. Then there are the core music therapy courses that students take around their third and fourth years. They must understand what it takes to use music functionally with different clients. They might take a class on music in special education. She teaches a course in music in medicine and her area of interest for research is in pain management. In addition to this training, music therapy students are required to have 180 practicum hours. Some of her colleagues at the hearing are out in the field working with music therapy students to understand what it means to work with different populations. Before earning the MT-BC they must still do a six-month internship at an AMTA approved site. They must then sit for the three-hour certification exam and pass it before earning the title MT-BC. They must complete the 100 hours of continuing education to maintain the credential.

Qualifications are unique due to the requirement to be a professional trained musician in addition to training and clinical experience in practical applications of biology, anatomy, psychology, and the social

and behavioral sciences. They actively create, apply, and manipulate various music elements through live, improvised, adapted, individualized, or recorded music to address physical, emotional, cognitive, and social needs of people of all ages. In contrast, when other disciplines report using music as a part of treatment, it involves specific, isolated techniques within a pre-determined protocol, using one pre-arranged aspect of music to address specific and limited issues. This differs from music therapists' qualifications to provide interventions that use all music elements in real time to address issues across multiple developmental domains concurrently.

She used an example of some SPU students working at Swedish Hospitals. Dr. Gordon Irving is the medical director for the pain and headache center. He and a pain specialist are actively trying to get music therapy at Swedish. They are working with their students to understand what it means to use music with pain patients. The MS unit was also interested in music therapy and recently instituted a practicum site with them.

Another example is the Experience Music Project (EMP) hosted with them a music therapy camp for children with autism. Parents gave great feedback and many stated it was the first time their child had been able to be part of a camp. EMP loved it because they were able to diversify their population.

Every music therapy experience is with a board certified therapist at that level of training. She tells her students their closes colleagues in terms of the rigor of the program are nursing students. Many think they are interested in this field until they see what it takes to get there.

She used Congresswoman Gabby Giffords' story of how music therapy was part of her treatment plan that helped with cognition, speech, and movement. Her music therapist who was also a brain injury specialist used singing to help her recapture her speech.

Patti Catalano came back up to take over the presentation at this point. She explained why they are seeking regulation of music therapy. She stated it is to protect the public from harm due to misuse of terms and techniques. They use specific training that allows them to determine reactions of clients, read when changes need to occur, and make sure they provide appropriate closure so the client is at a safe spot. Without the training, someone might have a situation where music brings a client to a situation they may not be ready for. They might not have the skills to determine when a client might need to be led back out, or have a different type of music. She gave an example of some of her clients with autism get "disregulated" if the music is way too fast or way too slow. She needs to be able to determine where they are physiologically and emotionally so they can be in a state ready to learn. If their state is disregulated and too high or too low, etc., they cannot be ready to learn.

They need to ensure competent practice through their training and curriculum that is accredited. They want to know from state to state that the training and exam is consistent. They also want to protect access to music therapy services. She said when they met with state agencies; regulations often require state certification for education and health care. If they don't have that state credential, there are restrictions in service delivery.

Over the last decade in a half, music has been heavily researched by neuroscientists, music therapists, and other scientists. According to Dr. Patel, a neuroscientist in San Diego, our brains light up like a Christmas tree when we're processing harmony. She said they now know that the image we had of music only being

activated on one side of the brain is too simplistic and inaccurate. She said we can see changes in our brains and in our bodies and way of being with music. Certification would also validate the prominence of music therapy in state, national and international work settings. Currently music therapists are listed as a related service with the Department of Education. They are on Medicaid and Medicare, Medicare Perspective payment system and they are recognized as an allied health service with the general services administration. They wish we had that in Washington so our citizens could access their services fully.

Certification would establish educational and clinical training requirements, examination and continuing education, a scope of practice and an ethics review procedure. One of their requirements for continuing education is to have ethics training every five year cycle.

Further gains include protecting consumers of music therapy, that residents can easily determine qualified therapists, and that facilities wanting to provide music therapy can comply with state regulations in employing them.

She briefly described their timeline of working for certification (See slide 16 for timeline). The initial draft bill from the Senate Health and Long-Term Care Committee called for registration, but later drafts changed it to a certification. Ms. Catalano wrapped up by stating that the benefits to certification are that music therapy providers are qualified clinicians with the education, clinical training and national board certification requirements for the profession. There would be improvements in access to services and facilities would be able to hire music therapists and comply with state regulations regarding hiring of health care and education providers.

She asked whether they feel they are the only people who can use music in Washington – absolutely not. They know many of their colleagues use music beautifully within their professions. They do not own music nor do others. Music is a universal language which makes it powerful. People can communicate musically in ways they cannot verbally. They want to define what music therapy is and who is eligible to practice. It is only through defining and regulating it that we can ensure residents have complete access to services and that when they ask for music therapy services, they know they are getting what they asked for.

Panel Questions

Miranda Bayne stated that she heard them say harm is related to access to music therapy services in a variety of settings, but she also heard music therapy is approved by Medicare and Medicaid. She asked the applicant to clarify.

Ms. Catalano responded it's on the newest assessment for nursing homes as one of the services. It is done along with recreation therapy there. There is a prospective payment system that is used, but not all can acquire it through them. It is listed as a related service through the Department of Education for IDEA legislation. It is included in the "shopping list" of services, not listed specifically. Their intent was stated to say there are other services your child may potentially benefit from, but they have to follow the same criteria as speech-language pathology, occupational therapy, and physical therapy that they must be proven as educationally beneficial. If proven, then the service should be provided in the school setting. What they are finding is that without it being specifically listed, school districts are not actively seeking

out music therapy. There are a few districts that have allowed some in a few schools. A few children's IEPs list music therapy for their child, which has been honored by some school districts but not others.

Ms. Bayne asked whether they are positing that if music therapists were certified, the schools wouldn't be able to deny music therapy.

Ms. Catalano replied that they have been told by different state agencies that they need that state recognition in order for them to list music therapy on the codes. That's where there would be more accessibility of services.

Peter Beaton stated that his review of the documents shows him it is great what music therapists do. He asked about page 10 of the applicant report that states since this type of regulation is not available for music therapy, there are frequently therapists who cannot provide the services in certain settings. Is there a long list of examples of where you are currently prevented from providing services?

Ms. Catalano replied that she has some specific examples she has dealt with. She stated that last school year there was a PTA who wanted to provide music therapy services for a developmental preschool program. They proposed it to the interim head of the department of special education at the school district with parental support and agreement the parents would fund it. The school district denied the proposal even though they wouldn't have to pay for it. What it came down to was after the parents gave pushback the district finally agreed but made it clear this would not be the school district providing music therapy. There was some friction with the school district regarding the use of the IEP and including music therapy.

Mr. Beaton asked about hospitals, nursing homes, mental health facilities, treatment centers, etc. whether there were more examples of access issues. Ms. Catalano said they will follow up about that.

Micah Matthews asked if the applicants could speak to instances of harm to patients. Ms. Catalano stated since there is no recognition of music therapy there is no board to report complaints to. They have anecdotal stories in state and specific examples out of state.

Mr. Matthews asked her to provide those stories. Ms. Catalano said she would follow up later in the hearing.

Ms. Bayne asked again about the issue of harm. In the report it said a person claiming to be a music therapist but does not have the proper training could potentially cause significant health and safety risks. What is the health risk of a person using music who is not a music therapist?

Dr. Brown replied she teaches a class called psychology of music, which is her background, physiological and psychological effects of music. She talks to her students about, can music hurt. If it can heal, can it hurt? A trained music therapist will understand the power of music and have respect for it, creating a sound environment. Not everyone responds to sound the same way. A trained music therapist would understand you can't just put on an IPod, especially for a vulnerable individual. A lot of her research is dedicated to if you are in a medical facility and a physician asks for an IPod for a patient and wonders whether it would hurt them. She stated they need to understand what it would do to the patient physiologically as well as psychologically. That is what this training is about, how does rhythm affect an individual, and how do you choose music, realizing someone could decide for her what would relax her in a hospital without asking her. She is a classically trained musician and she tells her students if she was in

a hospital and someone looked at her chart and noticed she was a musician and would love a certain piece of music; there are several pieces that would elevate her heart rate immediately. They would not know any better. Her students need to know the power of music and that they can uplift but they can also hurt.

Ms. Bayne asked a follow up question that on the one hand they want to protect themselves from the people who want to call themselves music therapists without training. On the other hand it seems like they are attempting to ensure facilities and employers can recognize what their training is and access their services. She stated she understands the title protection but asked what certification gets them in terms of helping the potential client to know they have that training. She said they have the board certification, so what's the difference.

Ms. Woolsey replied that it's not only title protection but protecting the public because there are people who will represent themselves to their clients as music therapists. They feel like they are getting a trained music therapist with the certification and degree and a scope of practice. It protects the public because when someone is asking for a music therapist; that is what they are getting.

Mr. Beaton asked about physiological responses aside from heart rate that they use to gauge the therapy is working.

Dr. Brown said it depends on the setting and on the client. There are many variables one takes into consideration. First and foremost they ask the person. They never assume. If they can get direct feedback, that is ideal. There are other ways to rate pain. They can also get information from family members. That is information gathering that can be used to assess. They work with social workers, educators, etc. to have as complete a picture as possible to understand what goals they need so work toward using music to get there. She said they are constantly evaluating what they are doing to make sure there is no harm.

Mr. Matthews asked the applicants to detail more about the 180 hours of clinical training, what classes are required. He also asked whether they work with other allied health professionals to make sure they are not doing harm in their areas of specialty.

Dr. Brown stated psychology of music. She said they are evidence-based and there is literature on that. The 180 hours as an undergraduate that is completely supervised by her colleagues. The students may go out one day a week working side by side with people like Patti Catalano to understand the process. But before they can designate themselves as music therapists there is the six-month clinical training, which is full-time. They are music therapy interns during that time. Once they have demonstrated competency and proficiency in a number of areas, they are eligible to take the exam. They must pass the exam before they are a board certified music therapist.

Ms. Woolsey added there are also the core music classes they must complete, as well as abnormal psychology, music theory and history.

Mr. Beaton asked for more specificity on bodily responses besides heart rate. What does it mean?

Dr. Brown said they can go back and look at data on pain responses such as respiration and heart rate to see whether someone is tense or in a relaxation mode. Ms. Woolsey added an example of a music therapist often working with physical therapists on gait training for seniors or people suffering from stroke or Parkinson's. They can see physiologically what the response to music is to the rhythm as well as

the music that can be monitored and changed if necessary to a more effective gait pattern. She said they can do it with a metronome, but what music adds to it is structure. They have found gait training is not whether you can get from point A to point B but how a person is getting there in his or her stride. When going from point A to B, if it was simply getting to those points, it wouldn't matter. But what they are seeing is how the gait becomes an effective pattern, creating less risk for falling for these patients. People with Parkinson's can use this to get out of a "freeze" or stop them from freezing. If they learn words along with a melody, they can use it outside of therapy to get out of the freeze. They can also measure infant responses to music through neural imaging so now they can measure brain response to music.

Ms. Catalano read a story of harm that a music therapist had shared with them that they had included in their proposal documents. The music therapist was working in a major children's hospital when one of the PICU doctors called him or her in to consult on a case. There was a young teenager who ran his snowmobile into a tree and suffered a traumatic brain injury. He was in a stage of coma where he was extremely agitated. His parents consulted with someone who claimed to be a music therapist, but was not. That person programmed music for them to play at their child's bed side to help him relax. The result of that music was increased agitation, increased heart rate (to dangerous levels), and decreased oxygen saturation rates. This necessitated increased sedation medication which can have negative side effects.

Luckily, the doctors knew to call in the qualified staff (music therapist) to consult on the case. They were playing some beautiful Mozart concerto when the music therapist arrived. The child was in restraints and writhing on his bed. When the mother was asked if her son liked classical music and if that would have been his music of choice to relax to prior to the accident, she replied, "Oh no. He hates classical music!" The music therapist then asked them to turn the music off, but his agitation continued. He or she asked what music he would relax to and his parents refused to say because they were ashamed. Once it was explained they could deal with his poor musical taste after recovery and explained why they would be using music purposefully and cited some research, the parents were on board. His sister revealed he liked to relax to gangster rap. His mother said this was unimaginable to her, but for this child, that is what would work. So, after conducting further assessment, a music listening program was set up specifically for him. As soon as the music started playing that would work to help him relax, he let out a huge sigh and visibly relaxed. His heart rate lowered to normal in less than three minutes and his oxygen saturation rate went from 82% to 96% and remained stable. He was able then to relax and fall asleep without further

Ms. Bayne asked about the third criterion regarding cost benefit. She said she read somewhere in the materials that there are 45 music therapists in Washington. In terms of covering regulatory costs, she stated the applicant had said it will be covered by licensing fees. She asked whether the applicant considered discipline costs, whether they could cover high enough licensing fees for everything including discipline. She warned that one large disciplinary case could raise licensing costs substantially.

Ms. Catalano said they are aware the fees must cover everything.

Mr. Matthews gave some examples of licensing fees, stated that a large percentage of the fees are due to discipline, and asked what a reasonable fee would be for the applicant for such a small number of practitioners.

Ms. Catalano wondered how this is all figured. Ms. Weeks stated they should really consider this a warning that small professions can end up with very high licensing fees because they are shared by so few

practitioners. She gave the example of genetic counselors, a newly licensed group with a similar number (around 50) and their fees are around $450 per year, so they need to look at whether their proposal is cost-effective.

Ms. Catalano said that will definitely be a consideration.

Mr. Beaton asked for a better example showing unregulated practice can clearly endanger public health, safety and welfare to meet the criterion.

Ms. Catalano said it is difficult to find these since there is nobody to report problems to. They only have anecdotal evidence or information from other states. She reiterated that care must be taken with music because there are physiological responses. Improper training can cause harm. They need to know who is providing the service.

As an example of physiological changes that occur, she told a story of her mother-in-law recently being in the ICU under distress. She watched her mother-in-law's O^2 and heart rate stats closely because she knew she needed lower heart rate to decrease the distress.

Ms. Bayne stated the board certified music therapists have a higher level of education and knowledge and do a different level of work than the thanatologists and others. She asked whether the concern is that others are representing themselves as music therapists or those bringing music into other types of treatment don't know the difference. Or is there a large problem with representation by non-qualified people calling themselves music therapists?

Ms. Catalano responded there are different levels of care in Washington, many using passive music and watching for physiological and emotional responses. She stated they have a different level of training, and include active music making in their practice, as well as having an internship and clinical training.

Ms. Bayne tried to clarify if music therapists were certified, would it stop some treatment settings from hiring someone who is not a music therapist, or whether it is an educational issue between the different types of music professions.

Ms. Catalano stated if they are doing music therapy it is a problem. There may be a harpist at the bedside, a trained musician playing for ambient music, while the music therapist is working with a client, so it can be confusing. They want the facilities to know they are getting music therapy.

Ms. Bayne asked wouldn't the person hiring them know the difference and know to look for certification? She asked what certification gets them in terms of that person understanding what a music therapist has that another type of music professional does not. She asked what certification does to protect those people from unregulated practice.

Dr. Brown stated validation from the state would matter. A degree program says something, and so would the state be saying that with certification. Everyone can use music but when you say you are a board certified music therapist, it should mean something and we are asking for recognition of that.

Ms. Catalano added that when a hospital hires a therapeutic musician or music therapist, it is dependent on their goals. If certification leads to things like reimbursement, that will also help hospitals and others recognize they should hire specific music professionals for different goals. Reimbursement will help

hospitals provide more services if they can recoup their costs. Services can be expanded because they will be able to afford them.

Ms. Bayne stated the need for reimbursement doesn't tell us how unregulated practice leads to harm.

The applicants asked whether it would be helpful to provide a list of people who have represented themselves as music therapists who are not. Ms. Weeks replied only if it will show harm.

Mr. Matthews asked whether the national board has a mechanism to verify certification status.

Ms. Catalano stated they do, and it is very simple. There is an area on their website, www.cbmt.org, under Certification, and Status. By entering the person's name they can easily verify their certification status.

Mr. Matthews asked how that would be more difficult for an organization hiring a music therapist to make sure their certification is current.

Ms. Catalano stated it comes back to educating on what they are getting, what is validated. The AST does go out to educate different settings on what music therapy can do for them. It is really the education piece.

Mr. Matthews agreed they should continue to educate people.

Ms. Catalano stated she is constantly educating people and are continuing to grow. There were four new music therapists that have moved into Washington recently.

Public Testimony

Roger Pawley, Snohomish County Music Project

Mr. Pawley is executive director of the music project. They support the legislation. He is not a musician or music therapist so is coming at this from a business perspective. He was asked a few years ago to join the Everett Symphony to try to save it. They couldn't save it but they came up with a new organization (Snohomish County Music Project) with an expanded mission of advocacy for music education. There hadn't been a music program in their area for 25 years. They are connecting with different groups to keep music programs in their schools.

The other initiative was that the community's nonprofits needed help raising money. They came up with a benefit orchestra and helped senior services raise a lot of money. Their mission is to use the power of music to inspire people to do good in their community. It became very clear music therapy would address many issues in the community and they realized they should bring music therapy into their mission. They are designing a program to bring music therapy to veterans, youths, seniors with dementia and depression. They are committed to increasing accessibility. There should be more than 45 music therapists in our state.

He told a story about the Everett Herald running a recent editorial called Hate Music and a Shooting, about the Wisconsin shooting and whether music caused it. Can we blame music for people's actions? He wrote a letter agreeing with the position that was published and he asked whether we can harness the power of music for good things. Music therapists are doing that.

He stated they urge support for this proposal for the health and safety of the community. They deserve to have the same recognition as other mental health professionals and the music project wants to be able to hire music therapists.

Regarding dangers, he asked wouldn't they be the same as any other mental health professional, for example a patient with PTSD or adjudicated youth in a therapeutic environment with a trained mental health professional, but in this case they are using music. He asked don't we want someone who is qualified and certified. We don't depend on the real estate association to credential real estate agents in the state.

Mark Gjurasic, Washington Occupational Therapy Association (WOTA)

He began by stating their testimony was submitted to the department prior to the hearing. Although WOTA supports the use of music therapists and acknowledges their benefit, they have some concerns. They oppose the legislation and the need for regulation for certification. They have concerns with the scope of practice in the proposal which overlaps with the occupational therapist (OT) scope in RCW 18.59. Many OTs use music as a modality in their practice. WOTA supports professional regulation that benefits the consumer; however they do not support this legislation. They offered amendment to protect OTs' right to use music in their practice. They believe the amendment would have been adopted if the bill had passed out of the committee.

Here is the amendment language: New section 2, no person may practice music therapy or represent oneself as a music therapist by use of any title unless certified as provided for in this chapter or licensed as an occupational therapist as defined by RCW 18.59.020(3)."

Since this hearing, WOTA has continued dialogue with the music therapists at both the local and national level to more closely study their proposed Scope of Practice and educational background.

To illustrate the scope of practice concerns, Mr. Gjurasic offered a table of a side by side comparison of defined practice areas in both Music Therapy and Occupational Therapy which look startlingly similar (attached at the end of this hearing summary). Mr. Gjurasic also added the following questions from WOTA on the sunrise proposal:

1. How does the proposed scope of practice for Music Therapists in the Sunrise Review application reconcile with their national AMTA documents of professional competencies, code of ethics and standards of practice, which are much broader in nature? WOTA is concerned that the broad scope of practice wording may be misinterpreted.
2. The therapy concepts outlined in the proposed Music Therapy certification bill sound very similar to concepts that are in our Occupational Therapy profession. For example, both professions may use music as a therapeutic modality with students with autism and use the term Sensory Integration as a description for therapeutic practices.
3. How would patient care be affected by the certification of Music Therapists?
4. What is the cost of this regulation versus the benefits? Will this be confusing to clients who already receive OT services which may overlap with Music Therapy goals?
5. How is access to Music Therapy currently restricted?

WOTA is interested in continuing dialogue to make sure all concerns are addressed and the needs of the public are best served.

Claudia Walker
Ms. Walker stated she was a music therapist for 30 years and was certified. She is now in the field of music thanatology and is representing this field today. She job-shares at the Everett Providence Regional Medical Center as a music thanatologist and she works with hospice patients in the community. She said she also represents eight other thanatologists in Washington. They are monitoring this legislation as a potential example for their profession for the future.

Their concerns about the proposal are more about the precedent it sets rather than the proposal itself since they do not represent themselves at music therapists. They are concerned the case for regulation must be convincing. While they agree with the value of music therapy, they have concerns the proposal doesn't make a compelling case because:

- There are ample tools available to evaluate the qualifications of music therapists for employers and the public.
- No significant harm has been demonstrated nor has evidence been provided showing music therapists have been shut out of employment.
- Costs of the proposal are underestimated. The state cannot delegate oversight and so would take on significant responsibility which would require the need to hire staff.

She reiterated they are not opposed to regulation but they do not feel the proposal makes the case for regulation at this time.

Cheryl Zabel, Music for Healing and Transition
She started by stating she is not a music therapist and would never presume to call herself one. She said they are music practitioners. They are also concerned with the bill's language that may restrict their ability to practice within the scope of their work. She read a letter from her executive director, Melinda Gardener, Chair of the Executive Board of the Sound and Music Alliance (SAMA), a 501c6, Not-for-Profit professional membership and trade organization. She said this letter was written at the direction of SAMA's Executive Board.

SAMA is a nonprofit professional membership organization bringing together those who believe that the conscious use of sound and /or music with positive intentionality has a place in healthcare, education, art, wellness and care for the environment. SAMA represents an array of disciplines, such as acousticians, caregivers, clinicians, educators, musicians, physicians, practitioners, researchers, and therapists.

The Executive Board of SAMA fully supports the desire of the Music Therapy profession to seek state licensing or state certification, and to regulate the use of their professional title, *Music Therapist*.

She stated they find that certain language in the bill has the potential of preventing other extensively-educated professionals who use music and sound as a modality for treating clients from practicing their profession and making a living in Washington.

She gave the following examples:
Section 1, # 3, defines what Music Therapy means. These sections also define some of the skills of other professionals, and are not unique to Music Therapy which has already been addressed to some extent today.

- The assessment of a client's emotional well-being, physical health, social functioning, communication abilities and cognitive responses to musical stimuli.
- The development and implementation of treatment plans based on a clients assessed needs, using music interventions including music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, music performance, learning through music and movement to music.
- The evaluation and documentation of the client's response to treatment.

Section 10 of the bill defines the terms "health profession," "certification," and "practitioner" solely in terms of state regulation. There are many disciplines that grant the title "practitioner" and confer "certification," that are not governed by state law but are governed by national accrediting or certification boards. In addition, the public, other health professionals, including the healthcare facilities that hire them, accept them as legitimate and respected professions.

She stated this letter was signed by a number of professionals and submitted to the department. She added she personally works 15-17 hours per week providing therapeutic music at bedsides at three hospices and skilled nursing facilities, not as a music therapist. She is constantly assessing and evaluating what music is appropriate for the patients, whether an elderly memory care patient or a critically ill patient. They are trained to monitor how the music is affecting the patient and they constantly adjust it to meet their needs. She also provides music in a thanatology role, assisting a patient in letting go in the final stages of life. She stated they are certified through their own organizations with standards of ethics. She wants to ensure these are recognized in the music therapy legislation so their practice is not restricted.

Someone on the panel asked for Ms. Zabel to identify her title. She replied Certified Music Practitioner, and that she would never presume to use the title music therapist. She said the public does call her a music therapist all the time and she is continuously correcting them and educating them to know the difference in training and what care is being provided.

Ms. Weeks asked what her certifying body is. Ms. Zabel replied the National Standards Board for Therapeutic Musicians. This board oversees the Music for Healing and Transition Program, in which she was trained and certified. She is the area coordinator for Washington.

Judy Anderson, Harp for Healing
She stated she is not at the hearing as an official representative, but is a clinical musician intern in a program for playing music at the bedside. Her profession is also certified by the National Standards Board for Therapeutic Musicians. She has worked for over a dozen years in the medical and legal fields, working with the physically and mentally disabled. As an active member of the bar association in California, she stated she is well aware of what labels mean. She stated she understands why they are

seeking this certification, but her concern is that a hospital reading the law may decide to play it safe and if someone is not certified, they won't let them play music at the bedside.

Ms. Anderson related a story from seven years ago as her father was dying in a hospice. She said when he was asleep she walked around and saw many lonely people and she was concerned about that. She ended up involved in this program. She wanted to emphasize the differences in their professions. They do not engage with the patients (she hasn't begun practicing yet because she's getting ready to start an internship). They are not therapists. They play live music. She stated the examples earlier about harm were with recorded music. Since they are playing live they can observe the patient and can often ask the patient if they want to hear music. They pay attention to patient reactions. Their first goal is to do no harm so they pay attention and are taught what to look for in the monitors. This is not interactive. They are in the background playing. If the patient falls asleep, that is a victory because it shows they are relaxed and that probably their pain is decreased. They don't have treatment or therapy plans or goals. They just hope to make the patient feel better.

The way the bill is written is confusing. She suggested the addition of a simple addendum. If she wants to go into a hospital and play for a family member, would they stop her under this bill? She understands what certification means, but suggests the addition of the following language:

> This law is not meant to apply to those who play music for patients without engaging in treatment or therapy. Family members, bedside musicians, therapeutic musicians and others playing at the bedside of patients without therapeutic interaction are excluded from the requirements of this law.

She just wants to make sure these people in hospices who can do a lot of good are not excluded from doing their work.

Melissa Johnson, Washington Speech-Language-Hearing Association
Ms. Johnson stated they have concerns about the broad scope of practice, specifically around the language in SB 6276, the communication disorder language in the definition section. It allows the assessment of communication disorders. Speech-language pathologists (SLPs) are uniquely qualified to assess and treat communication disorders. This bill includes a broad range of items under communication disorders. They don't think the education of music therapists supports this broad scope of practice. The SLP has a master's degree or doctoral degree, certification through ASHA, their national counterpart, and testing that goes along with it. They are concerned that leaving that language doesn't support the education a music therapist receives. They ask that the section be clarified, narrowed, or removed from the bill.

Micky Stewart
Ms. Stewart stated she is at the hearing as an expert in autism, not because she has been through a credentialed program as an MD, OT, speech therapist, or music therapist, but because she lives 24 hours a day with a teenager who needs constant adult supervision due to his autism. She stated she wanted to address the question of harm. Her child has been dismissed from speech therapy because the therapist could not deal with his behavior. He runs away, out of a therapy setting. He

hits. In addition to harm that could be done to her term through “disregulating,” which is over-excitement or inability to help him calm himself, harm can be done in restraining him. Harm can also be done to the practitioner if they don’t know how to deal with her child.

She has worked in medical facilities and with various practitioners. In this legislation there is a bit of a turf war. She said it was interesting to her when the speech-language therapists have said they aren’t really qualified. Speech therapists and OTs both do feeding therapy. As a parent and a person looking for qualified practitioners, she doesn’t think there should be only one practitioner whose territory it is to do these things exclusively.

She also stated one therapy does not work for all patients. For example, one medication doesn’t work for all patients with asthma. She has found that they have been able to reach their son through music. Her child has regressive autism, meaning he had language and other skills and lost them. The first time her out-of-state mother-in-law heard her grandson speak was when Ms. Stewart began the lyrics of a song and stopped and her son would sing the rest of the lyrics. Music reaches him. Rhythm reaches him. If he is disregulated he can jump on a small trampoline and calm down. If they are driving in a car and he is hitting the seat in front of him and they ask him to sing, he calms down.

Her concern is that she has a professional working with her son who understands his disorder and how to help him progress. Speech-therapists may ask a student to repeat something. Eye contact is a concern for children with autism because they don’t look at you when they speak. However, if her son is playing an instrument and needs to see when it is his turn, for example on the drums, he needs to take his cue from the other people playing music with him. He needs to pay attention so he doesn’t get criticized and in order to remain a part of that group, he must pay attention. It’s a painless way of learning some lessons for him.

As a parent she is concerned because when the panel asked about certification earlier, it seemed like everyone is certified, the thanatologists, the healing harpists, etc. She said it’s hard as a member of the public to figure out who does what. Also, there are a lot of people who want her money. Part of her job is separating the skilled from the unskilled people. Recognition from the state would help, and would help her in paying for services. As a parent, it is expensive to have a child with autism. Any help she can get through insurance paying for music therapy, or those who can get it paid through Medicaid, would be a great service.

She believes music and music therapy are fundamental to helping her child progress. She would like to see as much recognition as possible. When she hears people talk about the cost in regulating this, she stated there is already a mechanism in place, for example the medical board that oversees physicians in Washington. She says she is very comfortable in saying that music therapy has changed her son’s life. She would like to see other parents and children have that opportunity and she would like help in paying for it. State recognition makes a difference to her.

Ms. Weeks gave next steps in the process:

- There is an additional 10-day written comment period starting today through August 30 at 5:00 for anything you feel has not been addressed.
- We will share an initial draft report with interested parties in September for rebuttal comments. Those of you participating today will receive the draft as long as we have contact information for you.
- We will incorporate rebuttal comments into the report and submit it to the Secretary of the department for approval in October.
- Once the Secretary approves the report, it is submitted to the Office of Financial Management for approval to be released to the legislature. OFM provides policy and fiscal support to the Governor, legislature, and state agencies.
- It will be released to the legislature prior to legislative session, and will be posted to our Web site once the legislature receives it.

Participants

Applicants
Patti Catalano,
Wendy Woolsey
Carlene Brown

Pro
Wendy Zieve, music therapy
Roger Pawley, Snohomish County Music Project
Brook McKasson, music therapy
Nancy Houghton, Music Therapy Association of Washington
Micky Stewart, son with autism
Emily Muren, MT-BC and parent of child with disability

Con
Mark Gjurasic, Washington Occupation Therapist Association (oppose/concerns)

Concerns
Claudia Walker, music thanatology
Judy Anderson, Harp for Healing
Melissa Johnson, Washington Speech-Language-Hearing Association

MUSIC THERAPY: WASHINGTON STATE SUNRISE REVIEW

Washington State Music Therapy Task Force
August 20, 2012

Introduction to Music Therapy

Music Therapy is:

- **the clinical and evidence-based use of music interventions**
- **to accomplish individualized goals within a therapeutic relationship**
- **by a credentialed professional who has completed an approved music therapy program.**

What do music therapists do?

Music therapists
are *highly skilled musicians*
who use music interventions
to achieve therapeutic goals.

Therapeutic Goals…such as…

- Pain Management
- Improve coping skills
- Social, emotional, and spiritual support
- Facilitate and improve expression
- Decrease restlessness & agitation
- Enhance memory
- Assist in physical rehabilitation

Research in music therapy supports its effectiveness in a wide variety of healthcare and educational settings.

The role of a music therapist..

Assess functioning through musical responses

Develop treatment goals and objectives

Design music therapy sessions for individuals and groups based on client needs

Implement music therapy interventions

Evaluate response to treatment

Document client outcomes

Participate as member of interdisciplinary treatment team

Where do Music Therapists work?

- Rehabilitative facilities
- Medical hospitals
- Outpatient clinics
- Psychiatric hospitals
- Day care treatment centers
- Agencies serving persons with developmentally disabilities
- Community mental health centers
- Senior centers
- Nursing homes
- Hospice programs
- Drug and alcohol programs
- Correctional facilities
- Group homes
- Schools
- Private practice

Who Can Benefit from Music Therapy?

Infants→Preschoolers→School-aged→Teens→
Adults→Older Adults→People of all ages!

Developmental disabilities, speech and hearing impairments, physical disabilities, neurological impairments, medical illness, gerontology, autism, psychiatric disorders, Alzheimer's disease, hospice

Persons in correctional facilities; persons experiencing crisis, trauma, grief and other mental health issues

Education & Clinical Training

- Music therapists are trained at the **undergraduate** and **graduate levels**, completing a **comprehensive and rigorous curriculum** from a music therapy program **approved by the American Music Therapy Association** **(AMTA)** and **accredited by the National Association of Schools of Music (NASM).**

- Music therapists complete a minimum of **1200 hours** of **supervised clinical training** including a **six-month internship** in a competency based program.

Board Certification

- Upon completion of academic and clinical training, graduates are eligible to sit for the **certification exam** to earn the Board Certified Music Therapist (**MT-BC**) credential.

- Continuing Education: **100 hours of continuing education** in every five-year cycle thereafter must be completed in order to maintain the nationally accepted professional credential of MT-BC.

How are we different from other disciplines?

- **Qualifications are unique** due to the requirements to be a **professionally trained musician** in addition to training and **clinical experience in practical applications** of biology, anatomy, psychology, and the social and behavioral sciences.

- Music therapists **actively create, apply, and manipulate various music elements** through live, improvised, adapted, individualized, or recorded music to address physical, emotional, cognitive, and social needs of individuals of all ages.

How are we different from other disciplines?

In contrast, when other disciplines report using music as a part of treatment, it involves specific, isolated techniques within a pre-determined protocol, using one pre-arranged aspect of music to address specific and limited issues.

This differs from music therapists' qualifications to provide interventions that **utilize all music elements in real-time** to address issues across **multiple developmental domains concurrently.**

Music Therapy in the News

Congresswoman Gabby Giffords suffered a brain injury – she has relearned how to talk, partly credited to working with music therapists.

Why regulate music therapy?

It is necessary to regulate…

- **To Protect the public** from harm due to misuse of terms and techniques
- **To insure competent practice**
- **To protect access** to music therapy services

Current challenges…

- **Existing State Regulations** require official state certification for education & healthcare
- No state recognition means **restrictions in service delivery**
- Therefore, state residents have **difficulty accessing services**

What would certification do?

- **Recognize** music therapy as a valid, research-based health care service
- **Validate** the prominence of music therapy in state, national and international work settings
- **Establish** educational and clinical training requirements
- **Establish** examination and continuing education requirements
- **Establish** music therapy Scope of Practice
- **Establish** an ethics review procedure

Further gains

- Including music therapy in state-wide legislation that protects consumers of music therapy
- Washington residents and businesses can easily determine qualified music therapists
- Facilities wanting to provide music therapy services can comply with state regulations in employing music therapists

Attempts to address the problem – a timeline

Date	Event
September, 2007	Meetings with state agency officials indicated a need for state recognition – Depts. of Early Learning, Mental Health, DDD Waiver, Special Education Operations, Aging and Disability Services
January, 2008	Music Therapy licensure introduced (Rep. Darneille)
July, 2008	Sunrise Review not done – required official request from DOH

Timeline continued…

2008 - 2011

March, 2011

June, 2011

July, 2011

- Music Therapy State Recognition Task Force – Local Advocacy work
- **Music Therapy Hill Day – Olympia**
  - Legislators signed on for bill sponsorship
- Sen. Steve Conway, 29th LD facilitated meetings with Health & Long-Term Care Committee & Department of Health
- Chairs of Health & Long-Term Care Committee, and Health Care & Wellness Committee recommend bill for registry

Timeline continued…

August, 2011	Poll of Washington State music therapists by task force → support for pursuing state registration
September, 2011	Task Force contacted Counsel for Health & Long-Term Care Committee to pursue registry
November, 2011	Draft of bill sent to Task Force for review by Counsel for Health & Long- Term Care Committee

Timeline to certification…

December, 2011

January, 2012

- Bill draft sent to Task Force by Counsel reflecting certification instead of registry
- Bill language agreed upon and submitted for 2012 Legislative Session
- SB 6276 sponsored by Sen. Conway, Keiser & Pridemore
- HB 2522 companion bill sponsored by Reps. Darneille, Van De Wege & Goodman

Timeline to certification…

February, 2012	Music Therapists testify in public hearing for SB 6276 – Certification for music therapists
	Sen. Keiser decides bill should be submitted for a Sunrise Review
April, 2012	Sen. Keiser requests Sunrise Review from the DOH who notified Task Force
June 1, 2012	Task Force submits the Sunrise Review Report

Benefits to the public through certification

- Music Therapy Providers are qualified clinicians with the education, clinical training & national board certification requirements for the profession
- Improvement of access to services
- Facilities can hire music therapists and comply with state regulations regarding hiring of healthcare/education providers

Q & A

Thank you!

Appendix E

Written Comments

Music Therapist Sunrise
Public Comments
August 30, 2012

Comments Received Prior to Hearing

I am writing with a concern about the above mentioned bill. The current language would exclude the other practitioners and this means I cannot practice my livelihood. As a Certified Clinical Musician, I have studied with one of 3 national programs, all certified by the National Standards Board, to play at the bedside to assist in stabilizing vital signs and to play at hospice. We are trained in the use of various keys, harmonics, tempos and whether or not the music is familiar in order to assist individuals. We have standards of practice and training in ethics, hospital protocol, and hospice. We do not do the same things that music therapists do.

I do not wish to prevent music therapists from becoming licensed if that's what they want. But please, do not use exclusive language.

If I can provide any further information, please let me know. I have asked Sable Shaw of the National Standards Board to send you some information.
Beth Cachat

This email is in regards the certification of Music Therapists in the state of Washington. I am a practicing speech-language pathologist in outpatient, acute hospital, and inpatient rehab settings. I have had the opportunity to work in co-treatment sessions with music therapy for adults and children with a variety of diagnoses. I have seen patients drastically improve in speech, language, cognition, and pragmatics after the addition of music therapy to treatment. I have seen the positive effects of music therapy through many experiences such as a nonverbal woman post stroke miraculously singing the chorus to "Amazing Grace" initiated by the MT or a child with severe autism who finally made eye contact while playing with drums under the direction of the MT. Music therapy change behaviors, attitudes, and progress in treatment. More importantly it significantly change the lives of people who needed help.
Lauren F. Allen, M.S. CCC-SLP

I have read the proposed bill, I believe music can be beneficial, and believe in state recognition and licensing of health professions as a protection of the public, first and foremost. I wish to ad my support of senate bill 6276.
Gary Vigeant

I am a licensed psychologist with 20 years in clinical practice. I have a specialty in complex trauma with very seriously injured adults and adolescents. I use music in my practice to help ground patients who are overwhelmed or numbed during the work which is painful and difficult. According to these proposed regulations, I wouldn't be able to use or describe the music in my practice. Surely this is not intended. I should be able to use music and describe the use of music in my practice without running afoul of a credential that is at a lower level of training than my own.

In addition to my clinical psychological credentials, I studied piano for 9 years, and bring my ipad to my office to play musical recordings. I utilize Native American song, drum, and stories. On occasion, I also

play piano for various purposes including grounding, resourcing, education, and to facilitate the ventilation of emotions nonverbally, telling of a story or metaphor for healing purposes, etc.

Please be aware of unintended consequences regarding the use of music for those well qualified to use it in the context of their other practices and license. Music can augment a great many interventions and need not be a stand alone intervention.

Respectfully submitted, -Sandra
Sandra Paulsen, Ph.D

This proposed legislation is not about working for *a safer and healthier Washington*. It is about money and control. This puts Big Government and Big Medicine in charge of Music Therapy, with is one of the last bastions of private practice. Private practitioners will find it impossible in all but the most select cases to comply with the burdensome mandates that will be attached to certification that favors state and corporate medicine. We have already seen this happen with similar changes to the Counselors Licensing and Hypnotherapy Certification. The number of Counselors in practice dropped from about 16,000 to 10,000 soon after the new certification became effective. (Formerly, many counselors chose to work part time, without expensive facilities, providing more options for clients in terms of therapies and costs. - And absolute confidentiality. With the loss of almost 40% of Registered Counselors, this left an underserved client population who now have restricted care options.) Licensing music therapists as health care providers will (eventually) allow the state to obtain reimbursement under a socialized medical system. It is no secret that such a system is not cost-effective. Since a music therapy program requires very little in the way of medical resources, it would be a goldmine for enhancing revenue collection to support other under-funded programs.

Also, ask yourself what the alleged justification is for these changes. Have there been complaints and grievances about unprofessional conduct? Are practitioners or clients dissatisfied with the *status quo*? *Qui bono?* (Who benefits… follow the trail of money.)

Where does much knowledge of Musical Therapy originate? Is it ironic that tribal healers and aborigines (digeridoo) would be considered unqualified to practice (or even teach/speak in a free and open manner without choosing their words very carefully) under proposed changes?

Dr. Benjamin Rush, one of the signers of the constitution, reportedly said this about the Constitution around 1787:

"The Constitution of this Republic should make special provision for medical freedom. To restrict the art of healing to one class will constitute the Bastille of medical science. All such laws are un-American and despotic. ... Unless we put medical freedom into the constitution the time will come when medicine will organize into an undercover dictatorship and force people who wish doctors and treatment of their own choice to submit to only what the dictating outfit offers."
Dennis and Norene

I am a Certified Therapeutic Harp Practitioner who graduated from the International Harp Therapy Program in 2000. I am writing to you because I would like you to be aware of the community of therapeutic musicians of which I am a part.

I am not a music therapist. May I please offer a definition, as described by the National Standards Board for Therapeutic Musicians, of a music therapist and a therapeutic musician:

"The music therapist uses musical instruments and music making as therapeutic tools primarily to rehabilitate the normal functions of living and improve quality of life through studying and promoting measurable changes in behavior. A therapeutic musician uses the artistic application of the intrinsic elements of live music and sound to provide an environment conducive to the human healing process."

In WA SB 6276, it is very important that there is no language in the bill that is exclusive, that inadvertently limits therapeutic musicians from practicing their profession within the perimeters and guidelines we have established for ourselves in our particular therapeutic music trainings and under the guiding auspices of the National Standards Board for Therapeutic Musicians.

May I please use myself as an example to demonstrate to you the course of study, internship and CEU requirements and the actual practice I have done as a therapeutic musician to give you an overview and understanding of what one therapeutic musician has done to become and remain certified:

- Over an 8 month time period, I took 3 one-week modules in 3 different sites. Course of study in part included music development, psychology, hospital etiquette, death/dying, intunement and healing and hospice and hospital experiences.
- Fourth module of a 90 hour internship done over 10 months. I played therapeutic harp in a hospital in surgical service and rehab.
- Once certified, I have provided 430 service hours of therapeutic harp music in a hospital where I played in the Skilled Nursing Unit, Sub-Acute Rehab, waiting room lobbies, Neuro ICU, Cardio ICU, and Neuroscience unit. I also played therapeutic harp at an assisted living community, providing 143 service hours over a period of a year.
- I would also like to add that I am a classically trained musician (BA in music) and have studied harp for 20 years.
- CEU requirements to remain certified: 20 hours for each 2 year period. Examples in part include 30 hours of hospice training, 2 units of the Sacred Art of Living/Dying program, hospital pastoral care workshop on dementia, delusion and coma, medical terminology and private harp lessons.

I am trained to play at the bedside for the ill and dying, and at nurses' stations. I currently play therapeutic harp music on units (not in patients' rooms) to bring a relaxing and soothing presence to the often stressed staff, family members and patients in the units for which I play. The harp repertoire I may choose from may include Celtic, medieval, classical, popular, world music, improvisational or modal music. The choice of repertoire is guided by the needs of the space for which I play, to provide a calming presence in the environment I am in. This is not entertainment or a performance. It is functional music that serves a specific purpose.

Thank you for giving me the opportunity to share information with you about therapeutic music. I hope that this will help you understanding the importance of creating language in WA SB 6276 that is inclusive and that does not deny therapeutic musicians the right to practice their profession.
Barbara Broderick

I am writing to you to express my concerns with Senate Bill 6276, regarding the state certification of music therapists. I have no objection to nationally certified music therapists asking for state certification. My concern, after reading the bill, is that the current wording may prohibit hospitals, hospices and other businesses that care for the ill and dying from employing other types of medical music practitioners who have different kinds of certifications than music therapists. The example I'll use is my husband, Ron Pilcher. Ron works for Evergreen Hospice Center in Kirkland, Washington as a contracted certified Music-thanatologist. His job description involves playing prescriptive, palliative music for hospice patients with harp and voice. He sees patients for various issues such as physical pain, mental, emotional or spiritual suffering, respiratory compromise, sleep deprivation, depression and anxiety. His training as a

music-thanatologist involves reviewing the patient's history, taking vital signs and creating prescriptive music in the moment at the patient's bedside in response to that individual's specific and unique needs. He is referred to those patients by social workers, nurses, doctors and family members who see the positive effects these music-thanatology vigils can have, and many times is asked to work with individuals who are not responding well to other types of treatment such as medication. Ron earned his Certification in Music-thanatology (post Bachelor of Music degree) from the Chalice of Repose Project (CORP) in Mount Angel, Oregon. It was a rigorous 3-year program involving musical, spiritual, clinical and academic studies which was followed by a nine month internship and then a six month residency at Evergreen Hospice Center, where he is now employed.

Will Ron still be able to keep his job if SB 6276 is passed as currently written? I completely understand the Music Therapy Association of Washington wanting only certified candidates to be hired for music therapist jobs, but will this bill prevent hospitals and hospices from hiring other kinds of certified musician-clinicians like music-thanatologists? While there is some overlap in methodologies between the two there are also many differences between them, which is why they each have their own credentialing programs. If there is any possibility that the passage of this bill will result in Ron no longer being able to play for patients because he is not a certified music therapist, I urge you to consider adding language to the bill that will protect other types of certified musical deliveries that are currently in use in Washington. I believe it will benefit the people in our state to continue having both music therapy and music-thanatology available to them, with the care being administered by highly trained, certified personnel in both cases.

Thank you very much for reading my email. For more information about Music-thanatology, visit http://chaliceofrepose.org.
Linda Pilcher

We are writing to you as Music-Thanatologists*, a field separate from Music Therapy, and we are monitoring this legislation as a potential example for us in the future, while evaluating the pros and cons of seeking state government regulation of our profession.
Our concerns about this proposal are more about the precedent than about its application to our profession. Since we do not present ourselves as music therapists, this does not apply directly to us.

To the extent that it could provide a precedent for government regulation of the use of music in healthcare settings, we are concerned that the case be convincing. While affirming the value of Music Therapy we feel the proposal as written has certain deficiencies.
The proposal, in our view, does not make a compelling case for the necessity of the State to regulate the healthcare profession of Music Therapy:

1. There are ample tools available to the general public and to potential employers to evaluate the qualifications of a music therapist. They are the same tools as provided in this proposal. It is not necessary for the State to intervene.
2. A significant harm to the public has not been demonstrated in the proposal, nor has evidence of certified music therapists bearing the credential MT-BC, being shut out of employment.
3. The cost of state government regulation of the profession is underestimated in the proposal. The proposal suggests delegating oversight responsibility to the certifying board of the proposers (CBMT), but the State cannot eschew the responsibility and will have to create an effective oversight mechanism. The language of SB-6276 recognizes that the DOH would take on significant responsibility and authorizes hiring of staff at DOH to accomplish this. We think this is realistic but a compelling case for expenditure has not been made.

Again, we are not opposed to the concept of State regulation of the healthcare profession but for the reasons stated, we do not feel this proposal realistically projects the costs nor demonstrates the necessity of State intervention at this time.
Claudia Walker CM-Th
on behalf of the certified Music-Thanatology colleagues practicing in Washington State:
Jeri Howe CM-Th, Cynthia Dudgeon CM-Th *President, MTAI*, Roberta Rudy CM-Th, Lyn Miletich CM-Th, Donna Madej CM-Th *Certification Committee Chair, MTAI*, Betty Barber CM-Th, Catharine Drum-Scherer CM-Th *Vice President MTAI*, Julia Smith CM-Th

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My name is Maria Jokela, and I am a long term care professional writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

As a local long term care professional and Parkinson's support group facilitator, I see how beneficial music therapy improves the overall wellness of the demographic we serve. In an environment which can often be overwhelming with clinical facts and issues, music therapy (when made available) allows a more personal and relatable way to combat difficulties associated to aging and/or declining health.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for my facility and I would like to see others have the same access to services.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Maria Jokela

As the Washington Area Coordinator for the Music for Healing and Transition Program, I would like to offer the following comments during this Public Open Comment period:

The Music for Healing and Transition Program is one of several affiliated programs accredited by the National Standards Board for Therapeutic Musicians,
www.therapeuticmusician.com
www.mhtp.org

A complete list of other accredited organizations is listed on their website at the following link:
http://www.therapeuticmusician.com/styled-4/index.html

As a Certified Music Practitioner through the Music for Healing and Transition Program, we do not call ourselves Music Therapists and take great pains to correct misconceptions by the general public (on a daily basis). We don't want to interfere with the Music Therapists if they want to license themselves, but we are concerned that the language in the proposed legislation will prevent other clinical musicians from earning a living – this is very important since Washington law prevents one group from usurping another's income without grave reason. As a result, we are communicating the following information to you.

First, as a Certified Music Practitioner®, I personally work 15 - 17 hours a week, with 3 hospices, and 10 skilled nursing facilities in the Pierce/Thurston/Mason county area. Plus with a few Medicaid patients, paid by their guardians. This is how I make my living, in the most fulfilling way, bringing a healing and nurturing environment via live harp and song to the bedside of those critically and chronically ill as well as to hospice patients. I am enlisting the help of some of those organizations, who will be emailing you under separate cover about the benefits their patients have experienced through this important service.

Second, my background as a Certified Music Practitioner® encompasses the following:
1. I went through the Music for Healing and Transition Program (MHTP) certification program that that is a 501c3 Not-for-Profit, which has trained musicians to serve patients at the bedside since 1995.
   Website: www.mhtp.org
2. I am NOT a Music Therapist, but a clinical musician, specifically trained as a Certified Music Practitioner®
3. I have been required to meet medical and musical competencies, working within a specific Scope of Practice and Ethical Code.
4. MHTP has trained and certified 650 musicians, including 48 who are employed in the state of Washington.
5. I use the language Certified Music Practitioner®, to designate my certification level.

Third, the following information gives a great summary overview of the differences and benefits of therapeutic music versus Music Therapy. It is a direct copy from the FAQs page of the NSTBM website, and reads as follows:

Frequently Asked Questions about Therapeutic Music
(from the NSBTM website: http://www.therapeuticmusician.com/styled/index.html)

1. What does a therapeutic musician do?

A therapeutic musician uses the inherent healing elements of live music and sound to enhance the environment for patients in healthcare settings, making it more conducive to the human healing process.

2. What is the difference between a music therapist and a therapeutic musician?

The music therapist uses musical instruments and music making as therapeutic tools primarily to rehabilitate the normal functions of living and improve quality of life through studying and promoting measurable changes in behavior. A therapeutic musician uses the artistic application of the intrinsic elements of live music and sound to provide an environment conducive to the human healing process.

3. What is therapeutic music?

Therapeutic music is an art based on the science of sound. It is live acoustic music, played or sung, specifically tailored to the patient's immediate need, which brings music's intrinsic healing value to the bedside of the ailing.

4. What does healing mean?

We define healing as movement toward mental, physical, emotional and spiritual wholeness.

5. Who benefits from therapeutic music?

Those who commonly benefit are persons experiencing life's transitions such as birthing and dying, and

those experiencing terminal illness, injury, chronic illness and/or disease. Music may affect the listener physiologically, emotionally, mentally, and/or spiritually.

6. Where do therapeutic musicians work?

Therapeutic musicians work in a wide variety of healthcare settings. They work primarily at the bedside of patients in clinical environments including hospice, hospitals, high skilled nursing facilities, treatment centers and nursing homes. In the hospital they may work in areas that include pre-op, recovery, ambulatory care, ER, SICU, ICU, NICU, pediatric and psychiatric units.

7. Who is qualified to practice therapeutic music?

Persons who complete the approved therapeutic musician curricula and independent study from an accredited training program are qualified to practice as therapeutic musicians.

8. What is the National Standards Board for Therapeutic Musicians?

The National Standards Board for Therapeutic Musicians is a governing body for accredited programs that graduate therapeutic musicians. Its purpose is the development and advancement of the profession of bedside therapeutic music.

9. What are some misconceptions about therapeutic music?

A common misconception is that there is only one type, or style, of music that is beneficial for all patients. This is false. Each patient has unique needs, and the patient circumstances determine the type of music used. Other misconceptions are that therapeutic musicians are para-music therapists, merely entertainers, or have not received sufficient training. These are all false. Therapeutic musicians are certified through extensive training programs, which provide high-quality training and hold high standards for each graduate.

10. Is there research to support therapeutic music?

Although the documented effects of music on mood and physiology date back to the ancient Greeks and more recently to the Renaissance, today the effectiveness of music as a healing modality has been well documented in music therapy, music-medicine, nursing, psychology, and scientific literature.

Recently several controlled studies have been published which demonstrate the efficacy of live, therapeutic music in decreasing pain and anxiety and regulating heart rhythms.

11. How are therapeutic musicians paid?

Each healthcare facility funds therapeutic music differently. Funds may come out of a particular department's budget, or from the facility's foundation, auxiliary, special fund, or through a grant. Many therapeutic musicians work as employees and in private practice.

12. How is therapeutic music practiced in hospice?

Therapeutic music is used in hospice to provide support for the physical, emotional, spiritual and mental conditions of the dying and their loved ones.

13. What is a typical therapeutic music session like?

The therapeutic musician is trained to assess the patient's behavior, condition and communication in order to meet the patient's immediate need with appropriate therapeutic music.

14. What is the future of therapeutic music?

Since the inception of the therapeutic music field in the early 1990s, hundreds of well-trained and certified graduates are serving humanity and making a difference in the "comfort care" of the patients. An increasing number of healthcare facility administrators recognize the benefits that therapeutic music brings to their patients.

Please keep me posted of any and all public hearings. I will forward all information from you to the other Washington Certified Music Practitioners® and the NSBTM Legislative Action Committee. Please expect to hear from them as well as from other clinical musicians with descriptions of their training and scope of work.

We fully support the efforts of Music Therapists to obtain a legal certification framework for their specific profession. Please assure that this legislation does not hinder the abilities of other therapeutic musicians to continue in our work to serve the ill and dying.
Cheryl Zabel, Certified Music Practitioner, Harp/Song

My name is Wendy Zieve, and I am a board certified music therapist writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

I have seen in my practice that music therapy techniques have been effective with many individuals for whom other techniques have not worked. In particular, those who are non-verbal, such as those with autism, dementia, or stroke patients.
Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for many types of disabilities and I would like to see access to services in our state.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Wendy Zieve MA, MT-BC, Board Certified Music Therapist

My name is Barbara Wolff and am both a parent and grandparent of children who have benefited greatly from music therapy. I am in support of SB 6276.
When first introduced to the idea of adding music therapy to other therapies for our children, I was hesitant. I am now confident that music therapy has contributed greatly to their progress.

My daughter was adopted overseas at age 22 months. As a result, we have no medical history, However, because we had raised two healthy children to adulthood, we knew immediately that our daughter had neurological difficulties.

She has been seen by several professionals and participated in numerous therapies since age two. Music therapy has added a new dimension to her ability to concentrate, think ahead and plan. The music therapist is extremely knowledgable and professional.
My child now uses the piano to calm herself and has joined the music club at school.

My grandson, who is profoundly autistic and non verbal has clearly benefited from music therapy in ways that are apparent but difficult to describe.
When he returns to class after his session, he is quite happy and often more calm for the rest of the school day. This is not always the case with his other therapies. This may seem a minor observation but to him, his teachers and family, it is significant.

In summary, I believe that certification is essential for music therapists.

Please contact me if you have any questions. Barbara S Wolff

I am writing with regard to Senate Bill 6276. I have read the bill and appreciate the need for such a law. I certainly understand the need for basic qualification for people calling themselves music therapist.

I do have a concern, however. The law may inadvertently exclude others from playing music at the bedside of patients, including family members and bedside musicians. Bedside musicians, also known as therapeutic musicians, play music at the bedside of sick, injured, and dying patients without engaging in therapy. They can also play in emergency rooms, neonatal units, post-op recovery, and maternity wards, as well as nursing homes and for those in hospice care.

Playing live music at the bedside can help stabilize heart and breathing rates, calm patients, and reduce pain. For those who are dying, it can make the transition easier. There are training programs, certified by the National Standard Boards of Therapeutic Musicians. http://www.therapeuticmusician.com/

I have just finished the first half of the Harp for Healing program. The next section is playing at the bedside for patients in hospitals and in nursing homes. I will then be a Certified Clinical Musician. In that position, we do not do therapy and we do not interact with the patient, other than asking them if we can play and letting them know we can stop or play a different type of music if they request. This is very different from therapists who engage interactively with patients and have a treatment plan and specific goals. Bedside musicians merely play music to try to calm a patient, reduce pain, and help stabilize heart rhythm and breathing. We play for about 20 minutes with no expectations for specific results.

The law is clear that it applies to those engaging in therapy. However, some medical professionals and hospital administrators might not want to take the risk and will exclude everyone from playing music at the bedside of a patient, including family members, if they do not have the requirements called for in this bill. Therefore, I would propose a simple addition to the law to clarify the difference. For example:

“This law is not meant to apply to those who play music for patients without engaging in treatment or therapy with the patient. Family members, bedside musicians, therapeutic musicians and others playing at the bedside of patients without therapeutic interaction are excluded from the requirements of this law.”

If you have any questions about therapeutic musicians, please feel free to contact me.
Judy Anderson, J.D.

I am a Certified Therapeutic Harp Practitioner, having graduated from the International Harp Therapy Program (IHTP). This certification process meets the National Standards Board for Therapeutic Musician (NSBTM) requirements and specifically uses the harp as the key instrument.
I currently provide bedside harp music for patients within the Group Health Hospice system, offering comfort care to not only the patient, but often to family members present, staff involved in the patient's care, and occasionally even to their pets that are present.

As I understand it, the Music Therapy Association is proposing legislature (SB 6276) to establish certification guidelines for Music Therapists. As a retired Registered Dietitian, I do recognize the need for certification and regulations to "first do no harm" within the healthcare
setting.

Within the related area of healthcare there are multiple levels of education and training, i.e. MD, Physician's Assistant, Nurse Practitioners as Primary Care providers, RNs, LPNs, LVNs, in the Nursing Care, RDs and Dietetic Technicians in Nutrition Support etc. Within the area of Music Support there is also room for, as well as need, to provide this therapy/comfort/palliative care, at the different levels of training and expertise. As the son of one of my recent patients said to me within this discussion, "we need more end of life comfort care, not less".

It is of great concern that SB 6276 may in fact limit bedside music care to only Music Therapists, which would effectively eliminate many individuals that are highly skilled and trained from offering palliative and comfort care. Multiple Hospice and Long Term Care Facilities currently employ Certified Music Practitioners, like myself, in the state of Washington. They would loose there livelihood, as well as the tremendous desire to provide this end of life care.
Please do consider the impact of Senate Bill 6276.
Cynthia Golfus

My name is *Dennis Kaperick*, and I am a board certified Music Therapist writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

I have practiced music therapy at Western state Hospital for over thirty years. I have worked with every patient population and I have allied with all professional disciplines at WSH. Prior to this experience, I used music therapy with juvenile parolees in a pilot project after school program. Music therapy is a unique and valuable intervention in the therapy setting.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I know music therapy is important for my *patients* and I would like to see others have the same access to services.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Dennis Kaperick MM, MT-BC
It has come to my attention that some legislation is being proposed in WA state regarding the practice of Certified Music Practitioners and Music Therapists. We are lucky to have several Certified Music Thanatology Practitioners volunteering with our hospice program and I am concerned that this proposed legislation does not inhibit their practice in any way. These skilled professionals have gone through

extensive training to be certified in their Music Practitioner profession, which is very different than that of Music Therapists. It is extremely important not to lump the two categories together in making decisions regarding educational and training requirements, and that all be afforded the opportunity to provide their respective services within their given training. Thank you for your consideration.
Sherry Kraft, M.S., HOSPICE VOLUNTEER PROGRAM SUPERVISOR
Home Health & Hospice Services, Group Health Cooperative

My name is Nancy Houghton, MA, MT-BC and I am writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I work as a board-certified music therapist and a professor of music therapy at Seattle Pacific University. As a professional in the field I feel it is very important for music therapists to receive certification through Washington State.

As president of the Music Therapy Association of Washington, I have been privileged to be part of the growth of our profession in Washington State. A recent grant award has helped us start many new sites and reach out to many people who did not have access to services. The statecertification will ensure the integrity of our work as it continues to grow and spread in our state. Consumers and health administrators will benefit immensely.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to ensure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Nancy H Houghton, MA, MT-BC, Certified Neurologic Music Therapist
President, Music Therapy Association of Washington
Seattle Pacific University music therapy faculty

Please accept this letter as advocacy for Music Therapist Certification in the state of Washington.

As the parent of a special needs child, I am writing in support of SB 6276, as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with several board-certified music therapists and would like to share with you why I think it is crucial for music therapists to receive certification through Washington State.

My son has benefited greatly from his work with certified music therapists. In addition to enjoying the general benefits of music, rhythm, beat, etc., he has gained language skills, improved turn-taking ability, increased fine motor skills, and has increased his use of word recall/working memory via music therapy.

Music therapy offers a unique treatment modality for children with various needs, yet meets those needs in fun, meaningful ways. Music therapy differs greatly from general music classes in that the therapist is able to integrate a child's individual needs into thoughtful, balanced therapy goals, which target those individual needs. Music (song, instruments, voice, etc.) is the tool the music therapist uses to achieve goals and help a child progress. While most children enjoy music, only a trained music therapist can structure the music experience to provide *therapeutic benefit* during that enjoyment. Therapy goals cannot and should not be developed by general music professionals. Therefore, certification lends credibility to the professional, confidence to the parent, and appropriateness to the entire music therapy experience.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. The more we support state certification, the more therapists will be drawn to our state and the more services by those credentialed, competent providers will be offered to state residents. Music therapy is important for my child and I would like to see others have the same access to quality, reliable, credentialed professionals.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Vicki Boardman

As a Certified Clinical Musician and a founder the Music for Healing and Transition Program, I would like to offer the following comments during this Public Open Comment period:

The Music for Healing and Transition Program and the Clinical Musician's Program are two of several affiliated programs accredited by the National Standards Board for Therapeutic Musicians: www.therapeuticmusician.com
A complete list of other accredited organizations is listed on the website at the following link: http://www.therapeuticmusician.com/styled-4/index.html
Cerifited graduates of these nationally accredited programs do not call ourselves Music Therapists (we are Clinical Musicains and Music Practitioners, and may be referred to as "therapeutic musicians"), and we take great pains to correct misconceptions by the general public about the important differences in our titles. We are concerned that the language in the proposed legislation will prevent certified accredited clinical musicians and music practitioners from earning a living. As a result, we are communicating the following information to you.
Clinical Musicians and Music Practitioners are exquisitely well trained to use specifically therapeutic music one-on-one with patients in hospitals, hoispices, care homes and private homes. We work hard to meet specific medical and musical competencies, working within the Scope of Practice and Ethical Codes of the National Standards Board for Therapeutic Musicians.

The difference between a Music Therapist and a Music Practitioner or CLinical Musician is that a Music Therapist uses music as a tool in interactive therapy, while a Music Practitioner or Therapeutic Musicians uses music as the therapy itself. This allows us to play, often with impressive results, for patients who are not able to take part in interaction (such as comatose, post-operative, highly medicated, and very ill patients. This slight but important difference between us and Music Therapists means that both they and we are well utilized in medical facilities because we serve two separate functions within the same realm of need.

We fully support the efforts of Music Therapists to obtain a legal certification framework for their specific profession, but please assure that this legislation does not hinder the work of Clinical Musicians and Music Practitioners. Not only is it our livelihood, but it makes a positive difference in the lives of innumerable patients.
Laurie Riley, CMP, CCM

I am a Certified Music Practitioner and Advisor to students in the Music for Healing and Transition

Program. I am reiterating Executive Director, Melinda Gardiner's clarification of MHTP's mission of Certified Music Practitioners as different from Music Therapists.

Please follow through with the importance of this request.

Thank you for providing this opportunity to offer comments on the proposed 2012 twin bills, Washington State HB2522 and SB6276.

Some brief background information about MHTP:
MHTP is a 501c3 Not-for-Profit educational organization, incorporated in Texas in 1994, and designated a 501c3 by the IRS in 1995. Since 1995, MHTP has trained 648 musicians and has granted them the professional title of *Certified Music Practitioner® (CMP)*, designating that they are qualified to serve competently as therapeutic musicians in healthcare facilities. CMPs provide therapeutic music to individual patients, and create a healing environment for the patient. Please visit our website for more information on MHTP, at: www.mhtp.org

In order to receive the title of Certified Music Practitioner®, students complete a broad spectrum of class-work, are evaluated on their course work comprehension, are assessed for appropriate musicianship and therapeutic presence, complete an extensive internship in healthcare facilities, and must demonstrate that they have met specific competencies. Students must also agree to work within the parameters of both the Scope of Practice and Ethical Code for CMPs.

Of our 648 graduates, there are currently 48 Certified Music Practitioners® in Washington State. Many of them are employed by multiple hospices, hospitals, nursing homes and other healthcare facilities.

Certified Music Practitioners® may not, and do not, use the title Music Therapist.

The Music for Healing and Transition Program, Inc. is accredited by the National Standards Board for Therapeutic Musicians (NSBTM), meeting the training Standards, Scope of Practice and Ethical Code required by that Board for programs training therapeutic musicians. For more information on the NSBTM please view its website at: www.therapeuticmusician.com

Comments on the Bill:

1. The Board of Directors of the Music for Healing and Transition Program, Inc. completely supports the desire of the Music Therapy profession to seek state licensing or certification, and to regulate the use of their professional title, *Music Therapist*.
2. We find that certain language in the bill has the potential to prevent Certified Music Practitioners®, and other extensively-educated therapeutic musicians, such as Certified Music Thanatologists, from practicing their profession and making a living in the state of Washington. Some examples:

   Section 1, # 3, defines what Music Therapy means. These sections ALSO define some of the skills of Certified Music Practitioners® and are not unique to Music Therapy:

   a. "The assessment of a client's emotional well-being, physical health, social functioning, communication abilities and cognitive responses to musical stimuli."
   b. "…using music interventions including …. receptive music listening."
   c. "The evaluation and documentation of the client's response to treatment."
3. Section 10: The bill defines the terms "health profession," "certification," and "practitioner" solely in terms of state regulation. There are many disciplines that grant the title "practitioner" and confer "certification," that are not governed by state law but are governed by national accrediting or certification Boards. In addition, the public, other health professionals, and

the healthcare facilities that hire them to serve patients accept them as legitimate and respected professions.

The MHTP Board of Directors respectfully and strongly requests that any language in the bill that could be interpreted in a way that prevents other competent practitioners from making a living be revised.

Thank you very much for consideration of these comments.
Sheryl Akaka
Certified Music Practitioner
Music for Healing and Transition Program, CMP Advisor

My name is Krista Mercier, and I am a music teacher and member of Sigma Alpha Iota writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with Wendy Woolsey (also a member of SAI), a board-certified music therapist and I believe that it is very important for music therapists to receive certification through Washington State.

SAI is a professional women's music fraternity and one of our national objectives this year has been to increase the awareness in the community for Music Therapy. I have seen and heard firsthand the powerful affects that music therapy can have on patients. It is an incredibly healing and powerful therapy.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is so important to our community.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Krista Mercier

This letter is to praise Encore in Port Angeles, and Jim Couture, the director, for all the kind help he gives to his constituents daily. His smiling and gentle demeanor puts everyone at ease the minute they enter, and his music gives them a chance to sing or dance or just listen. It's enjoyable to watch and to see how much the participants enjoy being there.
Elizabeth Kelly

My name is David Knott, and I am a music therapist-board certified writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I currently work as a board-certified music therapist (MT-BC) at Seattle Children's Hospital and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

The field of music therapy has a long history of research and professional development that has lead us to the present state of practice. Discoveries in neuroscience have led to music therapy protocols that can help those that have had strokes relearn to walk http://csaweb125v.csa.com/discoveryguides/music_rx/review.pdf regain speech skills after a brain injury http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002088.pub2/abstract and help lessen negative

consequences of some psychological distress
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004025.pub3/abstract . While other music-oriented approaches exist, they do not have the same academic requirements, supervised training and ongoing continuing education and independent oversight that is required of an MT-BC, Music Therapist - Board Certified credential. Ongoing oversight by the Certification Board for Music Therapists (www.cbmt.org), our nationwide, independent credentialing body, ensures MT-BC's adhere to recognized standards of practice.

A common misconception about music therapy is that it is "just playing music for people." And while some sessions do appear to be just that, consideration of an individual's preferences and ongoing response to the intervention guide a music therapist's approach. Additionally, the provision of a receptive music experience is often just the beginning for an individual receiving music therapy treatment. The assessment process and, when possible, inclusion on or coordination with an interdisciplinary team allows the MT-BC the opportunity to create a treatment plan that may include more active uses of music (such as the Rhythmic Auditory Stimulation protocol in use for gait training, as referenced above) to motivate an individual in their rehabilitation process and in some cases provide the galvanizing neural stimulus that makes their recovery possible. Of course playing music for an individual after their stroke may be comforting and supportive, but if music interventions can be provided that challenge, inspire, prime and time that same individual's motor planning areas to achieve better outcomes in their efforts to walk again, the MT-BC is practitioner most prepared and capable of enacting that treatment plan.

This is where we need the help of the legislature. MT-BC's need state recognition in order to distinguish our profession, insure competent practice and improve access to services, thus continuing to move both the science and art of music therapy forward while providing our clients with the most efficient and effective therapeutic uses of music to meet their individualized goals.
David Knott, MT-BC

My name is Margi Ahlgren, and I am a the daughter of an elderly music therapy participant, writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

My mother, who has dementia, attends a day program where music therapy is integrated. She not only enjoys the music, but her demeanor improves along with her cognitive functioning. Were it not for her pleasant behaviors, I would not be able to keep her living at home with me.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for my mother, and I would like to see others have the same access to services.
Margi Ahlgren

My name is Jane Witmer, and I am an occupational therapist writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

Each summer, Wonderland Developmental Center in Shoreline, WA holds a summer camp for pre-school aged children with special needs who would not otherwise get special services during the summer break from school. Wendy Zieve, music therapist, led therapeutic music groups during two sessions of our camp program this summer. Her knowledge and training in music, combined with her knowledge of how to meet the wide variety of special needs among the campers, allowed each camper to benefit to the best of their abilities during the groups. Wendy's activities supported campers in learning important skills like taking turns, working together, and playing their own part in a group effort. All of the skills were nurtured in a fun and playful setting using music and music principles as a framework. Wendy's skill as a music therapist was very apparent and crucial to the success of the group.

Washington State Music Therapists have been working toward state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, ensure competent practice, and protect and improve access to music therapy services. It is imperative for all Washington State residents to have access to services provided by qualified, credentialed professionals. I believe music therapy is extremely beneficial for the children served by my agency and I would like to see others have the same access to this valuable service.
Jane Witmer, MS OT/L

My name is Ken Pendergrass, and I am a music educator writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

I have been teaching elementary school music since 2002 in Seattle Public Schools. I currently teach in the Central District of Seattle and serve three distinct kinds of students at my school: 1) Special Education students diagnosed with Autism; 2) General Education students, 89% who qualify for free and reduced lunch and are represented by 12 different language groups; and 3) Advanced Placement Program students. In regards to the first two groups of students, Music Therapy workshops and professional development opportunities provided by qualified and certificated Music Therapists are the *only* resources that have given me the tools to effectively reach these students.

My college education, preparation and certification to become a public school music teacher really only prepared me to serve the third group of students who typically come to school ready to learn and have strong family support. The majority of the students I serve, do not have these advantages when it comes to learning music. Music Therapy and access to qualified Music Therapists helps me look at the physical, emotional and mental needs of my students and adapt the curriculum to meet those unique needs.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for my students and I would like to see others have the same access to services.

Ken Pendergrass
Thurgood Marshall Elementary School, Music Specialist

Greetings from Salmon Creek! As the manager of Spiritual Care at Legacy Salmon Creek Medical Center, I am writing in support of SB 6276 as it goes through the Sunrise Review Process with the State

of Washington Department of Health. During the past decade, I have worked with board-certified music therapists serving in clinical settings. As with any professional serving in a clinical setting in our communities, it is important for music therapists to receive certification through Washington State.

Legacy Salmon Creek Medical Center opened seven years ago. During that time, we have had a couple of board-certified music therapists serve in the hospital setting, providing music therapy in ICU, NICU, Family Birth and general medical and surgical units. This past year we had a board-certified music therapist offering music therapy on our adult medical and surgical units each week as a volunteer. Patients, family members, nurses, physicians and other clinical staff all noted how music therapy reduced anxiety and stress, decreased pain and provided increased emotional and spiritual support. The music therapists who have served here are trained to provide a range of genres in music and to address care needs of patients from diverse backgrounds. More than one patient noted that the provision of music was the most helpful, comforting and healing service provided in the hospital. At times, medical and clinical staff as well as family members joined in singing together with the music therapist, increasing communication and understanding for all involved. Moreover, as patients near the end of life, the additional care of music therapy and music thanatology provide comfort and peace.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to insure competent practice by trained professionals, and to protect and improve access to music therapy services. In the future, we hope that all Washington State residents have access to services provided by qualified, credentialed professionals.

Thank you for your time and consideration. Please note this letter is attached as a document. Please do not hesitate to contact me if you have any questions or concerns.
Rev. Gwen Morgan, MDiv, BCC | Supervisor, Spiritual Care | Legacy Salmon Creek Medical Center

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My name is Karen Nestvold, and I the Development Manager and voice faculty member at Music Works Northwest in Bellevue, writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. Music Works is the only community music school in the state with a music therapy program. I have worked with the board-certified music therapists on staff here, and I think it is very important for all music therapists to receive certification through Washington State.

The clients who come to Music Works for music therapy services face a variety of challenges, from autism to Down's Syndrome and other neurologic and physical disorders. The board-certified music therapists here provide high quality treatment, through both one-on-one and group sessions. We have even started a choir for some of our music therapy clients, and others have enrolled in camps and classes with music students who do not face the same challenges. This interaction enriches the experience for all.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for the clients who come to Music Works, and I would like to see others have the same access to services.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Karen Nestvold, Development Manager and Voice Faculty Member

My name is Wendy Woolsey, and I am a board certified music therapist and adjunct faculty at Seattle Pacific University in the Music Therapy Department writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked as a board-certified music therapist for over 17 years and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

SB 6276 will increase access to music therapy services and ensure people are seen by a qualified music therapist. Over 44 music therapists in Washington provide a variety of services in facilities such as nursing homes, schools, hospitals, hospices, group homes, pre-schools, and adult day programs. Music therapy addresses a variety of goals. A music therapist uses melody to increase the sucking response in premature infants so they can be discharged from neonatal intensive care, songs and rhythm to access speech when the speech center of the brain is damaged like the music therapy services congresswoman Giffords received, and rhythm to coordinate or initiate movement in someone with Parkinson's disease so they feel safe walking across the street. Music therapists use songs to access memories in people with Alzheimer's so they can have quality moments with loved ones or use music to decrease anxiety and pain prior to surgery. We write songs to assist a child learn to count money, read or learn to tell time and music therapists assist terminally ill in composing songs to leave as legacy to their spouse and children. Many disciplines use music which is great. We are asking that certification be required for those who call themselves music therapists to insure they have the education, training and continuing education as defined by the American Music Therapy Association and Certification Board for Music Therapists so Washington consumers will have access to music therapy services by a qualified music therapist.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals.
Wendy Woolsey, MA, MT-BC

My name is Anne Vitort, and I am a board-certified music therapist writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

I have been a music therapist for about a year and a half. I am in private practice in Vancouver, WA. I have worked with clients in hospice, hospital, long-term care and memory care. I have also worked with children with developmental disabilities. The results I have seen have been amazing. Clients respond to music in ways other therapies cannot achieve. I have seen children with autism smile and talk when involved in music therapy. I have seen people with Alzheimer's sing familiar songs, I have seen people with Parkinson's move with ease and rhythm. I have seen people on hospice care and their families connect through music where words have failed them.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is a tremendously important service and I would like to see others have access to services.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.

Anne Vitort, MT-BC

My name is Mickey Stuart. I am a parent writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. In the past I have worked with several board-certified music therapists. At this time I would like to share my experiences and why I think it is important for music therapists to receive certification through Washington State.

I have a 14-year old minimally-verbal son who has been fighting regressive autism. Music has provided the avenue for him to continue to learn and use language. After he lost his ability to speak we brought him back by singing his favorite songs but leaving out the last word of each line. Slowly but surely he began to fill in the blanks, then he started singing entire songs by himself.

Singing helps him regulate his behavior too. If he is engaged in inappropriate activities we ask him to sing to us. Music moves him away from misbehavior and calms bursts of temper. Furthermore, we have seen how rhythmic activities can help calm him, allowing him to focus on the task at hand.

My only regret is that our school district does not employ a skilled Music Therapist to work with my son and his differently-abled peers. I think they need music as part of the curriculum on a daily basis.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to extend the competent practice of Music Therapy techniques and improve access to their services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is crucial to my son's continued development and well-being. The possibilities are endless. I would like to see others, whatever their challenges, have access to Music Therapy as well.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Mickey Stuart

If the American Music Therapy Association wishes to license their graduates in Washington State, that is their privilege. <u>However, they do not have the right to use language that would deny employment of graduates of other therapeutic music training organizations.</u>

Our concern is that the definition of who is eligible to practice therapeutic music in Washington might be limited to "music therapists" only. There are many graduates of other therapeutic music organizations that are well qualified in this area.

<u>If the legislature chooses to license therapeutic musicians, then ALL therapeutic musicians employed by healthcare institutions must be a part of the planning, not just graduates of one organization.</u>

As a graduate of the Music for Healing and Transition Program, Inc. I work as a Certified Music Practitioner for three hospices in the Kitsap - Tacoma area - Franciscan Hospice, Multicare/Good Samaritan Hospice, and Hospice of Kitsap County .
I do <u>not</u> call myself a music therapist, and inform others so that they understand that i am a Certified Music Practitioner.

Just a brief history.

1. It has been widely documented that music has been used therapeutically for thousands of years.
2. In the United States, the **Music Therapy Association** www.musictherapy.org was created in 1950,

originally as a means of teaching musicians to assist soldiers returning from WWII with PTSD. Graduates of the program are MT-BC Music Therapist, Board Certified.

Since 1950 there have been many other therapeutic music training organizations who have nationally certified their graduates to work in hospitals, hospices, skilled nursing facilities, etc. We are all very careful to call ourselves by our correct titles and to urge our employing organizations not to call us music therapists. Here are a few training organizations:

3. **The Music for Healing and Transition Program** - www.mhtp.org This is the organization through which I was certified. Graduates are Certified Music Practitioners (CMP). In the Seattle area there are CMPs working for Multicare/Good Samaritan Hospice, Franciscan Hospital, St. Francis Hospital, St. Clare Hospital, Highline Hospital and other healthcare organizations.
4. **Bedside Harp** - www.bedsideharp.com Graduates are Certified Harp Therapists This is the organization that certified the musician who heads up therapeutic music at Harrison Hospital in Bremerton.
5. **The Clinical Musician's Home Study Course** - www.laurieriley.com Graduates are Advanced Clinical Musicians. Another of this program is employed by Harrison Hospital.
6. **Chalice of Repose Project** - www.chaliceofrepose.org Graduates are Certified Music Thanantologists. The Providence Hospital system has Music Thanantologists on staff.
7. **International Harp Therapy Program** - www.harprealm.com Graduates are Certified Therapeutic Harp Therapists.
8. **International Healing Musician's Program** - www.healingmusician.com Graduates are Certified Healing Musicians. Several in the Seattle area employed by Multicare/Good Sam Hospice and St. Francis Hospital.
9. **Healing Harps** - www.healingharps.org Graduates are Professional Service Musicians.
10. Other therapeutic musician training organizations are **Gentle Muses, Healing Musician's Center, and Vibroacoustic Harp Therapy**. These are only a few of the better known groups.

Cordially, Carole Glenn, CMP

My name is Carla Carnegie, and I am a music therapist writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. As a board-certified music therapist, I would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

As a fairly new professional in the field, I live and work in the Spokane area, where most of the professionals, and general populace are not familiar with what a music therapist is, does, or can accomplish in the lives of their loved ones. Most believe it is a "new" idea, since they have not seen it practiced. However, for the facilities that have hired me to provide music therapy services for their clients with dementia and Alzheimer's disorders, they are pleased and amazed at what is observed and accomplished through the relationship of client/music therapist. A client that is not verbal, nor responsive to most interaction, becomes responsive in facial and body language, rhythmically moving hands, arms and feet to the beat of the music with medium level prompts, and continuing the rhythm beyond the initial prompting on her own. Another client that seldom speaks or expresses thoughts, tells a story that all the other clients can enjoy and have some kind of relationship to, through the musical experience the music therapist presents. These are but two reasons having a music therapist as part of the treatment team is benefiting the clients to fulfill their potential, and to help maintain domains of function.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for my elder clients, and I would like to see others have the same access to services.

Carla Carnegie, MT-BC

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1. *As a Certified Music Practitioner® through the Music for Healing and Transition Program, Cheryl Zabel went through a certification program that that is a 501c3 Not-for-Profit, training musicians to serve patients at the bedside since 1995.*
2. *Cheryl Zabel is not a Music Therapist, but a clinical musician specifically trained as a Certified Music Practitioner®*
3. *Cheryl Zabel is required to meet medical and musical competencies, working within a specific Scope of Practice and Ethical Code.*
4. *The Music for Healing and Transition Program (MHTP) has trained and certified 650 musicians, including 48 who are employed in the state of Washington.*
5. *They use the language "Certified Music Practitioner®*
6. *Cheryl Zabel is employed by Multicare Hospice as an Independent Contractor.*
7. *Describe what service has been provided (e.g. therapeutic music at bedside for hospice patients):*
8. *Approximate number of hours per month:*
9. *How this has helped the patient(s):*
10. *Any other comments:*

Multicare/Good Samaritan Hospice currently contracts with 5 therapeutic music practitioners to provide comfort to terminally ill patients who reside in their personal homes, adult family homes or residential facilities. The musicians provide a much needed service for our patients and their families who are experiencing losses including physical and mental limitations, loss of independence and spiritual needs. Music is provided at bedside for our hospice and palliative care patients in a variety of forms including voice, harp, guitar, and keyboard. Therapeutic musicians bring comfort with intent by customizing live music to the individual patient-following the rhythms of breathing and also providing memory enhancement for our patients.

The approximate number of hours provided per month from our therapeutic musicians range from 15-30. Our music practitioners receive 15-20% of our comfort therapy referrals every month.
Margaret Winczewski , Multicare

My name is Kris McGrew and I am a parent writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

We began taking our autistic son, Grady, to music therapy as he had show an extreme interest and love of music from the time he was an infant. He seems to find comfort in the rhythms and melodies of music which do a fantastic job of soothing Grady. Furthermore, music is the only area where we have been told that Grady is developing typically as a normal child. The structure of the therapy matched with his love of music has allowed him to feel good about himself and be proud of his progress. Much of his and other autistic children's' frustrations are with their inability to make progress. The therapy has been priceless for his happiness. He literally runs from the car to the front door of the facility and starts getting prepared for his therapy session the night before. Of all the therapy that Grady receives, we have seen the most happiness from him during his music therapy.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I

think music therapy is important for my son and I would like to see others have the same access to services.

Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Kris McGrew

I am writing in support of excluding therapeutic musicians from the DOH certification of music therapists as proposed in SB 6276.

I am currently enrolled in the clinical home study program, Harp for Healing, which will give me the title Certified Music Practitioner. There are several programs like this accredited by the National Standards Board for Therapeutic Musicians (NSBTM). NSBTM is the governing body for these accredited programs that graduate therapeutic musicians. Its purpose is to promote the development and advancement of the professional bedside therapeutic musician. Therapeutic musicians are not music therapists.

Therapeutic musicians use live music as a service to enhance the environment in healthcare settings by playing *passively* either at the bedside or elsewhere in the facility for patients, their families and staff. Therapeutic music enhances the healing process and comforts those in pain, under stress or in the dying process.

By comparison, music therapists use musical instruments and music making as tools to rehabilitate normal life functions by studying and promoting changes in behavior and by working *actively* one-on-one with patients.

Therapeutic musicians should be excluded from the provisions of SB 6276 because they are not mental health practitioners. They enhance environments for healing and transition. Therapeutic musicians also undergo an educational process designed particularly for those in pain, therefore language of SB 6276 should allow a continuation for them to play at the bedside.
Monica Schley, harpist

As a harpist, I am a 2002 music practitioner graduate of the Music for Healing and Transition Program who has been on contract with Good Samaritan Hospice for the purpose of providing comfort to those in need. Please, I encourage you to give careful consideration to what Melina Gardner and others representing MHTP have requested with respect to inclusionary language in the currently proposed music therapy legislation. Thank you for your time.
Markey Sandhop

I am writing in regards to the bill SB 6276 relating to certification of Music Therapists.
I do not want to interfere with the Music Therapists ability to protect their credentialing or to promote professional licensing by the state, but I am concerned that the language in the bill may prevent me from earning a living, practicing my profession, and serving my patients. I have heard that in other states similar bills have inadvertently affected other clinical musicians (who are not Music Therapists) to practice their profession.
I am not a Music Therapist, but a clinical musician, specifically trained as a Certified Therapeutic Harp Practitioner. I graduated from the International Harp Therapy Program, a certification program based at San Diego hospice, training musicians to serve patients at the bedside. I am required to meet medical and musical competencies, working within a Scope of Practice and Ethical Code. As a contractor with

Assured Hospice of Jefferson and Clallam Counties, as well as Jefferson Healthcare, I offer therapeutic music at the bedside for hospice patients, to help facilitate states of comfort, relaxation, and support, and to help improve overall quality of life.
Thank you for understanding the need to ensure that this bill not interfere with the ability of my colleagues and I to practice our profession and serve our patients.
Shannon Ryan

I am a Certified Music Practitioner® through the Music for Healing and Transition Program, and a Certified Harp Therapy Musician through the International Harp Therapy Program, and went through intensive clinical and music training to serve the patient at the bedside since 1995, with therapeutic music. I am not a Music Therapist, but a therapeutic musician specifically trained to use music and the various elements of music to address the immediate need of the patient. I am required to meet clinical and musical competencies, working within a specific Scope of Practice and Ethical Code, and more to become certified. There are approximately one thousand certified practitioners of therapeutic music in the US. Forty-eight are employed in the state of Washington. I have personally worked in Seattle in healthcare facilities such as Baily-Bouchey House, Providence Medical and Virginia Mason.

I eventually became executive director for the Music for Healing and Transition Program between 1999-2003, and now am director of the Healing Musician Center which specializes in continuing education opportunities for graduates of programs accredited through the National Standards Board for Therapeutic Musicians.

Healthcare organizations have realized that therapeutic music at the bedside can:

- Augment pain management of the terminally ill
- Relieve anxiety of the chronically ill
- Accelerate physical healing of post-
- surgery and injured patients
- Ease the delivery process of the birthing mother
- Facilitate the transition process of the dying
- Reduce stress & blood pressure of the chronically ill
- Relieve body and mental tension of pre-operative patients.

I appreciate you taking this under consideration to reword the text in SB 6276. Thank you.
Stella Benson, CMP, CTHP, National Standards Board for Therapeutic Musicians
Advisory Board

I'd like to lend my support for music therapy certification. Last year my kids got to experience music therapy at their elementary school in Seattle through MusicWorks Northwest. We had a wonderful experience at the school with our music therapist through MusicWorks Northwest. The special education kids loved it and learned a lot from it. I think it's really important to have someone who is college educated with a degree in music therapy and board certified working with the kids as a music therapist. Without that background, training, and skill-set I don't think the service would be as professional, or even accepted as a program in the public schools.
Janet Wickersheim

I serve as Chief Nursing Officer for Harrison Medical Center and am writing you today regarding Senate Bill (SB) 6276. While Harrison supports the intent of SB 6276, if the proposed legislation pertaining to

the credentialing of music therapists is passed in its current form it could have a significant impact on Harrison Medical Center's ability to provide compassionate and comforting care to its patients. It would also significantly impact our staff who provide therapeutic music to our patients.

Since 2006, therapeutic musicians and drum circle facilitators have provided evidence-based services to thousands of Harrison's patients, visitors, and staff. Portions of the Senate Bill and Sunrise Review Applicant Report contain language that could adversely impact other music and sound healthcare professionals by limiting or prohibiting their role in patient care. Such restrictions would be to the detriment of patients who benefit from music and sound interventions some of which may overlap with that of music therapists. So, unless modified, SB 6276 could restrict or eliminate patients' access to these healing services.

Below are just two examples of the value of therapeutic music as it is received by patients, their loved ones and our staff members. I hope you will reconsider specific portions of SB 6276; specifically those restrictions regarding credentialing of music therapists.

Specific comments regarding the impact of care provided by Harrison's music therapists…
6/6/2012 – "*Dear Ms. Enns, Thank you so much for visiting my brother, in room 368 yesterday. Your Shenandoah and Danny Boy made his day. He has been somewhat depressed and very ill with an infection and you certainly cheered him up. I appreciate it so much".*

8/9/2012 - "I played for an elderly man who is very hard of hearing, but who had played the violin. His family asked me to get very close to him so he could hear, and he seemed frustrated that he couldn't hear the harp very well. As I played he reached out and gently laid his hand on the harp post, and smiled and said "I can feel that!". He held the harp as I played various songs, and then he asked for a hymn. As I played the hymn, he started to cry, and his wife encouraged him to "just let it out", and she held his hand and she cried a little too. Afterwards he held my hand and thanked me several times, saying "You made my day!", and she said I had played all his favorite songs. She said "You couldn't have come to a better room!"
Cynthia M. May RN, MSN, Chief Nursing Officer

I am writing to show my support of Music Therapists and certification at the state level. The amount knowledge, education, time and dedication it takes to become a certified Music Therapist, is something that should be protected and acknowledged. For individuals who did not earn this title, the misuse of terms and techniques could have a negative impact on understanding for clients. I have seen the benefits of a qualified Music Therapist, and how she has become part of an interdisciplinary team. I am available to answer further questions you may have.
Abby Huberty CTRS (Certified Therapeutic Recreation Specialist)
Fort Vancouver Convalescent Center

My name is Susan Tyler, and I am a parent writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapist to receive certification through Washington State.

During his fifth year, I watched my son increasingly withdraw socially and retreat into his own world. He was diagnosed with PDD-NOS. Now six, he has spent the last few months in weekly music therapy. Our music therapist is impressive. She's great about incorporating goals my son is working on in speech and O.T. The musical activities she uses are individualized and adapted throughout each session to engage and encourage participation. I am amazed at the progress he has made. He is talking significantly more,

and he is interacting more with other kids. Today he sang me a song! I wish we had resources to continue longer as well as to provide music therapy to my other child with neurological issues.

I understand Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals I think music therapy is important for my children and I would like to see greater access to services. I also think state certification would help preserve and promote the therapeutic value of music therapy, as opposed to recreational music.
Susan Tyler

I am a parent of a 17 year old boy, Seth, who recently suffered a severe traumatic brain injury. I would love to come testify on behalf of the music therapist, but due to the care my son requires I cannot. Please accept this as my plea to recognize music therapy as a state certified service. Referencing SB 6276 Sunshine Review Process with the Washington State Board of Health.

After 18 days at Tacoma General Hospital my son was discharged to Seattle Children's Hospital for 7 weeks of rehab. He was unable to roll over, was incontinent of bowel and bladder and very verbally abusive. He suffered a slight hearing loss as well as the loss of most of his vision. No one could reach him. His recreational therapist invited David Knott, the hospitals board certified music therapist, to come and play for him. Music had been a big part of Seth's life. As soon as David started playing the ukelele, Seth calmed down. We were able to communicate with him and he even asked for his instrument. David had opened a door with the music. I believe Seth's recovery started then. Unfortunately, Seth only received music therapy once a week. My wish is that it would be made available more frequently. Maybe with certification maybe more money would be available for more therapy. I don't doubt that Seth would have done even better with more music therapy.

I think it is important to have qualified, board certified music therapist. State certification would improve the likelihood of receiving quality music therapy.
Sheri Barronian

My name is Shannon Baker-Spoor, and I am the Manager of Therapeutic Programming at Auburn Regional Medical Center Behavioral Health Units, inpatient and outpatient services. I am writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a Board-Certified Music Therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.
I have employed Music Therapist the last 13 years of my professional career in our Behavioral Health Program where we work with advanced Alzheimer's patients and older adults who are challenged by Depression or other life changing events. The music therapists that I have experience with are clinically focused and work from various therapeutic models. The music is their medium but it is their ability to assess and provide effective interventions that move individuals from acute discomfort emotionally and physically to stable psych, as well as overall quality of life. The music therapist also provides milieu management, functions as a central entity in treatment team planning with an interdisciplinary focus. Our music therapists have also been sought out to provide treatment in our New Acute Rehab Unit as there is evidenced based practice that Board Certified Music Therapist can provide a positive and significant impact on the patient's neurological healing and rehabilitation.
Washington State Music Therapist have been working towards state certifications with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all

Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for my program and the client's we serve at Auburn Regional Medical Center. I would like to see others have the same access to services.
Thank you for your time and consideration. Please do not hesitate to contact me if you have any questions.
Shannon Baker-Spoor, LICSW
Manager of Therapeutic Programming
Auburn Regional Medical Center

I am writing with concern about legislation that is currently being considered that could potentially devastate my career. I am a Certified Healing Musician. I received my certification through the International Healing and Transition Program in 2004. This program required me to complete coursework in medical and musical areas as well as a number of client hours – playing for people who were sick or dying. After completing the requirements and receiving my certification I have been working as an independent contractor for two hospices, one hospital and some private pay clients for eight years now. I understand that the intent of the legislation was to protect music therapists' credentials, but that the way it was written it does not acknowledge or exempt other music modalities. I understand that as written this legislation may take away my opportunities for gainful employment and my services to those who are sick and dying and in need of comfort. Of particular concern is wording in 6276 Sections 3 a, b and c that could cause legal problems for myself and others. Please consider rewriting this legislation so that it only refers to music therapists and not to those of us who have a different type of service or clinical purposes for music, such as that of therapeutic musicians. These are different roles with different training and career paths and should not be confused and lumped together.

The benefits for my clients and their families has been wide-spread, from easing pain and anxiety, to helping to work through grief. I've had people say that they hadn't been able to process their grief until my visit, that their spouse hadn't slept that deeply in years, that their pain was gone for the first time in weeks, that they felt loved, that they hadn't relaxed like that in years, their blood pressure is lower, etc. A caregiver at a facility I visited said she could tell when I had been there as my very anxious patient was so much calmer for days after my visit. I could give you so many stories of the benefits of my work, but I must end this to send it in by the deadline. Please reword the legislation so that I can continue to help these patients who are sick and dying.
Bonnie Steinkamp, Certified Healing Musician

My name is Dr. Carlene J. Brown, MT-BC and I am Associate Professor and Chair of the Music Department at Seattle Pacific University. I am also the Director of the SPU Music Therapy Program – the first and only undergraduate degree program in the state of Washington. I am writing this letter in support of **SB 6276** as it goes through the Sunrise Review Process with the State of Washington Department of Health.

As a Board-Certified Music Therapist I can speak directly to the impact that certification will have upon our community. I am training students at SPU to meet national standards and be prepared to sit for the national board exam. The program is extremely rigorous and requires unique skill sets that go far beyond being a good musician. The field of music therapy is an allied health field; I tell my students that their closest colleagues on campus are nursing students.

During their academic training they must complete 180 hours of clinical work in practicum sites in the Puget Sound region. I have been working closely with social service agencies, medical facilities, school systems, etc. that are extremely interested in having a music therapy student work with their clients. I am

asked regularly by agency professionals if the students' training is recognized by the state of Washington. It is unfortunate that the answer is no.

The work of music therapists is being recognized by a number of facilities, such as Seattle Children's Hospital, Swedish Hospital, the Caroline Kline Galland Homes, Seattle Children's Home, YWCA Angeline's, Seattle Public Schools, and many others. The administrators of these facilities understand and appreciate the level of training required in the field of music therapy.

State certification will matter not only for Washington State Music Therapists but also for the growing number of agencies wanting to employ a music therapist. Having clear, distinct, state-wide guidelines will ensure that services provided will meet a standard of training.
Carlene J. Brown, Ph.D., MT-BC, Associate Professor and Chair, Director, Music Therapy Program, Seattle Pacific University

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My name is Ramona Holmes, and I am a university music education professor writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

Music educators work with all students, including many students with special needs. My university music education students need to be ready to meet the federal standards in the Individuals with Disabilities Education Act (IDEA) and the even more powerful Washington state curriculum guidelines which require that special education students specifically have music available for them. To prepare my music education students for this task, I have routinely included board certified music therapists as part of my Music in Special Education class. These specialists have added in-depth guidance for my students by providing specific strategies, adapted materials and focused curriculum that they can apply in the classroom. Fortunately, at Seattle Pacific University, we now have a full Music Therapy program, so my students have the opportunity to work side by side with music therapy students and board certified music therapists. These music therapists have a breadth of knowledge that form a life line for music educators. While P-12 music educators need to be ready to teach choral, instrumental and general music from Medieval to current, various genres, from here and around the world with materials that meet the developmental needs of pre-school through high school, they are not always ready for the range of special needs that a board certified music therapist can treat. The chance to work with a board certified music therapist helps them design the most appropriate curriculum to work with the wide range of students with special needs in their music classes

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for my university music education students and I would like to see others have the same access to services.
Dr. Ramona Holmes, Seattle Pacific University Music Department

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I am writing in support of SB 6276 which calls for Certification for Music Therapists. I have been a music therapist since 1979 and have lived and worked in the Seattle area for the past 25 years. I recently returned to school and received my Master's in Neurologic Music Therapy. In the interim between acquiring my Bachelor's degree and my Master's degree, I have seen the profession of music therapy grow by leaps and bounds. Always an important facet in working with children, music therapy has been a related service for children in special education since the early inception of the federal laws regulating

education for children with special needs in the late 1970s and continues to be a related service under the IDEA legislation that governs special education now. Research has also grown by leaps and bounds and because of advances in neuroimaging, we can actually see how music effects our brain processing. What we've known for years has been verified by these advanced techniques - music is uniquely powerful in helping us make changes in our lives.

In spite of music therapy's long history, with its more contemporary roots evolving after World War II in VA hospitals over 65 years ago, music therapy has been a more recent addition on the Washington scene. Music therapists have worked for the last 30 years in the area but It has only been in the past few years that a music therapy degree program was offered at Seattle Pacific University. I have worked in private practice, gerontology, and in a community music school. During that time what I have seen is that accessibility to services is key for families in need of services. Currently it is often based on an ability to pay rather than need based. Therefore many families go without services. The effect is Washington State families are underserved because they must pay out of pocket. State certification improves accessibility to services because state education and healthcare agencies that require state recognition for service provision will then be able to include music therapy in that service provision.

Along with access to services, Washington state residents and agencies must be able to identify who is eligible to provide music therapy services. This happens through certification because through the certification process, the educational and clinical training requirements, the examination requirements, and the continuing education requirements for the music therapist will be determined. Proper training protects the public from harm due to misuse of terms and techniques. Proper training ensures the recipient of services and their families that the music therapist is qualified and working within the music therapy scope of practice.

Music therapists understand that many people use music within their practice. Certification of music therapy does not limit the use of music. We know that music belongs to everyone. What certification does is clearly identify what music therapy is and who is eligible to practice it.

Thank you for facilitating the Sunrise Review process. We appreciate being a part of this process and look forward to helping Washington State residents understand what music therapy is and how it fits into the healthcare field.
Patti Catalano, MM, MT-BC

My name is Ellen McKamey, and I am a Licensed Certified Occupational Therapy Assistant writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have worked with a board-certified music therapist and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

Music is a powerful medium for affecting the mood and focus of the clients I work with in Mental Health at Western State Hospital. The person I have seen most proficient at using it is a board-certified music therapist. In addition to a thorough understanding of the effects of music, a music therapist comes equipped with a clinical understanding of the needs of the clients I serve, making him (or her) far more proficient than simply a musician, or a therapist using music. I have seen clients attention span lengthened, movement improve and memory come alive. One of the biggest effects is a change in mood that brings the client into engagement in the therapy process instead of the chronic withdrawal of many mentally ill patients.

Additionally the Music Therapist is a competent clinician who can work well with a treatment team, and make excellent assessments of a client’s needs. Like any other therapist working in this setting, the carry

their share of charting, leading groups, seeing clients individually, making recommendations for treatment, and setting up programing for clients.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for my clients, and the programing I implement and I would like to see others have the same access to services.
Ellen McKamey

My name is Carla Carnegie, and I am a music therapist writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. As a board-certified music therapist, I would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

As a fairly new professional in the field, I live and work in the Spokane area, where most of the professionals, and general populace are not familiar with what a music therapist is, does, or can accomplish in the lives of their loved ones. Most believe it is a "new" idea, since they have not seen it practiced. However, for the facilities that have hired me to provide music therapy services for their clients with dementia and Alzheimer's disorders, they are pleased and amazed at what is observed and accomplished through the relationship of client/music therapist. A client that is not verbal, nor responsive to most interaction, becomes responsive in facial and body language, rhythmically moving hands, arms and feet to the beat of the music with medium level prompts, and continuing the rhythm beyond the initial prompting on her own. Another client that seldom speaks or expresses thoughts, tells a story that all the other clients can enjoy and have some kind of relationship to, through the musical experience the music therapist presents. These are but two reasons having a music therapist as part of the treatment team is benefiting the clients to fulfill their potential, and to help maintain domains of function.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for my elder clients, and I would like to see others have the same access to services.
Carla Carnegie, MT-BC

August 15, 2012

Ms. Sherry Thomas
Department of Health
310 Israel Road SE
Tumwater, WA 98501

Dear Ms. Thomas:

On behalf of the American Speech-Language-Hearing Association (ASHA), I submit these comments in regard to the current sunrise review for certification of music therapists. ASHA is the professional, scientific, and credentialing association for more than 150,000 members and affiliates who are audiologists, speech-language pathologists and speech, language, and hearing scientists – 2,782 of whom reside in Washington.

In an April 2, 2012, letter to the Department of Health (DOH), Senator Karen Keiser states that music therapists (MT) help individuals with limited communication abilities "develop, regain, or retain speech through music therapy." Further, in the proposed legislation, Senate bill 6276, page 1, definitions section, it states that music therapy includes the assessment of "…communication abilities…" We do not believe that MTs are educated and trained to assess, treat, and remediate communication disorders.

Speech-Language Pathologists are Professionals Trained to Assess and Treat Communication Disorders

Speech-language pathologists (SLPs) are uniquely educated and trained to assess and treat speech, language, hearing, swallowing, balance, and cognitive communication disorders in children and adults. These services help children acquire language and enable individuals to recover essential skills to communicate about their health and safety, to safely swallow adequate nutrition, and to have sufficient attention, memory, and organization to function in their environments.

SLPs complete a comprehensive education program and must meet rigorous standards of practice which include the following.

- A master's or doctoral degree with 75 semester credit hours in a course of study addressing the knowledge and skills pertinent to the field of speech-language pathology
- A minimum of 400 clock hours of supervised clinical experience in the practice of speech-language pathology, with the supervision provided by individuals holding the ASHA Certificate of Clinical Competence (CCC)
- A passing score on a national examination administered and validated by the Educational Testing Service
- Completion of a supervised Clinical Fellowship (CF) to meet the requirements of the Certificate of Clinical Competence, the recognized standard in the field
- State licensure (SLPs are licensed in all 50 states and the District of Columbia)
- Completion of 30 hours of professional development activities every 3 years

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Scope of Practice

In its proposal to the DOH, the music therapists reference a number of documents including the Certification Board for Music Therapy (CBMT) Scope of Practice. This document broadly defines music therapy and states that MT can assess sensory, physical, cognitive, and communication abilities. We believe that a profession's scope of practice is limited to specific competencies acquired through education, training, and practical experience. For example, SLPs are trained to address a broad scope of communication disorders which would include swallowing. However, music therapists do not acquire the skills necessary to assess and treat communication disorders in their prescribed program of study and subsequent clinical training. SLPs on the other hand are the only professionals uniquely qualified and trained to evaluate and treat communication disorders**.**

Certification vs. Licensure

In the sunrise review, on page 9, it is indicated that certification will provide protections to the public. Full protections can only be provided under licensure with a licensure board to address any disciplinary issues that may arise.

We believe that–while speech-language pathology licensure provides consumer protection and a mechanism by which incompetent and/or unethical practitioners may be removed from practice–certification is the fundamental standard among major health professions and the most widely recognized symbol of competency for speech-language pathology professionals in this country. Whereas, licensure is important to legally perform our work, certification is important for internal professional recognition and external accountability.

While the CBMT scope indicates that MTs can assess and treat individuals with a wide range of disorders, we believe that SLPs are the only professionals that can appropriately assess and plan treatment for individuals with communication disorders. Therefore, we urge you reject the proposal to certify MTs with a broad scope of practice as defined in the current proposal.

Thank you for the opportunity to submit comments. Should you have any questions or need further information, please contact Eileen Crowe, ASHA's director of state association relations, at ecrowe@asha.org or by phone at 301-296-5667; or Janet Deppe, ASHA's director of state advocacy, at jdeppe@asha.org.

Sincerely,

Shelly Chabon

Shelly S. Chabon, PhD, CCC-SLP
2012 ASHA President

cc: Martin Nevdahl

Margaret Howard
6225 76th Street SE
Snohomish, WA 98290
July 31, 2012

Washington State Department of Health
310 Israel Road SE
Tumwater, WA 98501

To Whom It May Concern:

I am writing you today regarding the state certification of Music Therapists.

I am on the board of directors for Snohomish County Music Project, a local organization that believes in the therapeutic value of music. Through our Music as Medicine program, we recently put together a pilot project called Music Futures. Music Futures is a free music program for drug and alcohol addicted youth in Snohomish County. We provide the opportunity for these youth to come together once a week and learn to play music under the guidance of community mentors and a Music Therapist. The impact on these youth has been nothing short of transformative. With the help of our volunteers and our therapist, these children are leaving the margins of our society and becoming integrated into something positive and prosocial. They are also beginning to heal and regain the confidence that they lost throughout their walks with addiction.

Our state needs to support certification of Music Therapists. It is important not only for the continuance of services for impacted individuals, but also for the consistency and regulation of those services. I cannot speak for the general population, but I know that when making choices for providers for services to my core population, I look for professionals who are licensed and certificated. Best practice for my clients in any therapy or treatment must be intentional and educated. Supporting certification of music therapists supports better services for this fragile population.

Thank you,

Margaret Howard

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Health Systems Quality Assurance

Re: SB 6276

Dear Ms. Thomas:

The signatures on this letter are from supervisors and employees who currently work directly with a certified music-thanatologist at *Evergreen Hospice Center in Kirkland, Washington,* a *King County Public Hospital*. We wish to express our concern with language contained in a bill currently under consideration by the Washington State Legislature that could potentially limit and restrict music-thanatology from being used as a modality in the care of our patients. Senate Bill 6276 addresses state certification of Music Therapists and the language of this bill narrowly defines the use of music as a clinical modality. Because music-thanatologists earn their credentials through successful completion of a three-year graduate level program specifically designed to address the needs of those in Hospice care, we feel that this bill should not restrict either the hiring of or clinical practice of music-thanatologists.

We find that music-thanatology in many cases is an effective means of reducing pain, fear, anxiety, agitation, restlessness, the need for opioids; slowing heart and respiratory rates, supporting deep sleep or relaxation, emotional or spiritual catharsis, and processing their thoughts and feelings. We have seen the effectiveness of music-thanatology as a clinical modality and want to be able to continue to offer it to our hospice patients. It is patients who will suffer if they are denied access to care that brings them relief, and music-thanatology is an important resource for our hospice team. We have no objection to Music Therapists seeking state certification, but not at the expense of losing other professional clinical modalities that have been proven through evidence based practice.

Sincerely: Desireé Schoon, RN CM, BSN Nurse case manager
Melanie Sturgeon RN BSN
CHDN Program Manager
Cynthia [illegible] RN

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Health Systems Quality Assurance

Re: SB 6276

Dear Ms. Thomas:

The signatures on this letter are from supervisors and employees who currently work directly with a certified music-thanatologist at *Evergreen Hospice Center in Kirkland, Washington,* a *King County Public Hospital*. We wish to express our concern with language contained in a bill currently under consideration by the Washington State Legislature that could potentially limit and restrict music-thanatology from being used as a modality in the care of our patients. Senate Bill 6276 addresses state certification of Music Therapists and the language of this bill narrowly defines the use of music as a clinical modality. Because music-thanatologists earn their credentials through successful completion of a three-year graduate level program specifically designed to address the needs of those in Hospice care, we feel that this bill should not restrict either the hiring of or clinical practice of music-thanatologists.

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Sincerely:

[signature] (Hope Wechkin, MD) Evergreen Hospice Medical Director
Diane Fiumara RN (Diane Fiumara) Program Manager Hospice
[signature] (ZerLynn Frair) manager
Christine Clement (Christine Clement) - Manager MSW, LICSW
Carol Williams RN, CHPN - Staff hospice RN
Melinda Paper RN - Interim Director
Ann Marie O'Neill ARNP
Carol Barber, LICSW, MSW
Lana J. Bolton RN BSN Hospice
[signature] Caluth RN CHPN
Rebecca [signature] MSW, Hospice Social Worker
Melissa Lubatti - Coordinator - Hospice Volunteers

KATHARINE J. WILMERING, MSW PMHNP BC
SeaChange Psychotherapy Services
1900 N. Northlake Way, Ste. 127
Seattle, WA 98103-9051
632-9522 (ph)/(877-883-1876 (fax) / www.kwilmering.com

August 16, 2012

Sherry Thomas
Health Systems Quality Assurance
Office of the Assistant Secretary
310 Israel Road
Tumwater, WA 98504-7850

Re: Proposed Music Therapist Certification: HB 2522

Dear Ms. Thomas:

I am concerned about the wording of this bill. On the one hand, I am happy to see music therapists get title recognition, since it will open the door to insurance reimbursement and other support for music therapy. On the other hand, I want to make sure that you know that some practitioners provide professional services that the bill lists as being specific to music therapists.

Some of us are employed to play music at the bedside of people who are sick or dying, either in health care facilities or in the patient's home. Our intensive training and certification involves assessing the patient's needs and playing music that moves them to a calmer and more comfortable state of mind and body. After consultation with health care staff, we might bring a harp into a willing patient's room, note their grimaces of pain or look of anxiety, and pick music that we know from our training will increase their comfort. In the patient record we will document the intervention and results. Similarly, we can help a patient and family through the dying process. We do not make diagnoses or intervene in any way beyond that as a music therapist would. Please see mhtp.org for a description of our training and scope of practice.

The second group, closely related, are music thanatologists, who play more specifically for dying patients and their families. See http://www.mtai.org/index.php/what_is .

Third are GIM (Guided Music and Imagery / Bonney Method) practitioners, who go through rigorous training in a method pioneered by one of the early music therapists. Not all have degrees as music therapists. http://www.ami-bonnymethod.org/

Fourth are certified cross-cultural music practitioners. We have years of training in using chants and sounds from an array of cultures around the world to support physical, mental, and spiritual health and bring the multicultural lens to the work in a way often neglected by traditional music therapy.

Fifth are Native American healers who use the traditional interventions of singing, music, and drumming in their ceremonies with the sick.

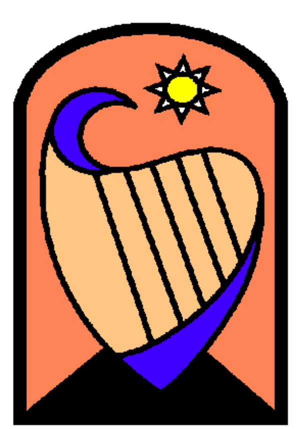
We are careful not to identify ourselves as “music therapists” and, perhaps more importantly, do not feel a need to. I would appreciate your clarifying the language of this bill so that we may continue to practice in the safe and effective ways we have done for decades.

Sincerely,

Kathy Wilmering, MSW PMHNP BC
1900 N Northlake Way Ste 127
Seattle WA 98103-9051

The Music for Healing and Transition Program, Inc.

P.O. Box 127, Hillsdale, NY 12529 • 518-325-5546 • mhtp@mhtp.org



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August 6, 2012

Dear Ms. Thomas:

Thank you for providing this opportunity to offer comments on the proposed 2012 twin bills, Washington State HB2522 and SB6276.
I am the Executive Director of the Music for Healing and Transition Program, Inc. (MHTP), and am writing to you at the direction of MHTP's Board of Directors.

Some brief background information about MHTP:
MHTP is a 501c3 Not-for-Profit educational organization, incorporated in Texas in 1994, and designated a 501c3 by the IRS in 1995. Since 1995, MHTP has trained 648 musicians and has granted them the professional title of *Certified Music Practitioner® (CMP)*, designating that they are qualified to serve competently as therapeutic musicians in healthcare facilities. CMPs provide therapeutic music to individual patients, and create a healing environment for the patient. Please visit our website for more information on MHTP, at: www.mhtp.org

In order to receive the title of Certified Music Practitioner®, students complete a broad spectrum of class-work, are evaluated on their course work comprehension, are assessed for appropriate musicianship and therapeutic presence, complete an extensive internship in healthcare facilities, and must demonstrate that they have met specific competencies. Students must also agree to work within the parameters of both the Scope of Practice and Ethical Code for CMPs.

Of our 648 graduates, there are currently 48 Certified Music Practitioners® in Washington State. Many of them are employed by multiple hospices, hospitals, nursing homes and other healthcare facilities.

Certified Music Practitioners® may not, and do not, use the title Music Therapist.

The Music for Healing and Transition Program, Inc. is a 501c3 Not-for-Profit educational organization. According to IRS regulations, financial support is tax-deductible as a charitable donation.

The Music for Healing and Transition Program, Inc. is accredited by the National Standards Board for Therapeutic Musicians (NSBTM), meeting the training Standards, Scope of Practice and Ethical Code required by that Board for programs training therapeutic musicians. For more information on the NSBTM please view its website at: www.therapeuticmusician.com

Comments on the Bill:

1. The Board of Directors of the Music for Healing and Transition Program, Inc. completely supports the desire of the Music Therapy profession to seek state licensing or certification, and to regulate the use of their professional title, *Music Therapist*.
2. We find that certain language in the bill has the potential to prevent Certified Music Practitioners®, and other extensively-educated therapeutic musicians, such as Certified Music Thanatologists, from practicing their profession and making a living in the state of Washington.

   Some examples:

   Section 1, # 3, defines what Music Therapy means. These sections ALSO define some of the skills of Certified Music Practitioners® and are not unique to Music Therapy:

   a. "The assessment of a client's emotional well-being, physical health, social functioning, communication abilities and cognitive responses to musical stimuli."
   b. "…using music interventions including …. receptive music listening."
   c. "The evaluation and documentation of the client's response to treatment."
3. Section 10: The bill defines the terms "health profession," "certification," and "practitioner" solely in terms of state regulation. There are many disciplines that grant the title "practitioner" and confer "certification," that are not governed by state law but are governed by national accrediting or certification Boards. In addition, the public, other health professionals, and

the healthcare facilities that hire them to serve patients accept them as legitimate and respected professions.

The MHTP Board of Directors respectfully and strongly requests that any language in the bill that could be interpreted in a way that prevents other competent practitioners from making a living be revised.
Thank you very much for consideration of these comments.

Sincerely,

Melinda Gardiner, RN, CMP
Executive Director
For the Music for Healing and Transition Program, Inc. Board of Directors

The Music for Healing and Transition Program, Inc. is a 501c3 Not-for-Profit educational organization. According to IRS regulations, financial support is tax-deductible as a charitable donation.

THE CAROLINE KLINE GALLAND HOME

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Sherry Thomas, Policy Coordinator
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Dear *Ms. Thomas:*

My name is Lenya Treewater. I am a Board-Certified Dance/Movement Therapist overseeing the supervision of creative arts therapy (CAT) practicum students and other CAT interns. I am writing in support of SB 6276 as it goes through the Sunrise Review Process with the State of Washington Department of Health. I have supervised many music therapy students and would like to share with you my experience and why I think it is important for music therapists to receive certification through Washington State.

Kline Galland is home to many people in various stages of dementia. I usually have two students each quarter, at various levels in their training. But even with the newest students I am constantly impressed with their training, and their willingness to work with seniors with dementia - a very challenging population. Through my association with Seattle Pacific I know the education and fieldwork that is involved in training a music therapist. It is comparable to the training I received as a dance/movement therapist. I consider it a privilege to supervise these students, who have added so much to our programming.

Washington State Music Therapists have been working towards state certification with state agencies and legislators to protect the public from harm due to misuse of terms and techniques, to insure competent practice, and to protect and improve access to music therapy services. This is important to ensure that all Washington State residents have access to services provided by qualified, credentialed professionals. I think music therapy is important for the residents in my facility and I would like to see others have the same access to services.

Sincerely,

Lenya Treewater, MA, BC-DMT
Internship Coordinator
Kline Galland Home
lenyat@klinegalland.org

KLINE GALLAND
HONOR THY FATHER AND MOTHER

August 6, 2012

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Dear Ms. Thomas:

Thank you for providing this opportunity to offer comments on the proposed 2012 twin bills, Washington State HB2522 and SB6276.

I am the Chair of the Executive Board of the Sound and Music Alliance (SAMA), a 501c6, Not-for-Profit professional membership and trade organization. I am writing to you at the direction of SAMA's Executive Board.

Some brief background information:
The Sound and Music Alliance is a nonprofit professional membership organization bringing together those who believe that the conscious use of sound and /or music with positive intentionality has a place in healthcare, education, art, wellness and care for the environment.
SAMA represents an array of disciplines. Among them are: acousticians, caregivers, clinicians, educators, musicians, physicians, practitioners, researchers, and therapists. See www.soundandmusicalliance.org

Comments on the Bill:

1) The Executive Board of the Sound and Music Alliance, Inc. fully supports the desire of the Music Therapy profession to seek state licensing or state certification, and to regulate the use of their professional title, *Music Therapist*.
2) We find that certain language in the bill has the potential of preventing other extensively-educated professionals who use music and sound as a modality for treating clients from practicing their profession and making a living in the state of Washington.

   Some examples:

   Section 1, # 3, defines what Music Therapy means. These sections ALSO define some of the skills of other professionals, and are not unique to Music Therapy:

   (a) "The assessment of a client's emotional well-being, physical health, social functioning, communication abilities and cognitive responses to musical stimuli."
   (b) "The development and implementation of treatment plans based on a clients assessed needs, using music interventions including music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, music performance, learning through music and movement to music."
   (c) "The evaluation and documentation of the client's response to treatment."

3) Section 10: The bill defines the terms "health profession," "certification," and "practitioner" solely in terms of state regulation. There are many disciplines that grant the title "practitioner" and confer "certification," that are not governed by state law but are governed by national accrediting or certification Boards. In addition, the public, other health professionals, including the healthcare facilities that hire them, accept them as legitimate and respected professions.

PO Box 594, New York, NY 10101-0594 USA • Telephone (877) 551-SAMA (7262) • www.SoundandMusicAlliance.org
SAMA is a 501c6 Not-For-Profit membership organization. According to IRS regulations, financial support is not tax-deductible as a charitable donation, but it may be considered a business expense.

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Billie Thompson, PhD
Jeffrey Thompson, DC
Christina Tourin, CTHP, MT

Thank you very much for consideration of these comments as part of your deliberations on the bills.

Sincerely,

Melinda Gardiner
Registered Nurse, Certified Music Practitioner®; Music for Healing and Transition Program, Inc.
mhtp@mhtp.org

Sheila Allen –
Occupational Therapist; Pediatric Therapeutics
ssmiallen@aol.com

Zacciah Blackburn
Sound Practitioner, The Center for the Light Institute of Sound Healing and Shamanic Studies
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Barbara Crowe
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Lisa Rafel
Musical Performance Artist; Resonant Sounds, LLC
lisa@lisarafel.com

Therese Schroeder-Sheker
Music Thanatologist; Chalice of Repose Project
phoebe51@chaliceofrepose.org

Jeff Strong
Clinician, Artist; Strong Institute
jeff@stronginstitute.com

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Music-Thanatology Practitioners and Students, Residing in the State of Washington
Chalice of Repose Project Faculty

Sharon Murfin: sharonmurfin@gmail.com
Ron Pilcher: rmpilcher@frontier.com
Jessica Ryan: jessica_a_ryan@msn.com
Colin Lee: colinleephd@yahoo.ca
Therese Schroeder-Sheker: phoebe51@chaliceofrepose.org
Ken Thorp: k.t@earthlink.net

August 11, 2012

Washington State Department of Health
Sunrise Review: Certification of Music Therapists, SB 6276

To the DOH sunrise review board:

We first learned of SB 6276 and the proposed legislation for certification of music therapists in late July 2012. We are writing because we have grave concerns about the scope of this legislation. As written, it could be read to allow only "music therapists" certified under the legislation to use music as a modality of care in health care settings. The language of SB 6276 should be modified to more clearly define "music therapy," and to ensure that other recognized and highly regarded professional fields are not precluded from practicing in the State of Washington.

You will find 6 signatures at the end of this letter. As collaborative authors, in a unified voice, we each write in different roles and capacities: student, university faculty members and educators, clinical practitioners, physician. All of us share the fact that we have substantive educational and professional resumes, and write to you in professional maturity. We are not writing you as uninformed non-professionals.

We are all concerned with the language of SB 6276. Three of us are residents of the State of Washington; three of us are music-thanatology practitioners; one is a music-thanatology student with both undergraduate and graduate degrees; two are senior music-thanatology faculty members with multiple degrees and more than two decades of clinical and pedagogical experience; one is a physician who has served as medical director and professor for the music-thanatology educational program for 15 years; one is an educator and clinician of a prominent music therapy university program. All of us have deep personal and professional interests in fairness, and in ensuring that music-thanatologists will be able to continue practicing in this state.

We understand the need and interest of music therapists in the State of Washington to protect their own delivery systems, and we wholeheartedly support their objections to people misappropriating the term "music therapy" or "music therapist." However, the language of SB 6276 in its current form casts too broad a net. If this legislation prevents other professional fields that use the agency of music from practicing in the State of Washington, this would result in harm to the public.

In this statement, we describe why we are concerned with the language of SB 6276 in its current form.

Music-Thanatology Framework:
In February of 1992, after 19 years of research and development, music-thanatology as originated and pioneered by the Chalice of Repose Project mainstreamed medicine as a palliative medical modality. It was anchored in and integrated through hospital and hospice systems. That designation and

accomplishment – to be welcomed as a medical modality – is substantive and historically significant. Since that time, music-thanatology has been offered as a standard component of end-of-life care in every psycho-social setting where the dying are to be found: hospitals, hospices, long term care facilities, etc. Its expert practitioners have cared for the needs of tens of thousands of dying patients over the decades.

In September of 2012, having completed four consecutive decades of work, music-thanatology's history, as pioneered by the Chalice of Repose Project (with offices in Oregon, Minneapolis and other cities), is distinguished by numerous awards, publications, television documentaries and foundation grants. The field has its own history, definition, scope of practice, institute, university anchored curriculum, faculty, lexicon of terms, clinical foci, expert practitioners, field placements, clinical internships, clinical residencies, specific competencies and proficiencies, oral and written examinations, publications, newsletters, conferences, continuing education opportunities and requirements, comprehensive clinical data base designed for research, and professional academy. Its expert practitioners refer to themselves as music-thanatologists, and are extremely respectful and aware of the term music therapist. They do not misappropriate this term and have no history of the misappropriation of the term.

This letter is not the appropriate place or forum to describe the clinical theory of music-thanatology or its curriculum or any of the other details related to delivery or implementation. It is our goal however to identify for you a fundamental fact. There is a difference between music therapy and music-thanatology. The former is a rehabilitative work and the latter is entirely based on end-of-life palliative care. The two disciplines serve entirely different patient constituencies and its practitioners have different clinical focus and education. Without exception, the patients music-thanatologists receive are all actively dying; there is no hope of cure. All music-thanatology patient referrals come only from within hospital and hospice or long term care facility systems, and are ordered by staff physicians, nurses, social workers and chaplains. These referrals are given to the music-thanatologist on staff who is part of the interdisciplinary palliative care team, often referred to as the IDT team. Music-thanatologists serve patients with a terminal diagnosis with a prognosis of six months or less, and all patient referrals have a DNR, DNAR, AND or similar status.

Without the uses of additional medications, and with the benefit of music-thanatology delivery of prescriptive music, which is palliative, many patients experience marked pain relief as evidenced by: decreased pulse rate and heart beat; stabilized breathing patterns; change in body temperature; deep restorative sleep; emotional, mental or spiritual release; profound relaxation and decreased requests for even opioid derivative pharmaceuticals. The music thus delivered helps people to die differently than they would have had they died without this modality. It is especially helpful for those who are morphine intolerant. To deny patients this possibility because the current language of the SB 6276 proposal is a little too broad would be a tragedy for all concerned: patients, their surviving loved ones, hospital staff providers and administrators. It would also deny serious, educated individuals who are qualified practitioners a right to livelihood. It is apparent that the work of music-thanatology has no relationship to music therapy. Music therapy has historically described itself as a behavioral science, and serves many patient constituencies throughout the full spectrum of life, yet is focused on and concerned with rehabilitation. Music therapists work to help bring people back into the fullness of life. In contrast, music-thanatology is completely oriented to the dying process, and always has been. The focus is supporting patients in this culminating transition of a human life.

Chalice of Repose Project Educational Curriculum

In order to work with the dying with prescriptive music, a very particular graduate level reflective formation, education, orientation and expertise is developed over time. In our shared opinion, we also note that music-thanatology has a spiritual dimension for practitioners: they consider the work a vocation as well as a profession.

Music-thanatology students are engaged in a rigorous, three-year curriculum of study and praxis. For example, one of the signatories below completed the one-year prerequisite program in Contemplative Musicianship in 2011. This prerequisite program grounds students in the essential framework required for the practice of music-thanatology. The curriculum for the two-year Music-Thanatology Program, in which she is now enrolled, includes a variety of authors and instructors from multiple disciplines within medicine and the humanities. The curriculum embodies a rubric that develops five kinds of inter-disciplinary, cross-disciplinary and multi-disciplinary educational and formational tracks: 1) musical; 2) academic; 3) clinical; 4) medical; 5) and spiritual.

In order to complete all the program requirements of the music-thanatology program, all students, regardless of previous education and background, must successfully complete 36 extremely detailed and challenging modules, at one month intervals, and later successfully complete clinical musical reviews in order to qualify to enter clinical internship. Then, students enter into a supervised clinical internship, which lasts approximately 9 months depending upon the patient census and referral flow; write a thesis, and successfully complete comprehensive exams. Only then will an individual be publicly acknowledged by faculty, peers and the professional academy as professionally competent to practice in this field.

As music-thanatologists; we and our colleagues practice music-thanatology. We would not practice music therapy, as we are not trained in that discipline. We do want to state for the record however, that there are a small number of practitioners nationwide who have been board certified as music therapists who later enrolled in a music-thanatology educational program, and thus will be legitimately recognized as practitioners of both modalities: music therapy and music-thanatology. However, when a practitioner has dual credentials, they still do not mix modalities. They do not practice two modalities concurrently – this would be a contraindication and would ignore music-thanatology scope of practice parameters.

Concerns with Broad Language of SB 6276

The definition of "music therapy" in SB 6276 could be read to preclude anyone but music therapists certified by the Certification Board of Music Therapists from using music in health care settings or using music as a modality of care. Anyone deemed to be practicing "music therapy" without such certification could be charged with a gross misdemeanor for a first offense (364 days in jail and/or $5000 fine), and a Class C felony for a second offense. SeeRCW 18.130.190.

One of the rationales the Association of Music Therapists offers in support of their request for state licensure is that it is necessary to protect the public, because unqualified practitioners holding themselves out as music therapists can cause actual harm to patients. This is a valid rationale and is not disputed by any faculty members, peers or music-thanatology practitioners. However, we do not feel that practitioners of music-thanatology should be prevented from practicing in end-of-life care programs, nor should the initiative of music therapists prevent hospital and hospice employers from making competent administrative decisions about their own hires for patient care, whether salaried employees or contract.

On a personal note, students and faculty all experience a deep and genuine vocational call to practice music-thanatology in care of the dying. We certainly do not want to be charged with a crime for practicing in this state or any state as a music-thanatology professional, particularly since the pioneers have been doing so for almost 40 years.

Preventing the Practice of Music-Thanatology Would Harm the Public

If SB 6276 passes into law as written and music-thanatologists are prevented from working in medical settings in the State of Washington, the public would be denied the real and profound benefits that music-thanatology offers. We remain very respectful of our music therapy colleagues, and note that one can deduce from the materials they submitted to the legislature that care of the dying is not their primary focus

or even an area of specialty. While some music therapists might employ some music therapy methodologies that are considered palliative, their clinical focus is not care of the dying. The focus and orientation of the three year study in which music-thanatology students engage and commit themselves is entirely devoted to learning the clinical uses of prescriptive music in care of the dying. Music-thanatologists should not be precluded from serving the dying in the State of Washington.

Request that the Definition of "Music Therapy" be Modified to Eliminate Ambiguity and to Make Clear that Music-Thanatologists May Continue to Practice in the State of Washington

It may well be that those who drafted SB 6276 did not intend it to prevent the practice of music-thanatology in the State of Washington. As written, however, the definition of "music therapy" in the bill is so broad that it could be interpreted that way. The definition should be written more precisely and more narrowly, to make clear that professions such as music-thanatology that use music in clinical care settings are not outlawed.

We request that professionals in the music-thanatology field be allowed to participate in a revision of the language defining "music therapy" in the proposed legislation.

Sincerely,

Sharon Murfin, music-thanatology practitioner and senior faculty member, Chalice of Repose Project, and resident of Washington

Ron Pilcher, music-thanatology practitioner and resident of Washington

Jessica Ryan, music-thanatology student and resident of Washington

Therese Schroeder-Sheker, Chalice of Repose Project founder and senior faculty member, resident of Oregon

Ken Thorp, physician, radiologist, medical director and senior faculty member, Chalice of Repose Project Clinical Practice, resident of Michigan

Colin Andrew Lee, certified music therapist, department chair and practicing music therapist, Wilfred Laurier University, resident of Toronto, adjunct faculty, Chalice of Repose Project

Jim Couture, MA, MT-BC
719 E. 11th St.
Port Angeles, WA 98362
8/2/12

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas,

My name is Jim Couture. I am a board certified music therapist and director of Encore! Adult Day Center and Arts & Minds Memory Wellness Program. I am writing in support of certification of music therapists in Washington State.

At Encore! we use music therapy to help clients engage in the creative process to stimulate many areas of the brain and body, maximize abilities, access memories and utilize functional skills in a social setting.

By participating in planned, targeted music experiences clients live the best quality of life at home at the least expense to families and government programs for as long as possible.

Our clients cope with low vision, hearing impairment, mental health issues, developmental disability, Multiple Sclerosis, Alzheimer's disease, aphasia, stroke, Cerebral Palsy, and other challenging personality, physical and behavioral issues. But they all engage in the creative music process guided by a credentialed health professional - me.

At the center one may observe clients engaged in singing, lyric reading, drumming, rhythmic exercise, creative movement, cognitive music experiences, music games, song writing, music history, literature and theory, relaxation and stress management, music performance, reminiscence with and through music, choreographed movement, improvisation, the assessment process and discussion of related research.

I have been practicing as a credentialed music therapist for over thirty years. This has meant that agencies and organizations that have hired me have employed someone who has been well trained and qualified to provide the best therapeutic, evidence-based practice possible for their clients. It has also meant that these agencies and organizations would only hire a certified or licensed professional.

It is my desire that every citizen of Washington State have access to the services of a qualified, board certified music therapist should that therapeutic approach be recommended or requested.

Respectfully submitted,

Jim Couture, MA, MT-BC

(Second page includes photos from the center. All clients have signed release forms.)

Music Therapy at Encore! Adult Day Center

The table on the next six pages was submitted with the following message:

I am sending you this overview comparison at the request of Beth Cachat. It helps in understanding the different areas of music service providers.
Sable Shaw

DRAFT -- Therapeutic Music Services At-A-Glance -- DRAFT

An Overview of Music Therapy, Therapeutic Bedside Music Programs, and Music Thanatology

Over time, the number of practitioners using music in therapeutic ways has grown. This growth has occurred nationwide with certain pockets of the country having higher concentrations of one type of practitioner over another. This document provides a brief side by side summary of key elements among three practices. Some of these practices are younger in terms of formalizing their work and training, compared to others. Some of these practices are narrow in scope representing more of a specific service modality while others represent a defined profession with considerably wider scope. Common to all of these practices is the use of music to benefit the clients served.

Therapeutic Music Profession or Modality Information Element	Music Therapy AMERICAN MUSIC THERAPY ASSOCIATION	Music-Thanatology MTAI and The Chalice of Repose Project®, Inc., The Voice of Music-Thanatology™	Music for Healing and Transition National Standards Board for Therapeutic Musicians
Short Description	Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. *(AMTA, 2005)*	Music-thanatology is a professional field within the broader sub-specialty of palliative care. It is a musical/clinical modality that unites music and medicine in end of life care. The music-thanatologist utilizes harp and voice at the bedside to serve the physical, emotional and spiritual needs of the dying and their loved ones with prescriptive music. Prescriptive music is live music that responds to the physiological needs of the patient moment by moment.	Therapeutic music is an art based on the science of sound. It is live acoustic music specifically tailored to the patient's immediate needs. A therapeutic musician uses the inherent healing elements of live music and sound to enhance the environment for patients in healthcare settings in order to facilitate the healing process. Therapeutic music is music that can or may restore health or help the process of healing. The World Health Organization defines health as: "...a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." Therapeutic music helps the process of
Theoretical Framework	Varied & multiple theoretical frameworks employed (e.g., cognitive, humanistic, behavioral,	Music-thanatology is a contemporary field rooted in ancient contemplative and spiritual traditions. It has developed over the past three decades	

	psychodynamic, etc.)	through the foundational work of Therese Schroeder-Sheker .	healing through a mechanism known as entrainment, in which the individual responds to the vibratory elements of music – intention, rhythm, harmony, melody, tonal color – eventually resonating with them. The healing effects of therapeutic music include, but are not limited to: stabilizing physical-physiologic functions, reducing pain or anxiety, releasing emotions, and helping the process of dying.
Client Assessment Process Treatment Planning Documentation Re-assessment Process	✓ Formalized and Standardized ✓ ✓ ✓	✓ Formalized & Nonstandardized - No Observational assessment is an ongoing process: before, during and after therapeutic music is played.	✓ Formalized& Nonstandardized - **No** Subjective and objective assessment as well as multi-level processes (??) that deepen perceptual awareness. Observational assessment is an ongoing process: before, during and after therapeutic music is played.
Practice Setting(s)	Varied settings including: psychiatric and medical hospitals, rehabilitative facilities, outpatient clinics, day care treatment centers, agencies serving developmentally disabled persons, community mental health centers, drug and alcohol programs, senior centers, nursing homes, hospice programs, wellness centers, correctional facilities, halfway houses, schools, and private practice	At bedside in homes, hospitals and/or hospice facilities.	Including, but not limited to, hospital units, home and in-patient hospice, skilled nursing homes as well as other settings where music can be delivered directly to individual patients. Other settings might include: massage, reiki, dental and chiropractic practices, etc..
Population(s) Served	neonatal (NICU) services, special education & early intervention, physical or sensory impairment, mental health & psychiatric, developmental disabilitites, autism spectrum disorders, well adults & wellness,	Any person with a terminal diagnosis or actively dying.	Any person, of any age, who might benefit from therapeutic music. This includes patients, families and the care-team.

	medical inpatient, dementia & Alzheimer's, neurologic disorder, rehabilitation & habilitation services, hospice and palliative care		
Professional Organization	American Music Therapy Association (AMTA), a 501(c)(3). Website: www.musictherapy.org	The Music-Thanatology Association International (MTAI) stands as an independent professional organization and certifying body for music-thanatology worldwide. The American Academy of Music-Thanatology Professionals maintains recognition of Chalice of Repose Project® trained music-thanatologists.	The National Standards Board for Therapeutic Musicians (NSBTM) www.therapeuticmusician.com
Year Founded	Founded in 1998 as a union of the National Association for Music Therapy (founded in 1950) and the American Association for Music therapy (founded in 1971).	MTAI incorporated in 2003. Music-thanatology, as a profession in the U.S., was founded by Therese Schroeder-Sheker in 1973 along with her Chalice of Repose Project®, a 501(c)(3) nonprofit.	1994
Professional Journal(s)	*Journal of Music Therapy* *Music Therapy Perspectives* Published by AMTA	*Journal of the MTAI* launched in 2009. Articles typically appear in journals such as the *American Journal of Hospice & Palliative Medicine* and *Spirituality and Health International*	*The Harp Therapy Journal*, *The Music Practitioner* and other program releases
Who is qualified to practice?	Persons who complete one of the approved college music therapy curricula (including an internship) are eligible to sit for the national examination offered by the Certification Board for Music Therapists.	Certification is granted by MTAI based on demonstration of the professional standards for competency. Training programs are at Lane Community College, Portland, OR and through the Chalice of Repose Project®.	A person who has completed a therapeutic musician training program curricula and independent study. The NSBTM has set Standards for the profession, and has currently accredited four training programs that meet the Professional Standards.
Requirements for program admission	Meet college admission requirements plus audition on primary instrument	Demonstration of proficiency on an instrument, preferably harp. Basic understanding of music theory, including reading and notating music. Program application and interview process.	18 years or older (with rare exceptions), with appropriate references and required musical ability

Undergraduate degree awarded	Min. Credit Hrs. Requirement: 120 credit Typical Credit Hrs: 130 *Liberal Studies: 36 *Core Courses: 89 *Behavioral/NatScience: 18 *Oral Skills & Electives ~72 entry level degree programs in U.S. Note: Equivalency programs available for persons with other related degree(s)	Not applicable. However, trainees may come with experience and education in many possible disciplines.	Not applicable. However, trainees may come to an NSBTM approved training program with a degree(s), experience and other related skills and training. Four approved non-degree training programs: • Clinical Musician Home Study Course • Music for Healing and Transition Program • International Harp Therapy Program • International Healing Musician's Program
Non-degree training program and certification	Examples of Specializations/Certificates: *NICU MT – Neonatal Intensive Care Music Therapist *NMT – Neurologic Music Therapist, and Fellowship Awarded *FAMI - Fellow of the Association for Music and Imagery	The two training programs vary slightly but generally include a two year non-degree program. Online and onsite training components used. *CMP - Contemplative Musicianship Program *MTH –Music-Thanatologist *CM-TH – Certified Music-Thanatologist	Each accredited training program uses a different certification: *CCM - Certified Clinical Musician for the Clinical Musician Home Study Course, *CMP - Certified Music Practitioner for the Music for Healing and Transition Program, *CTHP - Certified Harp Therapy Practitioner the International Harp Therapy Program *CHM - Certified Healing Musician for the International Healing Musician's Program.
Classroom training hrs:	5,850 – 5,940 hrs	600 hrs	80 hours or equivalent
Clinical Practicum, Fieldwork, and Internship hrs:	1,200 hrs Internship roster available at AMTA	300 hrs	Minimum 45 hours of direct individual bedside musical delivery. Excludes patient, staff & family consultation or meetings, documentation, or between-patient time in the facility.
Graduate degree programs? Master's	✓ ✓	- **Planned**	- -

Doctoral	✓	-	-
Code of Ethics?	✓	**- Unpublished-**	✓
Standards of Practice?	✓	✓	✓
Credentialing and Designation	Music Therapist, Board Certified (MT-BC) The Certification Board for Music Therapists (CBMT), an independent organization, is the only organization to certify music therapists to practice music therapy in the U.S. Since 1986 it has been fully accredited by the National Commission for Certifying Agencies (NCCA). CBMT administers credentialing and the Board examination. Website: www.cbmt.org	- Training programs award certifications endorsed by MTAI, noted above in program certifications.	- NSBTM approves certifications, noted above in program certifications.
Continuing Professional Education	✓ 100 contact hrs. for every 5 yr. Board Certification cycle	- Planned as part of American Academy of Music-Thanatology Professionals and The Chalice of Repose Project®	✓
Quality Assurance	Music therapists participate in quality assurance reviews of clinical programs within their facilities. In addition, AMTA provides several mechanisms for monitoring the quality of music therapy programs which include: Standards of Practice, a Code of Ethics, a system for Peer Review, a Judicial Review Board, and an Ethics Board	-	Accreditation review conducted by NSBTM
Designations	*ACMT, CMT or RMT are listed on the National Music Therapy Registry (NMTR) and indicate international and former/older training designations. The MT-BC is officially recognized by AMTA and the NMTR will eventually be phased out.	-	-
Licensure	Some limited licensure, varies by	No state licensure	No state licensure

	state. MT-BC recognized as authoritative credential in many states.		
Service reimbursement	✓ Limited and variable by type of third party payer. Includes some Medicaid waivers.	No insurance or Medicaid/Medicare reimbursement. Funded privately, by grants and hospital or hospice foundations, etc. Also may be salaried and incorporated into a related position.	No insurance or Medicaid/Medicare reimbursement. Funded privately, by grants and hospital or hospice foundations, etc. Also may be salaried and incorporated into a related position.
For more information	Contact the American Music Therapy Association at 301-589-3300 www.musictherapy.org 8455 Colesville Rd., Ste 1000 Silver Spring, MD 20910	www.chaliceofrepose.org www.mtai.org http://lanecc.edu/ce/music/index.htm	www.therapeuticmusician.com

August 20, 2012

TO: **Department of Health**
310 Israel Road SE, Room 152/153
Tumwater, Washington 98501

RE: Certification of Music Therapists - SB6276/HB2522
Public Hearing and comments

FROM: Washington Occupational Therapy Association (WOTA)

Thank you for the opportunity to provide comment on the current Sunrise Review process for proposed Certification of Music Therapists, SB6276/HB2522.

Although WOTA supports the work of music therapists in our community and the benefit to clients, we have concerns about **the need for regulation of music therapists through certification.** We also have concerns that **the Scope of Practice outlined by AMTA has significant overlap with the Scope of Practice of Occupational Therapy.** In fact, many Occupational Therapists use music as a therapeutic modality in their everyday practice.

WOTA supports state regulation for health professions to protect consumers from harm. However, **as the bill is currently proposed and drafted, WOTA does not support this legislation (SB6276/HB2522).**

In order to protect our right to use music in our practice, WOTA offered the following amendment on SB6276 which was accepted by the Music Therapists at the legislative hearing on Jan 23, 2012:

"**NEW SECTION. Sec. 2.** No person may practice music therapy or represent oneself as a music therapist by use of any title unless certified as provided for in this chapter **or licensed as an occupational therapist as defined by RCW 18.59.020(3)."**

Since this hearing, WOTA has continued dialogue with the Music Therapists at both the local and national level to more closely study their proposed Scope of Practice and educational background.

To illustrate the Scope of Practice concerns, the table below offers a side by side comparison of defined practice areas in both Music Therapy and Occupational Therapy which look startlingly similar:

MUSIC THERAPY (See reference list below).	OCCUPATIONAL THERAPY (See reference list below)
"assist client's social skills and social interactions, decision-making, assist client in increasing task behavior, improve orientation person place or time, develop or rehab motor skills, ..."	"Occupational therapy services are provided for the purpose of promoting 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."
"address physical, emotional, cognitive and social needs for individuals of all ages. Music therapy helps individuals advance physically and cognitively.."	"Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life."
"...within the following domains (e.g. perceptual, sensory, physical, affective, cognitive, communicative, social, and spiritual)"	"Participation in activities and occupations that are meaningful to the client involves emotional, psychosocial, cognitive, and physical aspects of performance. Participation in meaningful activities and occupations enhances health, well-being, and life satisfaction."
"to facilitate movement, increase motivation, promote wellness, manage stress, alleviate pain, enhance memory, provide emotional support, create an outlet for expression, improve communication, and provide unique opportunities for interaction"	"Occupational therapy services enable clients to engage (participate) in their everyday life activities in their desired roles, contexts and environments, and life situations."

In reference to the Sunrise Review Hearing on August 20, 2012, **WOTA's questions/comments are the following**:

1. How does the proposed scope of practice for Music Therapists in the Sunrise Review application reconcile with their national AMTA documents of professional competencies, code of ethics and standards of practice, which are much broader in nature? WOTA is concerned that the broad scope of practice wording may be misinterpreted.

2. The therapy concepts outlined in the proposed Music Therapy certification bill sound very similar to concepts that are in our Occupational Therapy profession. For example, both professions may use music as a therapeutic modality with students with autism and use the term Sensory Integration as a description for therapeutic practices.

3. How would patient care be affected by the certification of Music Therapists?

4. What is the cost of this regulation versus the benefits? Will this be confusing to clients who already receive OT services which may overlap with Music Therapy goals?

5. How is access to Music Therapy currently restricted?

WOTA is interested **in continuing dialogue with the Music Therapists** through both our national and state associations to make sure all concerns are addressed and the needs of the public are best served. Thank you for this opportunity to comment.

If you have further questions, please contact:
Mark Gjurasic, WOTA lobbyist, at 360-481-6000 or mgjurasic@comcast.net OR
Rose Racicot, WOTA Legislative Committee, at contact info below.

Sincerely,

Rose M. Racicot, MS, OTR/L
Occupational Therapist
on behalf of Washington Occupational Therapy Association (WOTA)
Legislative Committee
rmracicot@gmail.com
206-242-8275

Reference Documents for above include:

AOTA Scope of Practice document:
http://www.aota.org/Practitioners/Official/Position/40617.aspx?FT=.pdf
AMTA's professional competencies, code of ethics, CBMT documents and Sunrise Review Application: http://www.doh.wa.gov/Portals/1/Documents/Pubs/MusicTherAppRpt.pdf

Comments Received After Hearing

I am a certified Music Practitioner residing in the state of Washington and would like to add comments of my experiences playing for sick or dying patients and the benefits of my abilities and training. I play the Hammered Dulcimer.

In the hospital setting I have been able to help exhausted people sleep when little or nothing else has worked. By matching their breathing I can calm or wake people, by changing the music. Many times I have been able to lower blood pressure & regulate heart beat. It's amazing what mode, beat and vibration can do to our bodies.

One significant instance was when in ICU, the nurse needed to perform a cut down procedure to a very anxious and exhausted patient. I was playing in the corner of the room. The patient was able to bear the procedure well and afterward went promptly to sleep, which was good, but the most significant thing was what the nurse said afterward. It helped him to perform the procedure in a better way. He was calmed also. many times the nurses have asked me to come play in their area because of the calm it brings besides what it does to the patient.

Live music works on our bodies in a way recorded music can't.

With dying patients, I have their relatives who, years later, still thank me for helping there loved one be released. One had been off life support of any kind for 2 weeks but his body was still hanging on. I played 2 sessions for him and he passed just shortly after the second.

I am very thankful for the ability and training I have received to be able to help these people.
Linda Higginbotham CMP

On behalf of the Washington Speech-Language-Hearing Association (WSLHA), I am commenting on the proposal to certify music therapists currently undergoing a sunrise review at the Department of Health (Department). WSLHA is the professional association representing speech-language pathologists and audiologists across Washington. WSLHA has concerns on the proposed scope of practice for music therapists, as outlined in SB 6276. Specifically, we are concerned that the proposed scope of practice includes the assessment of "communication abilities." We believe that the music therapy education does not support the inclusion of communication disorder assessment in their scope of practice.

As you know, speech-language pathology is defined as "the application of principles, methods, and procedures related to the development and disorders, whether of organic or nonorganic origin, that impede oral, pharyngeal, or laryngeal sensorimotor competencies and the normal process of human communication including, but not limited to, disorders and related disorders of speech, articulation, fluency, voice, verbal and written language, auditory comprehension, <u>cognition/communication</u>, and the application of augmentative communication treatment and devices for treatment of such disorders (RCW 18.35.010(18) (emphasis added).

The education and training an SLP receives clearly supports this scope of practice and establishes SLPs as the professionals who are uniquely qualified to assess communication disorders. An SLP must have a master's degree or a doctorate degree from an approved speech-language pathology program, which includes completion of supervised clinical practica experiences, and have completed an approved postgraduate clinical fellowship professional work experience (RCW 18.35.040(2)).

The advanced education and training an SLP receives supports their scope of practice outlined above, which includes the evaluation and treatment of communication disorders. In contrast, the entry level

education cited in the applicant’s report does not support the level of education and training necessary for a music therapist to evaluate and treat communication disorders. This education focuses on musical foundations, clinical foundations, music therapy, and general education, not on the specific education and training for the evaluation and treatment of communication disorders.

WSLHA respectfully requests that the Department reject the broad scope of practice included in the applicant’s request for certification.
Martin Nevdahl, MS, CCC-SLP, President

The Music for Healing and Transition Program (MHTP) submits the following as optional wording to be added to the Music Therapists' bills:

"This law is not meant to apply to those who are not Music Therapists, but who sing or play music for patients without a specific music therapy treatment plan. Family members, bedside musicians, therapeutic musicians, music thanotologists and others offering music at the bedside of patients are excluded from the requirements of this law."

We also think that the definition in the law of what music therapists do is a problem unless there is wording added that specifies that other professionals may use some of the listed musical approaches as well.
Thank you for your help with this!
Cheryl Zabel, Certified Music Practitioner, Harp/Song
Music for Healing and Transition Program Washington Area Coordinator

To: Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance

Dear Ms. Thomas,

On July 27th I sent you a letter addressing my concerns about SB 6276 and the possibility that it's broad wording could negatively impact my husband's current employment at a hospice center in Washington. My letter is now part of the public record, which I appreciate, but I have come to realize that I mistakenly circulated one inaccurate statement in it and now appreciate the opportunity to correct it publicly. The Chalice of Repose Project School of Music-Thanatology has had a long history which has included changing needs and growth over decades. This organization has always provided a certificate of completion upon successful completion of all their music-thanatology educational requirements. However, upon inquiry, I discovered that the Chalice of Repose Project does not describe itself as a certifying agency. I also have come to understand that the Chalice of Repose Project adopted the criteria published by the National Commission for Certifying Agencies and the Accreditation Body of the Institute for Credentialing Excellence at www.credentialingexcellence.org/ncaa. The NCCA affirms that accrediting agencies must be independent from the agencies that provide training courses and from faculty members who teach these courses, in order to avoid conflicts of interest. Correctly stated, my husband has earned his professional credentials from the Chalice of Repose Project School of Music-Thanatology and is now employed at Evergreen Hospice Center in Kirkland, Washington where he works as a professional music-thanatologist and delivers prescriptive music for hospice patients. Thank you for allowing me to correct myself, and please consider rewording SB 6276 so it will allow state certification of music therapists without adversely impacting the livelihoods of other types of professional musician-clinicians currently working in our state.

Sincerely,

Linda Pilcher
2708 120th Dr NE
Lake Stevens, WA 98258
425-334-0618

CC: The Chalice of Repose Project School of Music-Thanatology Faculty and Board of Directors.

Music-Thanatology Practitioners and Students, Residing in the State of Washington
Chalice of Repose Project Faculty

Sunrise Review on Music Therapist Certification: Comments in response to submissions and testimony presented at hearing on August 20, 2012

Sharon Murfin: sharonmurfin@gmail.com
Ron Pilcher: rmpilcher@frontier.com
Jessica Ryan: jessica_a_ryan@msn.com
Colin Lee: colinleephd@yahoo.com
Therese Schroeder-Sheker: phoebe51@chaliceofrepose.org
Ken Thorp: k.t@earthlink.net

August 27, 2012

Dear Ms. Thomas:

Request for amendment to language of proposed legislation

Several organizations have presented concerns about the language of proposed SB 6276 as it is currently written. In testimony presented at the hearing on August 20, 2012, music therapy representatives acknowledged that many professions use music. They stated it was not their intention to impact those professions, and that they were not taking the position that music therapists were the only ones who could use music.

However, if the language passes into law as written, a Practice Board will review disciplinary cases in light of the statutory language. The statutory language will govern adjudication, not verbal expressions of intent in this review hearing. To clarify the intent and ensure this legislation does not impact other professions, the language needs to be modified. At a minimum, SB 6276 should not proceed through the legislative process until the language has been revised, with review and input from professions and organizations that are impacted.

Inaccurate representations of the methods of other professions in testimony of music therapist representatives

During the testimony of the music therapist representatives, they displayed a slide stating that music therapy "provides interventions that utilize all music elements in real-time," while the use of music in other disciplines "involves specific, isolated techniques within a pre-determined protocol, using one pre-arranged aspect of music to address specific and limited issues." Speaking for Chalice of Repose Project music-thanatology practice, this is an inaccurate representation of how our music-thanatology associates deliver music in clinical settings.

CORP music-thanatologists deliver prescriptive music, live at the bedside of a patient. Each delivery is unique and dynamic, addressing the unique needs and circumstances of the dying person. It is always real-time using all musical elements; it is never "pre-arranged." We wish to correct the inaccurate portrayal of how other professions such as music-thanatology work with music.

Inaccurate information in the chart "Therapeutic Music Services At-A-Glance"

One of the files containing comments submitted prior to the hearing is a compilation of many comments received, and the last item in this file is a chart labeled "*Therapeutic Music Services At-A-Glance.*" The author of this chart is not identified, and the chart contains many inaccuracies. We identify the following inaccuracies as examples of how this chart misrepresents the practicum of music-thanatology. This is not

a comprehensive analysis of all inaccuracies; these examples are simply representative of the kinds of omissions and misstatements that concern us.

- The section labeled "Short Description" describes music therapy as evidence-based. Music-thanatology is also an evidence-based field, but the chart omits this important information. This omission is misleading, as it implies that music therapy is the only evidence-based field and that music-thanatology is not.
- The section labeled "Clinical Assessment Process" indicates that music-thanatologists do not engage in documentation. This is not an accurate statement. Music-thanatologists associated with the Chalice of Repose Project program are trained in clinical documentation and documentation methodology. By contractual obligation, CORP student interns and CORP professionals chart in hospital and hospice records, and maintain high standards of documentation in all clinical work. This historical documentation practice began in 1992, and has without exception been maintained for twenty years.

Sincerely,

Sharon Murfin, music-thanatology practitioner and senior faculty member, Chalice of Repose Project, and resident of Washington

Ron Pilcher, music-thanatology practitioner and resident of Washington

Jessica Ryan, music-thanatology student and resident of Washington

Therese Schroeder-Sheker, Chalice of Repose Project founder and senior faculty member, resident of Oregon

Ken Thorp, physician, radiologist, medical director and senior faculty member, Chalice of Repose Project Clinical Practice, resident of Michigan

Colin Andrew Lee, certified music therapist, department chair and practicing music therapist, Wilfred Laurier University, resident of Toronto, adjunct faculty, Chalice of Repose Project

August 27, 2012

Ms. Sherry Thomas
DOH Sunrise Review Board
State of Washington

Re: SB6276 Music Therapy Proposal

Dear Ms. Thomas,

We are writing you jointly to express our appreciation for both the testimony and response possibilities which are part of the SB6276 legislative process. We would like to express our concern however about one detail. In the series of written comments submitted by many individuals and groups prior to the August 20th and later posted on line and available for the public record, we note one troubling irregularity.

Without exception, all commentators provide signature and affiliation, so readers can become informed about the speaker or speakers. There is one exception to this in the final document titled: *"Therapeutic Music Services at a Glance."*

This document presents a chart with a series of columns with abbreviated descriptions about different fields, organizations, modalities etc. However, this chart appears to have been composed by an individual or group who failed to contact the organizations which they described. They did not seek confirmations from the organizations cited regarding accuracy prior to the submission of this document to the DOH, and this spoke as representatives of such agencies without permission. One of the two signatories below (Melinda Gardiner) had the opportunity of seeing this document as it circulated prior to submission to you and wrote to some colleagues on July 25, 2012 advising that it was inappropriate to send it in this condition to the DOH but somehow it was submitted anyway.

The process of anonymous submission and un-attributed authorship coupled with the lack of accuracy has impactful results. These inaccuracies are misleading, and do not seem to aid your legislative process of collating dependable information. Inaccuracies work to the detriment of some agendas while advancing others.

It is our understanding that these comments might remain part of public record, and if that is the case, we hope that the document described may be removed from the permanent record till such time as respectful remedy will prevent the public from becoming misinformed.

Thanking you for your time and consideration. Sincerely,

Melinda Gardiner
Executive Director,
Music for Healing and Transition Program
Email: **mhtp@mhtp.org**

Therese Schroeder-Sheker
Academic Dean,
The Chalice of Repose Project
Email: phoebe51@chaliceofrepose.org

Appendix G

Rebuttals to Draft Recommendations

Rebuttals to Draft Recommendations

Thank you for sending us the link to this comprehensive document as timely update. We will read the entire document with care, but we did read your formal recommendations on pages 2 and 15. We appreciate the tremendous work you and your department have already extended to all concerned, locally and nationally, and thank you for the opportunity to send in additional rebuttals by October 4 if we feel they are needed to represent music-thanatology or assist you or the public in gaining a fuller perspective. We have been awed by the opportunity to participate in this process, and awed by the strength, clarity, thoughtfulness, fairness and care extended to everyone, to all voices and ideas, and to many different professional constituencies.

We thank you, very sincerely and appreciatively,
Therese Schroeder-Sheker, on behalf of the Chalice of Repose Project Music-Thanatology Task Force

---

As a licensed Occupational Therapist in Washington, I do NOT support state certification of music therapists. This may infringe on our scope of practice, as well as that of other professions, creating problems and confusion. Music is so broad and valuable a modality that it should be available for all. What is "misuse" of music, after all? I do not see any danger posed to the public by allowing all people to use music therapeutically. Also, as your draft points out, there is an easy method of finding out credentials of a particular music therapist for any organization or agency who wishes to know the qualifications of an applicant. Thank you for accepting our input.
Susan Drake, MA, OTR/L

It appears that the 'Sunrise' approach would choose to have some number of 'victims' of a healthcare practice suffer substantial injury in order to accumulate sufficient legislative momentum before acting to limit or regulate future protections of the public. This would be a process that could and likely would take years to set in motion. I can only hope the political process will not driven by the special business interests like the very recent journalists revelations of the adult mental health care fiasco by the California corporation claiming that they are not accountable to DSHS.
Do we need to wait for and allow blatant and extensive human suffering before eventually regulating life-caring/sustaining/preserving 'professions'? The people of Washington do not need yet another 'loop hole' allowing the profitable and 'legal' abuse of our fellow humans, family, and loved ones.

Thank you in advance and Best Wishes,
Curtis Thompson
DAV Trained and Certified Veteran Service Officer (VSO)
King County Veterans Program Advisory Board
WDVA Veterans Legislative Liaison Committee (VLC)
NAMI Eastside Volunteer - AUSA and DAV Lifetime Member
NAMI Washington Board Member, NAMI Veteran and Military Council

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NAMI Washington Board Member, NAMI Veteran and Military Council

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Washington State Music Therapy Task Force
Sunrise Review for Certification for Music Therapists, SB 6276
Rebuttal Comments and Responses to the Sunrise Review Draft
October 4, 2012

We would like to thank the Department of Health for recognizing "the therapeutic benefit of music to address the cognitive, emotional, physical, social, or functional needs of clients, and the value of music to comfort and aid those who are sick, injured or dying" as well as the differences between music therapy training and practice and other modalities who use music. We appreciate the Department of Health's suggestion that local, state, or federal agency practices, rules or laws be addressed to increase access to music therapy and that adding state certification would be an unnecessary burden on music therapists at this time. The DOH's recognition of the national MT-BC professional credential for music therapists as "already standardized, with minimum education requirements set by the AMTA and an examination based on core competencies of music therapy administered by the CBMT" and thus not in need of state regulation confirms the high standards of training and practice for music therapists.

In light of the recommendation of the Department of Health, we would like to submit clarification comments addressing the information summary and recommendations by the Department of Health.

Within the summary of information, the review draft states "the key difference between music therapy and other music modalities is that a music therapist uses music or musical instruments to rehabilitate normal functions of living or improve the quality of life through studying the effect of music on clients and promoting measurable changes in behavior or function. Other modalities use live or recorded music to provide an environment conducive to the client's healing or transition to death." When considering how music therapy and other music disciplines are trained, the differences should be taken into consideration as well as the similarities. In addition to being trained musicians, music therapists are also trained in areas of abnormal psychology, cognitive and behavioral psychology, counseling techniques and behavioral management. This is where the element of "harm" truly comes into play. Thorough training takes time and many hours of hands-on practice, as provided for in a degreed program such as music therapy.

As noted by the summary, the correct terminology describing the action of House Bill 3310 in 2008 in not receiving a Sunrise Review at that time is better reflected in saying the review was denied because the Department of Health could not institute the process without the request of the House Health Care and Wellness Committee. In 2011 we reviewed the process in our work with state legislators and the Department of Health in order to follow the appropriate procedures as required by law and were informed that any request must formally come from the chairperson of House Health Care and Wellness Committee or the Senate Health and Long Term Care Committee.

The comprehensive nature of healthcare suggests that there will be some overlap in scope of practice items among comparable professions. Furthermore, this common ground among different professions provides options that best serve the diverse needs of clients. For example, both Occupational Therapy and Speech and Language Pathology address feeding issues. When therapists address similar treatment goals through the lens of their own specialized training, the therapeutic benefit for the patient is enhanced. Had SB 6276 passed out of committee during the legislative session in February 2012, it most likely would have already included amended language that would address the concerns of other disciplines regarding the safety of their use of music in their treatment. Amended language was submitted during the hearing of the bill. Concerns such as overlapping scopes of practice and practice protection can be handled during the processing of the bill before passage. In fact, many of the therapeutic musicians who sent in testimony and who testified were not AGAINST certification for music therapists. They supported it as long as exemption language could be included to protect their ability to practice.

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Under the third criterion on page 14 of the Recommendations document, it is stated that the proposed state certification would have arguably lower standards compared to what is required for a national certification because the continuing education requirement is not included in SB 6276. In email correspondence to our committee on November 17, 2011 from the counsel to the Senate Health and Long Term Care Committee, we were advised that "part of the regulatory process is to have the department determine what is the best method of regulation and what those qualifications are." We were informed that this would happen in the rule making process after the passage of the bill. If the state of Washington adopted the Certification Board for Music Therapists certifying criteria, it would automatically mean that continuing education or re-examination would be required for state certification since it is required for national certification.

We understand the parameters of the sunrise review criteria and process and appreciate that the department recognizes that the lack of a state credential is a barrier to services in certain educational and state facilities. We look forward to continuing our education of state and local agencies as well as collaboration with our healthcare colleagues to improve understanding of and accessibility to music therapy services for the people of Washington.

Respectfully Submitted,
Washington State Music Therapy Task Force
Patti Catalano, MM, MT-BC, Music Works Northwest, Bellevue, WA
Wendy Woolsey, MA, MT-BC, Adjunct Professor, Music Therapy Program Seattle Pacific University
Jim Couture, MA, MT-BC - Director, Encore! Adult Day Care & Arts and Minds Early Memory Loss Program – Port Angeles, WA
Carlene Brown, PhD, MT-BC, Associate Professor & Chair, Music Department
Director, Music Therapy Program, Seattle Pacific University
Brooke McKasson, MT-BC, Tacoma, WA
Wendy Zieve, MA, MT-BC, Sno-King Music Therapy Services, Shoreline, WA

Testimony

SB 133
Testimony

…divided into 3 separate

saved

Testimony files

Testimony
3 of 3 files

DATE: April 25, 2017

M E M O R A N D U M

TO: The Honorable Bruce Rauner, Governor
Senator John Cullerton, President of the Senate
Senator Christine Radogno, Minority Leader of the Senate
Representative Michael Madigan, Speaker of the House of Representatives
Representative Jim Durkin, Minority Leader of the House of Representatives
Bryan A. Schneider, Secretary of the Department of Financial and Professional Regulation

FROM: **The Illinois Music Therapy Advisory Board**

Jessica Baer, Chairperson, Director of the Division of Professional Regulation
Andrea M. Crimmins, Board Member
Louise Dimiceli-Mitran, Board Member
Kyle Fleming, Board Member
Candyce L. Gray, Board Member
Russell E. Hilliard, Board Member
Clifton Saper, Board Member

SUBJECT: Illinois Music Therapy Advisory Board Report and Recommendation

On behalf of the Illinois Music Therapy Advisory Board, chaired by the Director of the Division of Professional Regulation, Jessica Baer, this Report and Recommendation regarding music therapists in the State of Illinois, is hereby submitted in compliance with the Music Therapy Advisory Board Act, 20 ILCS 5070/*et seq*.

Illinois Music Therapy Advisory Board
Report and Recommendation

Mandated by 20 ILCS 5070/15

4/25/2017

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Illinois Music Therapy Advisory Board Generally

The Music Therapy Advisory Board Act, 20 ILCS 5070/*et seq.,* became effective on January 1, 2016 pursuant to Public Act 099-397, and created a seven (7) member Board which must issue a report regarding the following at minimum: (1) the best practices, curriculum, and training programs for an Illinois certification program for music therapists; (2) a certification and renewal process for music therapists and a system of approval and accreditation for curriculum and training; (3) a proposed curriculum for music therapists; and (4) best practices for reimbursement options and pathways through which secure funding for music therapists may be obtained. The Act reads in full:

Section 5. Definitions. As used in this Act:

"Board" means the Music Therapy Advisory Board.

"Music therapist" means a person who is certified by the Certification Board for Music Therapists.

"Music therapy" means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. The term "music therapy" does not include the diagnosis or assessment of any physical, mental, or communication disorder.

"Department" means the Illinois Department of Financial and Professional Regulation.

"Secretary" means the Secretary of Financial and Professional Regulation or his or her designee.

Section 10. Advisory board.

(a) There is created the Music Therapy Advisory Board within the Department. The Board shall consist of seven (7) members appointed by the Secretary for a term of two (2) years. The Secretary shall make the appointments to the Board within 90 days after the effective date of this Act. The members of the Board shall represent different racial and ethnic backgrounds, reasonably reflect the different geographic areas in Illinois, and have the qualifications as follows:

(1) three members who currently serve as music therapists in Illinois;
(2) one member who represents the Department;
(3) one member who is a licensed psychologist or professional counselor in Illinois;
(4) one member who is a licensed social worker in Illinois; and
(5) one representative of a community college, university, or educational institution that provides training to music therapists.

(b) The members of the Board shall select a chairperson from the members of the Board. The Board shall consult with additional experts as needed. Four members constitute a quorum. The Board shall hold its first meeting within 30 days after the appointment of members by the Secretary. Members of the Board shall serve without compensation. The Department shall provide administrative and staff support to the Board. The meetings of the Board are subject to the provisions of the Open Meetings Act.

(c) The Board shall consider the core competencies of a music therapist, including skills and areas of knowledge that are essential to bringing about music therapy services to communities by qualified individuals. As relating to music therapy services, the core competencies for effective music therapists may include, but are not limited to:

(1) materials to educate the public concerning music therapist licensure;
(2) the benefits of music therapy;
(3) the utilization of music therapy by individuals and in facilities or institutional settings;
(4) culturally competent communication and care;
(5) music therapy for behavior change;
(6) support from the American Music Therapy Association or any successor organization and the Certification Board for Music Therapists;
(7) clinical training; and
(8) education and continuing education requirements.

Section 15. Report.

(a) The Board shall develop a report with its recommendations regarding the certification process for music therapists. The report shall be completed no later than 12 months after the first meeting of the Board. The report shall be submitted to all members of the Board, the Secretary, the Governor, the President of the Senate, the Minority Leader of the Senate, the Speaker of the House of Representatives, and the Minority Leader of the House of Representatives. The Department shall publish the report on its Internet website.

(b) The report shall at a minimum include the following:

(1) a summary of research regarding the best practices, curriculum, and training programs for designing a certification program in this State for music therapists, including a consideration of a multi-tiered education or training system, statewide certification, non-certification degree-based levels of certification, support from the American Music Therapy Association and Certification Board for Music Therapists, and the requirements for experience-based certification;
(2) recommendations regarding certification and renewal process for music therapists and a system of approval and accreditation for curriculum and training;
(3) recommendations for a proposed curriculum for music therapists that ensures the content, methodology, development, and delivery of any proposed program is appropriately based on cultural, geographic, and other specialty needs and also reflects relevant responsibilities for music therapists; and
(4) recommendations for best practices for reimbursement options and pathways through which secure funding for music therapists may be obtained.

(c) The Board shall advise the Department, the Governor, and the General Assembly on all matters that impact the effective work of music therapists.

Legal Standards and Analytical Structure

Illinois law sets policies and objective standards for legislative review of proposed licensing statutes. Illinois law calls for a structured cost-benefit policy analysis of proposals for new professional regulation. The law places upon the proponents of new regulation the burden to demonstrate the genuine necessity of that regulation to the protection of the public. 20 ILCS 2105/2105-10 of the Civil Administrative Code of Illinois, Department of Professional Regulation Law, states in pertinent part:

> "The practice of the regulated professions, trades, and occupations in Illinois is hereby declared to affect the public health, safety, and welfare of the People of this State and in the public interest is subject to regulation and control by the Department of Professional Regulation. It is further declared to be a matter of public interest and concern that standards of competency and stringent penalties for those who violate the public trust be established to protect the public from unauthorized or unqualified persons representing one of the regulated professions, trades, or occupations; and to that end, the General Assembly shall appropriate the necessary funds for the ordinary and necessary expenses of these public interests and concerns as they may exceed the funding available from the revenues collected from the fees and fines from the regulated professions, trades, and occupations."

If regulation of the profession is found necessary by the legislature based upon the criteria and is "a matter of public interest and concern that standards of competency and stringent penalties for those who violate the public trust be established," then "the General Assembly shall appropriate necessary funds," consistent with the public interest. *Id.*

The State of Illinois recognizes a hierarchy of regulation:

1. ***Licensure***: Licensure, or "practice act protection," is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency.

2. ***Certification***: State certification programs are similar to licensure in that individuals must meet specified requirements and obtain a certificate through the state to practice within a profession. However, unlike licensure policies, certification programs are generally conditional on the individual obtaining certification.

3. ***Registration***: Typically, registration programs create voluntary requirements for individuals working in a registered profession. Individuals who meet specified requirements are eligible to register with the State. Only registered professionals can use the title "State registered."

4. ***Title Protection***: Title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s) as set forth in law. Practitioners may not be required to register or otherwise notify the state that they are engaging in the relevant practice and practice exclusivity does not attach, unless the specific regulatory title is used. In other words, anyone may engage in the particular practice, but only those who satisfy prescribed requirements may use the enumerated title(s).

Profile of the Profession

Music therapists are skilled musicians who use music interventions to achieve therapeutic goals.[1] They assess an individual's functioning through response to music; design music interventions and therapy sessions based on treatment goals, objectives, and the individual's needs; and evaluate and document treatment outcomes.[2] The music therapist may be part of an interdisciplinary team including medical, mental health, occupational therapy, physical therapy, or other educational professionals. Currently, an Illinois state credential is not required to practice music therapy.[3]

Music therapists are not alone in providing therapeutic interventions through music. Music thanatologists, therapeutic musicians, music practitioners, clinical musicians, therapeutic harp practitioners, healing musicians, guided music and imagery/Bonny method practitioners, and others provide comfort to the ill, injured or dying, typically by playing music in hospitals, psychiatric units, hospices, residential facilities and other settings.[4] Each music modality has a training program and some are credentialed or accredited by national organizations. Native American healers, traditional healers, and other cross-cultural healers use music, song, and instruments to support a person's or family's physical, mental, or spiritual health in hospitals, hospice, and other health facilities.[5] In addition, some musicians play for the sick and dying with no stated therapeutic goal other than the person's relaxation and enjoyment.[6]

The practice of music therapy is not regulated in Illinois. There are several professions that use or may use music as a treatment modality or as an adjunct to treatment:

State-credentialed professions including, but not limited to:

- Psychologists
- Occupational therapists
- Speech-language pathologists
- Mental health counselors
- Marriage and family therapists
- Social workers
- Hypnotherapists
- Massage therapists

Non-state-credentialed professions:

- Music therapists
- Therapeutic musicians
- Music thanatologists
- Certified music practitioners
- Native American and other traditional healers
- Clinical musicians
- Therapeutic harp practitioners
- Healing musicians
- Guided music and imagery/Bonny method practitioner.

[1] "American Music Therapy Association." About the American Music Therapy Association | What Is the American Music Therapy Association | American Music Therapy Association (AMTA). (date accessed 07 Mar. 2017).

[2] *Id.*
[3] *Id.*
[4] Information Summary and Recommendations Publication Number 631-037 (2012*): Washington State Department of Health* Dec. 2012. (date accessed 27 Feb. 2017).
[5] *Id.*
[6] *Id.*

A key difference between music therapy and other music modalities is that a music therapist uses music or musical instruments to rehabilitate normal functions of living or improve the quality of life through studying the effect of music on clients and promoting measurable changes in behavior or function. Other modalities use live or recorded music to provide an environment conducive to the client's healing or transition to death. Training levels also differ. A nationally certified music therapist completes a bachelor's degree program that may include classes in abnormal psychology, cognitive and behavioral psychology, counseling techniques, and behavioral management. Training in other music modalities varies from no formal training to graduate level educational programs.

Best Practices, Curriculum, and Training Programs

Certification Board for Music Therapists

National certification for music therapists is available from the Certification Board for Music Therapists (CBMT). The CBMT is the only organization to certify music therapists to practice music therapy nationally. Its MT-BC program has been fully accredited by the National Commission for Certifying Agencies (NCCA) since 1986. Some music therapists may hold older designations as a registered music therapist (RMT), certified music therapist (CMT), or advanced certified music therapist (ACMT) issued by the American Association of Music Therapy (AMTA) or the National Association of Music Therapy. These two groups merged into the AMTA, and designees are listed on the National Music Therapy Registry. By the year 2020, AMTA will have phased out the AMT, CMT, and ACMT designations as well as the national registry. After this time, music therapists seeking national certification must obtain a MT-BC credential.

There are currently 7,106 music therapists maintaining the MT-BC credential and participating in a program of recertification designed to measure or enhance competence in the profession of music therapy.[7] The credential, MT-BC, is awarded by the CBMT to an individual upon successful completion of an academic and clinical training program approved by the AMTA and successful completion of a written objective examination demonstrating current competency in the profession of music therapy.

American Music Therapy Association

The American Music Therapy Association's purpose is the progressive development of the therapeutic use of music in rehabilitation, special education, and community settings. AMTA is governed by a 15-member Board of Directors which consists of both elected and appointed officers. Membership in AMTA consists of nine categories: professional, associate, student, inactive, retired, affiliate, patron, life, and honorary life. As of February 2017, over 3,800 individuals hold current AMTA membership.[8] Candidates for Music Therapy Board Certification must have successfully completed the academic and clinical training requirements for music therapy, or their equivalent as established by the AMTA.[9]

Formal Education Options for a Music Therapist

Bachelor's degrees in music therapy are available from 70 U.S. colleges and universities approved by the AMTA and accredited by the National Association of Schools of Music.[10] The AMTA requires music therapy students to complete at least 1,200 hours of supervised clinical training and a six-month internship in a competency- based program. Music therapists who complete academic and clinical training are eligible

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[7] "The Certification Board for Music Therapists." Image Description. (date accessed 07 Mar. 2017).
[8] "American Music Therapy Association." About the American Music Therapy Association | What Is the American Music Therapy Association | American Music Therapy Association (AMTA). (date accessed 07 Mar. 2017).
[9] "Eligibility Requirements." Image Description. (date accessed 07 Mar. 2017).
[10] "American Music Therapy Association." Becoming a Music Therapist, Working in Music Therapy | A Career in Music Therapy | American Music Therapy Association (AMTA). (date accessed 07 Mar. 2017).

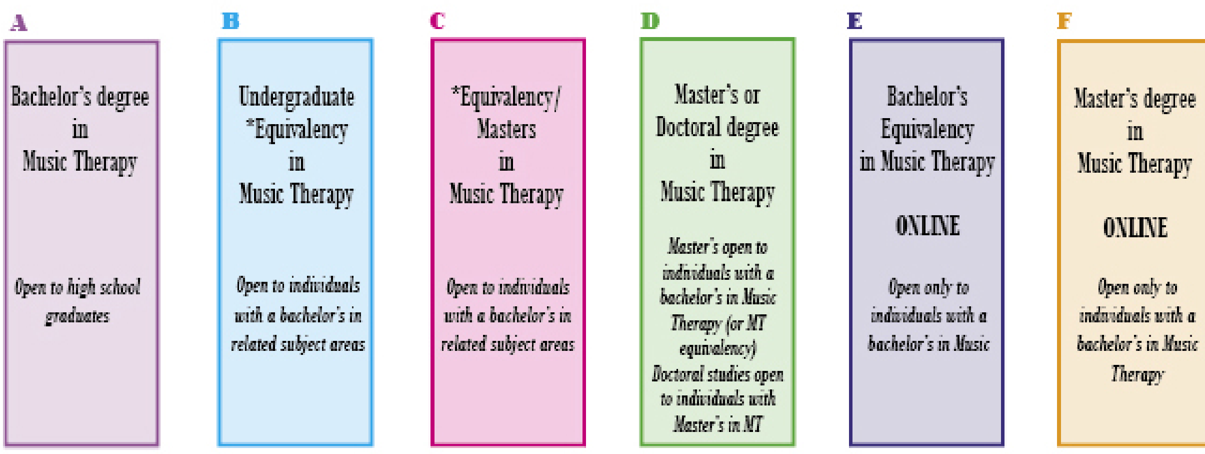
to take a national exam offered by the CMBT, and upon passage earn a Music Therapist-Board Certified (MT-BC) national certification.

The education of a music therapist's undergraduate curriculum includes coursework in music therapy, psychology, music, biological, social and behavioral sciences, disabilities, and general studies. Entry level study includes practical application of music therapy procedures and techniques learned in the classroom through required fieldwork in facilities serving individuals with disabilities in the community and or on-campus clinics. Students learn to assess the needs of clients, develop and implement treatment plans, and evaluate and document clinical changes.

Individuals who have earned a baccalaureate degree in an area other than music therapy may elect to complete the degree equivalency program in music therapy offered by most AMTA-approved universities. Under this program, the student completes only the required coursework without necessarily earning a second baccalaureate degree. Graduate programs in music therapy examine issues relevant to the clinical, professional, and academic preparation of music therapists, usually in combination with established methods of research inquiry.

Candidates for the master's degree in music therapy must hold a baccalaureate degree. Some schools require either a bachelor's degree in music therapy, the equivalency in music therapy, or that the candidate be working concurrently toward fulfilling degree equivalency requirements. Candidates must contact individual universities for details on pre-registration and entry requirements. Although there is no AMTA-approved doctoral degree in music therapy, selected universities do offer coursework in music therapy in combination with doctoral study in related academic areas.

Educational Path/Options for a Music Therapy Degree



If:

- You are a high school graduate, then you may be eligible for option A.
- You have a Bachelor's in a related subject (Education, Psychology, etc.) then you may be eligible for option A or B.
  - Subject to approval by the Program Director, individuals who have earned a baccalaureate degree in an area other than music therapy may elect to complete the equivalency program in music therapy offered by most AMTA-approved universities. Under this program, the student

completes only the required coursework necessary to satisfy professional competencies in music therapy without necessarily earning a second baccalaureate degree. Individuals who have a bachelor's degree specifically in music are also eligible to pursue a Master's degree in Music Therapy (C) offered by AMTA-approved degree programs, by first completing the required undergraduate music therapy coursework including the internship, (essentially the Music Therapy equivalency described above) then moving onto the master's coursework.

- You have a Bachelor's in Music, then you may be eligible for option B, C or E (online).
- You have a Bachelor's in Music Therapy and are seeking a graduate degree, then you may be eligible for option D or F (online).
- You have a wealth of music experience and/or strong musicianship (but no degree in music), then you are eligible for option A. [11]

Bachelor's Degree Requirements

The music therapy degree is a professional music degree which requires an audition for acceptance into the school of music. This specialized degree is offered at over 70 colleges/universities whose degree programs are approved by the AMTA.

The degree is four or more years in length and includes 1,200 hours of clinical training, which is a combination of fieldwork experience embedded in music therapy courses and an internship after the completion of all coursework. The music therapy degree is designed to impart professional competencies in three main areas: music, music therapy, and related coursework in science and psychology. Knowledge and skills are developed through coursework and clinical training, which cover the theory and practical application of music therapy treatment procedures and techniques. The competencies are learned in the classroom, as well as in the required fieldwork with at least three different populations at facilities serving individuals with disabilities in the community and/or on campus clinics. The education and training culminate with in-depth supervised clinical training in the internship. Upon successful completion of the music therapy bachelor's degree an individual is eligible to sit for the national certification exam to obtain the credential MT-BC which is necessary for professional practice. The national exam is administered by the CBMT.

Academic Component

- The bachelor's degree in music therapy (and equivalency programs) shall be designed to impart entry-level competencies in three main areas: musical foundations, clinical foundations, and music therapy foundations and principles, as specified in the AMTA Professional Competencies.

- In compliance with NASM Standards, the bachelor's degree in music therapy shall be divided into areas of study as follows (based on 120 semester hours or its equivalent). Please note that the courses listed below each area of study are only suggested titles of possible courses or course topics.
    - Musical Foundations (45%)
    - Music Therapy (15%)
    - General Education (20-25%)
    - Electives (5%)

[11] "American Music Therapy Association." *Education and Clinical Training Information | American Music Therapy Association (AMTA).* (date accessed 27 Feb. 2017).

Music Therapy Undergraduate Equivalency

Individuals who have earned a baccalaureate degree in an area other than music therapy may elect to complete the equivalency program in music therapy offered by most AMTA-approved universities. Under this program, the student completes only the required coursework necessary to satisfy professional competencies in music therapy without necessarily earning a second baccalaureate degree. The equivalency program consists of all core music therapy courses at the undergraduate level, all clinical training requirements including the internship, plus any related coursework in science and psychology (i.e. anatomy, abnormal psychology, and other related courses).

Upon successful completion of the music therapy equivalency program an individual is eligible to sit for the national certification exam to obtain the credential MT-BC which is comparable to the eligibility of the baccalaureate degree as cited above.

Music therapists who complete either the bachelor’s degree in music therapy or its equivalent, acquire skills that allow them to provide music therapy services within the context of a treatment team. At this level, the music therapist utilizes music therapy techniques to meet clients musically and clinically. The music therapist demonstrates basic knowledge of assessment, treatment, documentation, and evaluation; communicates empathy and establishes therapeutic relationships; and demonstrates understanding of ethical principles and current standards of practice.

Master's Degree/Equivalency

Individuals who have a bachelor’s degree in music are eligible to pursue a Master’s degree in music therapy offered by 30 AMTA-approved degree programs, by first completing the required undergraduate music therapy coursework including the internship, (essentially the music therapy equivalency described above) then move onto the master’s coursework, which imparts further breadth and depth to the professional competencies, including advanced competencies in music therapy.

Master's Degree

A music therapist with a bachelor’s degree in music therapy can obtain a master’s degree in music therapy to expand the depth and breadth of their clinical skills in advanced and specialized fields of study such as supervision, college teaching, administration, a particular method, orientation, or population. The master’s degree programs offer a number of different titles which relate directly to curricular design. For example the Master of Science in Music Therapy places advanced music therapy studies within the context of allied health and the physical sciences, while the Master of Music Therapy places advanced music therapy studies within a disciplinary context of theory, research, and practice in music therapy.

Credentialed Music Therapists who obtain a master’s degree in music therapy, further expand the depth and breadth of their clinical skills. These skills added to professional practice in music therapy of sufficient duration and depth, allow the music therapist to gain a comprehensive understanding of the clinical process of the client and the therapist’s impact on that process. Through such experiences the music therapist moves beyond didactic knowledge to integrate rationale, theories, treatment methods, and use of self to enhance client growth and development. Based on a comprehensive understanding and integration of theories and practices in assessment, treatment, evaluation, and termination, the advanced music therapist takes a central and independent role in client treatment plans.

Doctoral Degrees

Some music therapy academic programs offer doctoral degrees in music therapy or related disciplines, which impart advanced competence in research, theory, development, clinical practice, supervision, college teaching, and/or clinical administration, depending on the title and purpose of the degree program.

Illinois Association for Music Therapy

The Illinois Association for Music Therapy (IAMT) is a chapter of the AMTA. The IAMT promotes the advancement of music therapy as a professional discipline in the state of Illinois through public education and advocacy, and provides professional development and continuing education opportunities for its members. The purpose of IAMT is to support the goals and objectives of the AMTA and the Great Lakes Region of AMTA and their respective governing documents.

Costs for Music Therapy National Certification

The CBMT exam currently costs $325.00, with retakes costing $275.00.[12] The online examination may be taken at sites around the country, including eleven locations throughout Illinois and one in the city of Chicago.[13] Upon passage, the individual receives a MT-BC credential. Music therapists must complete 100 hours of continuing education every five years to maintain their MT-BC credential.[14] The Department of Financial and Professional Regulation (IDFPR) estimates that 262 certified music therapists in Illinois could qualify for state licensure.[15]

The Illinois Regulatory Environment

Music therapy is one of the creative arts therapies, which also include art therapy, dance therapy and drama therapy.[16] According to the National Institute of Mental Health, creative arts therapies and expressive arts therapy are forms of psychotherapy that are "based on the idea that people can heal themselves through art, music, dance, writing or other expressive acts."[17]

While there are no laws specific to "music therapy," anyone who practices psychotherapy must at a minimum be registered as a psychotherapist in Illinois.[18] IDFPR currently regulates the following mental health professions:

- Clinical Professional Counselors and Professional Counselors;
- Marriage and Family Therapists;
- Psychiatrists;
- Clinical Psychologists;
- Sex Offender Evaluators and Treatment Providers; and
- Social Workers

Additionally, the following regulated professions may utilize music as a treatment modality:

- Audiologists and Speech-Language Pathologists;

[12] "Examination." Image Description. (date accessed 07 Mar. 2017).
[13] "AMP Log In." AMP Log In. (date accessed 07 Mar. 2017).
[14] "CBMT Definition Fact Sheet." Image Description. (date accessed 07 Mar. 2017).
[15] "Certified Music Therapist Search." Image Description. (date accessed 07 Mar. 2017).
[16] "NCCATA." NCCATA. 07 Mar. 2017.
[17] National Institutes of Health. U.S. Department of Health and Human Services. (date accessed 07 Mar. 2017).
[18] Clinical Psychologist Licensing Act (225 ILCS 15/2)(5).

- Massage Therapists;
- Occupational Therapists;
- Physical Therapists; and
- Respiratory Care Practitioners

Several unregulated professions in Illinois may also use music as a treatment modality, including but not limited to:

- Music Therapists;
- Therapeutic Musicians;
- Music Thanatologists;
- Traditional Healers;
- Healing Musicians;
- Therapeutic Harp Practitioners;
- Hypnotherapists; and
- Certified Drug and Alcohol Counselors

Attorney General Complaints

On May 02, 2016, IDFPR contacted the Illinois Attorney General's Office to assist in determining the number of complaints per year the Attorney General received regarding music therapists. IDFPR was also interested in learning about the nature of these complaints, if any. On May 17, 2016, Deborah Hagan, Chief Consumer Protection Division Illinois Attorney General's Office confirmed that there were no complaints against any music therapists to date.

Analysis

Based upon information contained in the music therapy advisory board report, interviews with interested parties and regulators of other counseling professions, written comments submitted by the Board, and independent legal and public health related research, the following issues were analyzed: potential harm to the public unregulated music therapy practice poses, effects of unlicensed practice, federal/state consumer protection laws, professional accreditation, insurance reimbursement, and costs.

A. Prevention of Public Harm

Examples of public harm provided by the Board include the following:

- Emotional harm;
- Psychological harm; and
- Unlicensed Practice.

Emotional harm

Music therapists often work with vulnerable populations (e.g. persons with intellectual or emotional disabilities, or persons coping with physical, mental, or terminal illness). Potential for harm exists if a nonqualified individual provides inappropriate applications of music therapy interventions that could cause emotional harm.

CBMT reported only five cases of harm throughout the entire country over a 16-year period, and there are currently about 7,106 board-certified music therapists throughout the United States.[19]

B. Unlicensed Practice/Misuse of Title

According to proponents of regulation, there are a growing number of unqualified individuals in the state claiming to be music therapists who do not hold a music therapy degree or MT-BC national credential. Proponents assert that individuals may misrepresent the music therapy profession, may represent themselves as being able to produce certain outcomes that are not evidence based, or may have a lack of supervised clinical training to demonstrate competency and proficiency in the practice of music therapy.

The CBMT requires any person representing himself or herself as a board certified music therapist to adhere to the standards of the music therapy profession as prescribed by the CBMT and the CBMT Code of Professional Practice.[20] Any complaints made by the public against a board certified music therapist should be brought to the attention of the CBMT for investigation and possible disciplinary action as defined by the CBMT Code of Professional Practice.[21]

C. Consumer Protection

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Illinoisans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

Whenever a business or an individual engages in activity that is likely to mislead the public, it may be considered a “deceptive trade practice”. Deceptive trade practices are prohibited due to the negative effects they have on consumers and the general public. Federal and state laws prohibit the use of deceptive trade practices. The Federal Trade Commission Act (FTC Act) governs deceptive trade practices. The Uniform Deceptive Trade Practices Act (UDTPA) is another piece of federal legislation that regulates deceptive trade practices. All fifty states have adopted some form of the Act in their own statutes.

Federal Consumer Protection

Prior to the implementation of consumer protection acts in the U.S., theories of freedom of contract and caveat emptor – “let the buyer beware” – controlled the merchant-consumer relationship.[22] The economic boom in the early and mid-twentieth century brought with it many new products and innovations, creating the need for a means to remedy breaches in the merchant- consumer relationship.[23] In response to a lack of consumer protection, Congress created the Federal Trade Commission Act in 1914, which prohibited “unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce.”[24] Congress limited enforcement of the FTC Act to a federal agency, rather than allowing suit by private plaintiffs, by creating the Federal Trade Commission.

[19] "The Certification Board for Music Therapists." Image Description. (date accessed 07 Mar. 2017).
[20] "The Certification Board for Music Therapists." Image Description. (date accessed 07 Mar. 2017).
[21] *Id.*

[22] Spencer Webber Waller et al., Consumer Protection in the United States: An Overview, 4 EUR. J. CONSUMER L. 803 (2011).
[23] "Home." ATRA. (date accessed 07 Mar. 2017).
[24] 5 U.S.C. § 45(a)(1).

In the 1960's, states began to enact a series of their own consumer protection acts, both in response to the public's view that the FTC was vastly ineffective and in response to a continuously growing marketplace that made recourse for the average consumer increasingly difficult.[25] In 1964, the National Conference of Commissioners on Uniform State Laws and the American Bar Association approved the Uniform Unfair and Deceptive Trade Practices Act ("UDTPA"). The UDTPA prohibits unfair or deceptive acts or practices affecting commerce. According to the National Conference of Commissioners on Uniform State Laws, approximately twenty-three states have enacted statutes similar to the FTC Act; while fourteen states have enacted a version of the UDTPA.

Illinois also has a Uniform Deceptive Trade Practices ("IUDTP") Act similar to other states' uniform acts. The IUDTP allows businesses to recover for deceptive trade practices,[26] while the Illinois Consumer Fraud and Deceptive Business Practices Act (CFA) focuses on individual consumer protection. The IUPTP allows for the same damages as are available for consumers under the CFA.

Illinois State Consumer Protection Laws

In Illinois, private individuals may bring actions under §10a of the Illinois Consumer Fraud and Deceptive Business Practices Act[27]. The CFA provides protections against fraud, deceptive business practices, and other white collar crimes. Section 2 (815 ILCS 505) states in pertinent part,

> "Unfair methods of competition and unfair or deceptive acts or practices, including but not limited to the use or employment of any deception fraud, false pretense, false promise, misrepresentation or the concealment, suppression or omission of any material fact, with intent that others rely upon the concealment, suppression or omission of such material fact, or the use or employment of any practice described in Section 2 of the "Uniform Deceptive Trade Practices Act", approved August 5, 1965, in the conduct of any trade or commerce are hereby declared unlawful whether any person has in fact been misled, deceived or damaged thereby. In construing this section consideration shall be given to the interpretations of the Federal Trade Commission and the federal courts relating to Section 5(a) of the Federal Trade Commission Act."[28]

This is so "whether any person has in fact been misled, deceived or damaged thereby."[29]

The language confers that it is considered a deceptive trade practice to claim to possess a degree or a title associated with a particular degree unless the person has been awarded the degree from a school that is accredited or otherwise authorized to grant degrees as specified in statute. Therefore, a person could not pose as a graduate of a music therapy program without first having a degree.

In addition to the statutory provisions contained in the CFA, the Illinois Attorney General's Consumer Protection Division is the State agency instilled with the responsibility for protecting Illinois businesses and consumers from fraud, unfair business practices, and deception. This work is carried out by the Illinois Charitable Trust Bureau, Consumer Fraud Bureau, Franchise Bureau, Military and Veterans Rights Bureau, and the Health Care Bureau. Informal dispute resolution programs can be utilized by consumers to voice

[25] Albert Norman Sheldon & Stephen Gardner, A Truncated Overview of State Consumer Protection Laws, C888 ALI-ABA 375, 380 (1994).
[26] 815 ILCS 510/1(5).
[27] 815 ILCS 505/1.

[28] 815 ILCS 505/2.
[29] *Id.*

complaints. The Consumer Fraud and Health Care Bureaus oversee these programs. Law enforcement actions based on violations of the CFA are instituted by the Attorney General's Office.

Remedies

Consumers and individuals who have been victimized through deceptive trade practices may have a variety remedies available for them in court.

Injunctive Relief and Punitive Damages

In 1990, the Illinois legislature amended the CFA to allow injunctive relief when appropriate.[30] Illinois does not require proof of monetary damages, loss of profits, or intent to deceive to obtain injunctive relief in cases of ongoing conduct.[31] But, a plaintiff must seek injunctive relief within the three-year statute of limitations.[32]

The CFA does not specifically allow the courts to award punitive damages. The courts, however, have interpreted the statute to include the awarding of punitive damages.[33] Section 10a(a) of the Consumer Fraud Act states that "any person who suffers actual damage as a result of a violation of this Act committed by any other person may bring an action against such person. The court, in its discretion may award actual economic damages or any other relief which the court deems proper..." Punitive damages must be proportionate to the nature and enormity of the wrong. These damages must be limited to an amount that would deter a person who was without pecuniary resources. One Illinois court recently held it undisputed that punitive damages are available for a violation under the Act.[34]

D. Accreditation for Curriculum and Training

The AMTA establishes the educational and clinical training requirements of music therapists. Music therapists must have a strong foundation in music. They must also have a basic knowledge of clinical and therapeutic practice. They must be able to apply the foundations and principles of music therapy, and they must be able to perform an assessment, plan treatment, and implement, document and evaluate treatment.[35]

A degree in music therapy and private board certification are credentials that offer consumers assurance of professional competency. Private certification is available to music therapists through CBMT. Only those individuals who hold this credential may represent themselves as board-certified music therapists, or place the initials MT-BC after their names. CBMT actively pursues individuals who falsely represent themselves as board-certified music therapists, and consumers can easily verify whether an individual is a board-certified music therapist.

Additionally, CBMT has the authority to deny, revoke, suspend and require additional education of board-certified music therapists who are in violation of the certification standards. This includes gross or repeated

[30] 815 ILCS 505/10a(c)
[31] Chicago's Pizza, Inc. v. Chicago's Pizza Franchise Limited USA, 384 Ill.App.3d 849 (1st Dist. 2008).
[32] McCready v. Illinois Secretary of State, 382 Ill.App.3d 789 (3d Dist. 2008).
[33] 815 ILCS 505/10a
[34] Dubey v. Public Storage, Inc., 395 Ill.App.3d 342 (1st Dist. 2009).

[35] "American Music Therapy Association." Becoming a Music Therapist, Working in Music Therapy | A Career in Music Therapy | American Music Therapy Association (AMTA). (date accessed 07 Mar. 2017).

negligence or malpractice in professional practice including a sexual relationship with a client, and sexual, physical, social or financial exploitation.[36]

Private certification represents a high level of professional competency, beyond what is necessary for public protection. Unlike private certification, the purpose of state regulation is to ensure practitioners have the minimum standards necessary to protect the health, safety and welfare of the public.

E. Reimbursement Options/Pathways to secure funding for Music Therapy

Proponents of new regulation argue that a separate and freestanding music therapy license would facilitate payment by insurers, governmental healthcare payers, and public school systems.

When considering insurance reimbursement, the Affordable Care Act mandates that insurers not discriminate against licensed health care providers, including those who practice alternative medicine, such as naturopaths, massage therapists and acupuncturists.[37] Health insurers can limit coverage they deem experimental or not medically necessary, and they often do. Treatments such as acupuncture, biofeedback, chiropractic care and electronic stimulation may be covered under certain policies; however, music therapy, aromatherapy, therapeutic touch massage and a long list of other interventions are usually not.[38]

However, since 1994 music therapy has been identified as a reimbursable service under benefits for Partial Hospitalization Programs (PHP)[39]. Falling under the heading of “activity therapy”, the interventions cannot be purely recreational or diversionary in nature and must be individualized and based on goals specified in the treatment plan.[40] There are currently a few states that also allow payment for music therapy services through use of Medicaid Home and Community Based Care waivers with certain client groups. And in some situations, music therapy interventions qualify for coverage under existing treatment categories such as community support, rehabilitation, or habilitation services.[41]

The American Music Therapy Association estimates that approximately 20% of music therapists receive third party reimbursement for the services they provide.[42] Music therapy is comparable to other allied health professions like occupational therapy and physical therapy in that individual assessments are provided for each client, service must be found reasonable and necessary for the individual’s illness or injury and interventions include a goal-directed documented treatment plan.[43] Companies like Blue Cross Blue Shield, United Healthcare, Cigna, and Aetna have all paid for music therapy services at some time.[44] Success has occurred on a case-by-case basis when the therapist implements steps within the reimbursement process. Like other therapies, music therapy is reimbursable when services are pre-approved and deemed medically or behaviorally necessary to reach the individual patient's treatment goals.[45]

The criterion for obtaining general insurance coverage requires an extensive analysis by the third party payer of the supportive evidence and clinical protocols established for healthcare interventions.[46] The music therapy profession is still defining these areas. An example of how the AMTA is tackling a specific area critical to advancing reimbursement efforts is through the research strategic priority.[47] This priority and its

[36] The Certification Board for Music Therapists. *CBMT Code of Professional Practice.* Revised October 4, 2011.
[37] The Patient Protection and Affordable Care Act (PPACA).
[38] Renter, Elizabeth, “Does Your Health Insurance Cover Alternative Medicine?” U.S. News (March 09, 2015).
[39] "American Music Therapy Association." FAQ's | Frequently Asked Questions | American Music Therapy Association (AMTA). (date accessed 07 Mar. 2017).
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] Judy Simpson, AMTA’s Director of Government Relations, Music Therapy Reimbursement. (February 2009).
[47] *Id.*

operational plan were developed to address the direction of research in support of evidence-based music therapy practice and improved workforce demand; and to recognize and incorporate, where necessary, federal, state and other entity requirements for evidence-driven research as it relates to practice policy and reimbursement.[48]

When new health related professions or health care technology is developed, insurers have to determine whether and how to incorporate them into an insurance plan. Decisions need to be made not only regarding whether to cover new treatments, but also how it should be reimbursed. Many private insurers subscribe to the services of technology assessment organizations, which evaluate the scientific evidence of emerging health technologies.[49] These organizations focus on issues related to safety, efficacy, clinical indications, and when possible, comparisons of competing technology.[50] Other insurers perform their own analyses rather than subscribe to an outside assessment organization.[51] Furthermore, most large insurers that subscribe to an outside assessment organization perform some health technology assessment in-house, as well.

Other resources for assessment include federally funded assessment centers, most often housed at various universities. Public payers such as Medicare and Medicaid may also use the analyses of technology assessment organizations; however, their coverage and reimbursement decisions also are influenced by existing legislative requirements and legislative procedures.

It is important to note that establishing a state recognition program does not guarantee automatic inclusion in various funding streams.[52] The music therapy community understands the need to provide research evidence to support reimbursement requests from different payment systems.[53] AMTA and CBMT provide guidance to music therapists in differentiating between state recognition goals and benefits and the completely separate payer-based process to seek coverage for music therapy interventions.[54]

F. Licensure Costs

Appropriations for the direct and allocable indirect costs of licensing and regulating each regulated profession, trade, occupation, or industry are intended to be payable from the fees and fines that are assessed and collected from that profession, trade, occupation, or industry, to the extent that those fees and fines are sufficient.[55] Section 2105-300(a) of the Civil Administrative Code of Illinois governs professions indirect cost fund; allocations; and analyses. It states in pertinent part:

> "Each cost allocation analysis shall separately identify the direct and allocable indirect costs of each regulated profession, trade, occupation, or industry and the costs of the Department's general public health and safety purposes. The analyses shall determine whether the direct and allocable indirect costs of each regulated profession, trade, occupation, or industry and the costs of the Department's general public health and safety purposes are sufficiently financed from their respective funding sources. The Department shall prepare the cost allocation analyses in consultation with the respective regulated professions, trades, occupations, and industries and shall make copies of the analyses available to them in a timely fashion."

Music Therapy state regulation would create a financial barrier for entry into the music therapy

[48] *Id.*
[49] American Academy of Actuaries, Issue Brief; Health Insurance Coverage and Reimbursement Decisions. September 2008.
[50] *Id.*
[51] *Id.*
[52] Judy Simpson, AMTA's Director of Government Relations, Music Therapy Reimbursement. (February 2017).
[53] *Id.*
[54] *Id.*
[55] Civil Administrative Code of Illinois. See (20 ILCS 2105/2105-300(a).

profession due to the small number of potential credential holders. Costs include processing credential applications, confirming education, examination scores, and criminal background checks. Costs also include processing renewals, responding to inquiries, investigating complaints, taking enforcement action if needed, recordkeeping, and rule making. IDFPR anticipates the number of music therapist disciplinary cases would be low. According to the Certified Board for Music Therapists, there were a total of 262 board certified music therapists in Illinois in 2017.[56] IDFPR's 2017 fiscal cost analysis for estimated licensing fees for music therapists would be approximately $2501.74. *(See IDFPR Cost Estimator Analysis).*

Moreover, state regulation would prevent other practitioners in various professions from using music as a therapeutic modality since licensure prohibits people from applying elements of the practice of music therapy without certification as a music therapist. Nurses, physical therapists, speech language pathologists, and other health providers may use music as an intervention to treat patients. Several credentialed mental health providers, rehabilitative and massage therapy professionals also use music as a treatment modality or as an adjunct to therapy. Licensure may inhibit their use of music as a treatment tool. In addition, it may prohibit recreational musicians from playing for the sick and dying with no stated therapeutic goal other than the person's relaxation and enjoyment.

Music Therapy Licensure in Other States

Currently, nine states regulate music therapists. Six of these states license music therapists or a broader profession that contains music therapists, with Utah having a hybrid practice and title protection act. One state of the nine that regulate music therapists, Wisconsin, requires registration rather than licensure, but this is a semantic difference. Finally, Connecticut provides for title protection.

Georgia

In Georgia, music therapists are licensed by the Secretary of State pursuant to statute.[57] Music therapists who obtain a Bachelor's degree from a school accredited by the American Music Therapy Association, completes a minimum of 1,200 hours of clinical training, has passed the examination offered by the CBMT, has "satisfactory results" of a criminal background check, and is at least 18 years old, can be licensed.[58] To renew a license a music therapist must maintain the credential of the CBMT and complete at least 40 hours of continuing education as approved by the CBMT.[59] Music therapists in Georgia can be disciplined for fraud, criminal convictions, negligence, discipline by another jurisdiction, physical or mental disability, or substance abuse issues.[60]

New York

In New York, music therapists are licensed under the blanket term "creative arts therapists" or "licensed creative arts therapists" by the Education Department of the Professions. In order to seek licensure in New York, creative arts therapists must have at least a master's or doctoral level degree, pass an approved licensure examination, and obtain at least 1,500 clock hours of supervised experience[61] New York does allow creative arts therapists to obtain a limited permit in order to train and obtain experience under a licensed supervisor.[62] Creative arts therapists must complete at least 36 hours of continuing education every three years unless certain exemptions apply.[63] Creative arts therapists can be disciplined in New York for

[56] "Certified Music Therapist Search." Image Description. (date accessed 07 Mar. 2017).
[57] O.C.G.A. § 43-25A-1 (2012) *et seq*.
[58] O.C.G.A. § 43-25A-5 (2012).
[59] O.C.G.A. § 43-25A-6 (2012).
[60] O.C.G.A. § 43-25A-8 (2012).
[61] NY Code § 79-11.1 – 79-11.3.
[62] There is no separate supervision license NY Code § 79-11.4.
[63] NY Code § 79-11.8(a)-(c).

unprofessional conduct, including but not limited to negligence, undue influence on clients, receiving or giving kickbacks, fee-sharing, fraud, failing to obtain a medical evaluation or consultation in the treatment of certain mental illnesses, prescribing or administering drugs, or using invasive procedures.[64]

Nevada

Music therapists in Nevada are licensed by the Nevada Bureau of Health Care Quality and Compliance, State Health Division. Music therapists are licensed to protect the public health, safety, and welfare from the practice of music therapy by unqualified or unlicensed persons.[65] Music therapist applicants will be deemed qualified in Nevada if he or she obtains at least a Bachelor's degree from a school accredited by the American Music Therapy Association, submits a fee, has a satisfactory criminal record, has passed the examination for board certification from the CBMT, and is at least 18 years old.[66] Music therapists must complete at least 100 hours of continuing education as approved by the CBMT every three years to maintain licensure in Nevada.[67] The Nevada State Board of Health can discipline music therapists for fraud, certain criminal convictions, substance abuse issues, unethical conduct as defined by the CBMT, and negligence.[68] Additionally, music therapists must satisfy child support obligations.[69]

Oklahoma

Music therapists in Oklahoma only recently became licensed by the State Board of Medical Licensure and Supervision, pursuant to a law that went into effect on November 1, 2016. Music therapists in Oklahoma must hold at least a bachelor's degree in music therapy by a program approved by the American Music Therapy Association, complete at least 1,200 hours of clinical training in an approved program, have passed the examination for board certification from the CBMT, be at least 18, and in good moral character.[70] Music therapy licenses in Oklahoma expire every two years and music therapists are required to remain in good standing with the CBMT.[71] Music therapists can be disciplined for practicing outside the scope of their license, certain criminal convictions, substance abuse issues, fraud, mental incompetence, negligence, or ethical violations.[72]

Oregon

Music therapists in Oregon are regulated by the Health Licensing Office. To obtain licensure in Oregon, a music therapist must pass the certification exam from the CBMT within the two years preceding his or her application, maintain certification with the CBMT, have a professional designation issued by the National Music Therapy Registry, and be at least 18 years of age.[73] To maintain licensure, music therapists in Oregon must complete at least ten (10) continuing education credits every year.[74] Music therapists in Oregon can be disciplined for failing to protect patient confidentiality, failing to comply with federal, state, or local regulations, acting unethically, negligence, or fraud.[75]

[64] NY Code §§ 29.1 & 29.15.
[65] NRS 640D.010.
[66] NRS 640D.110.
[67] NRS 640D.130.
[68] NRS 640D.170.
[69] NRS 640D.120.
[70] 59 O.S. § 889.5.
[71] 59 O.S. § 889.6.
[72] 59 O.S. § 889.11.
[73] O.R.S. § 681.710 & Oregon Administrative Rules 331-310-0020.
[74] Oregon Administrative Rules 331-320-0020.
[75] Oregon Administrative Rules 331-330-0010.

Rhode Island

Music therapists in Rhode Island are regulated by the Department of Health and are termed "registered," but the registration functions as a license. To qualify for registration as a music therapist in Rhode Island, an applicant must hold at least a bachelor's degree in music therapy from a school approved by the American Music Therapy Association, complete at least 1,200 hours of clinical training through a program approved by the American Music Therapy Association, pass the examination for board certification from the CBMT, currently be board certified as a music therapist, and be at least 18 years of age.[76] Registrations expire biannually and to renew successfully music therapists must remain board certified.[77] Music therapists may be disciplined for practicing outside of the scope of his or her practice, practicing on a non-renewed license, or any other violation of the Act or Rules.[78]

North Dakota

Music therapists in North Dakota are regulated by the North Dakota Board of Integrative Health Care, specifically the state board of integrative health care.[79] To qualify for licensure in North Dakota, music therapists must have graduated from a board-approved program, must complete a board-approved examination, must be in good standing with either the CBMT or the National Music Therapy Registry, have the physical, mental, and professional competency to practice, and not have committed any acts that would warrant discipline.[80] Music therapist licenses in North Dakota expire biannually and music therapists must complete forty hours of approved continuing education biannually.[81] Music therapists in North Dakota can be disciplined for fraud, substance abuse issues, certain criminal convictions, physical or mental disability, unethical or unprofessional conduct, negligence, sexual abuse, or aiding and abetting in unlicensed practice.[82]

Utah

Music therapists in Utah are regulated by the Division of Occupational and Professional Licensing. To qualify for certification as a music therapist, an applicant must be in good standing with the CBMT, be of good moral character, and pay an application fee.[83] Certificates expire biannually in Utah and to renew, a music therapist must show good standing with the CBMT.[84] Music therapists can be disciplined for unprofessional conduct as defined by rule, being disciplined in another jurisdiction or by the CBMT s, for failing to remain in good standing with the CBMT, or for using the title "state certified music therapist" without an active certification.[85] The Utah certification system functions closer to a title protection act than a practice act; however, it does allow for more disciplinary measures than traditional title protection acts.

Wisconsin

Music therapists in Wisconsin are regulated by the Department of Safety and Professional Services. Music therapists fall under a subset of creative arts therapists, which itself is a subset of psychotherapists.[86] A music therapist must be board certified by the CBMT, disclose any criminal convictions or pending criminal

[76] R23-20.8.3.
[77] R23-20.8.6-7.
[78] R23-20.8.10.1.
[79] N.D. Cent. Code § 43-59-01.
[80] N.D. Cent. Code § 43-59-02.
[81] N.D. Cent. Code § 43-57-07 and N.D. Admin. Code 112-03-01-09.
[82] N.D. Cent. Code § 43-57-08(2).
[83] Utah Code 58-84-201.
[84] Utah Code 58-84-202.
[85] Utah Code 58-84-301 and R156-84-502.
[86] SPS 140.2.

charges, and pay an application fee.[87] Registrations expire biannually and to renew a registration a music therapist must maintain certification by the CBMT.[88] To register as a psychotherapist, which is optional in Wisconsin for music therapists, an applicant must pass an examination on the Wisconsin statutes and rules that apply to the profession, hold a master's or doctoral level degree in music therapy from a school approved by the American Music Therapy Association, submit proof of completion of at least 3,000 hours of clinical training in the form of signed and sworn affidavits, pass the examination for certification from the CBMT, disclose any criminal convictions or pending criminal charges, and pay an application fee.[89] Psychotherapy registrations expire biannually and music therapists must remain in good standing with the CBMT in order to renew.[90] Music therapists can be disciplined for practicing beyond the scope of their registration, negligence, fraud, or unethical conduct.[91]

Connecticut

Music therapists in Connecticut are not strictly regulated by any one agency; instead, a recent law creates a title protection through criminal penalties.[92] Connecticut uses this same title protection scheme for art therapists.[93] This is in contrast to professions that are licensed in Connecticut by the Department of Health, such as psychologists.[94] Individuals who are not board certified by the CBMT and who have not graduated with at least a bachelor's degree from a program accredited by the American Music Therapy Association cannot call themselves "music therapists" or "certified music therapists."[95] An individual who wrongly uses either title is guilty of a class D felony.[96]

Sunrise Review in Other States

Two states have conducted a sunrise review for music therapy: Washington State in 2012 and Colorado in 2014. Neither state decided to regulate music therapists after the sunrise review was complete. In each instance, the state recognized the benefit music therapy had to the provision of care, but found the profession did not warrant licensure based on a variety of factors.

The Washington State Department of Health did not recommend the regulation of music therapy practice in its 2012 Sunrise Review Report.[97] The sunrise report was generated at the request of the Washington State Senate to evaluate Senate Bill 6276, which would have required any individual practicing music therapy or using the title "music therapist" to be certified by the Washington State Department of Health.[98] The proposed bill would have required music therapists to hold a bachelor's degree in music therapy and pass an examination in order to be certified.[99] Proponents of the bill stated certification would protect the public from improper practice, ensure competency, protect access to services through insurance reimbursement, validate the profession, establish credentialing, and provide a method to address consumer complaints or ethical violations.[100] Washington ultimately did not support the proposal because there was no clear threat to public health or safety from unregulated practice, there was no articulated public need to ensure competency above national certification requirements, the proponents failed to show the public could not be protected by more cost-efficient means, the bill placed a large financial burden on the small pool of

[87] SPS 141.01.
[88] SPS 141.02.
[89] SPS 141.04.
[90] SPS 141.05.
[91] SPS 142.05.
[92] Conn. Gen. Stat. NEW: Added by P.A. 16-66, § 35.
[93] Conn. Gen. Stat. NEW: Added by P.A. 16-66, § 36.
[94] Conn. Gen. Stat. § 20-187a.
[95] Conn. Gen. Stat. NEW: Added by P.A. 16-66, § 35.
[96] Conn. Gen. Stat. NEW: Added by P.A. 16-66, § 35.
[97] Music Therapy Sunrise Review, Washington State Department of Health (December 2012).
[98] *Id.*
[99] *Id.*
[100] *Id.*

music therapists to cover the costs of regulating the profession, and the bill would prohibit the use of other music-based therapies, including traditional healers and speech-language pathologists.[101] The proposed bill provided both practice and title protection and established a scope of practice for the profession.[102]

Washington considered testimony given in support and in opposition of the bill, including testimony from health professionals, advocacy groups, and music-based therapy practitioners.[103] It also considered the regulatory environment in Washington, national certification of music therapists, formal education options, the cost to become certified nationally, and how other states regulated music therapists.[104] It weighed the potential harm to the public from continued unlicensed practice against the harm in increased regulation.[105] Proponents of the bill stated during their testimony and written comments that regulation was needed to protect the public from the misuse of terms and techniques of music therapy due to an increasing number of unqualified individuals in Washington claiming to be music therapists.[106] When pressed on the matter, however, the proponents could only provide unverified, anecdotal evidence and no specific situations in the state of Washington.[107] While the proponents pointed out that there was no specific body in Washington to collect complaints, the national credentialing body at the time only received between 12 and 36 complaints per year even though there were over 5,400 credentialed music therapists at the time.[108] Washington State did find concrete harm to the public from increased regulation due to the increased financial barriers to entry of the profession and the prevention of other licensed professionals from using music as a therapeutic modality.[109]

The Colorado Department of Regulatory Agencies did not find a need for regulation of music therapists in its 2014 Sunrise Review Report.[110] Colorado's legislative process requires individuals or groups proposing legislation to regulate an occupation or profession to first submit information to the Department of Regulatory Agencies.[111] In evaluating the proposal, the Colorado Department of Regulatory Agencies considered the Colorado regulatory environment at the time, whether other states regulate music therapy, the potential for public harm if the profession remained unregulated, need for regulation, alternatives, and collateral consequences.[112] In weighing the potential for harm, Colorado considered a number of examples of emotional, psychological, and physical harm, misuse of the title, sexual assault, sexual misconduct, and financial exploitation.[113] It found that in the majority of these examples, there was either no harm or that any potential harm was better addressed in ways that did not require additional regulation.[114] In those examples where Colorado found the potential of harm, they also found the harm could be addressed in ways not requiring regulation.[115] Colorado further remarked the instances of harm were extremely rare, with only five instances of harm over a 16 year period even though there were over 6,000 music therapists certified by the board at that time.[116]

In evaluating whether there are alternatives to regulation, the Colorado Department of Regulatory Agencies considered recommendations to only use a title protection act.[117] It found consumer protection laws and private credentialing to provide adequate protection to consumers without the need for additional

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[101] *Id.*
[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.*
[107] *Id.*
[108] *Id.*
[109] *Id.*
[110] 2014 Sunrise Review: Music Therapists, Colorado Department of Regulatory Agencies Office of Policy, Research and Regulatory Reform. (October 15, 2014).
[111] C.R.S. 24-34-104.1.
[112] 2014 Sunrise Review: Music Therapists, Colorado Department of Regulatory Agencies Office of Policy, Research and Regulatory Reform. (October 15, 2014).
[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] *Id.*

regulation.[118] In evaluating collateral consequences, the Colorado Department of Regulatory Agencies considered whether criminal convictions would disqualify individuals from practicing music therapy and whether there should be any disqualifications.[119] While it recognized there were instances of music therapists committing heinous crimes, these instances were so rare it did not rise to the level of needing to regulate an entire occupation.[120] Ultimately, Colorado did not find sufficient evidence to warrant the regulation of music therapy practice based on the lack of potential harm and the lack of a need for regulation.[121]

Legislation Introduced in Other States

In 2013, the Arizona State Senate introduced a bill aimed at regulating music therapists. Senate Bill 1437 would have provided both, title and practice protection to music therapists who held at least a bachelor's degree from a program approved by the AMTA and who were certified by the CBMT. The bill was sponsored by Senators Kelli Ward and Adam Driggs in the Arizona State Senate and Representative Justin Pierce in the Arizona State House. The bill was ultimately vetoed by prior Governor Jan Brewer, who said in a letter accompanying the veto that the bill was ambiguous and failed to create basic oversight.[122] No legislation has been introduced since to regulate the profession in Arizona.

In 2015, Assembly Bill 1279 was introduced by California Assembly Member Chris Holden. The bill provided title protection for music therapists who held at least a bachelor's degree from a program approved by the AMTA and is certified by the CBMT. The bill was ultimately vetoed by Governor Jerry Brown who found the certification provided by the CBMT sufficient.[123]

In 2013, Indiana State Representative Suzanne Crouch introduced House Bill 1051. The bill would have provided title and practice for music therapists who are board certified by CBMT. The bill was vetoed by Governor Mike Pence, who cited the need for fewer licensed professions.[124] In 2015, Indiana instead began a pilot program which established procedures for individuals to apply to a professional licensing agency to become state certified if their profession is not currently licensed by Indiana.[125]

On January 31, 2017, Texas State Representative Sarah Davis introduced House Bill 1376, which created an advisory council to recommend whether licensure is necessary for music therapists in Texas. Currently, the bill has only been filed and has not been assigned to committee. House Bill 1376 follows a law passed in 1999 that created a carve out in the Licensed Professional Counselor Act for music therapists to practice without a licensed professional counselor license in Texas.[126]

[118] *Id.*
[119] *Id.*
[120] *Id.*
[121] *Id.*
[122] Chiappetta, Ralph. "Brewer Vetoes Bill Creating Music Therapy License." Cleveland19. 30 Apr. 2013. (date accessed 07 Mar. 2017).
[123] Brown, Edmund Jr., Office of the Governor, California. (October 11, 2015). *See* https://www.gov.ca.gov/docs/AB_1279_Veto_Message.pdf.
[124] "The Certification Board for Music Therapists." Image Description. (date accessed 07 Mar. 2017).
[125] Ind. Code § 215-1-5.5-2.
[126] Tex. Occ. Code § 503.060.

Overview of Fees & Licensees in Other States

Table 1: Fees for Licensure in Other States

State	Application Fee	Renewal Fee	Continuing Education Requirements
Connecticut	N/A	N/A	100 credits per Certification Board
Georgia	$100.00	$50.00	40 Hours every 2 years
New York	$371.00/Limited Permit - $70.00	$45.00/$70.00	36 Hours every 3 years
Nevada	$200.00	$150.00	100 Unites every 3 years
North Dakota	$150.00	$100.00	40 Hours every 2 years
Oklahoma	$50.00	$50.00	Not yet set
Oregon	$200.00	$50.00	10 Hours per year
Rhode Island	$90.00	Not set	100 credits per Certification Board
Utah	$70.00	$47.00	100 credits per Certification Board
Wisconsin	W/Psychotherapy - $75.00	$107.00	100 credits per Certification Board

Music Therapy Advisory Board Guests

The following guests spoke or submitted written statements to the Board:

Date	Person & Title
6/27/2016	Suzette Farmer, Utah Division of Occupational & Professional Licensing.
6/27/2016	Sherry Thomas, Policy Coordinator, Washington Department of Health: Health Systems Quality Assurance.
6/27/2016	Nancy Swanson, Illinois Music Therapy Association.
6/27/2016	Paula Worthington, University of Chicago, Harris School of Public Policy.
6/27/2016	Claudia Figueroa, University of Chicago, Harris School of Public Policy.
6/27/2016	Raul Meija, University of Chicago, Harris School of Public Policy.
6/27/2016	Cecelia Black, University of Chicago, Harris School of Public Policy.
6/27/2016	Carolina Arguto Salazar, University of Chicago, Harris School of Public Policy.
6/27/2016	Kyle Hillman, National Association of Social Workers.
6/27/2016	Joel Rubin, National Association of Social Workers.
8/30/2016	Leticia Metherell, State of Nevada Department of Health and Human Services Division of Public and Behavioral Health.
8/30/2016	Mike Simoli, Health Program Administrator, Center for Professional Licensing of the Rhode Island Department of Public Health.
8/30/2016	Jamie Adams, Records Management Supervisor, Wisconsin Department of Safety & Professional Services.
8/30/2016	Vivienne Belmont, Colorado Department of Regulatory Agencies.
8/30/2016	Megan E. Castor, Assistant Counsel, Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors of the Pennsylvania Department of State.
8/30/2016	Ari Bargil, Attorney, Institute for Justice.
8/30/2016	Elizabeth Kregor, Institute for Justice Clinic on Entrepreneurship.
9/26/2016	David Hamilton, Executive Secretary of the New York Office of the Professions.
9/26/2016	Jim Cleghorn, Executive Director of Georgia Board of Nursing and Music Therapists.
9/26/2016	Nicholas Goodwin, Office of Governor Mike Pence.
9/26/2016	Carolyn Kahn, Illinois Mental Health Counselors Association.
9/26/2016	Tom Parton, Prior President of the Illinois Speech Language Hearing Association.
10/31/2016	Terrence Koller, Ph.D., ABPP, Legislative Liaison, Illinois Psychological Association.
11/28/2016	Dr. Firas Nakshabandi, M.D., Member Illinois Psychiatrists Association.
11/28/2016	U-Jung Choe, Chair, Illinois Competitiveness Council.
11/28/2016	Meryl Camin Sosa, Esq., Executive Director, Illinois Psychiatric Society.
11/28/2016	Dena Register, PhD, MT-BC, Regulatory Affairs Advisor, Certification Board for Music Therapists.
11/28/2016	Judy Simpson, MT-BC, Director of Government Relations, American Music Therapy Association.
11/28/2016	Lisa Mahaffey, President, Illinois Occupational Therapy Association.
11/28/2016	Robin Jones, Advocacy Director, Illinois Occupational Therapy Association
11/28/2016	Emily Gibellina, Associate General Counsel, Office of Governor Bruce Rauner.
2/6/2017	Holly Schaefer, Founder & Executive Director, Safe Haven School.
2/6/2017	Mischa Fisher, Policy Advisor for Economic Development, Office of Governor Bruce Rauner.
2/6/2017	Cindy Ropp, Associate Professor of Music Therapy, College of Fine Arts, Illinois State University.
2/6/2017	Susan Frick, LSW, Rush Alzheimer's Disease Center.
2/6/2017	Martha Reggi, Chief of Business Prosecutions, IDFPR.
2/6/2017	Bryan Martin, Chief Financial Officer, IDFPR.
2/6/2017	Judy Simpson, MT-BC, Director of Government Relations, American Music Therapy Association.

Suzette Farmer

Suzette Farmer is a PhD, RN and has been working in licensing and regulation in Utah since 2014. Prior to that, she was a nursing faculty member. The Bureau licenses eight professions and currently licenses about 50,000 individuals in Utah. Nursing is the primary profession Utah regulates. Currently only 46 hold certification as music therapists in Utah.

On June 27, 2016, Ms. Farmer testified that Utah began licensing certified Music Therapists in 2014 and had issued 46 licenses, as of June 27, 2016. The initial application fee is $70.00, with a $45.00 fee per two year renewal cycle. Applicants in Utah must be board certified and in good standing with the private Certified Board for Music. This same standard applies for renewal applicants. Currently, Utah has no licensing board and no set rulemaking process, with no administrative actions taken to date. Ms. Farmer pointed out that Utah currently offers title protection to certified Music Therapists, and that the practice act allows for unlicensed practice as long as individuals are not claiming to be state certified music therapists. Suzette answered questions from the board, stating that Utah does not have a continuing education (CE) requirement, as the Certification Board for Music Therapists already requires 100 CE hours for every five year renewal cycle.

Ms. Farmer submitted a written statement via e-mail on May 03, 2016, stating that the State of Utah does not have a board for music therapy certification and attached copies of Utah's administrative rules and the Music Therapy Act. She reviewed Utah's licensure of music therapists since 2014, including the current regulatory structure, application requirements, fees, and disciplinary actions.

Sherry Thomas

Sherry Thomas is a Policy Coordinator at the State of Washington Department of Health. Ms. Thomas is a policy analyst in the Health Systems Quality Assurance Division and coordinates the division's legislative review process and consults on implementation of passed legislation and rule development. Ms. Thomas manages the sunrise review process to evaluate legislative proposals for new health profession credentials or increases in scopes of practice of already regulated professions. This is done using specific statutory criteria based on the belief that all individuals should be permitted to enter into a health profession unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession.

On June 27, 2016, Ms. Farmer explained that the sunrise review process in Washington State ended in 2012, with the final report recommendation that the profession not be certified. The proponents of regulation failed to demonstrate a "clear danger to the public" and that existing regulations at the national level protects against foreseeable public harm. The debate around the proposal to regulate focused on the scope of practice, as opponents expressed concern that regulation would overreach into or limit the scope of practice of other professions (i.e., occupational therapists, speech language pathologists). To date, Washington State shows no complaints or indication that unlicensed practice of music therapy has caused harm.

Ms. Farmer also submitted an example application for a new regulated profession used by the State of Washington and a sunrise review created by the Washington State Department of Public Health. The application asks general questions about the proposed profession and a clear statement explaining the need for regulation, the potential for public harm, and an exploration of policy alternatives to regulation, licensure, or certification.

The sunrise review ultimately concluded that the three criterion that would warrant regulation is if proponents could show that unregulated practice can harm or endanger health or safety, the public needs and will benefit from assurance of professional ability, and public protection cannot be met by other means in a more cost-beneficial manner. Based on the findings from the sunrise review, the Washington State Department of Public Health notified the state legislature that they did not support legislation requiring state certification of music therapists.

Nancy Swanson

Nancy Swanson is a board certified music therapist, with certification from the Certification Board for Music Therapists and is currently the owner of Nancy Swanson Music Therapy Services, Inc. Her company provides clinical music therapy services to a range of populations including dementia, hospice, oncology, children with special needs, and support groups. She is also the Government Relations Chair at the Illinois Association for Music Therapy.

On June 27, 2016, Ms. Swanson testified on reasons in favor of licensure, including insurance reimbursement, consumer protection, and increased consumer access to services. She also reviewed the public harm that necessitates regulation, including misrepresentation of credentials by individuals holding themselves out as music therapists, as well as types of client cases that require familiarization with medical concerns, risks, and clinical knowledge. Ms. Swanson provided an overview of the scope of practice for a music therapist and explained how the overlap with other professions works since music therapists do not perform diagnosis. She also discussed educational requirements for certification. Ms. Swanson answered Advisory Board member inquiries regarding the nature of disciplinary actions taken against music therapists, whether there are IMTA members who hold licensure in other fields, and whether there is any pending legislation in other states to license music therapists. Ms. Swanson presented a power point presentation on music therapy on the following topics:

Music Therapy: Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. The treatment process for music therapists involves the following:

- assessing a client's strengths and needs
- developing a treatment plan (non-musical goals)
- implementing music interventions to achieve non-musical goals
- assessing the patient's progress
- documenting assessments, treatment plans (including goals), client process, and discharge/termination plans

With regard to scope of practice, Ms. Swanson clarified that music therapists are not involved in in diagnosing conditions and disorders. She also noted that music therapists take a "whole person" treatment approach. Ms. Swanson also discussed the overlap of scopes of practice with other professions.

Music Therapists in Illinois: Illinois has 252 (243 in the AMTA handout) music therapists that have served over 13,000 residents in a wide variety of setting. Ms. Swanson shared the following information from the Certification Board for Music Therapists, regarding Illinois music therapists who hold additional degrees, licenses, and credentials:

Licenses & Certifications

4 – Licensed Clinical Professional Counselor
2 – Licensed Professional Counselor
3 – Music Educator K-12
1 – Professional Educator License
1 – Social Work
1 – Special Ed. Teaching Certificate
1 – Licensed Massage Therapist
1 – Developmental Therapist
1 – Certified Substitute
1 – Early Intervention Specialist Certification

Degrees
33 – Master's degrees in other professions
61 – Master's degrees in Music Therapy
3 – Doctorates

Current Recognition:
Ms. Swanson provided the following chart illustrating the current recognition of music therapists across the country:

STATE	TYPE	ESTABLISHED
WISCONSIN	REGISTRY	1998
NORTH DAKOTA	LICENSURE	2011
NEVADA	LICENSURE	2011
GEORGIA	LICENSURE	2012
UTAH	CERTIFICATION	2014
RHODE ISLAND	REGISTRY	2014
OREGON	LICENSURE	2015
OKLAHOMA	LICENSURE	2016
CONNECTICUT	TITLE PROTECTION	2016

Ms. Swanson submitted the following documents, attached as Exhibit 2.

University of Chicago, Harris School of Public Policy

Paula Worthington is a Senior Lecturer at the Harris School of Public Policy at the University of Chicago. She received her Ph.D. in economics from Northwestern University and has taught public policy graduate students the basics of state and local government fiscal policy analysis and cost-benefit analysis. Cecelia Black received her MPP from the Harris School of Public Policy in 2016 and has worked on various projects for community organizations and state government agencies, focusing on state/local finance and government operations. Raul Mejia has a MPP from the University of Chicago – Harris School of Public Policy. He has a particular interest in the way institutions and government intervention impact competition, trade and economic development. Claudia Figueroa received her MPP from the University of Chicago – Harris School of Public Policy. Claudia was Teaching Assistant for the University of Chicago undergraduate-level Politics and Policy course. Claudia is a Fulbright Scholar and has a Master's degree in Economics and a Bachelor's degree in Economics and Business from Catholic University, Santiago, Chile. Carolina Agurto has a MPP from the University of Chicago – Harris School of Public Policy. Carolina has oriented her professional and academic work toward studying how government intervention affects the efficiency of markets, focusing on the impacts that regulations have on competition, trade, innovation and sustainability.

Ms. Worthington, Ms. Figueroa, Mr. Meija, Ms. Black, & Ms. Salazar reviewed a music therapy sunrise review project they completed for IDFPR. They discussed background information on the profession, current market conditions, regulation of music therapy in other states, and compared the scope of practice of music therapy with that of related professions. They also provided a risk analysis of the need for licensure of music therapists, along with arguments for and against licensure. Finally, they recommended that music therapists not be licensed for several reasons, primarily a lack of public harm necessitating the license. Their recommendations came in PowerPoint form and in a white paper and was presented to the Board on June 27, 2016. They suggested that the Board explore title protection as an alternative to more restrictive regulation. They answered several questions from the Advisory Board on all aspects of their sunrise review project.

The group from the University of Chicago – Harris School of Public Policy ultimately concluded that the costs of creating a regulated license for Music Therapists would outweigh its potential benefits, and that no conclusive data exists to support music therapy licensing. The lack of licensure has slowed the growth of the music therapy profession, showing a growth in the number of music therapy professionals, their average annual salary, and current reimbursement rates from the State, Medicare, and private insurance. The public safety risk is minimal, as music therapists offer minimally invasive services as a team or under the Certification Board for Music Therapists (CBMT) certification process. States that regulate music therapists (Nevada, Oregon, North Dakota, Georgia, Utah, Rhode Island, and Wisconsin) have all adopted the CBMT standards as licensing requirements. States that rejected music therapy licensure (California, Colorado, Washington) all cited that the minimal public risk. Additionally, the UChicago group has found that licensure does not guarantee access to state Medicaid funding or other funds. Furthermore, they concluded that consumer protection would be maintained through the CBMT, the Federal Trade Commission, and the Illinois Attorney General's Office. Attached as Exhibits 3a and 3b are the following, the University of Chicago, Harris Policy School "Sunrise Review for Music Therapy"; and applicable power point presentation.

National Association of Social Workers Illinois Chapter

Kyle Hillman is the Director of Legislative Affairs for the National Association of Social Workers Illinois Chapter. NASW is the largest membership organization of professional social workers in the world with 150,000 members. The NASW Illinois Chapter is one of the association's largest chapters with over 7,000 members in Illinois alone. NASW strives to advance social work careers, grow social work businesses, and protect the profession. Mr. Rubin is the Executive Director for the NASW Illinois Chapter. NASW is the largest membership organization of professional social workers in the world with 150,000 members. The NASW Illinois Chapter is one of the association's largest chapters with over 7,000 members in Illinois alone.

Mr. Hillman thanked the Advisory Board for inviting him and Mr. Rubin to speak. He discussed the National Association of Social Workers' position against the licensure of music therapists. He provided an overview of several reasons against licensure, such as a concern that the music therapist programs lack the academic or clinical training to provide mental health services, that the Music Therapist Association already has a credential that allows the public to determine qualifications, & the low number of potential licensees in the state not warranting the expense of licensure. He suggested that if the Advisory Board decides to recommend licensure, that they consider that any title protection allow for other mental health professionals to use the term music therapists & requiring (as a condition for licensure) post-graduate supervised clinical experience and independent testing similar to that of licensed social workers ("LSWs") & licensed professional counselors ("LPCs"), both of which are the lower-level license in those fields, and that the scope of practice be severely limited without direct supervision by a clinical mental health licensed professional . Mr. Hillman & Mr. Rubin answered Advisory Board questions regarding the minimum educational and experience requirements for the lower-level social worker license. They spoke to the Board on June 27, 2016.

Leticia Metherell

Leticia Metherell is a Health Facilities Inspection Manager with Nevada's Division of Public & Behavioral Health. She helped develop the music therapy regulations that were adopted by the Board of Health and are now effective in Nevada. She developed music therapist licensing policies and procedures based on Nevada's statutes and regulations, developed the required licensure applications and currently oversees the music therapy licensing program for Nevada.

Ms. Metherell reviewed Nevada's licensure of music therapists since 2011 including the general regulatory framework, and licensure requirements. She also discussed that there have been no disciplinary actions taken against the 16 licensees in Nevada, and no complaints of unlicensed practice. Ms. Metherell cited Nevada's scope of practice rules and regulations and it licensure qualifications. *See:* NRS 640D.060 NRS 640D.110

Mike Simoli

Mike Simoli is a Health Program Administrator in the Center for Professional Licensing at the Rhode Island Department of Health. Mike has been with the Department of Health since 2002, and has functioned as the health program administrator for licensing since 2004. The Rhode Island Department of Health has authority over 600 license types, including health professionals, cosmetology, food protection, drinking water quality, lead/asbestos/radon, radioactive materials, and medical marijuana. Mike is also part of the technical Licensing Team which is responsible for ensuring the licensing software (System Automation's License2000) is compliant with all statutory & regulatory changes in Rhode Island.

Mr. Simoli reviewed Rhode Island's licensure of music therapists since 2014 including the general regulatory framework, and licensure requirements. He discussed that there are now three licensees, and answered Advisory Board member questions on the number of complaints of unlicensed practice, of which there have been none to date. Mr. Simoli cited Rhode Island's scope of practice rules and regulations and it licensure qualifications. *See:* R23-20.8.1-MUS.

Jamie Adams

Jamie Adams is a Records Management Supervisor in the Division of Professional Credential Processing at the Wisconsin Department of Safety and Professional Services. Jamie oversees the Health Credentialing Unit within the Division of Professional Credential Processing. He oversees 10 staff members that license approximately 70 different Health professions. James has been with the Health Credentialing Unit since 2014 and with the Department since 2013.

Jamie Adams reviewed Wisconsin's licensure of music, dance, and art therapists since 1999, including the general regulatory framework and licensure requirements. She discussed the total number of licenses issued, number of active licenses (75), and one reported case of discipline. Jaime Adams also highlighted Wisconsin's statutory definition of psychotherapy, included in the psychology licensure statute, and its interplay with music therapy. Jamie Adams provided information regarding the scope of practice for music therapists in Wisconsin, which is set by rule at Chapter SPS 142.01 of the Wisconsin Administrative Code.

Vivienne Belmont

Vivienne Belmont is a public policy analyst with the Colorado Office of Policy, Research and Regulatory Reform. She has worked for the state for over ten years and is an expert in occupational and professional regulation.

Ms. Belmont reviewed Colorado's sunrise review process, in which new regulated professions are proposed, and the criteria used in formulating a recommendation. She discussed the State's sunrise review of music therapy, which was initiated by the American Music Therapy Association's sunrise review application in 2013 seeking title protection regulation. Ms. Belmont discussed the final report that was issued[127], which recommended against title protection regulation of music therapists. She highlighted a few of the reasons for the recommendation, including a lack of demonstrated public interest or need, lack of demonstrated harm to the public from the unregulated practice of music therapy, and lack of complaints in the State against music therapists. Ms. Belmont answered Advisory Board inquiries regarding whether this may change in the future, and discussed the regulation of a new profession from a public protection standpoint rather than setting minimum standards for the profession. Colorado concluded that there was insufficient evidence for Colorado to separately regulation music therapists, or to protect the titles, "music therapist" or "board-certified music therapist." It ultimately recommended against the creation of a new regulatory program, and protecting the titles "music therapist" or "board-certified music therapist" due to lack of demonstrated public interest or need.

Megan Castor

Megan Castor, Esquire is an Assistant Counsel in the Office of General Counsel with the Bureau of Professional and Occupational Affairs for the Pennsylvania Department of State. She has been Counsel to the State Board of Social Work and State Board of Nursing since January 2014. Prior to that, she was an Assistant Counsel for the Pennsylvania Commission on Crime and Delinquency from 2011-2014. Prior to that, she practiced as a general private practitioner from – 2002-2011 in the areas of custody, divorce, criminal defense, civil litigation, wills and estates, & bankruptcy.

On August 30, 2016, Ms. Castor reviewed the title protection regulation of mental health professions in Pennsylvania. She explained that there is no separate license for music therapists, and that a professional counselor license allows for the practice of music therapy. Ms. Castor reviewed the educational requirements for licensure for professional counselors, as the education in several fields meet the requirements for licensure, such as education in psychology, dance, music, and art therapy. She discussed the expense of regulating music therapists separately, and that there have been bills pending in the Pennsylvania legislature with no progress at this time.

Ari Bargil

Ari Bargil is an attorney with the Institute for Justice ("IJ"). IJ is a national public-interest law firm, and the nation's leading law firm for liberty. IJ litigates cases in the courts of law and public opinion in four core areas: Property Rights, School Choice, Economic Liberty, and Free Speech. Mr. Bargil joined IJ in September 2012 and litigates constitutional cases to vindicate those rights in federal and state courts nationwide. Mr. Bargil is currently involved in two pending First Amendment cases involving occupational speech. In addition to occupational licensing generally, Mr. Bargil spoke on the First Amendment issues implicated by licensing a widely-recognized and protected form of speech—music.

Mr. Bargil thanked the Advisory Board for inviting him to speak and reviewed the Institute for Justice's position against full licensure of music therapists by highlighting several implications of licensure and suggesting less restrictive alternatives to licensure. Specifically, he discussed the First Amendment implications of regulating music as a restriction on a protected form of speech. Mr. Bargil explained how occupational licensing has led to excessive government regulation, and discussed consequences of

[127] "2014 Sunrise Review: Music Therapists." PDF. (date accessed 07 Mar. 2017).

occupational licensing, such as limitations on opportunity, inhibitions on competition, and stifling innovation. He discussed the types of circumstances that require more government oversight through licensure, such as a risk of harm to public health & safety, & suggested a form of title protection or registration as alternatives to licensing. Mr. Bargil answered Advisory Board member questions on all aspects of his testimony. He spoke to the Board on August 30, 2016 and a copy of his testimony can be found below:

Introduction

Good morning, and thank you for the opportunity to testify before you today. My name is Ari Bargil, and I am an attorney with the Institute for Justice ("IJ"). IJ is a national public-interest law firm, and the nation's leading law firm for liberty. IJ litigates cases in the courts of law and public opinion in four core areas: Property Rights, School Choice, Economic Liberty, and Free Speech. I joined IJ in September 2012, where I litigate cutting-edge constitutional cases to vindicate those rights in federal and state courts nationwide.

In addition to occupational licensing generally, my testimony today will address the First Amendment issues implicated by this board's consideration of licensing a widely-recognized and protected form of speech—music.[128]

The Consequences of Professional Regulation and Occupational Licensing

The drawbacks of occupational licensing are by now well-known. They limit opportunity, inhibit competition, and stifle innovation in the marketplace—outcomes which lead to increased prices, decreased options, and unmet demand. The occupational license has become the symbol of overzealous professional regulation in the United States. And yet, the growth of occupational licensing requirements has been exponential in last half century: According to License to Work, a 2012 study by the Institute for Justice, only one in twenty American workers needed a license to practice in a particular field in the 1950s; today, that number stands at roughly one in four.[129]

But by restricting entry into so many occupations—from hair braiders to interior designers—what do regulatory bodies (like this one) really accomplish? Are people really safer, or, more likely, is it just harder to compete and harder to earn a living? In recent years, the negative consequences of unnecessary occupational licensing have been criticized by groups of all stripes, ranging from my group, the Institute for Justice, to the Obama Whitehouse. The reason why there exists such uncharacteristically broad agreement on this issue, amongst such divergent groups, is simple: By requiring a license as a prerequisite to practice a trade, the government is effectively forbidding citizens from earning a living in a given field without the government's permission. Regardless of where you fall on the political spectrum, denying any person the ability to exercise their constitutional right to earn a living is something that every individual, and certainly every entity like this one, must take seriously. At the same time, courts have started to take note of the impropriety of unnecessary licenses. As just one example, in a powerful opinion, the Texas Supreme Court recently struck down a law requiring hundreds of hours of education and an occupational license simply to be authorized to provide eyebrow threading services.[130]

[128] I am currently involved in two pending First Amendment cases involving occupational speech. *See, e.g.*, *Ocheesee Creamery, LLC v. Putnam*, No. 4:14cv621-RH/CAS, 2016 WL 3570480 (N.D. Fla. Mar. 30, 2016) (representing a small family creamery that was forbidden from calling their all-natural skim milk "skim milk"); *Wollschlaeger v. Governor of the State of Florida* (a/k/a "Docs v. Glocks"), No. 12-14009, 2016 WL 2959373 (11th Cir. Feb. 3, 2016) (granting rehearing en banc) (amicus brief in support of a coalition of doctors who were prohibited from asking patients whether they owned a gun).

[129] "Data on Certifications and Licenses (CPS)." U.S. Bureau of Labor Statistics. U.S. Bureau of Labor Statistics, (date accessed 07 Mar. 2017).

[130] *Patel v. Texas Dep't of Licensing & Reg.*, 469 S.W.3d 69, 118, 122-23 (Tex. 2015) ("Courts need not be oblivious to the iron political and economic truth that the regulatory environment is littered with rent-seeking by special interest factions who crave the exclusive, state-protected right to pursue their careers . . . [But] [e]conomic liberty is deeply rooted in this Nation's history and tradition, and the right to engage in productive enterprise is as central to individual freedom as the right to worship as one chooses.") (Willett, J., concurring) (internal citations omitted).

So it is with great caution that this body must consider what is being asked of it here. Indeed, licensing is perhaps the single most powerful regulatory tool available to the government, at least as it relates to individual workers. And as such, it should be used sparingly, judiciously, and only where the circumstances absolutely demand it. Those circumstances are where, and only where, without the oversight of the government, there is a risk of harm to the health or safety of the public. This is why it is perfectly appropriate to recognize the practical legitimacy and efficacy of music therapy on the one hand, and yet still elect not to license its practice on the other. To view licensure as a mere government endorsement or a mechanism for allowing practitioners to bill insurance companies is to forget why governments license in the first place. Licensing is not appropriate for protecting those who already practice; it is to be used only to protect their clientele, or the public at large.

That is not to say that the government cannot regulate any profession for any reason. What it means is that licensing must be considered for exactly what it is: A tool of last resort. And so where governments do elect to regulate a profession, they should do so responsibly—by using the least restrictive means available to further whatever the goal of the regulation may be. In most instances, the least restrictive—but still effective—means of regulation is not licensure.

In this lens, when discussing music therapy, a practice that has seen no documented cases of actual harm resulting from its unlicensed practice, licensing is not the answer. Rather, the state of Illinois, if it must adopt any regulation at all, can choose among several less restrictive alternatives to licensing, which still meet all of state's goals. In so doing, the state must nonetheless be mindful of other constitutional rights—like the right of free speech—which are potentially implicated any time the government seeks to regulate speech (in this case music) or how a person refers to herself (in this case, as a music therapist).

First Amendment Implications

Music is speech.[131] And the government, if it wishes to regulate speech, must meet an extraordinarily high burden for its regulations to be constitutional.[132] Merely creating a specific definition of what constitutes music therapy does not cure the simple fact that, if Illinois elects to license music therapy, it will be illegal for an individual to play music without a license in certain circumstances. Such an outcome has obvious First Amendment implications, and thus requiring a license to practice music therapy is highly unadvisable.

Assuming the state is not interested in censoring those who wish to play music for the benefit of their specific audience, but still wishes to create a separate distinction for those desiring some sort of state-issued credential, the legislature must be mindful of the mistakes other states have made in apparent efforts to accomplish the same thing. More specifically, to the extent this body believes it is necessary to establish some sort of legislative separation, either to lend legitimacy and recognition to the practice of music therapy or, as we (have also heard/will hear) today, to create a pathway for insurance reimbursement, the state must steer clear of a separate set of possible First Amendment issues.

These First Amendment issues typically arise where states—separate from whether they have restricted who may practice—have limited how potential practitioners may refer to themselves. All too often, state governments craft laws that violate the First Amendment because they prohibit qualified, but uncredentialed, individuals from using common terms to truthfully describe themselves. The courts have repeatedly struck such titling acts down as unconstitutionally overbroad. For example, federal courts have ruled that, without regard to whether a license to practice interior design could be required, it was

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[131] *See, e.g.*, *Ward v. Rock Against Racism*, 491 U.S. 781, 790 (1989) ("Music is one of the oldest forms of human expression.").
[132] *See, e.g.*, *Reed v. Town of Gilbert*, 135 S.Ct. 2218, 2228 (2015) (holding that courts will apply strict scrutiny to content-based restrictions on speech, even where the government provides an "innocuous justification" for the law).

nonetheless unconstitutional to prohibit all interior designers from referring to themselves as such without such a license.[133] Likewise, a federal appeals court recently struck down a law which essentially restricted the use of the term "psychologist" to only those who had completed graduate work in psychology and were licensed to practice psychology in that particular state.[134] The court ruled that the law was unconstitutional because it prevented a highly qualified psychologist from referring to herself as a psychologist in campaign materials.[135] The way to avoid these problems is to go no further than the creation of a state registry of the state's music therapists. This provides an avenue for music therapists to obtain government recognition, without excluding those who do not have it from practicing. Moreover, it leaves all music therapists free to describe themselves as music therapists, while still providing for the unique designation of "registered music therapist" for those who have registered.

Conclusion

In conclusion, it is critical for the state to not only make sure that both credentialed and uncredentialed people may use music as therapeutic modality, but also that those who wish to do so are not forbidden from accurately describing themselves. What this means is that the state must not take wholesale ownership over the term "music therapy," and thus prevent any individuals from calling themselves "music therapists" unless they first obtain whatever credential or classification the state ultimately creates. To the contrary, the state must narrowly craft any legislation to make sure that all those who offer music therapy services may still hold themselves out as music therapists. The only constitutionally permissible restriction on titling, if this state desires to go in that direction, is to restrict music therapists from describing themselves as having any government-created designation or classification, unless, of course, they actually have it. This approach creates the sort of governmental recognition that proponents of music therapy licensing seek, and provides the necessary credentialing for insurance reimbursement under most insurance plans. But it accomplishes these goals without chilling the free speech of other properly educated mental-health professionals or well-intentioned musicians, and without restricting how those same practitioners may truthfully refer to themselves. And thus this is perhaps the only way to constitutionally regulate the practice of music therapy. Thank you for the opportunity to testify.

Elizabeth Kregor

Beth Kregor is the director of the IJ Clinic on Entrepreneurship. Under Beth's guidance, University of Chicago law students take their first steps into the practice of law by providing legal advice to lower- income entrepreneurs. Beth came to the IJ Clinic from the law firm Sidley Austin Brown & Wood. Beth received her Juris Doctor magna cum laude from the University of Michigan Law School in 1999. As an undergraduate, Ms. Kregor studied comparative literature at Yale University, graduating magna cum laude in 1996.

Ms. Kregor spoke to the Advisory board on August 30, 2016. She continued the discussion by Mr. Bargil regarding the consequences of occupational licensure, and recommended against full licensure of music therapists. She explained the exclusionary effect of licensure against disadvantaged individuals, both those who wish to practice music therapy and those who wish to receive services, leading to fewer jobs. She also discussed the exclusionary effect of licensure on innovation, by limiting diversity in the profession as a result of standardization of requirements of entry, leading to fewer developments in the field. Ms. Kregor reinforced Mr. Bargil's suggestions for alternatives to licensure, and answered Advisory Board member inquiries regarding the position of the Institute of Justice as it applies to other professions as well. She submitted the following testimony at the August 30, 2016, Music Therapy Advisory Board Meeting.

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[133] *See, e.g.*, *Byrum v. Landreth*, 566 F.3d 442 (5th Cir. 2009); *Roberts v. Farrell*, 630 F.Supp.2d 242 (D.Conn. 2009); *State v. Lupo*, 984 So. 2d 395 (Ala. 2007).
[134] *Serafine v. Branaman*, 810 F.3d 354 (5th Cir. 2016).
[135] *Id*. at 360-62.

Introduction

My name is Beth Kregor. I'm the Director of the Institute for Justice Clinic on Entrepreneurship at the University of Chicago Law School. We provide free legal assistance, advocacy, and support for the low-income entrepreneurs who are using their creativity and their hard work to make over their lives, their blocks, and sometimes their industries. We also put on the South Side Pitch. We're currently reviewing applicants from all over the south side, who want a chance to pitch their businesses at our big event in October – a little like Shark Tank – and potentially take their business ideas to the next level. We hope to showcase the positive entrepreneurial energy on the South Side and neighborhoods like it, which is often overlooked.

In my work, every day, I see how low-income entrepreneurs are affected by laws that limit who can start a business and how that business can start. I see how those laws hold people back and how important it is to cabin those laws so that they are only on the books when absolutely necessary to protect health and safety. My hope here today is to give some examples from my work that will add to my colleague's points. Together, we recommend that the Board advise against creating a license for music therapists.

The Consequences of Licensing Music Therapists

Creating a license for music therapy would pose serious risks to the profession and to the public. The idea of creating a license, of course, is limiting who can practice music therapy. The exclusive credentials may seem desirable to people who already have them. But, I'm here today to remind the Board that the license would not only be exclusive – it would be exclusionary. It would exclude people who could be wonderful music therapists, and it would exclude new ideas and innovations. As a result, there would be fewer jobs and fewer developments in music therapy, and the people of Illinois would have fewer options to get advice about using music to heal and grow.

Excluding People

First, a law like the one proposed in Illinois last year would require extensive formal training for people to become music therapists. Getting a B.A. in music therapy requires resources, time not working, and the foresight to pick a career path early on. This disadvantages lower-income people like my clients who may not be able to afford spending years in college. It also disadvantages minorities, who are less likely to go to college. In Illinois, the racial gap for college degrees has been growing. There's a 16% gap between whites and African-Americans, and a 26% gap between whites and Latinos.[136] People who realize through life experience that they want to provide music therapy have to choose between working and going back to school later in life.

We should all take a lesson from interior designers. The American Society of Interior Designers urged states to create licenses for interior design practice, even though there was not a track record of customers who had been hurt by unlicensed practice. Professors who studied the difference between states that adopted the license and states that didn't found some important consequences. In licensing states, interior designers charged more to customers, there were fewer people working as interior designers, plus minorities and older designers were disproportionately shut out by degree requirements.[137]

Imagine what could happen in Illinois if music therapy required an expensive license. Imagine a woman living in Englewood on the South Side of Chicago. She has been working with youth to curb violence

[136] http://younginvincibles.org/wp-content/uploads/2016/01/YI-State-Report-Cards-2016.pdf.
[137] https://www.ij.org/images/pdf_folder/economic_liberty/designed-to-exclude.pdf.

for years. She decides to start a program that will train young people to express themselves with rap and other music making so that they can learn how to think through their impulses and react to life non-violently. She wants to hire talented musicians who grew up in the same neighborhood. She believes that this therapy will help young people's minds develop. But the law would make it illegal for her to communicate that to funders or potential participants.

These are the kinds of programs that entrepreneurs are starting on the South Side and the kinds of new ventures applying to South Side Pitch. These are the kind of therapies that this law would shut out.

Excluding Ideas

Another risk of licensing music therapists is the risk of shutting down innovation and creativity. When the only people who are allowed to practice music therapy have the same training and the same career path, they may respond to problems in similar ways. The law would prohibit other people from experimenting with new methods and new ideas.

Imagine a nanny who has success with a music therapy for a child who has severe social anxiety or autism. Imagine she wants to offer the method to other families struggling with similar problems. She would not be allowed to start that business unless she went back to school and had hours of training. Her insight would be lost, most likely. Or imagine a techie person who figures out an algorithm so that signs of growing anxiety are caught by a FitBit or a Facebook add-on and then recommends calming music in a playlist. That technology, which wasn't anticipated by the licensing statute, might be against the law.

Conclusion

To make sure that the field of music therapy is open to new people and new insights, it is very important to limit the exclusionary barriers put up by the government. Where there is no grave risk that the public will be harmed by unlicensed practice – and there is a serious risk that the public will be harmed by cutting off certain music therapists who are cut from a different cloth – then the state should not get involved.

David Hamilton

David Hamilton is a licensed master social worker in New York State. Dr. Hamilton was appointed Executive Secretary to the State Board for Social Work and the State Board for Mental Health Practitioners in the New York State Education Department by the Board of Regents on March 1, 2003. Prior to that, Dr. Hamilton was the Executive Secretary for Podiatry, Physical Therapy and Ophthalmic Dispensing. He has a bachelor of science in psychology from Loyola Marymount University, a master's in social welfare degree from the University of California, Los Angeles (1989) and a doctorate in social work from Virginia Commonwealth University. Prior to joining the Education Department, he was the Associate Director for Catholic Charities at the New York State Catholic Conference and staff associate for government relations at the National Association of Social Workers, New York State Chapter. He testified on September 26, 2016. His statement to the Board is below:

Thank you for the opportunity to share information about licensure of creative arts therapists in New York. I hope this is helpful to your discussions and questions about licensure for music therapists in Illinois. In 1891, medicine became the first profession licensed by the New York State Board of Regents. New York's unique system of professional regulation, recognized as a model for public protection, has grown to encompass 800,000 practitioners and over 30,000 professional practice business entities in more than 50 professions.

Guided by the Regents, a 17-member citizen body elected in a joint session by the State Senate and Assembly, the professions are within New York State's unified system of education - The University of the State of New York. This recognizes the key role education plays in both preparing licensed professionals and in ensuring their continuous development.

The State Education Department, under Regents' direction, administers professional regulation through its Office of the Professions, assisted by the State Boards for the Professions. The State Board for Mental Health Practitioners consists of three licensees in each of the four professions (mental health counseling, marriage and family therapy, creative arts therapy and psychoanalysis), three public members and a psychiatrist. I was appointed as the Executive Secretary by the Board of Regents in February 2003 to implement the law creating these four professions.

Although New York had licensed physicians, registered professional nurses, psychologists and certified social workers (MSWs) the latter two licenses provided title-protection only. While individuals in those professions could diagnose mental illness and provide psychotherapy, so could any person—regardless of education, training or experience. This placed the public at risk from unqualified and unethical practitioners, including licensed professionals whose license was revoked, suspended or annulled by the Board of Regents, who offered services to individuals in need of care under the generic title of “psychotherapist” or “counselor.”

In 2002, Chapter 420 provided a restricted scope of practice for two MSW-level practitioners (LMSW & LCSW); Chapter 676 provided a restricted scope for licensed psychologists and established the four new mental health professions. Most importantly, this restricted the practice of psychotherapy to individuals licensed or authorized under the law, as of January 1, 2006. Chapter 676 defined the requirements for licensure and the “scope of practice” for these four professions, recognizing the unique training, education, experience and examination requirements for each title. The Board of Regents, with the assistance of the State Board, promulgated regulations in 2004 to implement the law, including special provisions for licensure without examination for certain individuals and unprofessional conduct in the practice of the professions.

Some of the key provisions of the law and regulations for those licensed under Article 163, including creative arts therapists, include:

Education: Receipt of a master’s degree in creative arts therapy, acceptable to the Department, in order to apply for licensure and a limited permit to practice under supervision while meeting the experience and/or examination requirements for licensure:

- Part 52.34 of the Commissioner’s Regulations establish the requirements for a program in New York that wishes to become license-qualifying for creative arts therapy. This includes preparation in one or more of the creative arts therapies, including but not limited to art, music, dance, drama, psychodrama, or poetry therapies, for the practice of creative arts therapy as defined in section 8404(1) of the Education Law. There are 11 New York schools with a program leading to licensure as a LCAT; four of those master’s degrees are in music therapy.
- Graduates of a license-qualifying program have met the education requirement; those applicants from out-of-state must undergo an individual transcript evaluation to determine if they have met the education requirements or need additional graduate course work and/or clinical internship. Only the American Art Therapy Association’s master’s degree standards have been determined acceptable to the Department.

Limited permit: Individuals who have submitted the application for licensure, $371 and met the education requirements, as defined in law and regulation, may apply for a limited permit to practice creative arts

therapy under the supervision of a qualified supervisor in an authorized setting, as defined in law and regulation. The applicant and supervisor must submit the permit application (Form 5) and permit fee ($70) for review by the State Board.

Chapter 676 initially authorized a two-year limited permit for applicants in mental health counseling and a one-year permit for applicants in creative arts therapy, marriage and family therapy and psychoanalysis; all were eligible to apply for a one-year extension if, in the determination of the Department, the applicant was making progress toward meeting the experience and/or examination requirements. Chapter 485 of 2013 amended the law to authorize an initial two-year permit and up to two one-year extensions, at the discretion of the Department, for all four professions.

Permit supervisors must be licensed and registered in NY (LCAT, LCSW, Psychologist, Physician or RN/NP), employed by the same setting as the permit holder, have access to the patient and patient records, and is responsible for all services provided to the patient under his/her supervision. Applicant who employ a permit supervisor or consult with a licensed professional, without consent of the employing setting and informed consent of the patient could be charged with unprofessional conduct under the law and regulations.

Supervised Experience: The applicant must complete 1,500 post-degree supervised hours in a legal manner in New York or in another jurisdiction. The experience must include the supervised practice of psychotherapy and assessment and evaluation using the DSM. Verification of supervised experience is submitted by the supervisor and no less than two-thirds (1,000) of the minimum 1,500 post-degree hours must include direct client contact. This regulations state remaining experience may consist of other activities that do not involve direct client contact, including but not limited to, recordkeeping, case management, supervision, and professional development, as determined by the supervisor.

Examination: There is no national examination for "creative arts therapy" so the regulations allow the applicant to meet the examination requirement must pass one of the following:

- "Board Certification" examination offered by the Certification Board for Music Therapists (CBMT);
- "Board Certification" examination offered by the Art Therapy Credentials Board (ATCB); or
- New York Case Narrative Examination administered by CASTLE Worldwide, Inc. This consists of two timed-narratives describing the assessment, evaluation and treatment of a patient that demonstrates the appropriate use of creative arts therapy theories and interventions. Narratives are scored by Licensed Creative Arts Therapists, most of whom are current or former members of the State Board.

New York will accept score transfers for tests taken for licensure in another jurisdiction when submitted by the examination vendor. However, New York does not accept English-as-a-Second-Language arrangements for examinations in any profession. Part 59 of the Commissioner's Regulations require an applicant for licensure to demonstrate English language proficiency by passing a licensing examination, acceptable to the Department, given in English.

Moral Character: An applicant for a license or limited permit must be of good moral character, as determined by the Department. An applicant who answers "yes" to questions about misdemeanor or felony arrests or convictions; disciplinary action in another jurisdiction or profession; or termination by an employer or education program, must provide a detailed explanation. This information is reviewed by the Office of Professional Discipline and, as appropriate, may result in a telephone screening and an in-person three-member panel of Board members assigned by the Executive Secretary to determine if the applicant meets the moral character requirement.

Licensure and Registration: When all requirements have been met, the Department may issue a license to practice creative arts therapy and use the restricted title "Licensed Creative Arts Therapist." A licensee may specify in advertising the profession in which he or she is licensed (e.g., music, art, dance/movement) and may add modalities used in his/her practice or populations that are served (e.g., children or adults). The licensee is responsible for knowing that he/she is competent, based on education, training and experience. The name of a professional corporation or "d/b/a" must include the licensed profession and comply with the laws, rules and regulations of the Department in regard to advertising. Advertising that is misleading, deceptive or inaccurate could result in charges of unprofessional conduct under Part 29 of the Regents Rules.

A New York license is valid for life, unless it is revoked, annulled, suspended by or surrendered to the Board of Regents. In 2015 the Department issued a new license to 112 creative arts therapists. As of July 1, 2016, there were 1,716 LCATs registered to practice; 1,456 at an address in New York, 252 in another part of the U.S. and 8 with a non-U.S. address. The LCAT license and title does not indicate the licensee's modality or practice area, e.g., music therapy. The registration address may be the home or work address; although multiple settings may be registered, only the first one is counted in the registration statistics. You can access information about licensure of new LCATs from 2011 to 2015 and the geographic distribution of licensees at www.op.nysed.gov/prof/hmp/mhpcounts.htm.

The licensee must submit the registration application and triennial fee ($176) every three years to practice the profession and use the restricted title. Willful practice without registration is defined as professional misconduct. A licensee who practices without being registered may reinstate by paying the delayed fees and a $10 fee for each month of un-registered practice. Licensees are responsible for notifying the Department within 30 days of a change in name or address; registration notices are mailed 4 months prior to the end of the registration period.

Continuing Education: Effective January 1, 2017, each LCAT, LMHC, LMFT and LP must complete 36 months of continuing education from a provider approved by the Department, on the basis of an application and $900 fee. Approved providers are listed on our website and the Board is reviewing and approving applications. No organization is "deemed approved" and all must apply, pay the fee and meet all requirements in the law and regulation, in the determination of the Department. No more than one-third of the required hours may be self-study courses taken from Department-approved providers and supervision of practice is not acceptable experience.

The CE requirement is pro-rated, for those with a registration period that started prior to January 1, 2017. Licensees are exempt in the first registration period after initial licensure and when inactive. Those returning to practice must complete the hours required from January 1, 2017 (or the last date of registration after that date) to the start of the new registration period to return to practice. Failure to comply could result in disciplinary action. Licensees may apply for a one-year conditional application by paying the $241 triennial fee ($196 + $45) for the conditional period, completing all required CE and submitting verification of those hours along with an application for the two-year registration and $241 fee. Please see www.op.nysed.gov/prof/mhp/catcehome.htm.

Professional Practice: A licensed creative arts therapist is authorized to practice the profession, as it is defined in section 8404 of the Education Law:

a) the assessment, evaluation, and the therapeutic intervention and treatment, which may be either primary, parallel or adjunctive, of mental, emotional, developmental and behavioral disorders through the use of the arts as approved by the department; and

b) the use of assessment instruments and mental health counseling and psychotherapy to identify, evaluate and treat dysfunctions and disorders for purposes of providing appropriate creative arts therapy services.

A licensed professional is responsible for practicing within his/her education, training and experience. New York does not require or recognize national certification as a substitute for a professional license nor does such certification change the definition of practice. A licensee who practices beyond the authorized scope could be charged with misconduct.

Boundaries of Practice: The Rules of the Board of Regents define unprofessional conduct in all professions (Part 29.1) and the health professions, including LCAT (Part 29.2). Section 8407 of the Education Law and Part 29.15 of the Regents Rules also set boundaries of professional conduct for LCATs and other individuals licensed under Article 163:

1) It shall be deemed practicing outside the boundaries of his or her professional competence for a person licensed pursuant to this article, in the case of treatment of any serious mental illness, to provide any mental health service for such illness on a continuous and sustained basis without a medical evaluation of the illness by, and consultation with, a physician regarding such illness. Such medical evaluation and consultation shall be to determine and advise whether any medical care is indicated for such illness. For purposes of this section, "serious mental illness" means schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention-deficit hyperactivity disorder and autism.

2) Any individual whose license or authority to practice derives from the provisions of this article shall be prohibited from:

   a) prescribing or administering drugs as defined in this chapter as a treatment, therapy, or professional service in the practice of his or her profession; or
   b) using invasive procedures as a treatment, therapy, or professional service in the practice of his or her profession. For purposes of this subdivision, "invasive procedure" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or other means. Invasive procedure includes surgery, lasers, ionizing radiation, therapeutic ultrasound, or electroconvulsive therapy.

Complaints against licensed professionals or unlicensed practitioners may be submitted by individuals, organizations or employers. All complaints are investigated and, as appropriate, a member of the appropriate State Board is consulted and may participate in an early settlement conference. Cases that cannot be resolved at an early level may be presented to a three-member panel, appointed by the Executive Secretary. Disciplinary action that results from criminal convictions or actions by another jurisdiction are referred to the Board of Regents Review Committee for a hearing and recommendation. All consents, applications to surrender, revocations and suspensions are taken by the Board of Regents and final actions are posted on the Office of the Professions website: www.op.nysed.gov/opd/rasearch.htm.

Diagnosis: Early versions of legislation proposed to license creative arts therapists and others under Article 163 including the word “diagnosis.” However, this was stricken from the legislation that was approved by the Legislature and Governor. The scope of practice for a creative arts therapist does not include diagnosis. Section 8411(3) of the Education Law and 79-11.5 of the Commissioner’s Regulations allow a licensed creative arts therapist to use the Diagnostic and Statistical Manual of the American Psychiatric Association to assess an individual in order to provide appropriate services within the scope of practice. Although the licensee may use such an assessment tool, there is nothing to authorize the creative arts therapist to diagnose

mental illness. A licensee who practices beyond the scope of practice, or engages in activities that are within the scope but in which the licensee is not competent, may face charges of unprofessional conduct under Part 29 of the Regents Rules.

Unlicensed practice: New York restricts the ownership of professional practices to licensed professionals and authorized entities. Generally, a for-profit business may not employ licensed professionals or offer professional services to the public; this is commonly referred to as the "corporate practice restriction" in the Education Law. For instance, CVS Minute-Clinics are not authorized to employ physicians and nurses to provide medical services, although pharmacists in a New York may administer flu shots. Sections 6512 and 6513 of the Education Law define as a felony the unauthorized practice of a profession or use of a licensed title by one or individuals. A licensed professional who aids and abets illegal practice may be charged with unprofessional conduct. A not-for-profit or religious corporation may only employ licensed professionals with an operating certificate from an appropriate government agency, e.g., Department of Health or Office of Mental Health, or a waiver from the corporate practice restrictions in New York law, issued under section 6503-a of the Education Law. LCATs and others licensed under Article 163 are not authorized by the Education department to provide services in schools. Those roles are restricted to licensees credentialed as a pupil personnel service professional (e.g., school social worker, school psychologist, school nurse and school dental hygienist). Article 163 professions have been discussing with the Office of Teaching and P-12 Education in the Department whether or not those professions could be made eligible for similar PPS credentials.

Exemption: Article 163 includes exemptions that allow other licensed professionals to provide services that overlap with creative arts therapy, mental health counseling, marriage and family therapy and psychoanalysis, as well as CASACs, lawyers and pastoral counselors who provide services that may overlap. There are also exemptions for students enrolled in New York license-qualifying programs to allow those students to complete a supervised internship under a qualified supervisor licensed in New York. The exemptions do not authorize the use of any restricted title, so that an individual with a bachelor's in music therapy who is providing case management and care coordination in a nursing home can engage in those activities, but cannot provide psychotherapy and counseling nor use a title to infer licensure as a "creative arts therapist."

Bachelor's Educated Music Therapist: The Assembly sponsor of the legislation that became Chapter 676 provided a memorandum that clarified his intent not to disenfranchise bachelor's educated individuals providing music therapy services that do not require licensure. The Department developed the attached guidance in related to activities that do not require licensure and may be performed by an unlicensed individual, including an individual with a bachelor's degree in music therapy.

Before Chapters 420 and 676 of 2002 were signed, certain executive branch agencies, including the Office of Mental Health, Office of Alcoholism & Substance Abuse Services and Office for People with Developmental Disabilities sought an exemption from licensing laws until January 1, 2010 for individuals employed in State operated programs or in those programs operated by not-for-profits regulated, funded or approved by OMH, OASAS and OPWDD. Those agencies, and others, have argued since 2009 (prior to the end of the exemption) that the oversight of the facilities is sufficient and licensure of individuals is not required; instead, they argue that licensure is only necessary for "private practice." The exemption has been expanded and extended several times since January 1, 2010. The 2016-2017 State Fiscal Year Budget (starting April 1, 2016) extended the exemption from licensure to July 1, 2018 allowing any individual to provide creative arts therapy in exempt programs. Additional information about the license, practice and conduct of the professions is available on our website: http://www.op.nysed.gov/prof/mhp/catlic.html. If you have any questions I would be happy to address those at this time.

Jim Cleghorn

Jim Cleghorn is the Executive Director for the Georgia Board of Nursing and has served in that role since August 2010. His staff also supports the licensure process for music therapists in Georgia. Prior to his work with the Board, Mr. Cleghorn served as the Business Analyst for the Office of Secretary of State of Georgia. In that role, he worked with the agency's Professional Licensing Boards Division to review licensure and discipline processes, identify inconsistencies and inefficiencies, and recommend improvements to maximize constituent services, agency productivity and protection of the public. He was appointed by the Board of Directors of the National Council of State Boards of Nursing to serve on the Commitment to Ongoing Regulatory Excellence (CORE) Committee in 2012. In 2013, the Georgia Nurses Association awarded him the Excellence in Partnership with Nursing Award. He currently serves as a member of the Board of Directors of the National Council of State Boards of Nursing.

Mr. Cleghorn, spoke to the Advisory Board on September 26, 2016 and reviewed Georgia's title protection regulation of music therapists since 2012. He discussed the total number of active licenses (114), the seven (7) complaints (six were for unlicensed practice and one for unethical conduct), which did not relate to patient issues, and the advisory role of the State board. Mr. Cleghorn referenced Georgia law on scope of practice and licensure regulations. See: Section 43-25-1 and Rule 590.11-1.01 of the Georgia Administrative Code.

Nicholas Goodwin

Nicholas Goodwin, Deputy Legislative Director and Professional Licensing Agency Policy Director in the Office of Governor Mike Pence, spoke to the Advisory Board on September 26, 2016. Mr. Goodwin served in the administration as the Director of Communication and Legislative Affairs for the Professional Licensing Agency. Prior to that, he worked for the Indiana House of Representatives for four years.

Mr. Goodwin reviewed Indiana's recent consideration of licensing music therapists, which did not result in licensure. He discussed legislation that was introduced in 2013 & supported by professional associations.

Legislation in Indiana: Mr. Goodwin spoke about Senate Enrolled Act 273, which was introduced during the first regular session of the 118th General Assembly, requiring state certification of music therapists. It defined music therapy as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship through an individualized music therapy treatment plan for the client that identifies the goals and objectives and potential strategies of the music therapy services appropriate for the client using music therapy intervention, which may include music improvisation, receptive music listening, song writing, lyric discussion, music imagery, music performance, learning through music, and movement to music." House Enrolled Act establishes Pilot Program for State Registration of Privately Certified Individuals under an organization supporting an occupation not a regulated under Indiana law can become "state registered." An organization must submit an application before July 1, 2017, which will be reviewed by Indiana's professional licensing agency. A public hearing will be held before the jobs creation committee, which would then make a recommendation to the executive director. Finally, the executive director would approve the supporting organization. If he or she rejects it, an affirmative vote of two-thirds of the committee's members, may reverse a determination made by the executive director.

Veto Message from the Governor: On May 18, 2013, Governor Michael Pence vetoed Senate Enrolled Act 273, which would have mandated state certification for music therapists. The veto message stated:

Indiana will created jobs through lower taxes and less regulation. Licensing can create barriers to the market and restrict competition. Over the last ten years, licensing has exploded in Indiana. In 2004, approximately 340,000 Hoosier held professional licenses. Currently more than 470,000 Hoosier hold some form of professional license. Some licensing opens new markets and streamlines existing practices and procedures. Senate Enrolled Act 273 does not meet that standard.

Carolyn Kahn

Carolyn Khan is the Executive Director of Bridges to New Day, nfp. The mission of the agency is to provide educational, prevention and intervention services that foster non-violence in the lives of children and adults. Ms. Khan has a master-degree in counseling from Governors State University. She is a licensed clinical professional counselor (LCPC) and a certified domestic violence professional (CDVP). Ms. Khan is past president of the Illinois Certified Domestic Violence Board and still serves on that board. She is past president and current board member of the Illinois Mental Health Counselors Board. Ms. Khan has presented numerous presentations on a variety of issues though out Illinois on such subjects as: effects of violence on children; domestic violence; interventions with children, adolescents and adults exposed to violence; interventions with adults and child; helping children/adults deal with loss and other clinical issues. Carolyn Kahn testified on September 26, 2016 and submitted the following statement on behalf of the Mental Health Counselors Association.

To Whom It May Concern,

While the Illinois Mental Health Counselor Association Professional Board understands the value that music can offer in a therapeutic setting, we have concerns regarding the legitimacy of a license/certification that does not require any clinical training before the said license/certification is obtained. In reading the legal stipulations regulating the acquisition of a Certificate in Music Therapy, we observed the requirements for musical training but saw no mention of any obligatory counselor training before the certificate is obtained. We believe that the term "Therapist" is viewed by the public as representative of someone with specific training, and therefore the term "Music Therapist" seems to indicate some level of clinical mental health knowledge. Additionally, we are concerned that without appropriate training, a person practicing music therapy could miss important clues that may indicate the presence of severe depression, suicidal thoughts, or other serious issues that require the attention of a professional licensed counselor or social worker. Dance Therapists and Art Therapists are required to have a master's degree in order to be licensed in the State of Illinois. We are concerned that Music Therapists will be viewed as though they have been trained to deal with mental health issues as do the Dance and Art Therapists.

In reviewing the options available to ensure that a Music Therapist receives an appropriate level of mental health training, we considered suggesting that several courses be added to the current certification requirements. However, it seems that in order to obtain an adequate amount of training, the necessary coursework and internship would too closely resemble current licenses. Therefore, we recommend that the following option be considered:

A person seeking a Certificate in Music therapy would also need to obtain a Master's Degree in Counseling or Social Work with the aim of getting licensed as a professional counselor or social worker. The candidate could then work towards a Certificate in Music Counseling either during their Master's coursework or after the degree is completed. This process would provide the candidate with the clinical training needed to practice counseling while maintaining the music therapy component.

Sincerely,

Illinois Mental Health Counselor Association Professional Board

Tom Parton

Tom Parton is a speech language pathologist at Normal Community West High School in Normal, IL. He also teaches an Autism Seminar class at Illinois State University. Mr. Parton's clinical interests are in language/literacy and autism spectrum disorders. He is currently the Past-President of the Illinois Speech-Language-Hearing Association. Mr. Parton is a Fellow of the Illinois Speech Language and Hearing Association. He has been active in various local and state associations and has presented at local, state, and national conferences. The following statement was presented to the Board on September 26, 2016 on behalf of the IL Speech-Language-Hearing Association.

The 2000 members of the Illinois Speech-Language-Hearing Association are concerned about the licensing of music therapists in the state of Illinois. ISHA believes that Music Therapists participate in unlicensed practice in the areas of speech--- language pathology, audiology, occupational therapy, physical therapy, and counseling among others. Music therapists should not be authorized by Illinois law to diagnose communication disorders, as currently stated in the Music Therapy Advisory Board Act, and should not be authorized to treat communication disorders.

The Certification Board for Music Therapy (CBMT) broadly defines music therapy and states music therapists can assess sensory, physical, cognitive, and communication abilities.

Music Therapists do not have a standardized assessment tool to identify individuals who may benefit from music therapy, to develop individualized treatment plans, or to determine when those plans are consistent with other medical, developmental, mental health, or educational services being provided to the client.

In defining "music therapy," the Music Therapy Advisory Board Act states that the term "music therapy" does NOT include the diagnosis or assessment of any physical, mental or communication disorder. While ISHA supports this restriction in the Act, our members believe it does not go far enough. ISHA believes a definition of "music therapy" in a licensure or certification statute should also prohibit music therapists from treating communication disorders.

Speech--Language Pathologists complete a comprehensive education program that meets rigorous standards of practice. SLP training includes the following:

- A master's or doctoral degree with 75 credit hours in a course of study addressing the knowledge and skills pertinent to the field of speech---language pathology using a validation process.
- A minimum of 400 clock hours of supervised clinical experience in the practice of speech-language pathology, under the supervision by an individual holding the American Speech-Language-Hearing Association Certificate of Clinical Competence (CCC).
- Pass a national examination administered and validated by the Educational Testing Service.
- Complete a supervised Clinical Fellowship to meet the requirements to earn the CCC, the recognized standard in the field.
- Complete a minimum of 30 hours of professional development every three years.

Music Therapists are not subject to the same rigorous qualifications standards and do not acquire the skills necessary to assess and treat communication disorders in their course of study and clinical training. In reviewing academic catalogs for music therapist programs in Illinois, students enrolled in a music therapist program are required to complete 26 semester hours. However, speech---language pathology programs

include approximately 52 semester hours in assessment, development, and communication. In addition, speech---language pathologists are also required to complete a master's level degree in order to be a licensed practitioner in Illinois. We believe SLPs are the only professionals trained and uniquely qualified to assess and plan treatment options for communication disorders.

Another major concern is that there are no Current Procedural Terminology (CPT) codes maintained by the American Medical Association that appropriately describe music therapist services. Therefore Music Therapists frequently use CPT codes associated with services provided with the scope of practice of other licensed providers, including speech---language pathologists and audiologists.

CPT codes that we use as speech---language pathologists to bill for services are only reimbursed one time, per day, per facility. If a patient received services from a music therapist and the CPT code was billed, a speech---language pathologist could not also bill for that code in the same day and also be reimbursed. The language used to describe CPT code 92507 states "Treatment of speech, language, voice, communication and/or auditory processing disorder."

For these reasons the Illinois Speech-Language-Hearing Association would oppose the licensing of music therapist in the state of Illinois if the scope and practice in the legislation includes assessing and treating communication disorders. I am happy to answer any questions the Board members may have.

On behalf of the Illinois Speech-Language-Hearing Association
Tom Parton, M.S. CCC---SLP/L
Past---President

Terrence Koller

Terrence Koller, is a licensed clinical psychologist and former executive director of the Illinois Psychological Association. Currently, Mr. Koller is the Legislative Liaison for the Illinois Psychological Association and Private psychotherapy practice.

The Illinois Psychological Association firmly believes in ensuring that persons with a mental or emotional disorder are provided with competent care. In that vein it has always advocated for the highest standards of training before an individual is licensed to independently diagnose and treat mental illness. For psychologists that is a doctorate degree, although we realize that there are master's degree trained individuals who competently provide many of these services. Licensed professionals are held to a higher standard of behavior than their non-licensed counterparts.

The Illinois Psychological Association has some concerns related to the licensing of Music Therapists. I will list them below:

1. We have always opposed the licensure of a technique where consumers might believe that they are receiving comprehensive mental health treatment when in reality they are benefitting from an adjunctive treatment. Our fear is that, by licensing certified music therapists, many of whom have Bachelor's degrees or Master's degrees, and limited educational exposure to psychopathology, psychological theory and interventions, consumers may believe that music therapy alone will be enough to treat their problems.
2. We believe that there is a mechanism for licensure that the Music Therapists can take that will allow them to become independent practitioners while also obtaining the training necessary to treat mental and emotional disorders. They can become Licensed Clinical Professional Counselors.

3. One issue that we monitor in all licenses is that the license does not prohibit appropriately trained Clinical Psychologists from doing work they have already been doing such as using music as part of their treatment regime.

Illinois Psychiatric Society

Firas Nakshabandi, M.D. is a member of the Illinois Psychiatric Society and a Child & Adolescent Psychiatry Fellow Department of Psychiatry & Behavioral Neuroscience University of Chicago Medicine. Meryl Camin Sosa, Esq. has been the Executive Director of the Illinois Psychiatric Society for over 10 years. The Illinois Psychiatric Society is a district branch of the American Psychiatric Association. The mission of the Illinois Psychiatric Society is to advocate for the highest quality care for patients with psychiatric disorders which include substance use disorders, to represent the profession of psychiatry, and to serve the professional needs of its membership.

Dr. Nakshabandi and Ms. Sosa attended the November 28, 2016, board meeting. Dr. Nakshabandi reviewed his experience working with music therapy and the use of music from his personal perspective as a psychiatrist. He discussed the makeup of a multidisciplinary team that includes music therapists, practice settings (e.g., ICU, outpatient treatment), and examples of the types of disorders and conditions his patients have who respond well to music (attention deficit disorder, confidence issues). He expressed an interest in exploring research that addresses the effects of different types and levels of music in creating certain outcomes. Dr. Nakshabandi expressed concern over whether regulation of music therapy would require other professions to undergo additional educational training in order to use music in their practices. He answered extensive Advisory Board inquiries on all aspects of his testimony, such as the use of music as a modality and music therapy as a profession. Ms. Sosa suggested that if the Advisory Board recommends licensure, that there be some exemption language for other professionals that use music, and encouraged careful drafting of legislation language.

Certification Board for Music Therapists & American Music Therapy Association

Dena Register is an Associate Professor and Director of the Music Therapy program at West Virginia University. As the Regulatory Affairs Advisor for the Certification Board for Music Therapists, she works with music therapists across the country on obtaining professional recognition. She helped developed and launch the first music therapy Master's degree program in Southeast Asia at Mahidol University College of Music in 2013. Judy Simpson, MT-BC is Director of Government Relations for the American Music Therapy Association. She represents the profession with legislators, agencies, and coalitions on the state and federal level. She is the co-author of "Music Therapy Reimbursement: Best Practices and Procedures".

Ms. Register and Ms. Simpson provided a comprehensive review of the standards required for the Music Therapist – Board Certified credential on the Board Meeting on November 28, 2016. They also provided a review of the regulation of music therapy across the United States. Ms. Register and Ms. Simpson discussed the music therapy curriculum, the difference between credentials and certification, two examples of public harm caused by music therapists that provided substandard care, a definition of "assessment" that is unique to the profession, and ethics standards. Ms. Register and Ms. Simpson discussed the different codes of ethics for music therapists. The American Music Therapy Association issues a Code of Ethics that applies to its association members. The Certification Board for Music Therapy issues a Code of Professional Practice that applies to all music therapists with the MT-BC credentials. Ms. Simpson submitted statements entitled, "Music Therapy Reimbursement" and "Music Therapy Reimbursement Information". See Exhibits 4a and 4b. They presented a power point on the following topics:

Music Therapy State Recognition

Education

- *Comprehensive and Unique*
- *Competency Based*
- *Undergraduate Prerequisites*
- *Health and Education Applications*
- *All Ages*
- *Different than other music professions*
- *Educators*
- *Practitioners*
- *Thanatologists*

Prescribed Curriculum

- *Professional Studies-50%*
- *Music Therapy 30%*
- *Clinical Foundations 20%*
    - *i.e., Statistics, Anatomy & Physiology,*
    - *Healthcare Ethics, Abnormal Psychology,*
    - *Human Diversity, Special Education,*
    - *Human Development, Biology*
- *Music 40%*
- *General Education 10%*

Clinical Training

- *Minimum 1200 supervised hours*
    - *At least 900 hours in focused internship*
- *Multiple Settings throughout program*
- *Clinical Observation and Client Contact for minimum of six semesters*

CBMT

- *Member of Institute for Credentialing Excellence (ICE)*
    - *Promotes Best Practice for Credentialing Community*
- *Accredited by National Commission for Certifying Agencies (NCCA)*
- *Created in cooperation with PSI/AMP*
    - *Applied Measurement Professionals*
    - *Psychometrically sound and legally defensible exam*

MT-BC Credential

- *Practice Analysis conducted every 5 years*
- *Exam revised to reflect current clinical practice*
- *Resulting in Board Certification Domains*
- *Requires 100 hours of continuing education every five years*

Potential for Harm

- *Recognizing and responding to situations where there are clear and present dangers to a client and/or others.*
- *Recognizing the potential harm of music experiences and using them with care.*

- *Recognizing the potential harm of verbal and physical interventions during music experiences and using them with care.*
- *Observing infection control protocols (e.g., universal precautions, disinfecting instruments).*
- *Recognizing the client populations and health conditions for which music experiences are contraindicated.*
- *Complying with safety protocols with regard to transport and physical support of clients.*

Recognition Options

- *Title Protection*
    - *Connecticut*
- *State Certification*
    - *Utah*
- *Registry*
    - *Rhode Island, Wisconsin*
- *License*
    - *Georgia, Nevada, North Dakota, Oklahoma, Oregon*

Code of Ethics

- *AMTA Code of Ethics*
- *Association Members*
- *CBMT Code of Professional Practice*
    - *All MT-BCs*
- *Oregon License Regulations*
    - *Adopted AMTA Code of Ethics*

Illinois Occupational Therapy

Lisa Mahaffey is the sitting President of the Illinois Occupational Therapy Association. She has been an occupational therapist for 30 years working primarily in mental health. She is currently working as an associate professor in the Occupational Therapy program at Midwestern University in Downers Grove and completing work toward her PhD in Disability Studies at the University of Illinois at Chicago. Robin Jones, MPA, COTA/L, ROH has 35 years of occupational therapy practice and is currently serving as the Advocacy Director for the Illinois Occupational Therapy Association. She currently is on faculty in the Department on Disability and Human Development at the University of IL at Chicago and operates the Great Lakes ADA Center, one of 10 federally funded technical assistance centers on the Americans with Disabilities Act of 1990. Ms. Jones has previously served as a member of the Illinois Occupational Therapy Licensure Committee."

Ms. Mahaffey and Ms. Jones spoke to the Advisory Board on November 28, 2016, regarding the Illinois Occupational Therapy Association's position on music therapy licensure. While the Association is not in opposition to the profession seeking regulation, it does not support a licensure practice act at this time without sufficient evidence that there is evidence supporting the potential harm to the public or if being done strictly for the purposes of reimbursement. Ms. Mahaffey and Ms. Jones raised concerns over previous practice act legislation that appeared to propose that the use of music in the practice of other professions would constitute a violation of the act. The Association takes a neutral position to the language of the current Music Therapy Advisory Board Act. Ms. Mahaffey and Ms. Jones suggested that the Advisory Board consider

factors such as the need for regulation of the music therapy profession, the need for a license vs. title protection, and whether the lack of public harm warrants regulation of the profession. They also suggested that if the Advisory Board recommends a practice act, that it include language creating an exemption from licensure for other professions that use music in their practices.

U-Jung Choe

U-Jung Choe attended and testified at the November 28, 2016, music therapy board meeting. Ms. Choe testified on the Illinois Competitiveness Council, which was established by Executive Order 16-13[138] signed by Governor Rauner. The Executive Order requires over forty State agencies, including IDFPR, to review their administrative rules as part of the Cutting the Red Tape Initiative. Through this review, these agencies are to ensure that their rules meet certain guidelines, such as that the rules do not impose unduly burdensome requirements on business or have a negative effect on job growth in Illinois. The Executive Order requires each of these agencies to complete this review by May 1, 2017, and submit quarterly report to the Council until the deadline. She answered Board member inquiries regarding the Executive Order's relation to this Advisory Board, including other State agencies included in this review process that deal music therapy topics of interest to the Advisory Board such as reimbursement options through Medicaid (Illinois Department of Healthcare and Family Services) and insurance (Illinois Department of Insurance).

Holly Schaefer

Holly Schaefer is the founder & Executive Director of Safe Haven School & advocate for creative arts therapists. She spoke to the Board on February 06, 2017 and gave the following statement:

Hello everyone. I'm Holly Schaefer, the founder and Executive Director of Safe Haven School. I'm honored to be addressing you about the value of music therapy. Our school is a private therapeutic day school created solely for students with severe emotional challenges that interfere with their ability to succeed in their public school. Ours is a very unique program because we don't take students who are verbally or physically aggressive, otherwise known as externalizers because they externalize their emotions. Our students are internalizers. They turn their emotions in on themselves resulting in severe anxiety and/or depression and/or ADHD and/or autism spectrum disorder. Left unaddressed, these students engage in self-injurious behaviors, suicidal ideation or plans, school refusal, or the inability to physically move. Often they are unable to identify the feelings that lead to these behaviors.

The vast majority of people who internalize their emotions are highly artistic either visually, musically, or theatrically. That is why our school provides art, music, and drama therapy. Art therapy is fairly typical at therapeutic day schools. But not so with music therapy. And I believe the reason for this is that music therapists lack the legitimacy that certification and licensing at the state level would give them. When we applied for initial approval with the Illinois State Board of Education, they required not only the music therapists' certificate but documentation from the organization for whom they work that they are qualified to deliver services in a school environment.

Music has always been important to adolescents and pre-adolescents. This is a time in their development where they begin to individuate, see themselves as individuals, forming the identity that will define who they are as adults. Music is a significant source of finding that identity. Lyrics may express the anger and frustration they feel at having to follow rules they find inane, the heartache from a broken

[138] Executive Order 16-13. https://www.illinois.gov/Government/ExecOrders/Pages/2016_13.aspx.

relationship, the pain and hopelessness they feel from deep within because they don't feel important or that they matter, or are caught in the jaws of untreated depression or anxiety. Lyrics may also be uplifting, inspirational, joyous, or energizing.

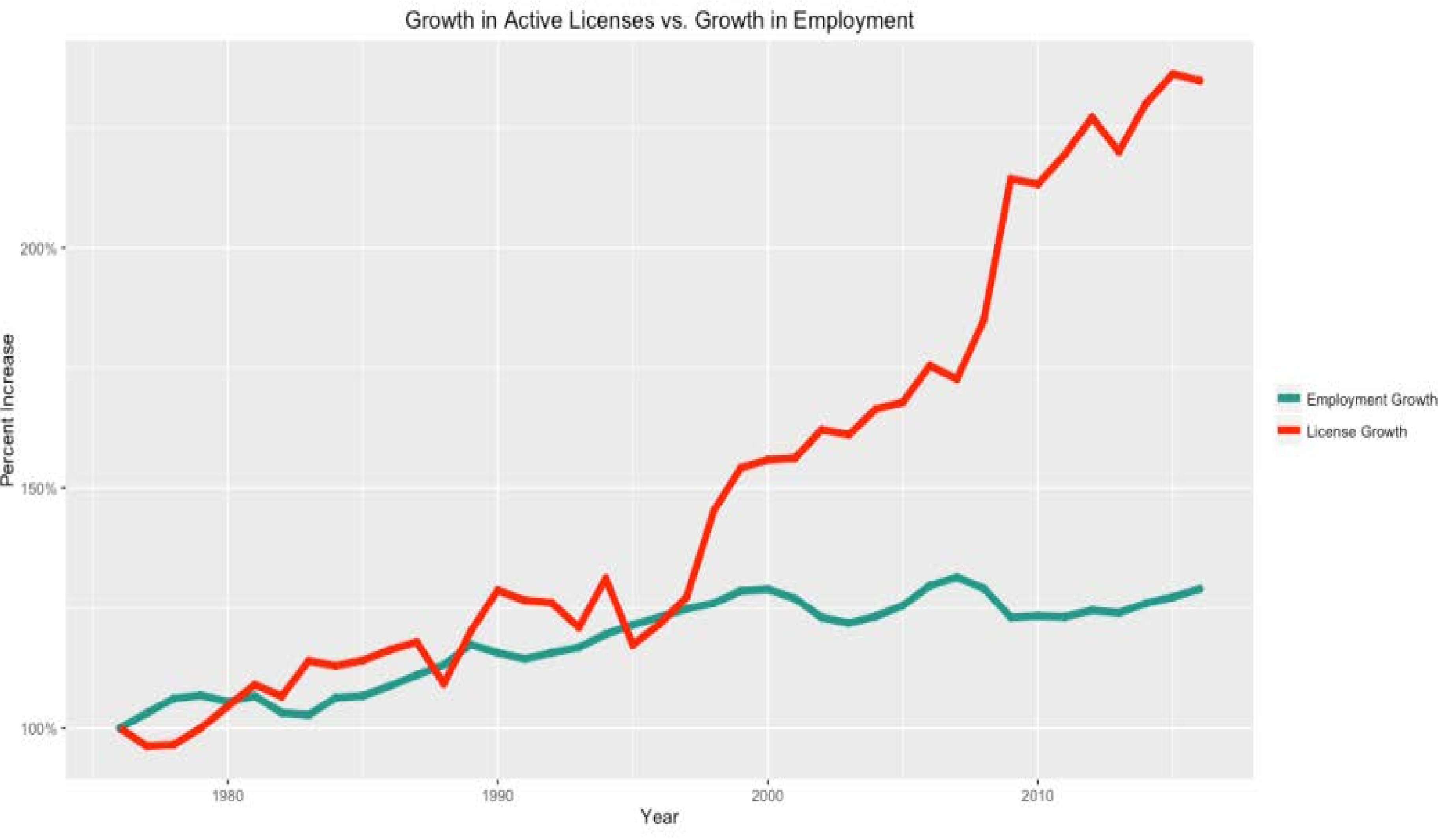
Everywhere we go we see young and old with earbuds in their ears. "Music is the art of the soul" the ancient saying goes. Clearly many thousands of individuals agree. But there are also those who do not connect with music who cannot fathom its importance. And these are the individuals who need to understanding. Connecting with troubled youth through music is so natural. And I believe that schools everywhere, private and public, would include this modality in the therapy services they offer if it was recognized by a governing board.

Mischa Fisher

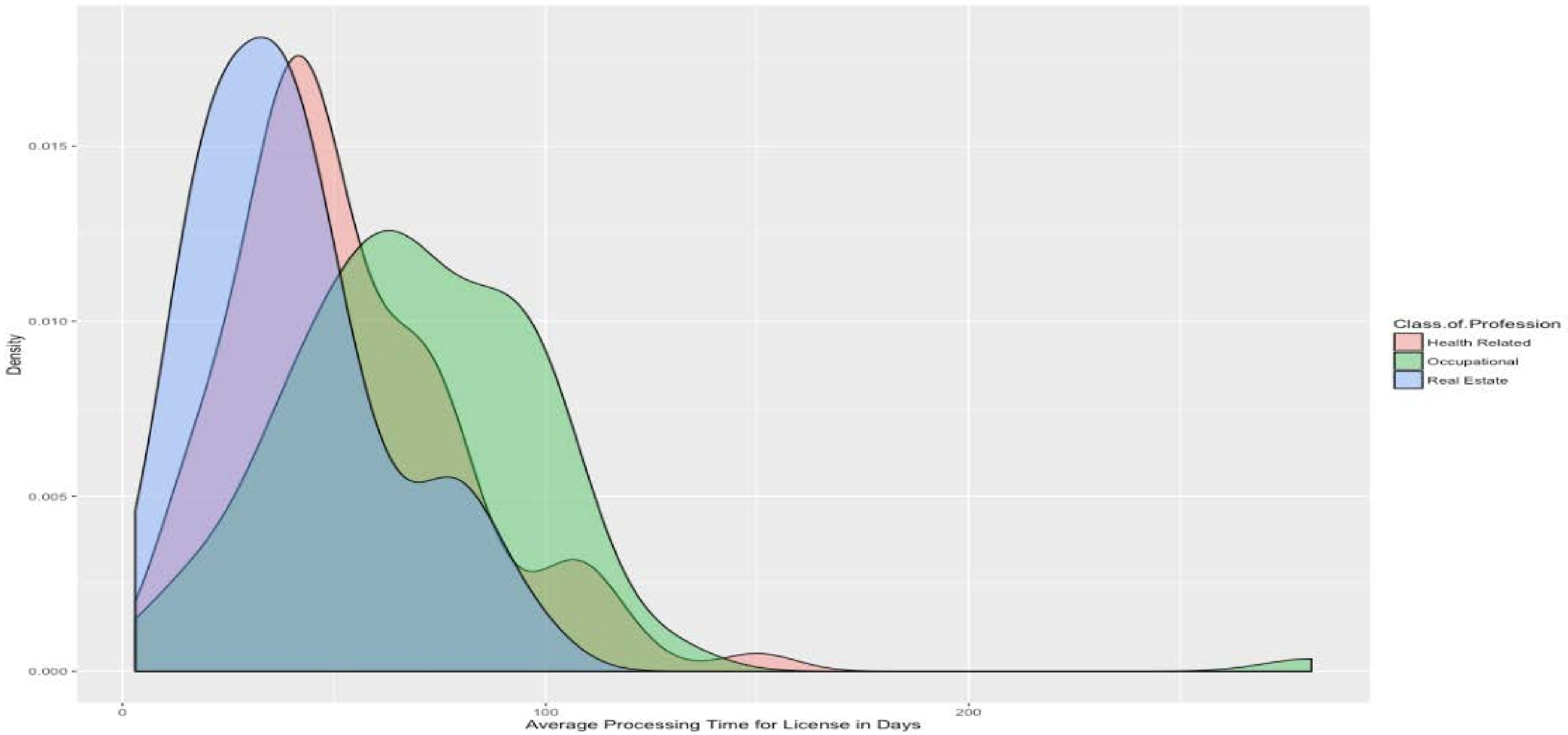
Mischa Fisher, the Policy Advisor for Economic Development to the Governor of the State of Illinois, spoke before the Advisory Board on February 06, 2017. Mr. Fisher discussed the Governor's approach to occupational licensing in Illinois.

Because a license is a barrier to entry of the profession, Mr. Fisher encouraged the Advisory Board to conduct a cost benefit analysis in making its recommendations regarding licensure. Examples of benefits include ensuring public safety and quality assurance of services provided. Costs include initial licensing costs, compliance costs, continuing education, and opportunity costs (e.g., lost wages while waiting to receive a license).

In Illinois, one of three individuals needs a license for employment, which is above the national average of one in four individuals. There are approximately 2.1 million licensees in the State. Mr. Fisher provided the following chart that illustrates that the growth of licensure far exceeds the growth of employment in Illinois:



Mr. Fisher also provided a chart that illustrates the average processing times by IDFPR for professional licenses in three categories:



Finally, Mr. Fisher reviewed several alternatives to licensure, depending on the profession, including registration and certification. He also noted that the fact that a profession is licensed does not necessarily prevent people from engaging in practices for which a license is needed.

Susan Frick

Susan Frick, MSW, has worked at the Rush Alzheimer's Disease Center for 12 years. She helps coordinate a variety of training programs for staff of residential care facilities who work with people who have Alzheimer's disease. She co-facilitates Without Warning, a monthly support group for individuals and families who live with early onset Alzheimer's. She also works with patients and families in the Rush Memory Clinic.

Thank you for this opportunity. I'm a licensed social worker and have worked with people who have Alzheimer's disease for almost 30 years. For 8 years, I worked in long term care, as a Special Care Unit Director for a 74 bed Alzheimer's unit. Then I worked in a corporate level consulting with numerous skilled care units as they developed their Alzheimer's programs. For 20 years, I have worked at the Rush Alzheimer's Disease Center in Chicago. As one of 29 federally funded Alzheimer's Centers our mission is to provide research studies for people with Alzheimer's, people at risk, healthy seniors and caregivers. Our mission also includes providing education for the seniors, caregivers, the public and health care professionals. The final part of our mission is to provide care for people with Alzheimer's disease.

Through our efforts to provide care, for the past 13 years, I have coordinated Without Warning, a large support program for families living with younger onset Alzheimer's disease. People with younger onset Alzheimer's disease are 65 years old or younger when diagnosed. This program is for both the person with Alzheimer's disease and their family members, which includes spouses, parents, children, friends and professional caregivers. This award-winning program is the largest of its kind in the country. When Without Warning started, we had an average of 15 people at a meeting. We now average 70 people. At times, we can have around 25 people with Alzheimer's. Currently we break into 2 groups for people with Alzheimer's disease and 5 groups for family members.

A major reason for the success of the Without Warning program is our board-certified music therapist, who has been with us since the program started. Because of her music therapy education and experience working with people living with Alzheimer's disease, she skillfully uses music to help people maintain their identity and positive well-being. She at times can have over 10 people in her group who are all at a different stages of the disease. Her skills have been invaluable at connecting with people. In some cases, the people in her group have very limited abilities to interact with others. For example, if a person in the Without Warning group begins to cry due to feeling confused, lost, and anxious, the music therapist uses this client's preferred music, altering the music in the moment as necessary, to help soothe and transform her mood to where the client is then singing and dancing. Each month we meet, I witness the clients in our music therapy group leave the session feeling in a state of well-being and connected to others.

Music therapists skillfully address multiple domains, such as social, emotional, cognitive and spiritual and client issues in one session, manipulating the various aspects of music to accomplish these outcomes. Untrained musicians do not have the knowledge or experience in applying therapy techniques within the music experience. Especially in elder care, there is a dramatic difference between music therapy and music for simple enjoyment. People who are not specifically trained as a music therapist should not be allowed to use that title.

Over my years working with people who have Alzheimer's disease, I have witnessed times when people have tried to work in roles for which they are not qualified or trained. From such encounters, I've seen people with Alzheimer's left feeling empty and unsupported. When such encounters continue to happen you often see an increase in anxiety and behaviors. In residential settings this can lead to in an increase use of psychotropic medications. Through my role at the Rush Alzheimer's Disease Center, I provide dementia specific training for staff who work in continuing care communities. A good part of my teaching looks at how staff's interactions have a role in keeping people with Alzheimer's in a space of wellbeing. Because of their

Alzheimer's disease people can often feel lonely, depressed and confused. They need people working with them who understand how their interactions can lift them up and help them feel connected to others. A qualified music therapist provides that skill.

Many skilled care facilities are not always able to afford a music therapist. In the future a pathway for reimbursement of music therapy should be considered. Thank you for this opportunity to share my experiences with people with Alzheimer's disease and the invaluable role of a qualified music therapist.

Martha Reggi

Martha Reggi, Chief of Business Prosecutions at IDFPR, spoke to the Advisory Board on February 6, 2017. Ms. Reggi previously served as an Associate General Counsel at IDFPR. She provided an overview of IDFPR and the disciplinary process, which would apply to music therapists if they regulated by IDFPR. Ms. Reggi presented a power point on the following topics:

Complaints: Ms. Reggi explained that the disciplinary process begins when a complaint is filed in the Complaint Intake Unit. The person who filed the complaint is referred to as the "complainant" and the person against whom the complaint is filed is referred to as the "respondent." The complaint is then referred to the appropriate Investigations Unit, where it is then assigned to an investigator.

Investigations: Once received by the investigator, he or she conducts interviews of all parties as necessary, gathers relevant documents and information (e.g., medical records, billing records, correspondence between the complainant and the respondent), and visits any facilities where the allegations occurred if needed. Once the investigator completes the investigation, the case is either closed or referred to prosecutions. Complaints can be closed for a number of reasons, including an expiration of the statute of limitations, that there was insufficient evidence to prove a violation, that the allegations even if true are not a violation, or that the allegations are unfound. If the complaint is referred to prosecutions, there are two tracks (1) formal, and (2) informal.

Prosecutions – Formal Track: Under the formal track, a prosecutor in the appropriate Prosecutions Unit files a formal complaint against the respondent stating the allegations with citations to the statutory and administrative rule provisions allegedly violated. If the respondent does not appear before IDFPR to contest the allegations, an Administrative Law Judge ("ALJ") enters a default judgment against the respondent and the case is forwarded to the applicable board or committee for review. If the respondent appears, litigation proceeds (discovery, conferences, and status hearing) and ultimately leads to a formal hearing, which is a trial. At the conclusion of the trial, the ALJ submits a report of the case and recommended discipline, along with the record, to the applicable board or committee for review. The board or committee, which is advisory to the IDFPR, deliberates the case and make a recommendation to the Director, which may include discipline. Finally, the Director, with authority granted by the Secretary, adopts or rejects the Board's recommendations by issuing a final administrative order.

Prosecutions – Informal Track: In the informal track, an informal conference is held with the prosecutor, respondent, respondent's attorney (if represented), and one or two board members. If all parties reach an agreement, it is executed in a settlement agreement called a consent order, which must be approved by the Director. If an agreement is not reached, the case proceeds through the formal track.

Discipline and Administrative Review: Ms. Reggi also provided information on the appeals process, called "Administrative Review," and examples of the types of discipline that IDFPR can impose:

- Non-Public
    - Administrative Warning Letter

    - Non-Public Consent Order
- Public
    - Reprimand
    - Refuse to Renew a license
    - Probation
    - Suspension
    - Revocation
    - Fines up to $10,000 per violation (typically)

Cindy Ropp

Cindy Ropp, EdD, MT-BC, serves as Associate Professor for the Illinois State University, College of Fine Arts in Normal, Illinois. Dr. Ropp teaches undergraduate and graduate music therapy coursework. She is also responsible for all administrative aspects of the music therapy program. Dr. Ropp is a current advisor for all graduate students in music therapy.

On February 06, 2017, Dr. Ropp testified at the music therapy advisory board meeting about Illinois State University standards for undergraduate degree requirements. She stated that while curriculum varies by school, the three main areas in which a student must demonstrate competency are: musical foundations, clinical foundations, and music therapy foundations and principles. In addition to completing academic coursework, the bachelor's degree requires a 6-month supervised internship off campus. Master's degrees in Music Therapy focus on advanced clinical practice and research. In Illinois, the only program to offer the graduate degree is Illinois State University. Dr. Ropp discussed the certification process and reviewed the American Music Therapy Association standards for clinical training and the certification process. Ms. Ropp supports music therapy licensure in the state of Illinois if criteria for licensure lines up with the American Music Therapy Association, allows us to work within our scope of practice, and is cost-effective.

Bryan Martin

Bryan Martin is the Chief Financial Officer for IDFPR. He has been with IDFPR since September 2013. Mr. Martin obtained a master's degree in Business Administration in 2010 at Eastern Illinois University. On February 27, 2017, Mr. Martin testified on the cost analysis he produced for the IDFPR for regulating the music therapy profession. The following cost analysis was provided to the music therapy advisory board members:

IDFPR Cost Estimator
Music Therapy - DRAFT 2-3-17

Personnel Costs						54.013%	7.65%	$ 24,000		
# of Pos	Vacant Job Title or Employee Name	Does position travel most of the time?	Percentage of Employee Needed	Monthly Salary	100% Annual Salary	100% Annual Retirement	100% Annual Social Security	100% Annual Group Insurance	100% Annual Overhead Costs	Total Annual Cost based on %
1	Office Coordinator	No	100%	$ 3,877	$ 46,524	$ 25,129	$ 3,559	$ 24,000	$ 5,600	$ 104,812
2	Office Coordinator	No	100%	$ 3,877	$ 46,524	$ 25,129	$ 3,559	$ 24,000	$ 5,600	$ 104,812
3	Investigator I (Licensing)	Yes	100%	$ 4,639	$ 55,668	$ 30,068	$ 4,259	$ 24,000	$ 17,600	$ 131,595
4	Prosecutions (Tech Advisor Adv Prog Spec)	No	100%	$ 8,570	$ 102,840	$ 55,547	$ 7,867	$ 24,000	$ 5,600	$ 195,854
5	PSA - CC	No	5%	$ 9,472	$ 113,664	$ 61,393	$ 8,695	$ 24,000	$ 5,600	$ 10,668
6	SPSA - JW	No	5%	$ 8,312	$ 99,744	$ 53,875	$ 7,630	$ 24,000	$ 5,600	$ 9,542
7	PSA - RD	No	5%	$ 3,750	$ 45,000	$ 24,306	$ 3,443	$ 24,000	$ 5,600	$ 5,117
8	Technical Advisor II- AA	No	5%	$ 5,180	$ 62,160	$ 33,574	$ 4,755	$ 24,000	$ 5,600	$ 6,504
9	SPSA - Dir	No	5%	$ 10,341	$ 124,092	$ 67,026	$ 9,493	$ 24,000	$ 5,600	$ 11,511
10	SPSA - SG	No	5%	$ 9,708	$ 116,496	$ 62,923	$ 8,912	$ 24,000	$ 5,600	$ 10,897
11	SPSA - JR	No	5%	$ 7,725	$ 92,700	$ 50,070	$ 7,092	$ 24,000	$ 5,600	$ 8,973
12	SPSA - HA	No	5%	$ 6,348	$ 76,176	$ 41,145	$ 5,827	$ 24,000	$ 5,600	$ 7,637
13		No	5%		$ -	$ -	$ -	$ -	$ -	$ -
14		No	5%		$ -	$ -	$ -	$ -	$ -	$ -
15		No	5%		$ -	$ -	$ -	$ -	$ -	$ -
16		No	5%		$ -	$ -	$ -	$ -	$ -	$ -
17		No	5%		$ -	$ -	$ -	$ -	$ -	$ -
18		No	5%		$ -	$ -	$ -	$ -	$ -	$ -
19		No	5%		$ -	$ -	$ -	$ -	$ -	$ -
20		No	5%		$ -	$ -	$ -	$ -	$ -	$ -
Total				$ 81,799	$ 981,588	$ 530,185	$ 75,091	$ 288,000	$ 79,200	$ 607,923

Annual Employee Overhead Cost Estimate	Traveling Employee	Office-Based Employee
Contractual	$ 1,000.00	$ 1,000.00
Travel	$ 12,000.00	$ -
Commodities	$ 500.00	$ 500.00
Printing	$ 500.00	$ 500.00
Equipment	$ 1,000.00	$ 1,000.00
EDP	$ 2,000.00	$ 2,000.00
Telecom	$ 600.00	$ 600.00
Total	$ 17,600.00	$ 5,600.00

Program Overhead Costs Estimate	
I.T. Startup Costs	$ - *
Other Startup Costs	$ - *
Other Annual Costs	

Est. Fine Revenue =	$ -

**To be amortized over 5 years using straight-line amortization*

$ 607,922.56	Total Annual Costs
243	Population
$ 2,501.74	Estimated Annual Fee

Illinois Music Therapy Advisory Board Recommendation Overview

Following nine (9) Board meetings, 38 witnesses' testimonies, and approximately $20,137.93 in Illinois Department of Financial and Professional Regulation ("Department") resources and staff time in support of the Board, the following Illinois Music Therapy Advisory Board members make their recommendation:

- ✓ Jessica Baer, Chairperson
- ✓ Andrea Crimmins, Board Member
- ✓ Louise Dimiceli-Mitran, Board Member
- ✓ Kyle Fleming, Board Member
- ✓ Candyce L. Gray, Board Member
- ✓ Russell E. Hilliard, Board Member
- ✓ Clifton Saper, Board Member

Board members Crimmins, Dimiceli-Mitran, Fleming, and Hilliard recommend the following:

1) **Establish licensure by way of a professional practice statute for music therapists to protect the public and vulnerable client populations from harm;**

2) **Establish licensure of music therapists to ensure a professional standard of excellence in the implementation and practice of music therapy; and**

3) **Substantially lower fees from the cost proposed in the fiscal analysis for licensure as the proposed costs are prohibitive.**

In addition, Board members Dimiceli-Mitran and Fleming recommend that a masters in music therapy be a licensure requirement in order to ensure professionals acquire the knowledge, skills, and abilities for competence in the current practice of music therapy due to advanced training in specialized fields.

Board members Baer, Gray, and Saper recognize the therapeutic benefit of music to address the cognitive, emotional, physical, social, or functional needs of clients, and the value of music to comfort and aid those who are sick, injured, or dying. However, these Board members do not support state licensure of music therapists for the following reasons:

1) **There is no empirical evidence of provable public harm or consumer protection inefficacy related to the practice of music therapy;**

2) **The cost of regulation is unduly burdensome to music therapists, other licensed professionals, and the people of the State of Illinois, with less restrictive means available to ensure skilled practice; and**

3) **Regulation of music therapy by the Department is not a pathway to insurance reimbursement.**

Illinois Music Therapy Advisory Board Recommendation

A. Board Members Crimmins, Dimiceli-Mitran, Fleming, & Hilliard's Recommendation

1) Protection of the Public from Harm.

It is our belief that the most effective way to minimize public harm, specifically to vulnerable populations such as persons with Alzheimer's disease, autism spectrum disorder, young children with special needs, and military populations is to require state licensure via practice act. In the absence of regulation, we believe specific populations are not protected from harm due to misuse of terms and techniques of music therapy. Moreover, potential for harm exists if a nonqualified individual provides inappropriate applications of music that could cause emotional and or physical harm.

There are multiple entities that provide a risk of potential harm for the Illinois population. However, there is a lack of formally documented complaints on non-music therapy professionals causing harm when applied inappropriately. Without regulation, there is no official venue to report complaints. The main purpose of the AMTA and CBMT is to serve and monitor the work of credentialed music therapists. In order to increase understanding, the CBMT and AMTA began recording reports from members when it was observed that non-music therapists caused harm using music. Additionally, clinical research has indicated potential for harm if music is applied inappropriately. Music therapists are educated and trained to understand these contraindications. In frequent cases, health care administrators and other professionals lack understanding about the education, training, scope of practice, and credentialing process that defines the difference between a music therapist and a non-music therapist. Even hospital administrators have confusion as to the regulation of music therapists, indicating that education on the scope of practice of music therapy is required. This is further evidence that regulation would help protect the public from receiving services from untrained, non-credentialed practitioners.

The current lack of music therapy licensure in the state leaves Illinois residents at risk for negative social, emotional, and physical consequences due to the inability of an untrained individual having no experience or understanding of assessment, treatment planning, and evidence-based music therapy protocols. No known, official complaints have been made to the state of Illinois regarding music therapy, but just because it is not documented does not mean there is no public harm occurring or risk for harm in the future. For example, in neonatal intensive care units, evidence-based music therapy protocols are established to ensure safety by considering decibel levels, type of music, and duration or frequency of music intervention. For instance, using drum circles present a scenario of potential harm for newborns' ears and any drumming levels must be sufficiently controlled and contained to prevent any lasting harm. A non-music therapist using inappropriate music intervention would cause physical harm to the underdeveloped sensory systems of premature fragile infants. Licensure would ensure that only qualified, trained individuals who have met the education, clinical training and examination requirements will be able to practice music therapy.

Board member Fleming noted that shortly after the shooting incident at Sandy Hook Elementary School in Connecticut, the community had issues with practitioners claiming to be music therapists and engaging in unlicensed practice. Additionally, music therapists intervening too soon after the shooting incident potentially caused psychological harm to community members, causing a distrust in various counseling professionals in the community.

2) Establish a Minimal Professional Standard.

State regulation would ensure a professional standard of excellence in the implementation and practice

of music therapy. After careful consideration of the testimony presented and discussion among the advisory board members, it is our recommendation that, absent the establishment of state mandated minimum standards, the Illinois General Assembly, enact minimum qualification, education, and ethical standards for music therapists.

We believe state licensure will lead to competent and ethical music therapy practice. Licensure would require practitioners to meet certain qualifications and establish a system for Illinois residents to verify education and training, since some music therapists do not follow CBMT or AMTA requirements. As a result, the people of Illinois have difficulty distinguishing between professionals that use or may use music as a treatment modality or as an adjunct to treatment; including but not limited to, therapeutic harp practitioners, mental health counselors, music thanatologists, etc. Music therapists frequently address similar treatment goals as other allied health professionals. What distinguishes music therapy from other therapies, however, is the use of music as the therapeutic tool. In the music therapy profession even highly trained experts can make mistakes, showing the need for licensure and professional standards to be established to heighten such standards. Given that other music related professions do not have such a high standard of care; it is essential that an established skill set be outlined for this profession.

Board member Fleming also recommends that means for insurance reimbursement be explored, although he understands that the Department of Financial and Professional Regulation is not the avenue for such a request.

Board member Dimiceli-Mitran also recommends that an analysis of music therapists working with the developmentally and physically disabled geriatric populations be examined to assist with licensure. Such music therapists serve a different function than psychological based music therapists and this would require a closer look for licensure purposes.

3) Lower Costs in Fiscal Proposal.

It is also our recommendation that the Illinois General Assembly lower the Department's 2017 fiscal cost proposal outlining the direct and allocable indirect costs of licensing and regulating music therapy. Given the average annual earnings of music therapists, licensure would be more accessible if costs were reduced. The current proposed cost analysis may discourage skilled music therapists from entering the profession.

Board member Fleming also recommends that similar professions such as social workers and licensed professional counselors be licensed and added to the population pool to lower the costs for individual music therapists. Drama therapists, art therapists, and recreation therapists also have joint interests with music therapists and could assist in lowering costs overall by adding more to the license population pool. Board member Hilliard noted that the State of New York attempted similar bundling of licenses for regulation of creative therapy practice; however, this presented various problems leading to New York separating the various professions.

Board member Dimiceli-Mitran recommends that a volunteer music therapist investigator, or more, be used to save costs as done in other states.

B. <u>Board Members Dimiceli-Mitran & Fleming's Masters Recommendation.</u>

Board members Dimiceli-Mitran and Fleming recommended state licensure with the stipulation that a master's in music therapy degree is obtained, by first completing the required undergraduate music therapy

coursework. By way of background, the music therapy degree is a professional music degree which requires an audition for acceptance into the school of music. This specialized degree is offered at over 70 colleges and universities whose degree programs are approved by the American Music Therapy Association.

The Board heard many hours of testimony from various guests, as set forth in this Report. A common theme among these guests was the importance of a music therapy graduate degree because the curriculum imparts professional competencies in three main areas:

- music;
- music therapy; and
- related coursework in science and psychology.

Education and clinical training of music therapists is unique because it involves not only foundations in music and music therapy, but also includes coursework and practical applications in biology, anatomy, psychology, social and behavioral sciences.

It is our belief that music therapy is a master's level practice. Music therapists who obtain a master's degree in music therapy expand their skills by allowing the music therapist to gain a comprehensive understanding of the clinical process of the client and the therapist's impact on that process. We feel that the understanding of theories and practices in assessment, treatment, and evaluation allows the advanced music therapist to take a central and independent role in client treatment plans.

C. Board Members Crimmins & Hilliard Dissent to Masters Recommendation.

Board member Crimmins strongly opposes the Master's Recommendation for licensure because the profession of music therapy is a bachelor's level entry field, as defined by the education standards set forth by the nationally recognized AMTA, and the credentialing standards of the CBMT. It would be detrimental and illogical to dictate something different for the State of Illinois only. Additionally, it is inaccurate that music skill, music therapy theory/principles, and science/psychology courses are taught at the graduate level. These courses are also taught at the undergraduate level and all areas of professional competence, scope of practice, and the certification domain apply to bachelor's level music therapy.

Board member Hilliard also opposed the Masters Recommendation for licensure.

D. Board Members Baer, Gray, and Saper's Recommendation.

1) Lack of Public Harm Evidence.

Illinois law sets policies and objective standards for legislative review of proposed licensing statutes. Illinois law calls for a structured cost-benefit policy analysis of proposals for new professional regulation. The law places upon the proponents of new regulation the burden to demonstrate the genuine necessity of that regulation to the protection of the public. 20 ILCS 2105/2105-10.

If regulation of a profession is found necessary by the legislature based upon the criteria outlined in the Civil Administrative Code of Illinois, 20 ILCS 2105/2105-10, and is "a matter of public interest and concern that standards of competency and stringent penalties for those who violate the public trust be established," then "the General Assembly shall appropriate necessary funds," consistent with the public interest.

Based upon information contained in this Report, interviews with interested parties and regulators of other counseling professions, written comments submitted by the Board, and research conducted by the Department, there is no clear recognizable threat to public health and safety from the unregulated practice of music therapy. The Department's finding is consistent with both the Colorado and Washington State sunrise reviews, which concluded that there is no demonstrated public interest or need to warrant the creation of a new regulatory program or to protect the title, "music therapist" or "board-certified music therapist."

Testimony and written comments were provided by supporters of state licensure that regulation was needed to protect the public from the misuse of terms and techniques of music therapy due to an increasing number of unqualified individuals in Illinois claiming to be music therapists. However, when asked about specific instances of public harm, witnesses could only provide unverified, anecdotal evidence and no specific situations in the state of Illinois. Based upon independent legal and public health related research conducted by the Department, the following was reported:

- As of May 2016, the Illinois Attorney General's Office confirmed there were no complaints against any music therapists.
- Instances of harm are extremely rare, with only five (5) instances of harm reported by the national credentialing body over a 16-year period, even though there were over 6,000 music therapists certified by the board at that time.
- Other states that have instituted a full licensure program have reported extremely low numbers of disciplines and/or complaints for substantive practice issues.

The public can be effectively protected by other means in a more cost-beneficial manner. Fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Illinoisans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer. In Illinois, individuals may bring actions under the Consumer Fraud Act (CFA). Under the CFA, it is a deceptive trade practice to claim to possess a degree or a title associated with a particular degree unless the person has been awarded the degree. Moreover, consumers can file a complaint with the Illinois Attorney General's Office, which protects consumers from unfair business practices.

The majority of music therapy complaints reported are for unlicensed practice, which is not directly correlated to public harm. A degree in music therapy and private board certification are credentials that offer consumers assurance of professional competency. Private certification is available to music therapists through the Certification Board for Music Therapy (CBMT). Only those individuals who hold this credential may represent themselves as board-certified music therapists, or place the initials MT-BC after their names. CBMT actively pursues individuals who falsely represent themselves as board-certified music therapists, and consumers can easily verify whether an individual is a board-certified music therapist. The CBMT also has the authority to deny, revoke, suspend and require additional education of board-certified music therapists who are in violation of the certification standards. This includes gross or repeated negligence or malpractice in professional practice including a sexual relationship with a client, and sexual, physical, social or financial exploitation.

2) Undue Burden of Cost and Less Restrictive Means to Ensure Skilled Practice.

State licensure would place a heavy financial burden on the small pool of potential music therapy practitioners to cover the state's costs of regulating the profession. Appropriations for the direct and allocable indirect costs of licensing and regulating each regulated profession, trade, occupation, or industry

are intended to be payable from the fees and fines that are assessed and collected from that profession, trade, occupation, or industry, to the extent that those fees and fines are sufficient. (20 ILCS 2105/2105-300(a)). According to the Certified Board for Music Therapists, there were a total of 262 board certified music therapists in Illinois in 2017. Music Therapy state regulation would create a financial barrier for entry into the music therapy profession due to the small number of potential credential holders.

The Department's 2017 fiscal cost analysis for estimated licensing fees is $2,501.74, per music therapist. Costs include processing credential applications, confirming education, examination scores, and criminal background checks. Costs also include processing renewals, responding to inquiries, investigating complaints, taking enforcement action if needed, recordkeeping, and rule making.

Licensure is not needed to ensure the qualifications of music therapists because qualifications for a national music therapist credential are already standardized, with minimum education requirements set by the AMTA and an examination based on core competencies of music therapy administered by the CBMT. Music therapists seeking to maintain a CBMT credential must pay the costs of obtaining a music therapy degree, CBMT testing, and continuing education. State licensure would be an additional expense to the already existing costs associated with national certification, without a corresponding increase in public benefit.

Based upon testimony provided by witnesses, state regulation would prevent other practitioners in various professions from using music as a therapeutic modality since licensure prohibits people from applying elements of the practice of music therapy without certification as a music therapist. Occupational therapists, nurses, physical therapists, speech language pathologists, and other health providers may use music as an intervention to treat patients. Several credentialed mental health providers, rehabilitative and massage therapy professionals also use music as a treatment modality or as an adjunct to therapy. In Illinois there are various pathways for clinicians to obtain licensure in counseling, social work, or psychological services. Currently, music therapists are able to provide music therapy interventions as part of the counseling, social work, or psychological services they are providing, if they already hold licenses in these professions. Licensure may inhibit their use of music as a treatment tool and encroach on the scope of practice of other professions. In addition, it may prohibit the use of music-based therapy by Native Americans and other traditional healers who may use music therapy to aid the sick, injured, or dying.

3) Licensure is Not a Pathway to Insurance Reimbursement.

Supporters of regulation believe that a separate and freestanding music therapy license would facilitate payment by insurers, governmental healthcare payers, and public school systems.

Witnesses provided oral testimony that the criterion for obtaining general insurance coverage requires an extensive analysis by the third party payer of the supportive evidence and clinical protocols established for healthcare interventions.[139] The music therapy profession is still defining these areas. An example of how the AMTA is tackling a specific area critical to advancing reimbursement efforts is through the research strategic priority.[140] This priority and its operational plan were developed to address the direction of research in support of evidence-based music therapy practice and improved workforce demand.[141] And to recognize and incorporate, where necessary, federal, state and other entity requirements for evidence-driven research as it relates to practice policy and reimbursement.[142]

[139] Judy Simpson, AMTA's Director of Government Relations, Music Therapy Reimbursement. (February 2009
[140] I*d.*
[141] *Id.*
[142] *Id.*

The American Music Therapy Association estimates that approximately 20% of music therapists already receive third party reimbursement for the services they provide.[143] Music therapy is comparable to other allied health professions like occupational therapy and physical therapy in that individual assessments are provided for each client, service must be found reasonable and necessary for the individual's illness or injury and interventions include a goal-directed documented treatment plan.[144] Companies like Blue Cross Blue Shield, United Healthcare, Cigna, and Aetna have all paid for music therapy services at some time. Success has occurred on a case-by-case basis when the therapist implements steps within the reimbursement process.[145] Like other therapies, music therapy is reimbursable when services are pre-approved and deemed medically or behaviorally necessary to reach the individual patient's treatment goals.

It is important to note that establishing a state recognition program does not guarantee automatic inclusion in various funding streams. The music therapy community understands the need to provide research evidence to support reimbursement requests from different payment systems. AMTA and CBMT provide guidance to music therapists in differentiating between state recognition goals and benefits and the completely separate payer-based process to seek coverage for music therapy interventions.

[143] American Music Therapy Association." *FAQ's | Frequently Asked Questions | American Music Therapy Association (AMTA)*. (date accessed 15 Mar. 2017.)
[144] *Id.*
[145] *Id.*

Acknowledgments

The Illinois Music Therapy Advisory Board would like to thank the following Board members and participants who assisted in Board meetings and this report.

Illinois Music Therapy Advisory Board
Jessica Baer, Chairperson, *Director of the Division of Professional Regulation*
Andrea M. Crimmins, Board Member
Louise Dimiceli-Mitran, Board Member
Kyle Fleming, Board Member
Candyce L. Gray, Board Member
Russell E. Hilliard, Board Member
Clifton Saper, Board Member

Department of Financial and Professional Regulation of the State of Illinois
Bryan Schneider, Secretary of the Department of Financial and Professional Regulation
Martha Reggi, Chief of Business Prosecutions
Milana Lublin, General Counsel to the Board
John Webb, Director of Legislative Affairs for the Department
Bryan Martin, Chief Financial Officer for the Department
Munaza Aman, Assistant General Counsel for the Department
Vaughn Bentley, Staff Attorney for the Department
Dennis Jung, Office of the Secretary
Steven Monroy, *prior* Staff Attorney for the Department
Stephanie Rosienski, Law Clerk for the Department
Jay Stewart, *prior* Director of the Division of Professional Regulation
Daniel Kelber, *prior* Acting Director of the Division of Professional Regulation
Azeema Akram, *prior* General Counsel to the Board

Board Meeting Guest Speakers
Sherry Thomas, Policy Coordinator, Washington Department of Health: Health Systems Quality Assurance
Suzette Farmer, Utah Division of Occupational & Professional Licensing
Nancy Swanson, Illinois Music Therapy Association
Paula Worthington, Claudia Figueroa, Raul Meija, Cecelia Black, Carolina Arguto Salazar, University of Chicago, Harris School of Public Policy
Kyle Hillman & Joel Rubin, National Association of Social Workers
Deborah Hagan, Illinois Attorney General's Office, Chief of the Consumer Protection Division
Leticia Metherell, State of Nevada Department of Health and Human Services Division of Public and Behavioral Health
Mike Simoli, Health Program Administrator, Center for Professional Licensing of the Rhode Island Department of Public Health
Jamie Adams, Records Management Supervisor, Wisconsin Department of Safety & Professional Services
Vivienne Belmont, Colorado Department of Regulatory Agencies
Megan E. Castor, Assistant Counsel, Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors of the Pennsylvania Department of State
Ari Bargil, Institute for Justice
Elizabeth Kregor, Institute for Justice Clinic on Entrepreneurship
David Hamilton, Executive Secretary of the New York Office of the Professions
Jim Cleghorn, Executive Director of Georgia Board of Nursing and Music Therapists
Nicholas Goodwin, Professional Licensing Agency

Carolyn Kahn, Illinois Mental Health Counselors Association
Tom Parton, President of the IL Speech Language Hearing Association
Terrence Koller, Illinois Psychological Association
Dr. Firas Nakshabandi & Meryl Camin Sosa, Esq., Illinois Psychiatrists Association
Dena Register, Certification Board for Music Therapists
Lisa Mahaffey, President, and Robin Jones, Advocacy Director, Illinois Occupational Therapy Association
U-Jung Choe, Illinois Competitiveness Council
Holly Schaefer, Safe Haven School
Cindy Ropp, Illinois State University
Mischa Fisher, Policy Advisor for Economic Development, Office of Governor Bruce Rauner
Susan Frick, Rush Alzheimer's Disease Center
Judy Simpson, American Music Therapy Association

Board Meeting Guests
Stacey Massey, Institute for Justice Clinic on Entrepreneurship
Meryl Camin Sosa, Esq., Executive Director, Illinois Psychiatric Society
Cindy Ropp, Associate Professor in College of Fine Arts – Music Therapy Program, Illinois State University
Emily Gibellina, Associate General Counsel, Office of Governor Bruce Rauner

Exhibits

The following are attached as exhibits to the Board's Report:

1. Board Meeting Minutes
    a. April 25, 2016
    b. June 27, 2016
    c. August 30, 2016
    d. September 26, 2016
    e. October 31, 2016
    f. November 28, 2016
    g. February 06, 2017
    h. March 06, 2017
    i. April 10, 2017

2. Illinois Association of Music Therapy submitted documents.
    a. American Music Therapy Association and the Certification Board for Music Therapists, "Music Therapy State Recognition: National Overview June 2016"
    b. American Music Therapy Association and the Certification Board for Music Therapists, "Scope of Music Therapy Practice 2015"

3. University of Chicago, Harris Policy School
    a. The University of Chicago, Harris Policy School "Sunrise Review for Music Therapy"
    b. Power point presentation

4. American Music Therapy Association
    a. "Music Therapy Reimbursement"
    b. "Music Therapy Reimbursement Information"

Exhibit 1(A)

Illinois Department of Financial & Professional Regulation Division of Professional Regulation Music Therapy Advisory Board Minutes

Date: April 25, 2016
Call to Order: 10:05 am – Jay Stewart, Chairperson
Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor Room 9-171A Chicago, IL 60601
Board Members Present: Jay Stewart, Chairperson; Andrea M. Crimmins, Board Member; Louise Dimiceli-Mitran, Board Member; Kyle Fleming, Board Member; Candyce L. Gray, Board Member
Board Member(s) Absent: Russell E. Hilliard, Ph.D., Board Member
Staff Members Present: Martha Reggi, Associate General Counsel; Azeema Akram, Assistant General Counsel

Topic	Discussion	Action
Roll Call	Jay Stewart, present Andrea M. Crimmins, present Louise Dimiceli-Mitran, present Kyle Fleming, present Candyce L. Gray, present Russell E. Hilliard, Ph.D., absent	
Introductions	Each Board member, Department staff, and guest introduced themselves.	
Chairperson Election		A motion was made by Stewart / seconded by Dimiceli-Mitran to elect Stewart as Chairperson. Motion passed unanimously.
New Business	Overview of Music Therapy Advisory Board Act: Stewart provided an overview of the Music Therapy Advisory Board Act. Board Orientation by General Counsel: General Counsel provided a Board Orientation regarding ethics, the Open Meetings Act, public speaking engagements, and other relevant matters for Board members. Analysis of Potential Witnesses: Board members analyzed potential witnesses for future meetings. Tax Preparer Board Report Review: Board members reviewed the Board's Report to gain guidance on the structure of their own report. Travel vouchers and statement of economic interests forms were made available to Board members. Potential future meetings were discussed.	
Adjournment		There being no further business to discuss, a motion was made by Gray / seconded by Fleming to adjourn at 10:50 am. Motion passed unanimously.

Exhibit 1(B)

Illinois Department of Financial & Professional Regulation Division of Professional Regulation
Music Therapy Advisory Board Minutes

Date: June 27, 2016

Call to Order: 11:01 A.M. – Jay Stewart, Chairperson

Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor Room 9-171A

Chicago, IL 60601

Board Members Present: Jay Stewart, Chairperson Andrea M. Crimmins, Board Member,
Louise Dimiceli-Mitran, Board Member
Kyle Fleming, Board Member
Candyce L. Gray, Board Member
Clifton Saper, Board Member

Board Member(s) Absent: Russell E. Hilliard, Board Member

Staff Members Present: Azeema Akram, Assistant General Counsel
Munaza Aman, Staff Attorney
Steven Monroy, Staff Attorney

Guests: Nancy Swanson, Illinois Music Therapy Association
Paula Worthington, Claudia Figueroa, Raul Meija, Cecelia Black, & Carolina Arguto Salazar, University of Chicago–Harris School of Public Policy
Kyle Hillman & Joel Rubin, National Association of Social Workers – Illinois Chapter
Elizabeth Kregor & Stacy Massey, Institute for Justice Clinic on Entrepreneurship

Via phone:
Suzette Farmer Utah Division of Occupational & Professional Licensing
Sherry Thomas, State of Washington Department of Health

Topic	Discussion	Action
Roll Call	Jay Stewart, present Andrea M. Crimmins, present Louise Dimiceli-Mitran, present Kyle Fleming, present Candyce L. Gray, present Clifton Saper, present Russell E. Hilliard, absent	
Introductions	Each Advisory Board member, Department staff, and guest introduced themselves.	
Approval of April 25, 2016 Minutes		A motion was made by Dimiceli-Mitran / seconded by Gray to approve the April 25, 2016 meeting minutes. Motion passed unanimously.
Analysis of Advisory Board Action	Chairperson Stewart reviewed the previous meeting that took place and reviewed the agenda. Ms. Akram circulated a copy of correspondence from the Illinois Attorney General's Office stating that the Consumer Protection Division has received no complaints against music therapists to date.	

	Guest Suzette Farmer Utah Division of Occupational & Professional Licensing Ms. Farmer reviewed Utah's licensure of music therapists since 2014, including the general regulatory framework, licensure application requirements, fees, and disciplinary actions. She also clarified that music therapists who are licensed in Utah receive title protection only, and answered Advisory Board member inquiries regarding the number of licensees and continuing education requirements. Guest Sherry Thomas, State of Washington Department of Health Ms. Thomas reviewed Washington's sunrise review process, which ended in 2012. She discussed the final report that was issued, which recommended against requiring state certification of music therapists. Ms. Farmer highlighted a few of the reasons for the recommendation, including lack of a demonstrated clear threat to public health & safety from the unregulated practice of music therapy, the financial burden on the small number of potential licensees to cover the cost of regulating the profession, and the opposition from several other professions (e.g., occupational therapy, speech-language pathology) that had concerns about restricting the use of music in their fields. Ms. Farmer answered Advisory Board member inquiries regarding any complaints filed against music therapists and whether the potential licensure of music therapists in the State of Washington has been recently revisited. Guest Nancy Swanson, Illinois Music Therapy Association Ms. Swanson thanked the Advisory Board for inviting her to speak and discussed the Illinois Music Therapy Association's ("IMTA") position advocating for licensure of music therapists. She reviewed the reasons in favor of licensure, including insurance reimbursement, consumer protection, and increased consumer access to services. She also reviewed the public harm that necessitates regulation, including misrepresentation of credentials by individuals holding themselves out as music therapists, as well as types of client cases that require familiarization with medical concerns, risks, and clinical knowledge. Ms. Swanson provided an overview of the scope of practice for a music therapist and explained how the overlap with other professions works since music therapists do not perform diagnosis. She also discussed educational requirements for certification. Ms. Swanson answered Advisory Board member inquiries regarding the nature of disciplinary actions taken against music therapists, whether there are IMTA members who hold licensure in other fields, and whether there is any pending legislation in other states to license music therapists. Guests Paula Worthington, Claudia Figueroa, Raul Meija, Cecelia Black, & Carolina Arguto Salazar, University of Chicago–Harris School of Public Policy Ms. Worthington, Ms. Figueroa, Mr. Meja, Ms. Black, & Ms. Salazar reviewed a music therapy sunrise review project they completed for the Department. They discussed background information on the profession, current market conditions, regulation of music therapy in other states, and compared the	

	scope of practice of music therapy with that of related professions. They also provided a risk analysis of the need for licensure of music therapists, along with arguments for and against licensure. Finally, they recommended that music therapists not be licensed for several reasons, primarily a lack of public harm necessitating the license. They suggested that the Advisory Board explore title protection as an alternative to more restrictive regulation. They answered several questions from the Advisory Board on all aspects of their sunrise review project. Guests Kyle Hillman & Joel Rubin, National Association of Social Workers – Illinois Chapter Mr. Hillman thanked the Advisory Board for inviting him and Mr. Rubin to speak. He discussed the National Association of Social Workers' position against the licensure of music therapists. He provided an overview of several reasons against licensure, such as a concern that some related professions (e.g. speech therapy) lack the academic or clinical training to provide mental health services & the low number of potential licensees. He suggested that if the Advisory Board decides to recommend licensure, that they consider title protection &/or requiring post-graduate supervised clinical experience similar to that of licensed social workers ("LSWs") & licensed professional counselors ("LPCs"), both of which are the lower-level license in those fields. Mr. Hillman & Mr. Rubin answered Advisory Board questions regarding the minimum educational and experience requirements for the lower-level social worker license.	
Old Business	Analysis of Potential Witnesses: Advisory Board members analyzed potential witnesses for future meetings. The Advisory Board discussed potential future meetings dates for August and September. Travel vouchers were distributed to Advisory Board members.	
Adjournment		There being no further business to discuss, a motion was made by Dimiceli-Mitran / seconded by Crimmins to adjourn at 12:54 P.M. Motion passed unanimously.

Exhibit 1(C)

Illinois Department of Financial & Professional Regulation
Division of Professional Regulation
Music Therapy Advisory Board Minutes

Date: August 30, 2016

Call to Order: 10:05 A.M. – Daniel Kelber, Acting Chairperson

Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor
Room 9-171A, Chicago, IL 60601

Board Members Present: Daniel Kelber, Acting Chairperson
Andrea Crimmins, Ph.D., MT-BC, Board Member
Louise Dimiceli-Mitran, LCPC, MT-BC, Board Member
Kyle Fleming, MT-BC, Board Member
Candi Gray, LCSW, Board Member
Russell Hilliard, Ph.D., LCSW, MT-BC, Board Member
Clifton Saper, Ph.D., Board Member

Board Member(s) Absent: None.

Staff Members Present: Azeema Akram, Assistant General Counsel
Vaughn Bentley, Law Clerk, Office of General Counsel
Stephanie Rosienski, Law Clerk, Office of General Counsel

Guests: Ari Bargil, Attorney, Institute for Justice
Elizabeth Kregor, Institute for Justice Clinic on Entrepreneurship

Via phone:
Leticia Metherell, State of Nevada Department of Health and Human Services, Division of Public and Behavioral Health
Mike Simoli, Center for Professional Licensing of the Rhode Island Department of Public Health
Jamie Adams, Wisconsin Department of Safety & Professional Services
Vivienne Belmont, Colorado Department of Regulatory Agencies
Megan Castor, Pennsylvania Department of State

Topic	Discussion	Action
Roll Call	Daniel Kelber, Acting Chairperson, present Andrea Crimmins, Ph.D., MT-BC, Board Member, present Louise Dimiceli-Mitran, LCPC, MT-BC, Board Member, present Kyle Fleming, MT-BC, Board Member, present Candi Gray, LCSW, Board Member, present Russell Hilliard, Ph.D., LCSW, MT-BC, Board Member, present Clifton Saper, Ph.D., Board Member, present	
Introductions	Each Advisory Board member, Department staff, and guest introduced themselves.	
Analysis of Advisory Board Action	Ms. Akram reviewed the previous meeting that took place and reviewed the agenda. Ms. Akram informed the Board that the representative from the American Music Therapy Association who was scheduled to testify	

	will attend a future meeting, and that another guest from the State of Pennsylvania is attending via telephone. <u>Guest Leticia Metherell, State of Nevada Department of Health and Human Services, Division of Public and Behavioral Health</u> Ms. Metherell reviewed Nevada's licensure of music therapists since 2011 including the general regulatory framework, and licensure requirements. She also discussed that there have been no disciplinary actions taken against the 16 licensees in Nevada, and no complaints of unlicensed practice. Ms. Metherell answered Advisory Board questions regarding how the music therapy licensure began in the State of Nevada. <u>Guest Mike Simoli, Center for Professional Licensing of the Rhode Island Department of Public Health</u> Mr. Simoli reviewed Rhode Island's licensure of music therapists since 2014 including the general regulatory framework, and licensure requirements. He discussed that there are now 3 licensees, and answered Advisory Board member questions on the number of complaints of unlicensed practice, of which there have been none to date. Mr. Simoli also answered Advisory Board inquiries regarding the terminology of "registration" and "licensure." <u>Guest Jamie Adams, Wisconsin Department of Safety & Professional Services</u> Ms. Adams reviewed Wisconsin's licensure of music, dance, and art therapists since 1999, including the general regulatory framework and licensure requirements. She discussed the total number of licenses issued, number of active licenses (75), and one reported case of discipline. Ms. Adams also highlighted Wisconsin's statutory definition of psychotherapy, included in the psychology licensure statute, and its interplay with music therapy. She answered Advisory Board questions regarding supervisor qualifications and music therapists who practice psychotherapy. <u>Guest Vivienne Belmont, Colorado Department of Regulatory Agencies</u> Ms. Belmont reviewed Colorado's sunrise review process, in which new regulated professions are proposed, and the criteria used in formulating a recommendation. She discussed the State's sunrise review of music therapy, which was initiated by the American Music Therapy Association's sunrise review application in 2013 seeking title protection regulation. Ms. Belmont discussed the final report that was issued, which recommended against title protection regulation of music therapists. She highlighted a few of the reasons for the recommendation, including a lack of demonstrated public interest or need, lack of demonstrated harm to the public from the unregulated practice of music therapy, and lack of complaints in the State against music therapists. Ms. Belmont answered Advisory Board inquiries regarding whether this may change in the future, and discussed the regulation of a new profession from a public protection standpoint rather than setting minimum standards for the profession. <u>Guest Megan Castor, Pennsylvania Department of State</u>	

	Ms. Castor reviewed the title protection regulation of mental health professions in Pennsylvania. She explained that there is no separate license for music therapists, and that a professional counselor license allows for the practice of music therapy. Ms. Castor reviewed the educational requirements for licensure for professional counselors, as the education in several fields meet the requirements for licensure, such as education in psychology, dance, music, and art therapy. She discussed the expense of regulating music therapists separately, and that there have been bills pending in the legislature with no progress at this time. Ms. Castor answered Advisory Board inquiries regarding the number of professional counselors who practice music therapy and number of complaints. Guest Ari Bargil, Institute for Justice Mr. Bargil thanked the Advisory Board for inviting him to speak and reviewed the Institute for Justice's position against full licensure of music therapists by highlighting several implications of licensure and suggesting less restrictive alternatives to licensure. Specifically, he discussed the First Amendment implications of regulating music as a restriction on a protected form of speech. Mr. Bargil explained how occupational licensing has led to excessive government regulation, and discussed consequences of occupational licensing, such as limitations on opportunity, inhibitions on competition, and stifling innovation. He discussed the types of circumstances that require more government oversight through licensure, such as a risk of harm to public health & safety, & suggested a form of title protection or registration as alternatives to licensing. Mr. Bargil answered Advisory Board member questions on all aspects of his testimony. Guest Elizabeth Kregor, Institute for Justice Clinic on Entrepreneurship Ms. Kregor thanked the Advisory Board for inviting her to speak and continued the discussion by Mr. Bargil regarding the consequences of occupational licensure, and recommending against full licensure of music therapists. She discussed the exclusionary effect of licensure against disadvantaged individuals, both those who wish to practice music therapy and those who wish to receive services, leading to fewer jobs. She also discussed the exclusionary effect of licensure on innovation, by limiting diversity in the profession as a result of standardization of requirements of entry, leading to fewer developments in the field. Ms. Kregor reinforced Mr. Bargil's suggestions for alternatives to licensure, and answered Advisory Board member inquiries regarding the position of the Institute of Justice as it applies to other professions as well.	
Approval of June 27, 2016 Minutes		A motion was made by Saper / seconded by Fleming to approve the June 27, 2016 meeting minutes. Motion passed unanimously.
Old Business	Analysis of Potential Witnesses: Advisory Board members analyzed potential witnesses for future meetings. The Advisory Board discussed potential future meetings dates for October and November.	

	Travel vouchers were distributed to Advisory Board members. Ms. Akram reminded the Advisory Board to consider the issues raised by the guests at prior, current, and future meetings in formulating a recommendation to be included in the Advisory Board's report due next year. Mr. Kelber answered questions about licensure and its alternatives in addressing the concerns raised by the industry, the public, and the government.	
Adjournment		There being no further business to discuss, a motion was made by Hilliard / seconded by Gray to adjourn at 12:57 P.M. Motion passed unanimously.

Exhibit 1(D)

Illinois Department of Financial & Professional Regulation
Division of Professional Regulation
Music Therapy Advisory Board Minutes

Date: September 26, 2016

Call to Order: 10:06 A.M. – Jessica Baer, Chairperson

Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor Room 9-034, Chicago, IL 60601

Board Members Present: Jessica Baer, Chairperson
Andrea Crimmins, Ph.D., MT-BC, Member (via phone)
Louise Dimiceli-Mitran, LCPC, MT-BC, Member
Kyle Fleming, MT-BC, Member
Candi Gray, LCSW, Member
Russell Hilliard, Ph.D., LCSW, MT-BC, Member (via phone)
Clifton Saper, Ph.D., Member

Board Member(s) Absent: None.

Staff Members Present: Azeema Akram, Assistant General Counsel
Vaughn Bentley, Law Clerk, Office of General Counsel
Stephanie Rosienski, Law Clerk, Office of General Counsel

Guests: Tom Parton, Past-President of the Illinois Speech Language Hearing Association
Kevin Morphew, Attorney, Sorling Northrup

Via phone:
David Hamilton, Executive Secretary, Office of the Professions (New York)
Jim Cleghorn, Georgia Board of Nursing and Music Therapists
Nicholas Goodwin, Office of Governor Mike Pence
Carolyn Kahn, Illinois Mental Health Counselors Association

Topic	Discussion	Action
Motion to Allow Members to Attend via Phone		A motion was made by Gray / seconded by Dimiceli-Mitran to allow Crimmins to attend by phone due to personal illness pursuant to 5 ILCS 120/7 of the Open Meetings Act. Motion passed unanimously. A motion was made by Dimiceli-Mitran / seconded by Gray to allow Hilliard to attend due to employment pursuant to 5 ILCS 120/7 of the Open Meetings Act. Motion passed unanimously.
Roll Call	Jessica Baer, present Andrea Crimmins, present via phone Louise Dimiceli-Mitran, present	

	Kyle Fleming, present Candi Gray, present Russell Hilliard, present via phone Clifton Saper, present	
Introductions	Each Advisory Board member, Department staff, and guest introduced themselves.	
Analysis of Advisory Board Action	Ms. Akram reviewed the previous meeting that took place and reviewed the agenda. Ms. Akram informed the Board that an additional guest was in attendance via phone from the Illinois Mental Health Counselors Association. <u>Guest David Hamilton, Office of the Professions</u> Mr. Hamilton reviewed New York's licensure of creative arts therapists since 2002, which includes music therapy, by providing an overview of legislative history and the general regulatory framework. He discussed the licensure requirements including approved education, completion of 1,500 post-degree supervised hours, exemptions from licensure, and continuing education. Mr. Hamilton also discussed the practice of psychotherapy in New York and how it relates to the scope of practice for creative arts therapists. He answered Advisory Board member questions regarding all aspects of his testimony. <u>Guest Jim Cleghorn, Georgia Board of Nursing and Music Therapists</u> Mr. Cleghorn reviewed Georgia's title protection licensure of music therapists since 2012, including the general regulatory framework and licensure requirements. He discussed the total number of active licenses (114), the seven (7) complaints (6 were for unlicensed practice and one for unethical conduct) which did not relate to patient issues, and the advisory role of the State board. Mr. Cleghorn answered Advisory Board member inquiries regarding the push for licensure by professional associations and the limits of title protection. <u>Nicholas Goodwin, Office of Governor Mike Pence</u> Mr. Goodwin reviewed Indiana's recent consideration of licensing music therapists, which did not result in licensure. He discussed legislation that was introduced in 2013 & supported by professional associations. The bill was vetoed by Governor Pence who cited concerns about job creation, specifically that licensure can create barriers to the market and restriction on competition. Mr. Goodwin also discussed the Pilot Program for State Registration of Privately Certified Individuals, which serves as an alternative to licensure that increases the public trust in professionals without the concerns raised by full licensure. <u>Guest Carolyn Kahn, Illinois Mental Health Counselors Association</u> Ms. Kahn thanked the Advisory Board for inviting her to speak and reviewed the Illinois Mental Health Counselors Association's position against the potential licensing of music	

	therapists. Specifically, she discussed concerns over the lack of clinical mental health training required for certification and recommended the addition of several courses to the current requirements. She noted that the addition of these courses and training requirements would resemble licensure requirements for professional counselors and social workers, whose scopes of practice allow for the practice of music therapy, and recommended that the current licensure for those professions along with a certificate in music therapy serve as an alternative to creating a new license. Ms. Kahn answered Advisory Board member questions regarding suggested coursework areas from the professional counselor licensure requirements. Guest Tom Parton, Illinois Speech Language Hearing Association Mr. Parton thanked the Advisory Board for inviting him to speak and reviewed the Illinois Speech Language Hearing Association's position against the potential licensure of music therapists. Specifically, he discussed the Certification Board for Music Therapy's definition of music therapy and concerns about treating communication disorders. He also discussed the minimum qualifications for a licensed speech-language pathologist in comparison to requirements for certification as a music therapist, and the billing issues raised by music therapists using Current Procedural Terminology (CPT) codes assigned to licensed professions due to lack of codes for music therapy services. Mr. Parton answered Advisory Board inquiries regarding the training & use of music therapy in speech-language pathology.	
Approval of August 30, 2016 Minutes		A motion was made by Fleming/ seconded by Gray to approve the August 30, 2016 meeting minutes. Motion passed unanimously.
Old Business	Analysis of Potential Witnesses: Advisory Board members analyzed potential witnesses for future meetings. The Advisory Board discussed potential future meetings dates for October and November. Travel vouchers were previously distributed to Advisory Board members.	
Adjournment		There being no further business to discuss, a motion was made by Gray / seconded by Dimiceli-Mitran to adjourn at 11:23 P.M. Motion passed unanimously.

Exhibit 1(E)

Illinois Department of Financial & Professional Regulation
Division of Professional Regulation
Music Therapy Advisory Board Minutes

Date: October 31, 2016

Call to Order: 10:06 A.M. – Azeema Akram, Assistant General Counsel

Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor Room 9-171A, Chicago, IL 60601

Board Members Present: Jessica Baer, Acting Chairperson (via phone)
Andrea Crimmins, Ph.D., MT-BC, Member
Louise Dimiceli-Mitran, LCPC, MT-BC, Member
Kyle Fleming, MT-BC, Member (via phone)
Candi Gray, LCSW, Member
Clifton Saper, Ph.D., Member

Board Member(s) Absent: Russell Hilliard, Ph.D., LCSW, MT-BC, Member

Staff Members Present: Azeema Akram, Assistant General Counsel
Vaughn Bentley, Law Clerk, Office of General Counsel
Stephanie Rosienski, Law Clerk, Office of General Counsel

Guests: Via phone:
Terrence Koller, Ph.D., ABPP, Legislative Liaison, Illinois Psychological Association

Topic	Discussion	Action
Motion to Allow Members to Attend via Phone		A motion was made by Gray / seconded by Dimiceli-Mitran to allow Fleming to attend by phone due to employment pursuant to 5 ILCS 12/7 of the Open Meetings Act. Motion passed unanimously. A motion was made by Crimmins / seconded by Dimiceli-Mitran to allow Baer to attend by phone due to employment pursuant to 5 ILCS 120/7 of the Open Meetings Act. Motion passed unanimously.
Roll Call	Jessica Baer, present via phone Andrea Crimmins, present Louise Dimiceli-Mitran, present Kyle Fleming, present via phone Candi Gray, present Russell Hilliard, absent Clifton Saper, present	
Analysis of Advisory Board Action	Ms. Akram reviewed the previous meeting that took place and reviewed the agenda.	

	Ms. Akram noted that David Hamilton, Executive Secretary, Office of the Professions (State of New York), who was a guest at the previous meeting, had followed up with written comments regarding New York's licensing of creative arts therapists. The written comments had been distributed to Advisory Board members prior to the current meeting. <u>Guest Terrence Koller, Illinois Psychological Association</u> Dr. Koller thanked the Advisory Board for inviting him to speak and reviewed the Illinois Psychological Association's concerns related to the potential licensing of music therapists. Specifically, he discussed consumer protection against inaccurate information relating to the use of music therapy in mental health treatment, how the current scope of practice of licensed professional counselors & licensed clinical professional counselors allows for the use of music therapy, and overlap with the use of music by appropriately-trained clinical psychologists in their treatment regimes. Dr. Koller answered Advisory Board member questions regarding the use of music therapy by clinical psychologists, the education obtained by those clinical psychologists, and the possibility of an exemption from music therapy licensure for other licensed mental health treatment providers practicing within the scope of their licenses. The Advisory Board extensively reviewed Section 15 of the Music Therapy Advisory Board Act ("Act"), 20 ILCS 5070, & the report to be issued thereunder. The report shall be issued in April 2017 with recommendations regarding the certification process for music therapists in accordance with the requirements of Section 15 of the Act.	
Approval of September 26, 2016 Minutes		Action deferred until the next meeting.
Old Business	The Advisory Board discussed potential future meetings dates for November. Travel vouchers were previously distributed to Advisory Board members.	
Adjournment		There being no further business to discuss, a motion was made by Dimiceli-Mitran / seconded by Crimmins to adjourn at 11:10 A.M. Motion passed unanimously.

Exhibit 1(F)

Illinois Department of Financial & Professional Regulation
Division of Professional Regulation
Music Therapy Advisory Board Minutes

Date: November 28, 2016

Call to Order: 10:05 A.M. – Jessica Baer, Chairperson

Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor Room 9-171A, Chicago, IL 60601

Board Members Present: Jessica Baer, Chairperson
Andrea Crimmins, Ph.D., MT-BC, Member
Louise Dimiceli-Mitran, LCPC, MT-BC, Member
Kyle Fleming, MT-BC, Member
Candi Gray, LCSW, Member (via phone)
Russell Hilliard, Ph.D., LCSW, MT-BC, Member (via phone)

Board Member(s) Absent: Clifton Saper, Ph.D., Member

Staff Members Present: Azeema Akram, Assistant General Counsel
Vaughn Bentley, Law Clerk, Office of General Counsel
Stephanie Rosienski, Law Clerk, Office of General Counsel

Guests: Firas Nakshabandi, M.D., Member, Illinois Psychiatric Society
Meryl Camin Sosa, Esq., Executive Director, Illinois Psychiatric Society
U-Jung Choe, Chair, Illinois Competitiveness Council

Via phone:
Dena Register, PhD, MT-BC, Regulatory Affairs Advisor, Certification Board for Music Therapists
Judy Simpson, MT-BC, Director of Government Relations, American Music Therapy Association
Lisa Mahaffey, President, Illinois Occupational Therapy Association
Robin Jones, Advocacy Director, Illinois Occupational Therapy Association

Topic	Discussion	Action
Motion to Allow Members to Attend via Phone		A motion was made by Dimiceli-Mitran / seconded by Fleming to allow Gray to attend by phone due to family emergency pursuant to 5 ILCS 12/7 of the Open Meetings Act. Motion passed unanimously. A motion was made by Dimiceli-Mitran / seconded by Crimmins to allow Hilliard to attend due to employment pursuant to 5 ILCS 120/7 of the Open Meetings Act. Motion passed unanimously.
Roll Call	Jessica Baer, present Andrea Crimmins, present Louise Dimiceli-Mitran, present	

	Kyle Fleming, present Candi Gray, present via phone Russell Hilliard, present via phone Clifton Saper, absent	
Analysis of Advisory Board Action	Ms. Akram reviewed the previous meeting that took place and reviewed the agenda. Ms. Akram informed the Advisory Board that the representative from the Office of Governor Bruce Rauner who planned to testify would not be attending due to a scheduling conflict, and that another guest from the Illinois Competitiveness Council would be testifying on the same subject. Guests Dena Register, Certification Board for Music Therapists, and Judy Simpson, American Music Therapy Association Ms. Register and Ms. Simpson provided a comprehensive review of the standards required for the Music Therapist – Board Certified credential. They also provided a review of the regulation of music therapy across the United States. Ms. Register and Ms. Simpson discussed the music therapy curriculum, the difference between credentials and certification, two examples of public harm caused by music therapists that provided substandard care, a definition of "assessment" that is unique to the profession, and ethics standards. They answered extensive Advisory Board inquiries on all aspects of their testimonies, including insurance reimbursement and the wide variety of settings in which music therapists practice. Guests Lisa Mahaffey and Robin Jones, Illinois Occupational Therapy Association Ms. Mahaffey and Ms. Jones reviewed the Illinois Occupational Therapy Association's position regarding music therapy, that the Association is not in opposition to the profession and opposes a licensure practice act. They raised concerns over previous practice act legislation that appeared to propose that the use of music in the practice of other professions would constitute a violation of the act. The Association takes a neutral position to the language of the Music Therapy Advisory Board Act. Ms. Mahaffey and Ms. Jones suggested that the Advisory Board consider factors such as the need for regulation of the music therapy profession, the need for a license vs. title protection, and whether the lack of public harm warrants regulation of the profession. They answered Advisory Board inquiries regarding language creating an exemption from licensure for other professions that use music in their practices, and the differences between certain provisions in the previously proposed practice act and the Music Therapy Advisory Board Act. Guests Firas Nakshabandi, M.D. and Meryl Camin Sosa, Esq., Illinois Psychiatric Society Dr. Nakshabandi reviewed his experience working with music therapy and the use of music from his personal perspective as	

	a psychiatrist. He discussed the makeup of a multidisciplinary team that includes music therapists, practice settings (e.g., ICU, outpatient treatment), and examples of the types of disorders and conditions his patients have who respond well to music (attention deficit disorder, confidence issues). He expressed an interest in exploring research that addresses the effects of different types and levels of music in creating certain outcomes. Dr. Nakshabandi expressed concern over whether regulation of music therapy would require other professions to undergo additional educational training in order to use music in their practices. He answered extensive Advisory Board inquiries on all aspects of his testimony, such as the use of music as a modality and music therapy as a profession. Ms. Sosa suggested that if the Advisory Board recommends licensure, that there be some exemption language for other professionals that use music, and encouraged careful drafting of legislation language. Guest U-Jung Choe, Illinois Competitiveness Council Ms. Choe reviewed the Illinois Competitiveness Council, which was established by Executive Order 16-13 signed by Governor Rauner. The Executive Order requires over forty State agencies, including the Illinois Department of Financial & Professional Regulation, to review their administrative rules as part of the Cutting the Red Tape Initiative. Through this review, these agencies are to ensure that their rules meet certain guidelines, such as that the rules do not impose unduly burdensome requirements on business or have a negative effect on job growth in Illinois. Ms. Choe stated that the Executive Order requires each of these agencies to complete this review by May 1, 2017, and submit quarterly report to the Council until the deadline. She answered Board member inquiries regarding the Executive Order's relation to this Advisory Board, including other State agencies included in this review process that deal music therapy topics of interest to the Advisory Board such as reimbursement options through Medicaid (Department of Healthcare and Family Services) and insurance (Department of Insurance).	
Approval of September 26, 2016 Minutes Approval of October 31, 2016 Minutes		A motion was made by Baer / seconded by Fleming to approve the September 26, 2016 meeting minutes. Motion passed unanimously. A motion was made by Crimmins / seconded by Dimiceli-Mitran to approve the October 31, 2016 meeting minutes. Motion passed unanimously.
Old Business	The Advisory Board discussed potential future meetings dates for January through April 2017. Travel vouchers were previously distributed to Advisory Board members.	
Adjournment		There being no further business to discuss, a motion was made by

		Crimmins / seconded by Fleming to adjourn at 11:52 A.M. Motion passed unanimously.

Exhibit 1(G)

Illinois Department of Financial & Professional Regulation
Division of Professional Regulation
Music Therapy Advisory Board Minutes

Date: February 06, 2017

Call to Order: 10:39 A.M. – Jessica Baer, Chairperson

Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor Room 9-171A, Chicago, IL 60601

Board Members Present: Jessica Baer, Chairperson
Andrea Crimmins, Ph.D., MT-BC, Member (via phone)
Louise Dimiceli-Mitran, LCPC, MT-BC, Member
Kyle Fleming, MT-BC, Member
Candi Gray, LCSW, Member
Russell Hilliard, Ph.D., LCSW, MT-BC, Member (via phone)
Clifton Saper, Ph.D., Member

Board Member(s) Absent: None.

Staff Members Present: Azeema Akram, Assistant General Counsel
Milana Lublin, Assistant General Counsel

Guests: Mischa Fisher, Policy Advisor for Economic Development, Office of Governor Bruce Rauner
Susan Frick, LSW, Rush Alzheimer's Disease Center
Martha Reggi, Chief of Business Prosecutions, Illinois Department of Financial & Professional Regulation, Division of Professional Regulation

Via phone:
Holly Schaefer, Founder & Executive Director, Safe Haven School
Cindy Ropp, Associate Professor of Music Therapy, College of Fine Arts, Illinois State University
Bryan Martin, Chief Financial Officer, Illinois Department of Financial & Professional Regulation

Topic	Discussion	Action
Motion to Allow Members to Attend via Phone		A motion was made by Dimiceli-Mitran / seconded by Gray to allow Hilliard to attend by phone due to employment purposes pursuant to 5 ILCS 12/7 of the Open Meetings Act. Motion passed unanimously. A motion was made by Fleming/ seconded by Dimiceli-Mitran to allow Crimmins to attend by phone due to personal illness pursuant to 5 ILCS 120/7 of the Open Meetings Act. Motion passed unanimously.
Roll Call	Jessica Baer, present Andrea Crimmins, present via phone	

	Louise Dimiceli-Mitran, present Kyle Fleming, present Candi Gray, present Russell Hilliard, present via phone Clifton Saper, present	
Analysis of Advisory Board Action	Ms. Akram distributed documents to Advisory Board member that were submitted by Judy Simpson, Director of Government Relations for the American Music Therapy Association, who spoke at the November 28, 2016 meeting. Ms. Simpson provided a Memorandum and a Reimbursement Overview, which addressed the topic of insurance reimbursement for music therapists. <u>Guest Holly Schaefer, Safe Haven School</u> Ms. Schaefer <u>Guest Mischa Fisher, Office of Governor Bruce Rauner</u> Mr. Fisher <u>Guest Cindy Ropp, Illinois State University</u> Ms. Ropp <u>Guest Susan Frick, Rush Alzheimer's Disease Center</u> Ms. Frick <u>Guest Martha Reggi, Illinois Department of Financial & Professional Regulation</u> Ms. Reggi <u>Guest Bryan Martin, Illinois Department of Financial & Professional Regulation</u> Mr. Martin	
Approval of November 28, 2016 Minutes		A motion was made by Gray / seconded by Fleming to approve the November 28, 2016 meeting minutes. Motion passed unanimously.
Old Business	The Advisory Board set its final two meeting dates, as follows: March 6, 2017 April 10, 2017 New travel vouchers were distributed to Advisory Board members.	
Adjournment		There being no further business to discuss, a motion was made by Dimiceli-Mitran / seconded by Saper to adjourn at 1:08 P.M. Motion passed unanimously.

Exhibit 1(H)

Illinois Department of Financial & Professional Regulation
Division of Professional Regulation
Music Therapy Advisory Board Minutes

Date: March 06, 2017

Call to Order: 12:03 P.M. – Jessica Baer, Chairperson

Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor Room 9-171B/C, Chicago, IL 60601

Board Members Present:
Jessica Baer, Chairperson
Andrea Crimmins, Ph.D., MT-BC, Member
Louise Dimiceli-Mitran, LCPC, MT-BC, Member
Kyle Fleming, MT-BC, Member
Candi Gray, LCSW, Member
Russell Hilliard, Ph.D., LCSW, MT-BC, Member
Clifton Saper, Ph.D., Member

Board Member(s) Absent: None.

Staff Members Present:
Azeema Akram, Assistant General Counsel
Daniel Kelber, Deputy General Counsel Division of Banks
Milana Lublin, Assistant General Counsel

Guests present:
In Person: Vaughn Bentley, IDFPR Staff Attorney; Eric Eisinger, IDFPR Policy and Outreach; Janel Hartoun. Assistant General Counsel; Martha Reggi, IDFPR Chief of Business Prosecutions; Stephanie Rosienski, Law Clerk; Kyle Hillman, National Association of Social Workers.

By Phone**:** Judy Simpson, Director of Government Relations of the American Music Therapy Association.

Topic	Discussion	Action
Roll Call	Jessica Baer, present Andrea Crimmins, present Louise Dimiceli-Mitran, present Kyle Fleming, present Candi Gray, present Russell Hilliard, present Clifton Saper, present	
Analysis of Advisory Board Action	Chairperson Baer thanked the music therapy advisory board members and guests for their involvement and commitment to the board. She asked that guests refrain from speaking while the advisory board discusses new business, and deliberates and provides its recommendation to the Department. Ms. Lublin distributed the Notice and Agenda, Open Meeting Minutes of February 06, 2017, and the Music Therapy Advisory Board Draft Report.	

	Chairperson Baer reviewed the meetings that have taken place to date and reviewed the agenda. In response to prior advisory board member request, board member Hilliard discussed the Illinois Department of Financial and Professional Regulation fiscal year 2017 cost analysis. Mr. Hilliard suggested various ways that would make the cost of music therapy licensure lower. In response to prior advisory board member request, board member Dimiceli-Mitran reviewed a document she prepared titled, "Music Therapy State Recognition Costs and Administrative Expenses". Guest Judy Simpson, Director of Government Relations of the American Music Association. Ms. Simpson discussed alternative pathways for practicing music therapists in Illinois to obtain state licensure. Chairperson Baer reviewed the April 25, 2017, music therapy advisory board report deadline and the process for reviewing the report and recommendation. The advisory board deliberated the recommendation of the report.	
Approval of February 06, 2017 Minutes		A motion was made by Gray/ seconded by Dimiceli-Mitran to approve the February 06, 2017 meeting minutes. Motion passed unanimously.
Motion to Allow Members to Attend via Phone	Mr. Hilliard excused himself from the advisory board meeting due to employment purposes and resumed his participation by means of telephone conference.	A motion was made by Gray/seconded by Dimiceli-Mitran to allow Hilliard to attend by phone due to employment purposes pursuant to 5 ILCS 12/7 of the Open Meetings Act. Motion passed unanimously.
Old Business	I. The Music Therapy Advisory Board final meeting is scheduled, as follows: • April 10, 2017 at 10:30A.M. II. Travel vouchers were collected by Ms. Lublin.	
Adjournment		There being no further business to discuss, a motion was made by Dimiceli-Mitran / seconded by Saper to adjourn at 1:08 P.M. Motion passed unanimously.

Exhibit 1(H)

Illinois Department of Financial & Professional Regulation
Division of Professional Regulation
Music Therapy Advisory Board Minutes

Date: April 10, 2017

Call to Order: 10:32 A.M.

Location: IDFPR – Division of Professional Regulation, 100 W Randolph, 9th Floor Room 9-171A, Chicago, IL 60601

Board Members Present:
Jessica Baer, Chairperson
Louise Dimiceli-Mitran, LCPC, MT-BC, Member
Kyle Fleming, MT-BC, Member
Candi Gray, LCSW, Member
Russell Hilliard, Ph.D., LCSW, MT-BC, Member
Clifton Saper, Ph.D., Member

Board Member(s) Absent: Andrea Crimmins, Ph.D., MT-BC, Member

Staff Members Present: Milana Lublin, Assistant General Counsel/FOIA Officer

Guests present: In Person: Erik D. Gruber

Topic	Discussion	Action
Roll Call	Jessica Baer, present Louise Dimiceli-Mitran, present Kyle Fleming, present Candi Gray, present Russell Hilliard, present Clifton Saper, present	
Approval of March 06, 2017 Meeting Minutes		A motion was made by Hilliard/ seconded by Grey to approve the March 6, 2017 meeting minutes. Motion passed unanimously.
Old Business	The Task Force reviewed the Task Force's report, recommendation and dissent. The Task Force discussed the distribution of the report, recommendation and dissent to the Governor, General Assembly, and the public on April 25, 2017. Travel vouchers were distributed to Task Force members.	A motion was made by Hilliard / seconded by Dimiceli-Mitran to adopt the draft Task Force report, recommendation and dissent as an accurate rendition of the recommendation made at the February 06, 2017 meeting. Motion passed unanimously.
Adjournment		There being no further business to discuss, a motion was made by Dimiceli-Mitran / seconded by Saper to adjourn at 11:01 A.M. Motion passed unanimously.

EXHIBIT 2A

Music Therapy State Recognition: National Overview 2016

The American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT) have collaborated on the State Recognition Operational Plan since 2005. The purpose of this joint national initiative is to achieve official state recognition of the music therapy profession and the MT-BC credential required for competent practice. Desired outcomes from this process include improving consumer access to music therapy services and establishing a state-based public protection program to ensure that "music therapy" is provided by individuals who meet established education, clinical training, and credential qualifications. Inclusion within state health and education regulations can also have a positive impact on employment opportunities and reimbursement and state funding options, while meeting clinical requirements of treatment facilities and accrediting organizations.

Current Recognition

Connecticut	Music therapy title protection established in 2016. Practitioners must hold the MT-BC credential.
Georgia	Music therapy license overseen by the Secretary of State utilizes an ad hoc volunteer Advisory Council. License created in 2012 and regulations approved in 2013. http://sos.ga.gov/index.php/licensing/plb/59
Nevada	Music therapy license overseen by the State Board of Health utilizes an ad hoc Advisory Council. License created in 2011 and regulations approved in 2012. http://health.nv.gov/HCQC_MusicTherapist.htm
North Dakota	Music therapy license overseen by the newly created Board of Integrative Health. License created in 2011 and regulations approved in 2013. http://ndbihc.org/
Oklahoma	Music therapy license managed by the State Board of Medical Licensure and Supervision was signed into law in 2016.
Oregon	Music therapy license managed by the Health Licensing Office was signed into law and regulations approved in 2015. http://www.oregon.gov/oha/hlo/Rules/MT-Final-Rules.pdf
Rhode Island	Music therapy registry managed by the Department of Health was signed into law in 2014 and regulations approved in 2015. http://webserver.rilin.state.ri.us/PublicLaws/law14/law14189.htm
Utah	Legislation creating a music therapy state certification managed by the Division of Occupational and Professional Licensing signed into law and regulations approved in 2014. http://www.dopl.utah.gov/licensing/music_therapy.html
Wisconsin	Music therapy registry created in 1998. http://dsps.wi.gov/Default.aspx?Page=2fad6e97-3d38-4cf9-8af2-1131c7684f40

2016 Legislative Activity

The following additional states filed legislation to recognize music therapist qualifications (education, clinical training, and national board certification), Colorado (title protection), Florida (registry), Iowa (license), Minnesota (license), Missouri (license), New Jersey (license), Ohio (license), Pennsylvania (license), South Carolina (license), and West Virginia (license)

For more information, please visit www.musictherapy.org and www.cbmt.org

EXHIBIT 2B

SCOPE OF MUSIC THERAPY PRACTICE

2015

Preamble

The scope of music therapy practice defines the range of responsibilities of a fully qualified music therapy professional with requisite education, clinical training, and board certification. Such practice also is governed by requirements for continuing education, professional responsibility and accountability. This document is designed for music therapists, clients, families, health and education professionals and facilities, state and federal legislators and agency officials, private and public payers, and the general public.

Statement of Purpose

The purpose of this document is to define the scope of music therapy practice by:

1. Outlining the knowledge, skills, abilities, and experience for qualified clinicians to practice safely, effectively and ethically, applying established standards of clinical practice and performing functions without risk of harm to the public;
2. Defining the potential for harm by individuals without formalized music therapy training and credentials; and
3. Describing the education, clinical training, board certification, and continuing education requirements for music therapists.

Definition of Music Therapy and Music Therapist

Music therapy is defined as the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. A music therapist is an individual who has completed the education and clinical training requirements established by the American Music Therapy Association (AMTA) and who holds current board certification from The Certification Board for Music Therapists (CBMT).

Assumptions

The scope of music therapy practice is based on the values of nonmaleficence, beneficence, ethical practice; professional integrity, respect, excellence; and diversity. The following assumptions are the foundation for this document:

- **Public Protection.** The public is entitled to have access to qualified music therapists who practice competently, safely, and ethically.
- **Requisite Training and Skill Sets.** The scope of music therapy practice includes professional and advanced competencies. The music therapist only provides services within the scope of practice that reflect his/her level of competence. The music therapy profession is not defined by a single music intervention or experience, but rather a continuum of skills sets (simple to complex) that make the profession unique.
- **Evidence-Based Practice.** A music therapist's clinical practice is guided by the integration of the best available research evidence, the client's needs, values, and preferences, and the expertise of the clinician.
- **Overlap in Services.** Music therapists recognize that in order for clients to benefit from an integrated, holistic treatment approach, there will be some overlap in services provided by multiple professions. We acknowledge that other professionals may use music, as appropriate, as long as they are working within their scope.
- **Professional Collaboration.** A competent music therapist will make referrals to other providers (music therapists and non-music therapists) when faced with issues or situations beyond the original clinician's own practice competence, or where greater competence or specialty care is determined as necessary or helpful to the client's condition.
- **Client-Centered Care.** A music therapist is respectful of, and responsive to the needs, values, and preferences of the client and the family. The music therapist involves the client in the treatment planning process, when appropriate.

Music Therapy Practice

Music therapy means the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapists develop music therapy treatment plans specific to the needs and strengths of the client who may be seen individually or in groups. Music therapy treatment plans are individualized for each client. The

goals, objectives, and potential strategies of the music therapy services are appropriate for the client and setting. The music therapy interventions may include music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, singing, music performance, learning through music, music combined with other arts, music-assisted relaxation, music-based patient education, electronic music technology, adapted music intervention, and movement to music. Music therapy clinical practice may be in developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational areas. Standards of practice in music therapy include:

- Accepting referrals for music therapy services from medical, developmental, mental health, and education professionals; family members; clients; caregivers; or others involved and authorized with provision of client services. Before providing music therapy services to a client for an identified clinical or developmental need, the music therapist collaborates, as applicable, with the primary care provider(s) to review the client's diagnosis, treatment needs, and treatment plan. During the provision of music therapy services to a client, the music therapist collaborates, as applicable, with the client's treatment team;
- Conducting a music therapy assessment of a client to determine if treatment is indicated. If treatment is indicated, the music therapist collects systematic, comprehensive, and accurate information to determine the appropriateness and type of music therapy services to provide for the client;
- Developing an individualized music therapy treatment plan for the client that is based upon the results of the music therapy assessment. The music therapy treatment plan includes individualized goals and objectives that focus on the assessed needs and strengths of the client and specify music therapy approaches and interventions to be used to address these goals and objectives;
- Implementing an individualized music therapy treatment plan that is consistent with any other developmental, rehabilitative, habilitative, medical, mental health, preventive, wellness care, or educational services being provided to the client;
- Evaluating the client's response to music therapy and the music therapy treatment plan, documenting change and progress, and suggesting modifications, as appropriate;
- Developing a plan for determining when the provision of music therapy services is no longer needed in collaboration with the client, physician, or other provider of health care or education of the client, family members of the client, and any other appropriate person upon whom the client relies for support;
- Minimizing any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborating with and educating the client and the family, caregiver of the client, or any other appropriate person regarding the needs of the client that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilizing appropriate knowledge and skills to inform practice including use of research, reasoning, and problem solving skills to determine appropriate actions in the context of each specific clinical setting.

Music therapists are members of an interdisciplinary team of healthcare, education, and other professionals who work collaboratively to address the needs of clients while protecting client confidentiality and privacy. Music therapists function as independent clinicians within the context of the interdisciplinary team, supporting the treatment goals and co-treating with physicians, nurses, rehabilitative specialists, neurologists, psychologists, psychiatrists, social workers, counselors, behavioral health specialists, physical therapists, occupational therapists, speech-language pathologists, audiologists, educators, clinical case managers, patients, caregivers, and more.

Music therapy-specific assessment, treatment planning, and implementation consider diagnosis and history, are performed in a manner congruent with the client's level of functioning, and address client needs across multiple domains.

Potential for Harm

Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices. The music therapist implements ongoing evaluation of client responses and adapts the intervention accordingly to protect the client from negative outcomes.

Music therapists use their knowledge, skills, training and experience to facilitate therapeutic, goal oriented music-based interactions that are meaningful and supportive to the function and health of their clients. These components of clinical practice continue to evolve with advances in basic science, translational research, and therapeutic implementation. Music therapists, therefore, participate in continued education to remain competent, know their limitations in professional practice, and recognize when it is appropriate to seek assistance, advice, or consultation, or refer the client to another therapist or professional. In addition, music therapists practice safely and ethically as defined by the AMTA Code of Ethics, AMTA Standards of Clinical Practice, CBMT Code of Professional Practice, CBMT Board Certification Domains, and other applicable state and federal laws. Both AMTA and CBMT have mechanisms by which music therapists who are in violation of safe and ethical practice are investigated.

The use of live music interventions demands that the therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs. Given the diversity of diagnoses with which music therapists work and the practice settings in which they work independently, clinical training and experience are necessary. Individuals attempting to provide music therapy treatment interventions without formalized music therapy training and credentials may pose risks to clients.

To protect the public from threats of harm in clinical practice, music therapists comply with safety standards and competencies such as, but not limited to:

- Recognize and respond to situations in which there are clear and present dangers to a client and/or others.
- Recognize the potential harm of music experiences and use them with care.
- Recognize the potential harm of verbal and physical interventions during music experiences and use them with care.
- Observe infection control protocols (e.g., universal precautions, disinfecting instruments).

- Recognize the client populations and health conditions for which music experiences are contraindicated.
- Comply with safety protocols with regard to transport and physical support of clients.

Definition of Governing Bodies

AMTA's mission is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. AMTA strives to improve and advance the use of music, in both its breadth and quality, in clinical, educational, and community settings for the betterment of the public health and welfare. The Association serves as the primary organization for the advancement of education, clinical practice, research, and ethical standards in the music therapy profession.

AMTA is committed to:

- Promoting quality clinical treatment and ethical practices regarding the use of music to restore, maintain, and improve the health of all persons.
- Establishing and maintaining education and clinical training standards for persons seeking to be credentialed music therapists.
- Educating the public about music therapy.
- Supporting music therapy research.

The mission of the CBMT is to ensure a standard of excellence in the development, implementation, and promotion of an accredited certification program for safe and competent music therapy practice. CBMT is an independent, non-profit, certifying agency fully accredited by the National Commission for Certifying Agencies (NCCA). This accreditation serves as the means by which CBMT strives to maintain the highest standards possible in the construction and administration of its national examination and recertification programs, ultimately designed to reflect current music therapy practice for the benefit of the consumer.

CBMT is committed to:

- Maintaining the highest possible standards, as established by the Institute for Credentialing Excellence (ICE) and NCCA, for its national certification and recertification programs.
- Maintaining standards for eligibility to sit for the National Examination: Candidates must have completed academic and clinical training requirements established by AMTA.
- Defining and assessing the body of knowledge that represents safe and competent practice in the profession of music therapy and issuing the credential of Music Therapist-Board Certified (MT-BC) to individuals that demonstrate the required level of competence.
- Advocating for recognition of the MT-BC credential and for access to safe and competent practice.
- Maintaining certification and recertification requirements that reflect current practice in the profession of music therapy.
- Providing leadership in music therapy credentialing.

The unique roles of AMTA (education and clinical training) and CBMT (credentialing and continuing education) ensure that the distinct, but related, components of the profession are maintained. This scope of music therapy practice document acknowledges the separate but complementary contributions of AMTA and CBMT in developing and maintaining professional music therapists and evidence-based practices in the profession.

Education and Clinical Training Requirements

A qualified music therapist:

- Must have graduated with a bachelor's degree (or its equivalent) or higher from a music therapy degree program approved by the American Music Therapy Association (AMTA); and
- Must have successfully completed a minimum of 1,200 hours of supervised clinical work through pre-internship training at the AMTA-approved degree program, and internship training through AMTA–approved National Roster or University Affiliated internship programs, or an equivalent.

Upon successful completion of the AMTA academic and clinical training requirements or its international equivalent, an individual is eligible to sit for the national board certification exam administered by the Certification Board for Music Therapists (CBMT).

Board Certification Requirements

The Music Therapist – Board Certified (MT-BC) credential is granted by the Certification Board for Music Therapists (CBMT) to music therapists who have demonstrated the knowledge, skills, and abilities for competence in the current practice of music therapy. The purpose of board certification in music therapy is to provide an objective national standard that can be used as a measure of professionalism and competence by interested agencies, groups, and individuals. The MT-BC credential may also be required to meet state laws and regulations. Any person representing him or herself as a board certified music therapist must hold the MT-BC credential awarded by CBMT, an independent, nonprofit corporation fully accredited by the National Commission for Certifying Agencies (NCCA).

The board certified music therapist credential, MT-BC, is awarded by the CBMT to an individual upon successful completion of an academic and clinical training program approved by the American Music Therapy Association (or an international equivalent) and successful completion of an objective written examination demonstrating current competency in the profession of music therapy. The CBMT administers this examination, which is based on a nationwide music therapy practice analysis that is reviewed and updated every five years to reflect current clinical practice. Both the practice analysis and the examination are psychometrically sound and developed using guidelines issued by the Equal Employment Opportunity Commission, and the American Psychological Association's standards for test validation.

Once board certified, a music therapist must adhere to the CBMT Code of Professional Practice and recertify every five years through either a program of continuing education or re-examination.

By establishing and maintaining the certification program, CBMT is in compliance with NCCA guidelines and standards that require certifying agencies to: 1) have a plan for periodic recertification, and 2) provide evidence that the recertification program is designed to measure or enhance the continuing competence of the individual.

The CBMT recertification program provides music therapists with guidelines for remaining current with safe and competent practice and enhancing their knowledge in the profession of music therapy.

The recertification program contributes to the professional development of the board certified music therapist through a program of continuing education, professional development, and professional service opportunities. All three recertification categories are reflective of the Practice Analysis Study and relevant to the knowledge, skills and abilities required of the board certified music therapist. Documentation guidelines in the three categories require applying learning outcomes to music therapy practice and relating them to the CBMT Board Certification Domains. Integrating and applying new knowledge with current practice, developing enhanced skills in delivery of services to clients, and enhancing a board certified music therapist's overall abilities are direct outcomes of the recertification program. To support CBMT's commitment of ensuring the competence of the board certified music therapist and protecting the public, certification must be renewed every five years with the accrual of 100 recertification credits.

NCCA accreditation demonstrates that CBMT and its credentialing program undergo review to demonstrate compliance with certification standards set by an impartial, objective commission whose primary focus is competency assurance and protection of the consumer. The program provides valuable information for music therapists, employers, government agencies, payers, courts and professional organizations. By participating in the CBMT Recertification Program, board certified music therapists promote continuing competence and the safe and effective clinical practice of music therapy.

AMTA and CBMT created this document as a resource pertinent to the practice of music therapy. However, CBMT and AMTA are not offering legal advice, and this material is not a substitute for the services of an attorney in a particular jurisdiction. Both AMTA and CBMT encourage users of this reference who need legal advice on legal matters involving statutes to consult with a competent attorney. Music therapists may also check with their state governments for information on issues like licensure and for other relevant occupational regulation information. Additionally, since laws are subject to change, users of this guide should refer to state governments and case law for current or additional applicable materials.

Publication 1/8/2015

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EXHIBIT 3A

Sunrise Review Music Therapy

Carolina Agurto
Cecelia Black
Claudia Figueroa
Raúl Mejía

March 16th, 2016

As part of a student project for the
Illinois Department of Financial and Professional Regulation

Advised by

Paula R. Worthington, Faculty Advisor
Wai-Sinn Chan, Professional Advisor

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Executive Summary

SB1595 signed by Governor Rauner in August 2015 created a Music Therapy Advisory Board to study the need and feasibility of music therapy regulation. This document is meant to offer initial recommendations concerning the question of music therapy licensure as the Board prepares to convene its review. In light of the Governor's focus and the upward trends for occupational licensure, this white paper uses a deliberate approach to understand the implications of music therapy licensure.

In this white paper, we analyze music therapy in five key areas: (i) scope of practice, (ii) market trends, (iii) regulation in other states, (iv) risks and (iv) overlapping professions. Music therapy is a clinical based profession that uses music intervention to address a diverse range of health conditions, such as autism, Alzheimer's, anxiety, and traumatic brain injury. The profession itself maintains industry standards through the Certification Board for Music Therapists (CBMT), a nationally recognized organization that provides an accredited professional certification program. In Illinois, music therapists receive funds from a mix of private and public funds. And, despite the organized efforts of music therapists, only seven states regulate music therapy through either a license, certificate, or registry. At the same time, state regulation has adopted CBMT's existing qualifications.

In terms of risk analysis, we find: (i) no substantive evidence showing unqualified therapists as serious public risk; (ii) that consumers are adequately protected with the existing consumer protection mechanisms such as the CBMT and the state attorney general's office; and (iii) no evidence to suggest that employment conditions limit music therapy's accessibility to consumers.

With a comprehensive understanding of the music therapy practice, we evaluate the need for licensure across seven criteria and conclude that music therapy does not warrant licensure, however, title recognition may be appropriate.
…

Introduction

Professional regulation aims to protect consumers by establishing a minimum set of standards in order to limit entry or even remove low-quality practitioners. Regulation, however, also restricts the supply of practitioners by erecting barriers to entry and potentially increasing the cost of services. Because of this, regulation should be imposed only on those occupations and professions that represent a risk to public health and safety.

On August 18, 2015, Governor Rauner signed SB 1595 into law. This bill created the Music Therapy Advisory Board with the objective of exploring the feasibility of regulating the music therapy practice in Illinois. Given the steady increase in unwarranted professional licensing across the United States, SB 1595 is important for two reasons. First, SB 1595 was introduced as the Music Therapy Licensing and Practice Act with no provisions for a sunrise review. The revised SB 1595 is now an opportunity to estabish music therapy regulation according to public welfare rather than politics. And secondly, SB1595 has come at a time when both Governor Rauner and IDFPR have focused more generally on enacting professional regulation that accurately addresses a profession's public risk.

The purpose of this document is to offer initial recommendations concerning the question of music therapy licensure as the Board prepares to convene its review. In order to respond to the question of licensure, we sought to understand music therapy across five key areas:

- The scope of music therapy
- Market trends
- Regulation and funding across states
- Public risks
- Comparable professions

With this analysis, we assess the current practice of music therapy using a seven point criteria for evaluating a profession's regulatory need adapted from the Virginia Board of Health Professions.[i] We believe the following criteria not only improves objectivity but allows regulators to think deliberately across intertwined aspects of regulation.

- **Criterion One: Public Risk**
  Unregulated, the profession causes significant public harm as a result of either: (i) the profession's specific practices, (ii) the clients served or (iii) the delivery of services.
- **Criterion Two: Specific Skillset**
  The profession requires specialized training and skills that the public must have assurance of.
- **Criterion Three: Professional Responsibilities**
  At least a portion of the scope of practice requires independent judgement and individual actions.

- **Criterion Four: Scope of Practice**
  At its core, the scope of practice is distinct from other regulated professions.
- **Criterion Five: Economic Impact**
  The economic cost of regulation appropriately matches its gains to public welfare.
- **Criterion Six: Alternatives to Regulation**
  There are no alternative policies or market mechanisms that adequately protect consumers in the absence of regulation.
- **Criterion Seven: Least Restrictive Regulation**
  If regulation is appropriate, the least restrictive form of regulation is to be used.

Using this criteria, this report finds no conclusive evidence to regulate music therapy. At the same time, we recognize music therapy as a distinct and specialized profession which operates within the highly licensed field of health professions. While there are barriers limiting the accessibility of music therapy, we found no conclusive evidence directly linking a lack of licensure to these barriers. In this regard, we recommend collecting more data on employment opportunities for music therapists. If further research shows that the regulatory status of music therapy does impact its accessibility, we recommend that the Department explores title protection which may elevate music therapy's status and as a result may improve public accessibility without the unnecessary burdens of a license.

The document is organized as follows. Part I defines the levels of regulation considered in this report. Part II provides an overview of the music therapy profession and details its scope of practice. Part III analyzes market conditions and trends at the national and state levels. In Part IV, we study the regulatory regime in other states to draw on national trends. Part V conducts a risk analysis to understand music therapy's regulatory need. In Part VI, we address the potential overlap between music therapy and the counseling professions. Finally, Part VII offers recommendations based on this reports comprehensive understanding of the music therapy practice and the criteria for regulatory need.

I. Levels of Professional Regulation

For consistency, this report considers four levels of professional regulation: licensure, certification, registration, and title recognition.

Licensure: Licensure is the most restrictive form of regulation. Professionals working in licensed professions must meet specified requirements and obtain a license through the State. Requirements typically include completion of a relevant educational program, professional exam, and/or a specified number of training hours. No individual can work in a licensed profession or practice within a defined scope of practice without a license. Generally there is a defined set of fines or legal penalties for those who unlawfully practice without a license.

Certification: State certification programs are similar to licensure in that individuals must meet specified requirements and obtain a certificate through the state to practice within a profession. However, unlike licensure policies, certification programs are generally conditional on the individual obtaining certification.

Registration: Registration programs create voluntary requirements for individuals working in a registered profession. Individuals who meet specified requirements are eligible to register with the State. Only registered professionals can use the title "State registered." Like licensure and certification, registration creates a list of registered professionals for consumers to verify.

Title Recognition: Title recognition is the least restrictive form of regulation. Title recognition defines the requirements to work within a profession and reserves a professional title to only those individuals who meet the requirements. Unlike the first three forms of regulation, title protection does not require individuals to register with the State and generally does not create specific policies to penalize or remove unqualified individuals working within the recognized profession.

II. Background

Music Therapy Organizations

The current practice of music therapy is best understood in the context of two national organizations: the American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT). Both are certified by the National Commission on Certifying Agencies and play a role in setting the standards for music therapists' education and qualifications.

The American Music Therapy Association (AMTA)

The AMTA is a professional organization of music therapists with the responsibility of approving music therapy academic, internship, and continuing education programs. Through the academic program approval committee, the AMTA sets the standard for the education of music therapists. The academic program approval

committee works with relevant accrediting agencies to first establish program requirements at a bachelor's, master's, and doctorate level and, second, to approve individual music therapy programs. Therefore, universities wishing to offer a recognized music therapy program must meet AMTA standards and earn AMTA approval. In Illinois, there are two bachelor programs and one master's program in music therapy.[ii]

The Certification Board for Music Therapists (CBMT)
The CBMT is also a professional organization but with the responsibility of approving individual music therapists through CBMT's music therapist certification. This certification has set a national standard for music therapist qualifications. A music therapist with a board certified title (MT-BC) must meet the following CBMT standards:[iii]

- Bachelor's in music therapy from an AMTA approved program
- 1,200 hours of clinical training
- Music Therapy Board Certification Examination
- 100 hours of continuing education per five year CBMT renewal period

What is music therapy? And, what do music therapists do?

Music therapy is a healthcare profession that uses music to address patients' physical, emotional, cognitive, motor and social needs within a therapeutic relationship. It can be applied to individuals or groups. Depending each client's needs, a music therapist creates a music-based treatment plan, which can include: musical improvisation, listening to music, singing, moving, song writing, lyric discussion, and imagery, among other techniques.

The most common uses of music therapy in Illinois address autism, Alzheimer's, dementia, developmental disabilities, and mental health.[iv] Moreover, as explained by the AMTA, music therapy can give people different avenues of communication and can be particularly helpful for those who have trouble expressing themselves with words.

The therapy can be targeted to musical or non-musical goals. Some examples of music therapy goals are the following[v]:

- Communication goals: improve verbal and non-verbal communication
- Socialization goals: increase socialization using instructions on music pieces
- Motor goals: improve gross and fine motor functioning through musical rehabilitation exercises
- Academic goals: improve academic performance by combining music with academic information
- Memory gains: singing familiar songs to access long-term memory
- Reduce stress and agitation: using instrumental and vocal music
- Pain relief: by using guided music listening and relaxation technics to improve tolerance to pain
- Decrease anxiety: through music listening, lyric analysis, music and imagery

In addition, as explained by Nancy Swanson, IAMT Government Relations Chair, each therapy is built around indicators that can allow the therapist to measure the client's progress. For example, the number of times the patient says the correct word at the right time is one way to measure progress for goals related to communication.

What does a traditional curriculum in music therapy look like?

A bachelor degree in music therapy provides competency in three different areas: musical foundations, clinical foundations and music therapy foundations. The curriculum has a strong practical focus with required practice in health facilities and clinics, where students learn to assess a client's needs, design a proper treatment plan, and evaluate the treatment progress[vi].

The particular courses vary from one institution to the other. Yet, the following list provides an example of common coursework[vii]:

- Music courses: applied music, aural skills, instruments, and voice techniques
- Psychology courses: general psychology, psychology of music, and influence of music
- Therapy related courses: observation and measurement, therapy activities, and therapy methods
- Clinical practicum and internship of 6 months

There are 70 different AMTA approved bachelor degrees in U.S. colleges and universities[viii].

What are the differences between music therapy and other professions that also use music?

Other professions also use music as therapeutic tools, such us:

- Music thanatologists use music (harp and voice) tailored to the physiological needs of patients who are dying.[ix]
- Therapeutic musicians are artists who use the healing elements of live music and sound to help the process of recovery.[x]

Unlike other music professions, in music therapy, music is used as a therapeutic tool to rehabilitate normal functions of patients or to improve patients' quality of life. Music therapists evaluate the effect of music on their clients using measurable indicators to evaluate changes in their behavior. In this sense, the clinical training of music therapists is key for their ongoing evaluation of the patient's response to the therapy. In contrast, other professions use music to create an environment that helps patient's recovery or eases their transition to death. Music therapists usually have more requirements to become a qualified professionals than other occupations. This includes considerably more clinical training hours (e.g. 1,200 hours of clinical training for music therapist vs. 100-125 hours in hospitals for therapeutic musicians[xi]).

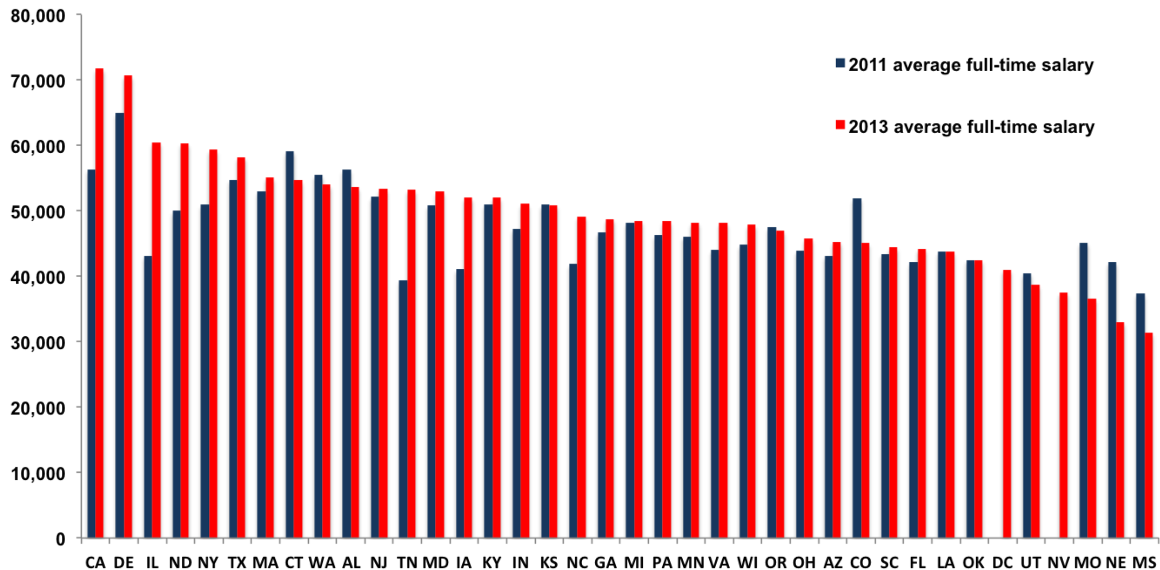
Consequently, the issue of distinguishing between music therapy and other professions that use music is a real issue. From a healthcare facility perspective, for example, therapeutic musicians might seem synonymous with music therapists. Regulation may help in this matter. However, in order to justify the costs of regulation, there must first be a clear need to distinguish music therapy from other professions.

III. Current Market Conditions

Music therapy in the United States has its origins after World War II, when musicians traveled to hospitals to entertain war veterans suffering from emotional and physical trauma. This led nurses and doctors to request that hospitals hire music professionals.[xii]

As of 2013, the reported average full-time salary at the national level was $51,899. Along with the number of music therapists, their salary has also been steadily rising during the last years.

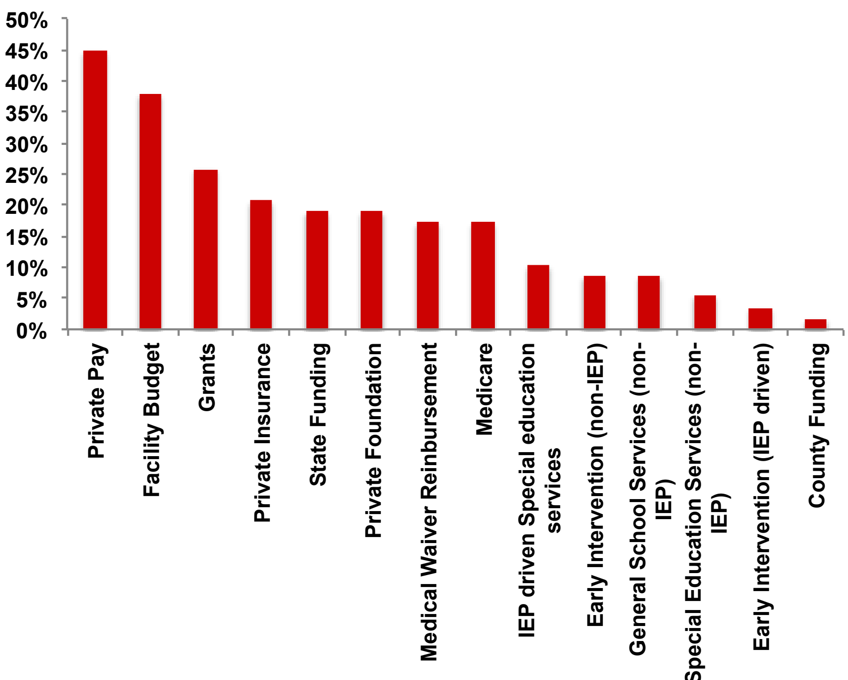
Figure 1. AMTA: Annual average reported salary, per state



Source: 2011 AMTA Member Survey and Workforce Analysis, 2013 AMTA Member Survey and Workforce Analysis

The job market for music therapists is growing on the whole. More people study music therapy in order to serve a growing demand. Currently, music therapists offer their services in all 50 states. The most common conditions treated by music therapists are developmental disabilities, Autism, Alzheimer, and learning disabilities. They mainly work in geriatric facilities, mental health facilities, medical settings and schools. Around 8% also report being self-employed. [xiii]

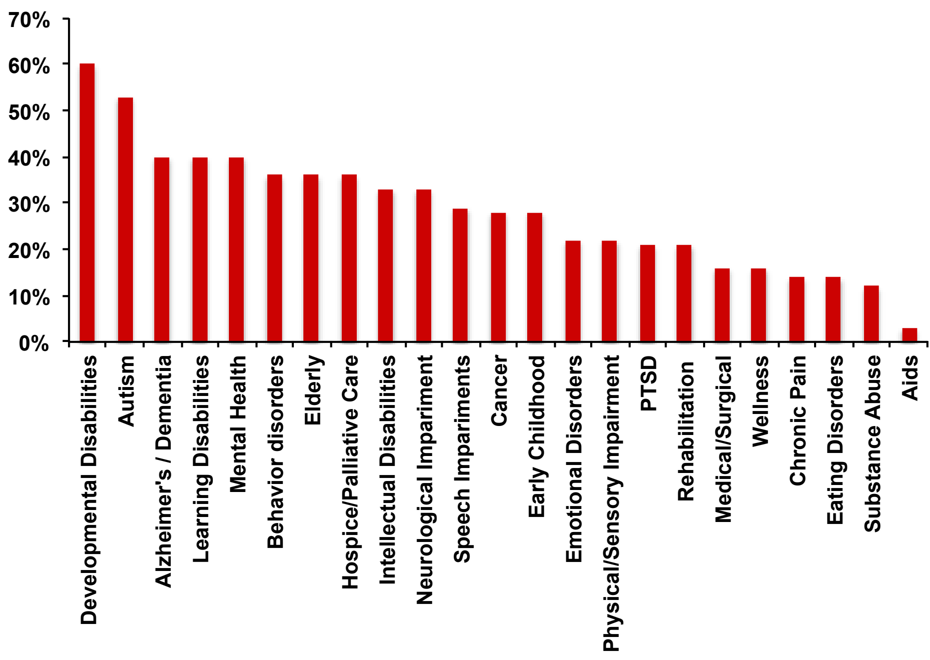
Figure 2. Percentage of Illinois music therapists who receive program funding, by funding type



Note: The survey used for the construction of this graph allowed for multiple responses. Because of this, total exceeds 100. Number of respondents: 128
Source: http://musictherapyillinois.org/about/fact-sheet/

In Illinois, there are currently 243 board certified music therapists. Music therapists in Illinois follow the national trends and work mainly on developmental disabilities, Autism, Alzheimer and mental health and work in educational, geriatric and medical settings. Currently, two institutions approved by the American Music Therapy Association (AMTA) offer degrees on music therapy in the State: Western Illinois University and the College of Fine Arts of the Illinois State University. Board certification appears to be valuable to music therapists. In a 2014 survey, 85% reported that their employers required board certification.

Figure 3. Most commonly treated conditions in Illinois, by percentage



Note: The survey used for the construction of this graph allowed for multiple responses. Because of this, total exceeds 100. Number of respondents: 128
Source: http://musictherapyillinois.org/about/fact-sheet/

IV. Music Therapy Regulation in Other States

In 2005, the AMTA and CBMT created a state recognition plan that has led to local music therapy task forces in 45 states.[xiv] As a result of their efforts, nearly half of the state legislatures in the United States have introduced bills regulating music therapy. The majority of these bills have either died in committee, expired, or are waiting for a sunrise review. However, seven states now regulate music therapy under occupation specific acts. Georgia, Nevada, North Dakota, and Oregon do this with a music therapy license; Utah offers a music therapy certificate; and Rhode Island and Wisconsin have a music therapy registration. While no state uses a general title protection policy to regulate the entire music therapy profession, Arizona defines the qualifications for music therapists working with developmental disabilities. In addition to music therapy specific regulation, four states offer alternative licenses.

Music Therapy Regulation Overview

A broad overview of state regulation provides insight into trends and the perceived need of music therapy regulation. However, it can be difficult to compare states within similar categories of regulation. One approach the Institute of Justice uses is to measure regulation by its burden or the difficulty of obtaining a license. In Table 1 we have applied this method (*see methodology*) to rank the seven states with music therapy regulation by their regulatory burden. Burden was measured on the

level of regulation (license, certificate, or registration) and four requirement categories: education level, clinical training hours, annualized continuing education hours, and annualized fees. Because the CBMT certificate is already required by the majority of employers, we used CBMT as a baseline and considered a state's burden to be any additional requirements beyond those needed for the CBMT. While these states vary slightly in the required continuing education hours and states fees, they primarily adopt CBMT's requirements, where in addition to education and training, applicants must pass the CBMT exam and maintain a current CBMT certificate.

Table 1. Comparison of state music therapy regulation ranked by burden

Ranking	State	Regulation	Education beyond CBMT	Training hours beyond CBMT	Annualized cont. ed beyond CBMT	Year Effective	Annualized fees	Active licensees
1	Nevada	License	0	0	13	2012	$ 58.33	15
2	Oregon	License	0	0	0*	2015	$ 125.00	--
3	North Dakota	License	0	0	0	2012	$ 87.50	12
4	Georgia	License	0	0	0	2014	$ 37.50	127
5	Utah	Certificate	0	0	0	2015	$ 58.50	**35**
6	Rhode Island	Registration	0	0	0	2015	$ 45.00	--
7	Wisconsin	Registration	0	0	0	1998	$ 37.50	50

*Required continuing education hours in Oregon are less than CBMT's required hours
Source: State departments of occupational licensing

<u>Music Therapy License</u>: Georgia, Nevada, North Dakota, and Oregon
As illustrated in Table 1, Georgia, Nevada, North Dakota and Oregon do not differ greatly from other music therapy regulation in terms of requirements. Without annual licensure and salary data, we cannot draw conclusions about the effects of licensure. The music therapy acts in all four states pay attention to potential professional overlap. In Georgia, in particular, occupational therapists, physical therapists, and speech and language pathologists opposed licensure for music therapists. As a result, the bill specifically states that the music therapy license shall not prevent any professions such as occupational therapists, speech and language pathologists, and audiologists from using music in their practice.

<u>State Certification: Utah</u>
Utah's state certification became effective in 2015. While eligible music therapists may apply voluntarily for the state certification, it is unlawful to use the title "state certified music therapist". However, a CBMT music therapy without state certification can still practice and advertise as a CBMT certified therapist.[xv] According to the bill's fiscal note, Utah expected 50 individuals to apply for certification in 2015. The bill was projected to earn $5,200 in annual revenue and cost $700 in expenditures.[xvi] Still in its first licensing period, Utah has 46 active certified music therapists. However, there are 87 music therapists in Utah with an active CBMT certificate, meaning that the state certificate has only attracted a little more than half of Utah's qualified therapists.

State Registration: Rhode Island and Wisconsin

Wisconsin and Rhode Island provide a voluntary state registration for music therapists. In Wisconsin, like Utah, only 59 out of 127 CBMT certified music therapists have registered.[xvii] Wisconsin is slightly unique from the other six states with music therapy regulation. First, it established a music therapy registration in 1998, long before AMTA's and CBMT's state recognition plan. Secondly, in addition to the voluntary registration, Wisconsin regulates music therapists working in psychotherapy through a license to practice psychotherapy. As a result, Wisconsin explicitly excludes psychotherapy from non-licensed music therapists' scope of practice. With a master's degree, qualified music, art, and dance therapists are eligible for the license in psychotherapy which Wisconsin defines as the "diagnosis and treatment of mental, emotional, or behavioral disorders (…) through the application of methods derived from established psychological or systemic principles for the purpose of assisting people"[xviii]

Other music therapy regulation: Arizona

Arizona's SB 1376 does not fit entirely within the traditional definition of title protection, however it operates in a similar fashion for music therapists contracting with the state agency of the Department of Economic Security's (DES) Division of Developmental Disabilities (DDD).[xix] SB 1376 defines the minimum qualifications required for music therapists working with developmental disabilities though the DDD program. Like other music therapy regulation, SB 1376 requires music therapists to hold an active certification from a national certification board like CBMT.

Alternative License

In addition to the states that regulate music therapy, four states offer an alternative license for music therapist (Table 2). New York has a creative arts therapist license which encompasses a combination of psychotherapy, with the practice of drama, music, art, or dance therapy. Pennsylvania and Texas have expanded their professional counselor license to include a master's in music therapy as an approved program for the counselor's education requirements. Wisconsin, mentioned above, has a license to practice psychotherapy. These four licenses are neither specific to music therapy nor required for music therapists. For example, in Pennsylvania, Texas, and Wisconsin, music therapists do not need a license in psychotherapy or counseling to practice music therapy, but are eligible to obtain if they choose to practice psychotherapy.

Table 2. Alternative License

State	License	Annualized Fee	Education	Clinical Training Hours	Additional Tests
New York	Creative Art Therapist License	$ 172.50	Masters	1500	0
Wisconsin	License to Practice Psychotherapy	$ 128.50	Masters	3000	0
Texas	Professional Counselor License	$ 153.00	Masters	3000	1
Pennsylvania	Professional Counselor License	$ 70.00	Masters	3000	0

Source: State departments of professional regulation

Like many other licensed health professions, these require a master's level of education and more clinical training hours than under the CBMT certificate. Because these licenses have more requirements and are primarily optional for music therapists, it is difficult to gauge how restrictive each license is. One important factor is the level of overlap between the scope of practice for music therapy and a license. The more overlap that exists the more restrictive a license will be. In the case of New York's creative arts therapist license, unlicensed music therapist cannot use the creative arts therapist title nor perform duties that fall under the restricted scope of creative arts therapist.[xx] However, because there is considerable overlap between these two, the creative arts therapist license is likely to create much larger barriers for music therapists than, for example, an expanded professional counselor's license.

Public Funding Across States

One argument for music therapy licensure is its importance on funding opportunities for music therapy. Licensure proponents argue that language under private insurance and Medicaid requires funds to only cover state licensed providers. Funding issues do create barriers for consumers trying to access music therapy. Given the low prevalence of state regulation and high prevalence of restricted funding sources, it is important to understand the relationship between the two.

The Medicare, Medicaid, and education spending are the three primary government sources of music therapy funding. Medicare is a federal health insurance plan for Americans who are age 65 and older and have paid into the system through income tax. For Medicare recipients, music therapy is a covered service under the mental health/Partial Hospitalization Program and because it is a federal program, it applies to Medicare plans throughout the Unites States.

Table 3. Funds allocated toward music therapy services

State	Music Therapy Regulation	Medicaid for adults w/ disabilities	Medicaid for children w/ disabilities	State education IDEA funds
Georgia	License			
Nevada	License			
North Dakota	License			
Wisconsin	Registration		✓	
New York	Creative Arts			✓
Texas	Counselor License	✓	✓	✓
Colorado	No	✓	✓	✓
Indiana	No	✓	✓	✓
Washington	No		✓	
Illinois	No	✓	✓	✓

Source: State Medicaid, Board of Education, and music therapy providers

Medicaid

Medicaid is health care coverage for low income households that is jointly funded by the federal and state government. Unlike Medicare, there is a basic Medicaid list of core services which states can amend using waivers and demonstration programs. There are no standard or mandatory waivers, however, a waiver will typically detail coverage for an eligibility group, such as children. It is in these waivers where states can list music therapy as a specific covered service. Typically, when music therapy is covered it is under waivers pertaining to children and adults with disabilities with titles similar to Texas' "Community Living Assistance and Support Services" waiver.[xxi] However, there are other waivers, such as waivers for palliative care and traumatic brain injury that occasionally include music therapy. For example, New York's Medicaid program covers music therapy under the Care at Home waiver for pediatric palliative care. In the waiver there is explicit language describing both who is eligible to receive the service and who is eligible to provide the service, including music therapists who are certified by accredited professional organizations.[xxii] While New York covers music therapy for palliative care it does not cover it as a general pediatric service for disabilities. For consistency, we researched music therapy's Medicaid status among waivers related only to adults and children with disabilities. We counted only waivers that explicitly stated music therapy as a billable service and used a small sample of states with various music therapy regulation.

The three states we researched with a music therapy license did not cover music therapy under any adults or children with disabilities waiver. Georgia, for example, is in the midst of a Medicaid redesign, however services listed for the New Options Waiver program for adults with disabilities lists occupational therapy, physical therapy and speech therapy but does not list music therapy.[xxiii] Conversely, Colorado covers music therapy under the Children's Extensive Waiver and

Supported Living Services Waiver.[xxiv] In Indiana it's covered under the Community Integration and Family Supports waivers, while Texas covers it under the Community Living Assistance and Support Services waiver. In all three states, music therapists must have a certification from a national professional organization.

A music therapist and state task force member in Washington State reported that only children are eligible to receive music therapy under Washington's Medicaid program which is a problem for many private practices like hers. However, she also said that in its sunrise review on music therapy licensure, the Department of Health denied licensure with the recommendation that the task force focus its efforts at the State's Department of Social and Health Services who directly oversee Medicaid programs.[xxv]

Most importantly, in Illinois, a music therapist with a bachelor's degree is considered a Qualified Intellectual Disability Professional. Under this category, music therapists can provide Medicaid services for people with disabilities but only as a member of a defined Interdisciplinary Team (IDT) focused on a patient's specific Individual Service Plan (ISP).[xxvi]This means that while Illinois Medicare can cover music therapy, a physician or referring provider must first show that it is medically necessary.

IDEA Education Funds

The third source of government funding is education spending, specifically Individuals with Disabilities Education Act (IDEA) funds. The federal government distributes IDEA funds to states through several block grants. Within these broad programing categories, states often have a lot of discretion over spending. It is within these IDEA grants, that a few states have allocated spending for music therapy. Like Medicaid, the state's discretion creates ambiguity around which services are funded and which are not. While states use a significant portion of IDEA funds on large, standardized programs, they also often award grants to specific school districts and individual school projects. Although for our purposes these smaller funds may go to music therapy programs, they are difficult to track. Therefore using the same sample of states, we researched IDEA funds at the broad state level to determine which states funded music therapy through the federal grant.

Of the three licensed states in our sample, we did not find any that earmarked IDEA funds for music therapy. However, a music therapist from CBMT did state that, as licensed professionals, music therapists in North Dakota are now eligible service providers for student's Individual Education Plans (IEP)[xxvii]. However, the most current state-wide manual for IEP procedures states that state licensure is only applicable for specific professions such as physical therapists.[xxviii] At the same time, it does not mention music therapy and therefore is not included as a state with IDEA funding for music therapy in Table 3.

New York, Texas, Colorado, Indiana, and Illinois are among states that do allocate IDEA funds to music therapy. New York lists part-time music therapists as an allowable use if IDEA funds.[xxix] Similarly, Texas lists music therapy as a school-based therapy that is included in IEPs.[xxx] In Illinois, music therapy is considered an additional service that students with disabilities are eligible for under an IEP. In this category, service providers must either have a state license or, as in music therapy, hold a credential from a recognized professional organization.[xxxi]

V. Risk Analysis of the need for Music Therapy License in Illinois

Arguments for Music Therapy Licensure

The CBMT and the Illinois Association for Music Therapy list several arguments to justify the licensure request for music therapy. These arguments can be organized in terms of the effected stakeholders:

a. For consumers:
   - To ensure music therapists are qualified individuals and that the therapy will not harm the client
   - To guarantee the availability of music therapy services
   - To expand consumer access to music therapy services
b. For current music therapists:
   - To comply with current employers' requirements
c. For healthcare facilities:
   - To provide guidance on distinguishing between music therapists, music practitioners, music thanatologists, and other non-music therapy musicians in healthcare
d. For both consumer and providers:
   - To increase access to public funding alternatives
e. For society in general:
   - To promote awareness of music therapy as a profession, its differences with other arts therapies or related professions, and its contribution

Risk Analysis of an Unlicensed Music Therapy Practice

Taking into account the previous arguments, it is pertinent to analyze whether an occupational license would effectively address CBMT and the Illinois Association for Music Therapy's concerns. The potential risks of not regulating music therapy in the state on Illinois can be classified into three main categories: (i) harm caused by unqualified therapists; (ii) mechanisms to protect consumers from malpractice; and, (iii) barriers preventing public access to music therapy services.

(i) Harm caused by unqualified therapists

We evaluated the risk caused by unqualified therapists using three categories of sources: music therapy reviews from other states, existing music therapy procedures in Illinois, and testimonies from music therapists. From these sources, we found the risk presented from unqualified therapists to be limited.

Other states that have investigated the potential of consumer harm have shown that in the case that music therapy is not well-performed, the potential emotional and psychological harm is not comparable to the potential permanent damage caused by other licensed professions, such as doctors. In Colorado's Department of Regulatory Agencies' (DORA) 2014 sunrise review in 2014, it studied examples of harm provided by the American Music Therapy Association. After studying 10 examples related to emotional, psychological and physical harms, DORA concluded the following:

"These cases do not demonstrate evidence that the unqualified practice of music therapy harms the public. In the cases presented in which clients were medically fragile, they were protected by other means."[xxxii]

Additionally, DORA analyzed the cases provided by the CBMT. Most of these cases provided evidence of harm to the public by board-certified music therapists. The type of harm were related to sexual abuse of children with developmental disabilities, sex with patients in psychiatric wards, and financial exploitation of elderly clients. In this regard, it is worth mentioning that an occupational license would not deter these types of misconduct, and since they can be considered crimes, the offenders can be subject to criminal sentences by the current judicial channels established for those purposes.

Secondly, through DORA's report and current practices in Illinois, it is evident that the potential risks for patients are mitigated in part because music therapy sessions are normally conducted under the supervision of other health professionals or are already screened for quality. Indeed, in Colorado's Sunrise Review, DORA found that in some of the examples of harm provided by the American Music Therapy Association, the music therapy was supervised by doctors and nurses.

In the specific case of Illinois, the Department of Human Services' Rule 132 59 ILAC[xxxiii] defines "therapy" to treat mental illness conditions and billed under Medicaid as follows:

"a treatment modality that uses interventions based on psychotherapy theory and techniques to promote emotional, cognitive, behavioral or psychological changes as identified in the ITP. Services shall be provided face-to-face, by telephone or videoconference."

Therefore, music therapy could be billable under Rule 132[xxxiv]; however, it needs to be part of an Individual Treatment Plan (ITP) which includes an attending physician or healthcare provider as well all as a team of mental health professionals. More

specifically, an ITP details the goals, type of services, the responsible professionals, the service intensity and progress indicators designed to treat a patient with mental illness.

Most importantly, under the ITP, music therapists must be board certified. Therefore, for Medicaid patients, a music therapy license would only reiterate qualifications already required under Rule 132. Secondly, Rule 132 describes an interdisciplinary team, whereby an attending physician or healthcare provider must recommend music therapy. In this situation, it is highly unlikely an unqualified music therapist would be permitted to practice without the fault pointed to the entire healthcare team.

Like Illinois' Medicaid rule, Illinois education funds already screen for quality by requiring music therapists receiving IDEA funds to have certification from a nationally accredited professional organization.[xxxv] Again, licensure would not reduce the risk rather reiterate existing standards. At the same time, music therapists working in the education system are most often working under IEPs that create a team of education providers with specified goals.

To gather more evidence regarding the potential harm of poorly performed music therapies, we interviewed two relevant stakeholders: Nancy Swanson, Government Relations Chair of the IAMT, and Kimberly Senna-Moore, CBMT Regulatory Affairs Associate. From them, we gathered several examples of potential harm:

NICU: One specialization of music therapy is working with premature babies in the NICU. Within the mother's womb, a fetus is stimulated by sound while also protected by the womb. For example, at seven months, a fetus can recognize its mother voice. However, premature babies are unprotected from the natural process of audio stimulation. Music therapists are trained to play the appropriate pitches and sounds to mimic the sound vibration of the womb for premature babies as they continue to develop. However, an untrained therapist can pose a serious risk by playing a wrong pitch and permanently damage its auditory system.

Cancer center: Another example is patients in cancer centers, who are particularly vulnerable when they are starting treatments. In this setting, someone without the proper music therapy training could open up emotions and generate emotional harm. Because the use of live music interventions demands that the music therapist not only possess unique musical abilities but also the knowledge and skills of a trained therapist, an unqualified music therapist cannot easily adapt therapies to sudden emotional changes.

Alzheimer's patients: For patients with Alzheimer's and other forms of dementia music therapy can slow memory loss and provide an alternative form of communication if speaking is difficult. However, music can also trigger severe states of anxiety. In nursing homes, where music therapy is often provided in groups, this anxiety can spread across patients. In these situations a music therapists can

quickly change techniques to calm patients whereas unqualified music therapists lack the training to quickly assess the situation.

Unconscious or comatose patients: For patients who are unconscious or in a coma, the music therapist needs to be highly skilled at recognizing patients' behaviors to know whether the music stimulus is helping or harming the client. In regards to unconscious patients, Senna-Moore provided a specific example:

A teenage boy was in a coma as a result of an accident. A family friend, who was musically talented but not a music therapist, offered to play music to help the teenager relax. Therefore on the request of the family, and knowing the friend was not a music therapist, the friend played Mozart in the patient's room. However, the patient became very agitated in response and his vital signs showed duress. His doctors then called in a trained music therapist who evaluated the situation and altered the music according to boy's music preferences and his responding vital signs.

In these examples, unqualified music therapist do present consumer risk, however, it is unclear if licensure would further protect consumers. In the first example, NICUs are highly controlled spaces that permit only qualified personnel. Without further evidence, we believe that in current NICUs only qualified music therapists with CBMT certificates are performing music therapy services. We believe this also true for cancer wards, where CBMT certification is already required. However, given the less stringent nursing home codes, this may pose more of a risk for Alzheimer's patients in nursing. Lastly, in the example of the teenager in a coma, licensure would not change the situation given that family knowingly admitted an untrained friend as a guest. Rather this example shows that appropriate knowledge and access is in place for the medical doctors knew how to respond and where to request for a qualified therapist.

(ii) Lack of consumer protection mechanisms in case of malpractice

Even in a case of music therapy malpractice, Illinois consumers already have alternative channels for filing their complaints. Two agencies, the Illinois Attorney General's Office and the Federal Trade Commission (FTC) are particularly well equipped to address music therapy malpractice.

1. Illinois Attorney General's Office

Attorney General Lisa Madigan's Consumer Protection Division protects Illinois consumers and businesses victimized by fraud, deception, and unfair business practices. The Consumer Protection Division works through the following bureaus: Consumer Fraud Bureau, Charitable Trust Bureau, Franchise Bureau, Health Care Bureau, and Military and Veterans Rights Bureau.[xxxvi]

In particular, the Consumer Fraud and Health Care Bureaus offer informal dispute resolution programs for consumers with complaints concerning their purchases and health care.

Consumers can file a complaint by mail or online at https://ccformsubmission.ilattorneygeneral.net/.[xxxvii] After the complaint is received, it is reviewed by attorneys, investigators, and other members of the Attorney General's staff involved in carrying out the responsibilities of the Illinois Attorney General. Finally, the complaint is sent to the party with which the person has a dispute to initiate legal procedures. The information might also be shared with governmental enforcement agencies responsible for consumer protection and other laws.

2. Federal Trade Commission

The FTC is a bipartisan federal agency with a unique dual mission to protect consumers and promote competition.[xxxviii] The FTC has three Bureaus:

- Bureau of Competition
- Bureau of Consumer Protection
- Bureau of Economics

In particular, the Bureau of Consumer Protection's mandate is to protect consumers against unfair, deceptive or fraudulent practices. The Bureau enforces a variety of consumer protection laws enacted by Congress, as well as trade regulation rules issued by the Commission. Its actions include individual company and industry-wide investigations, administrative and federal court litigation, rulemaking proceedings, and consumer and business education. In addition, the Bureau contributes to the Commission's on-going efforts to inform Congress and other government entities of the impact that proposed actions could have on consumers.[xxxix]

This Bureau has eight divisions: Division of Privacy and Identity Protection, Division of Advertising Practices, Division of Consumer & Business Education, Division of Enforcement, Division of Marketing Practices, Division of Consumer Response & Operations, Division of Financial Practices, Division of Litigation Technology & Analysis. Besides these divisions, the Bureau also has regional offices in Atlanta, Chicago, Cleveland, Dallas, Los Angeles, New York, San Francisco, and Seattle that help to amplify the national impact and local presence of the FTC.

To fill a complaint, consumers can do it online at www.ftc.gov/complaint, or by phone at +1 877-FTC-HELP. Once the complaint is filled, it is entered in the FTC's online database, which is used by many local, state, federal, and international law enforcement agencies. The information of the complaint helps the FTC and their law enforcement partners detect patterns of fraud and abuse, which may lead to investigations and eliminate unfair business practices. Even though, the FTC cannot

resolve individual complaints, they can provide information about what next steps to take.

Alternatively, if a patient was a victim of malpractice and they received music therapy through a hospital, for example, they can take legal actions against those institutions. Indeed, since these types of institutions are considered "health care providers", under Illinois laws, in a case of malpractice patients can sue them directly in case of harm. The 770 ILCS 23/5 defines "health care providers" as any entity in any of the following license categories: licensed hospital, licensed home health agency, licensed ambulatory surgical treatment center, licensed long-term care facilities, or licensed emergency medical services personnel.

On the other hand, there are ex-ante mechanisms that control music therapists' quality, mitigating in part the potential harm to patients in Illinois. Indeed, the Board's Code of Professional Practice regulates the practice of those music therapists certified by the CBMT. To maintain their board certification, they need to meet the requirements of quality standards established by the Code of Professional Practice. Failure to meet the requirement may lead to suspension or revocation of certification. Furthermore, the Code of Professional Practice also specifies disciplinary procedures for filling and reviewing complaints from consumers attended by certified music therapists[xl].

In the same way, the American Music Therapy Association (AMTA) regulates music therapists though their Code of Ethics. Their Code of Ethics "*is applicable to all those holding the MT-BC credential or a professional designation of the National Music Therapy Registry and professional membership in the American Music Therapy Association. This Code is also applicable to music therapy students and interns under clinical supervision*".[xli]

In conclusion, existing consumer protection mechanisms at the national and state level are effective at mitigating risk and therefore occupational licensing is not needed on the basis of consumer protection.
During the investigation we asked Kimberly Moore, Regulatory Affairs Associate of CBMT, if she could provide IDFPR with CBMT complaint data. Even though, we haven't been able to have access to that specific complaint data, it is advisable that the Music Therapy Advisory Board collects this kind of information from CBMT – together with FTC's and Illinois Attorney General's– in order to identify not only the magnitude of it, but also the common problems related to music therapy practice.

(iii) Barriers preventing public access

A third argument for licensure is that because music therapists work in a highly licensed field of health and education professionals, a lack of licensure prevents employment and funding opportunities and in return creates barriers for the public to access music therapy services.

The current regulatory status for music therapy in Illinois has not represented a barrier for their professional development. Indeed, according to the AMTA and Illinois Associations for Music Therapy, not only has the number of professionals increased in the last years (71.1% between 2011 and 2015), but their average salary per year has also increased (approximately 39.5% between 2010 and 2014). Moreover, music therapists in Illinois have been able to work in different settings besides private practice (i.e. hospices, nursing homes, schools, community organizations, etc.).

Additionally, as Figure 3 on page 10 shows, music therapists in Illinois are already funding from a variety of sources including education funds, Medicaid, and private facilities.

Furthermore, on the grounds of title protection it is already unlawful to incur unfair methods of competition and unfair or deceptive acts or practices to misled, deceive or damage any person[xlii]. Therefore, a person cannot claim having a university degree in music therapy without actually holding it, otherwise there could be legal consequences.

VI. Comparison of Music Therapists and Professional Counselors

Understanding a profession's relationship to current regulation is critical to evaluating its regulatory need. In particular, assessing new regulation in context to licensed professions in similar fields provides important benchmarks to gauge public safety risks and prevents redundant and overlapping regulation. Along these lines, effective regulation will limit the number of specialty licenses by regulating similar occupations together. Given the considerable overlap between music therapists and licensed professional counselors, licensing music therapy under the professional counselor license is one potential alternative to music therapy regulation.

Technically, Illinois defines a professional counselor as a therapist who works with individuals, couples, groups, and families to either (i) assess or diagnose for the purpose of developing treatment goals or (ii) implement and evaluate a treatment plan to improve mental, emotional or behavioral disorders that affect mental health.[xliii] This general definition allows the professional counselor license to encompass several specialties. In practice, license includes 4,000 licensed counselors practicing across a diverse set of mental health specialties such as art therapy, dance and movement therapy, and rehabilitation counseling.

In comparison, one definition of a music therapist is a practitioner who (i) assesses and diagnoses a client for the purpose of music therapy goals and (ii) implements a treatment plan to address physical, emotional, cognitive, and social needs of individuals. From these two definitions, music therapy appears to fit well within the broader counselor category-and many music therapists do. However, music therapy has many applications that extend beyond mental health. Illinois' professional counselor license would only apply to the portion of music therapy that falls under mental health, excluding a significant portion of the music therapy practice. For

example, music therapy plays an important role in helping nonverbal stroke and traumatic brain injury patients regain speech. In this sense music therapy is more aligned with speech and language pathology, which Illinois regulates under a distinctly different license than that of the counselors. However, at the same time, speech and language pathology also only aligns with a segment of the music therapy practice.

Professional qualifications are another important point of comparison. To become a professional counselor, Illinois requires:

- A master's degree in a counseling, psychology, or a related field as approved by the Department
- Completion of one graduate course in each of the 13 required content areas
- Completion of the National Counselor Examination

For music therapists, the CBMT certification does not require therapists to complete a master's degree. However, most graduate programs in music therapy fulfil the content requirements in each required subject of the counselor license. Therefore the board needs only to approve music therapy as an appropriate field of study to expand the counselor license to include music therapy. However, in addition to course content, regulation must also consider program availability. In Illinois, there are over 100 approved master's programs related to counseling.[xliv] By contrast, Illinois has only one graduate program in music therapy. Requiring music therapists to hold the credentials of other health professions would significantly reduce music therapy services in the State.

There are also substantial differences between the risk posed by music therapists and professional counselors. Market conditions mitigate the risk as the specific nature and small size of the music therapy market create demand primarily from knowledgeable consumers and regulated healthcare facilities. Additionally, unlike professional counseling which typically operates independent of other health providers, music therapy works as part of an interdisciplinary medical team. As a result, consumers face a much smaller risk of accessing unqualified music therapists. For example, if a consumer searches the internet for a marriage counselor in Chicago, they are inundated with marriage counseling advertisements, various consumer reviews, and a host of professional webpages. Alternatively, a similar search for a music therapist returns no advertisements and presents the Illinois Association for Music Therapists and CBMT's webpage as its top search results.

In sum, regulating music therapists under the existing professional counselor license requires simply the board's approval of music therapy as an appropriate field of study, such as dance and art therapy programs. However, regulatory ease alone does not warrant an expansion of the counselor license. In terms of scope of practice, music therapy is a distinct healthcare profession that the professional counseling license cannot fully capture. Similarly, the current state of music therapy does not present the same risks as a counselor. Therefore, regulating music therapy

as professional counseling will over estimate music therapy's risk to consumers and create unnecessary barriers to the labor market.

It is important to note that this analysis did not have enough data to analyze the competitiveness of music therapists in the mental health labor market. For example, one job posting for a creative arts therapist in Chicago did require a board certification from CBMT or the equivalent dance and art therapy associations in addition to a professional counselor license, clinical professional counselor license, or license in social work.[xlv] However, more information is needed in order to accurately consider competiveness as a factor for regulatory need.

VII. Recommendations

This report attempts to fully consider all aspects of music therapy in order to evaluate its regulatory need. In light of its scope of practice, current market conditions and state regulations, risk, and comparative professions, we find three conclusions:

- **At this time, there is no conclusive evidence to support a music therapy license.**
- **More data on consumer risk and labor markets will help the Advisory Board draw more precise conclusions on music therapy's regulatory need.**
- **The Board may wish to explore title protection as an alternative to more restrictive regulation.**

Returning to the criteria for evaluating a professions regulatory need clarifies important findings in this report and solidifies and highlights unresolved concerns.

1. **Public Risk:** There is no significant public risk. Music therapists deliver minimally invasive services as a team or under the CBMT certification.
2. **Specific Skillset:** The profession does require a specialized skillset however the need for public assurance is unclear.
3. **Professional Responsibilities:** The majority of the practice works closely with other health providers.
4. **Scope of Practice:** Due to the diversity of its practice, the scope of music therapy is distinctly different from other professions.
5. **Economic Impact:** The direct costs of regulation are unknown, however, given that there is little social gain in restrictive regulation, the costs will likely outweigh the benefits.
6. **Alternatives to Regulation:** The CBMT, AMTA, FTC, and Attorney General's office are all functioning alternatives that protect consumers in place of occupational regulation.

With these first six principles, the Advisory Board must find the regulation that meets the seventh criterion, the least restrictive regulation necessary. From the first six criterion, it is evident that the risk does not warrant restrictive regulation such as licensure or certification.

However, we find that music therapists do have a specialized skillset although it is unclear if the public must be able to rely on this education. Additionally, when taking into account the entire profession, it appears music therapists do have a distinct scope of practice from other professions. At this time, these two distinctions do not warrant any regulatory action. Yet, we do not want to minimize the challenges that music therapist face in distinguishing themselves as a specialized healthcare profession. With the current data, it does not appear that occupational regulation itself is the most appropriate means to address these challenges. However, more data on the labor market and types of complaints CBMT and AMTA receives will help the Board make final determinations on any potential benefits of regulation.

If further research shows that the regulatory status of music therapy does impact its accessibility, we recommend that the Department explores title protection. The Department can define title protection in many ways. This may mean using Arizona's approach and defining board certified music therapist as a qualified healthcare professionals with services appropriate for State funding. However, the Board must further investigate the Department's jurisdiction and the efficacy of title protection.

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Methodology: Calculating Regulatory Burden

Burden was measured on the level of regulation (license, certificate, or registration) and four requirement categories: education level, clinical training hours, annualized continuing education hours, and annualized fees. Because the CBMT certificate is already required by the majority of employers, we used CBMT as a baseline and considered a state's burden to be any additional requirements beyond those needed for the CBMT. Within these five categories there is at least three different units of measurement (hours, education days, dollars). To solve this problem we adopted the Institute of Justice's method and converted each category to z-scores and added the five z-scores for each state regulation.

Level of regulation: To measure the differences in regulation method, we arbitrarily assigned number values to licensure, certification, and registration. With the least restrictive, registration, valued at 2 and the most restriction, licensure, valued at 4.

Education level: To measure education, we simply multiplied 365 days by the standard number of years required by the education level. Secondly, we set CBMT standards as our base level and therefore subtracted CBMT's education requirements from each state's requirements. All states as well as the CBMT require a bachelor's degree and as a result every state has a zero value.

Annualized continuing education hours: Continuing education hours are set according to the renewal period. For CBMT, music therapists must renew their certificate every five years while Georgia renews every two years and Nevada every three. Therefore, the continuing education hours were annualized. CBMT's annualized 20 hours of continuing education were then subtracted from each state and the z-scores calculated.

Annualized fees: Fees were annualized using one initial licensing period and one renewal period. Regardless of any CBMT fees, state regulatory fees would be an additional costs so no CBMT fees were subtracted.

Lastly, we added the each requirement z-score for the total score. For the four requirements excluding music therapy, each state had fairly similar standards. Therefore, each requirement had roughly the same impact on the total score for states, so it was not necessary to weight individual requirements

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EXHIBIT 3B

Sunrise and Sunset Reviews

Prepared for:
Illinois Department of Financial
and Professional Regulation

February 27, 2017

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Sunrise Review of Music Therapy

Agenda

I. What is Music Therapy?

II. Music Therapy in Illinois

III. How do other states regulate Music Therapy?

IV. Are the risks associated to not regulating Music Therapy already addressed?

V. Conclusions and recommendations

What is Music Therapy?

- Use of music for physical, emotional, cognitive, and social needs

- Common treated conditions: autism, Alzheimer's, mental diseases, developmental disabilities, stroke, traumatic brain injury

- Bachelor’s approved curriculum in 3 areas:
  - Musical foundations
  - Clinical foundations (clinical practicum and internship of 6 months)
  - Music therapy foundations (observation & measurement, therapy activities)

- Challenges heard from music therapists:
  - Reimbursement difficulties without licensure
  - Risk from untrained “music therapist”
  - Limited visibility and recognition as a health profession

Two main organizations related to music therapy

- Advocacy for MT
- Approves college and university programs
- Membership
  - Fee for professional = $250

- Advocacy for MT
- Certification requirements:
  - Bachelor’s degree in music therapy
  - 1,200 hours of clinical training CBMT exam
  - 20 hours of continuing education (annualized)

Music Therapy in Illinois

- 85% report their employers required CBMT certification
- 243 certified music therapists living in 23 counties in 2015
- Approved educational programs in ISU and WIU
- 13,220 clients in 2014
- 2014 annual salaries $45,000 - $75,000
- Most common settings:
  - Hospices, nursing homes, schools, community organizations and private practice
- On April 2015, IDFPR created a Music Therapy Advisory Board

Sources:
Music Therapy Fact Sheet, Illinois Association for Music Therapy
AMTA Snapshot of the Music Therapy Profession

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Few states currently regulate music therapy

Number of States

5
4
3
2
1
0

MT License
Certificate
Registration
Expanded Counselor License
Alternative Regulation

**Wisconsin is counted in both "alternative regulation" and "registration"*

Source: CBMT and state legislatures

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The majority of states that do regulate music therapy have adopted CBMT requirements

State	Regulation	Year Effective	Annualized Continuing Education	Annualized Fees	Number of Active License
Nevada	License	2012	33 hrs	$ 58.33	15
Oregon	License	2015	10 hrs	$ 125.00	--
North Dakota	License	2012	20 hrs	$ 87.50	12
Georgia	License	2014	20 hrs	$ 37.50	127
Utah	Certificate	2015	n/a	$ 58.50	46
Rhode Island	Registration	2015	n/a	$ 45.00	--
Wisconsin	Registration	1998	n/a	$ 37.50	56

Source: State Departments of Professional and Occupational Licensing

Alternative licenses require more education and training than music therapy regulation

State	License	Annualized Fee	Education	Clinical Training Hours	Additional Tests
New York	Creative Art Therapist License	$ 172.50	Masters	1,500	0
Wisconsin	License to Practice Psychotherapy	$ 128.50	Masters	3,000	0
Texas	Professional Counselor License	$ 153.00	Masters	3,000	2
Pennsylvania	Professional Counselor License	$ 70.00	Masters	3,000	0

Source: State Departments of Professional and Occupational Licensing

Licensure does not guarantee access to state funding for MT services

State	Music Therapy Regulation	Medicaid for adults w/ disabilities	Medicaid for children w/ disabilities	State education IDEA funds
Georgia	License			
Nevada	License			✔
North Dakota	License			
Wisconsin	Registration		✔	
New York	Creative Arts			
Texas	Counselor License	✔	✔	✔
Colorado	No	✔	✔	✔
Indiana	No	✔	✔	✔
Washington	No		✔	
Illinois	No	✔	✔	✔

Source: State Medicaid, Board of Education, and music therapy providers

Why approve a license for music therapy?

Prevent harm caused by unqualified therapists

Generate mechanisms to protect consumers from malpractice

Improve employment conditions of professionals

The potential harm is not high nor irreversible, and can be mitigated

- Poorly conducted music therapies do not lead to serious psychological or physical damage

- Music therapy constitutes one part of an extensive treatment in which other professions are involved
  - Colorado Sunrise Review analysis
  - Music Therapy as part of ITP (Individual Treatment Plans) – IDHS

- It is nearly impossible to attribute negative effects solely to music therapy

Current alternative regulatory mechanisms already protect consumers from malpractice

- Board certified MT are ruled by CBMT's Code of Professional Practice
- MT associated to AMTA are ruled by its Code of Ethics
- Federal and state agencies receive complaints
  - Federal Trade Commission's Bureau of Consumer Protection
  - Illinois Attorney General
- Possibility to sue health care providers (hospitals, hospice, etc)

Ex ante

Ex post

Lack of licensure has not impeded growth of MT services in Illinois

- Positive trend in Illinois labor market
  - MT work in different settings besides private practice
  - Number of professionals increased in the last years (+71.1% 2011-2015)
  - Average salary per year (+39.5% 2010 - 2014)
  - 19% of MT receives funds from the state, 17% from Medicare, 21% from private insurance

- Bachelor's degree on music therapy sufficient to work as music therapist

- Consumer Fraud and Deceptive Business Practices Act
  - Unlawful to advertise as a music therapist without the bachelor's degree

- Additional signaling mechanism: CBMT certification

Conclusion and Recommendations

No evidence justifies a license for music therapy in the State of Illinois
IDFPR should provide title recognition to address MT challenges

Next suggested steps:

Strengthen the analysis with new data:

- Evidence of potential harm: cases collected by Task Force
- MT national complaints: information from the CBMT

Other issues:

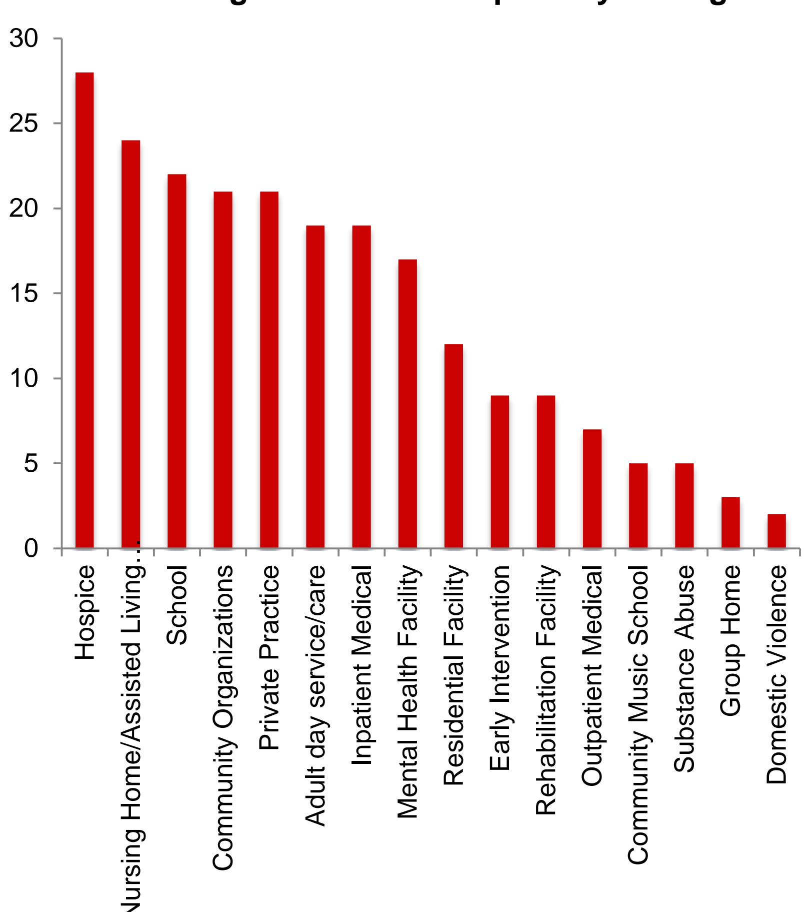
- Music therapy's risk and scope of practice do not align with the professional counselor license

Thanks!

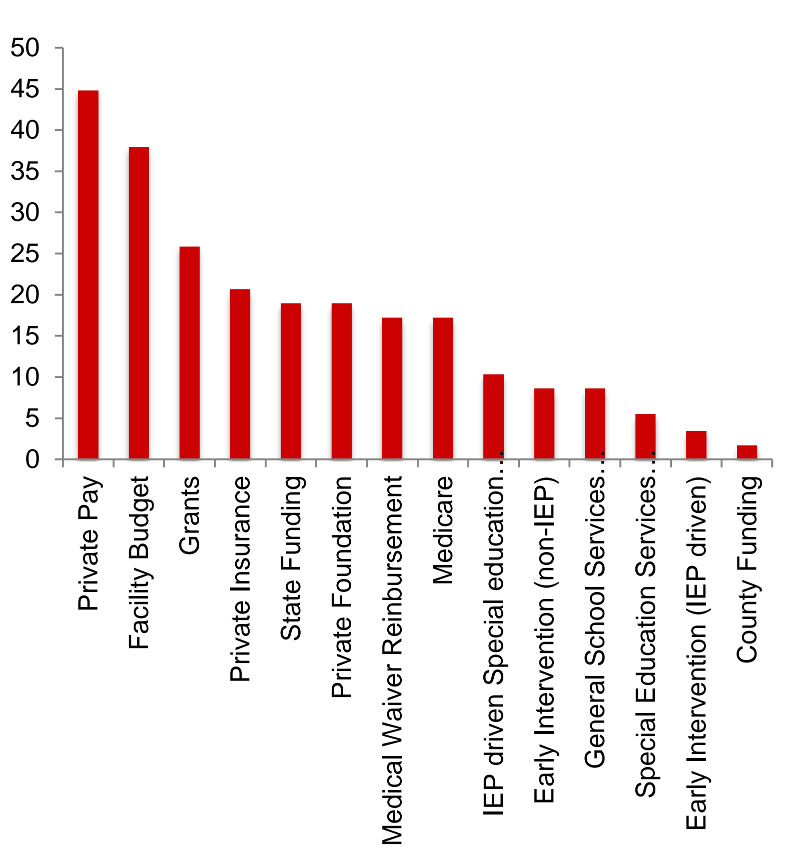
Questions?

Appendix

Music Therapy in Illinois



Percentage of music therapists by funding sources



Source: Music Therapy Fact Sheet, Illinois Association for Music Therapy

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In Illinois, including music therapy within the professional counselor license is one regulatory option

	Licensed Professional Counselors	Licensed Professional Counselors and Music Therapists	Music Therapists
Scope	**Includes several counseling specialties**	Develops treatment plan to improve mental, emotional or behavioral disorders that affect mental health	▪ **Use music interventions to improve speech and communication among nonverbal individuals** ▪ **Works within interdisciplinary teams**
Practicing Professionals	**4,800**		**240**
Education	Master's degree in accredited counseling program including art therapy, and dance movement therapy	Graduate programs must require one course across 13 subject areas including group dynamics, research and evaluation, and counseling techniques	Bachelor's degree in music therapy
Experience	0		1,200 hours
Risk	**Counselors work in popular fields with many avenues to access consumers**	▪ Works with vulnerable populations with increased risk of suffering emotional harm ▪ Handles confidential patient information	Unqualified MT prevents patients from receiving treatment at critical time for rehab

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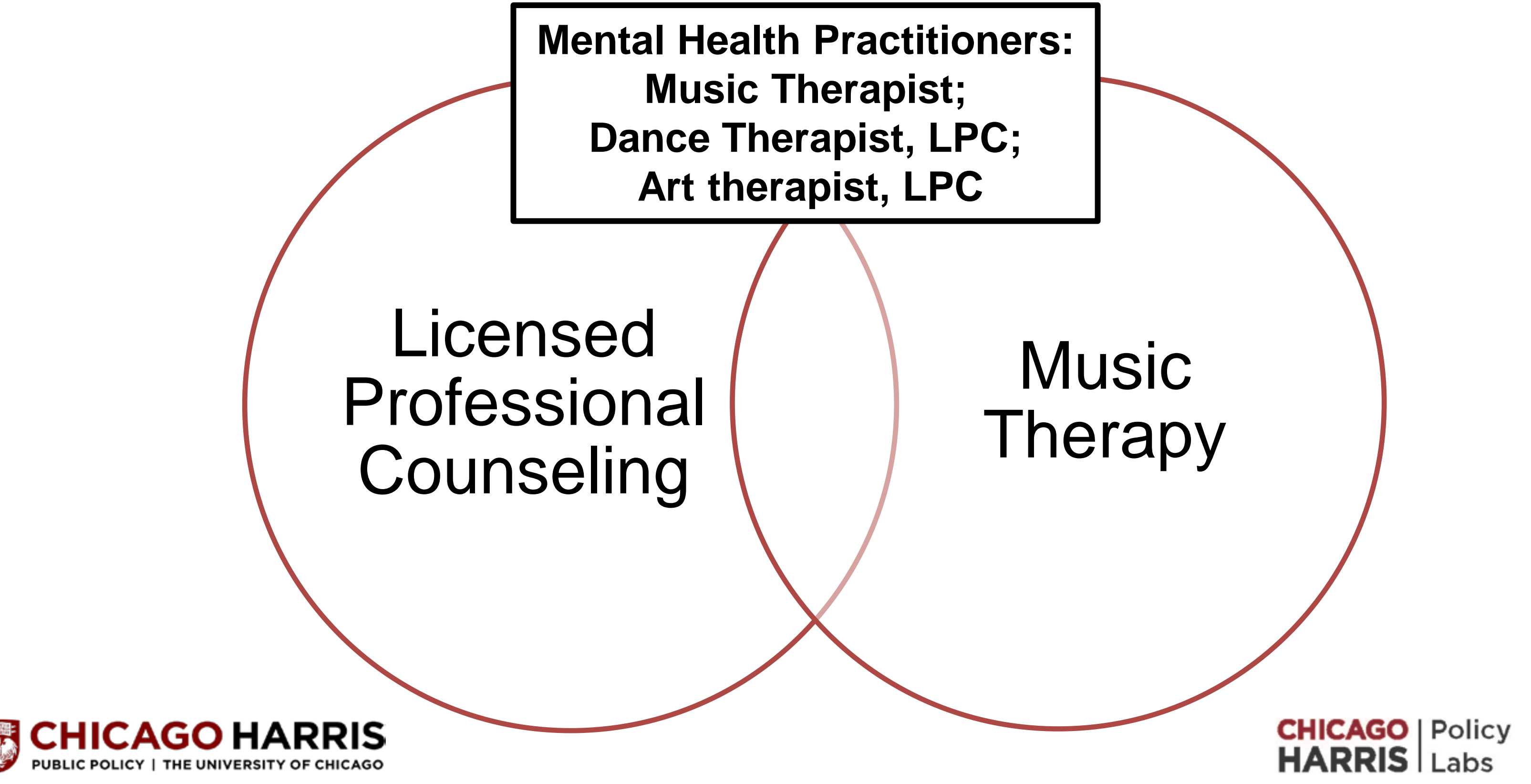
Music therapy does not carry the level of risk that warrants regulation under the professional counselor license

For music therapists in the mental health field, how does the professional counselor license affect access to the labor market?



State requirements are significantly different between music therapy regulation and alternative licensure

Music therapy Regulation	Alternative Regulation
Licensure	**Creative Art Therapist Licensure**
CBMT certified *Georgia, Nevada and Oregon*	Master's degree and 1500 hours of clinical training *New York*
Certification	**License to Practice Psychotherapy**
CBMT certified *Utah*	Master's degree and 3000 hours of clinical training *Wisconsin*
Registration	**Professional Counselor License**
CBMT certified *Wisconsin and Rhode Island*	Master's degree and 3000 hours of clinical training *Texas and Pennsylvania*

Source: State Departments of Professional and Occupational Licensing

EXHIBIT 4A

American Music Therapy Association

8455 Colesville Rd., Ste. 1000 • Silver Spring, Maryland 20910
Tel. (301) 589-3300 • Fax (301) 589-5175 • www.musictherapy.org

Reimbursement Overview

Medicare

A. Partial Hospitalization
Music therapy is a covered service in Partial Hospitalization Programs (PHP) using the Healthcare Common Procedure Coding System (HCPCS). Facilities can bill Medicare using HCPCS Code G0176 and Revenue Code 904 (Partial Hospitalization-Activity Therapy) to document that music therapy services were provided.

B. Prospective Payment System (PPS)
Music therapy services can be covered through the Medicare Prospective Payment System or PPS. Although music therapy does not receive direct reimbursement from Medicare for services provided, music therapists can be included as part of the package that is covered under the PPS within skilled nursing facilities/nursing homes, in-patient psychiatric programs, hospice programs, and in-patient rehab settings.

C. Minimum Data Set (MDS)
This extensive assessment tool has many sections in which music therapists can provide input to the treatment team but not all sections of this document have an impact on the reimbursement a facility receives from Medicare. To assist facilities access additional funding, music therapists can document minutes under Restorative Care. This program usually is managed by nursing and in many facilities, CNAs or certified nurse assistants facilitate this program. Some facilities, however, do not have the necessary staff that is trained to offer this service and as a result, these facilities turn to recreation therapy and music therapy for programming assistance.

Several programs that music therapists typically provide in skilled or residential care facilities may fall under Restorative Care. Exercise programs, socialization groups, and orientation sessions are a few examples of interventions that might help to address Restorative Care needs of clients. The best way to explore this option of documenting music therapy under the Restorative Care section of the MDS is by collaborating with the MDS coordinator in a facility.

Please remember that music therapy can not bill Medicare directly for services, but instead, can provide and document services under the existing Restorative Care section of the MDS. When quality services are provided and documented under this heading, the facility in turn, receives more reimbursement from Medicare. In other words, the facility receives an additional amount of funding on top of the flat daily PPS payment. In AMTA's communication with CMS regional offices across the country, we have learned that is not possible to determine the exact amount of additional reimbursement a facility receives when Restorative Care programming is offered. This is due to a variety of complex factors involved in the Prospective Payment System (PPS), such as the Case Mix Adjustment and RUGs or Resource Utilization Groups.

The MDS 3.0 assessment tool also lists music therapy under Section O. Special Treatments and Procedures, O0400. Therapies, F. Recreational Therapy (includes recreational and music therapy). Although this listing does not provide additional reimbursement for the facility, it does provide a more accurate vehicle for documenting physician-ordered music therapy services in settings utilizing the MDS and helps to validate the inclusion of music therapy as a part of the PPS daily rate.

Medicaid Waivers

Medicaid waivers are programs developed by each state that focus on specific client groups or diagnoses and provide additional services that are not covered by other funding sources. There are currently a few states that allow payment for music therapy services through use of Medicaid Home and Community Based Care waivers with certain client groups. In some situations, although music therapy may not be specifically listed within regulatory language, due to functional outcomes achieved, music therapy interventions qualify for coverage under existing treatment categories such as community support, rehabilitation, or habilitation services.

Examples

Arizona
Medicaid coverage for music therapy provided to individuals with developmental disabilities.

Indiana
Home and Community-Based Waivers managed by the Division of Disability and Rehabilitation Services includes music therapy as a covered service for the following three waiver programs: Developmental Disability Waiver, Autism Waiver, and Support Services Waiver.

Maryland
Music therapy is a covered service under the state's Autism Waiver and the Residential Treatment Center Demonstration Waiver.

Michigan
Music therapy is a covered service under the state's Medicaid Children's Waiver Program.

Texas
Music therapy is listed as a health service under several In Home and Family Support Program Waivers.

Wisconsin
Music therapy is a covered service within the Brain Injury Waiver (BIW) and the Children's Long-Term Support Waiver.

In addition to waiver program examples listed above, other states have utilized state and county agency funds and population specific waivers (i.e., autism, developmental disabilities) to cover the provision of music therapy interventions in a variety of settings. These states include:

California	**Colorado**	**Georgia**	**Hawaii**
Idaho	**Louisiana**	**Missouri**	**Minnesota**
Nevada	**New Jersey**	**North Carolina**	**Ohio**
Pennsylvania	**South Dakota**	**Virginia**	**Washington**

Private Insurance

Companies like Blue Cross Blue Shield, United Healthcare, Cigna, and Aetna have all paid for music therapy services at some time. Success has occurred on a case-by-case basis when the therapist implements steps within the reimbursement process and receives pre-approval for music therapy services.

Guidelines for Use of Current Procedural Terminology (CPT) Codes by Music Therapists

The American Medical Association CPT Editorial Panel has stated that music therapy services can be reported using existing CPT codes.

Policies on the use of CPT codes for procedures and interventions conducted by the Board Certified Music Therapist are **service specific, not discipline specific**. This is consistent with policies in use by third party administrators. Referrals for procedures are made by physicians to disciplines which are trained and qualified, in accordance with their scope of practice.

Music therapy services within select hospital in-patient programs have been successfully billed to private insurance companies when standard industry requirements are completed. These include:

Revenue Codes

Recommended revenue codes for reporting music therapy services on in-patient claim forms, include 0940, "Other Therapeutic Services-General Classification" or 0949, "Other Therapeutic Services." Use of these revenue codes is not a guarantee of reimbursement, but these codes assist facilities more accurately report the provision of music therapy services.

Other Payers

Workers' Compensation

As states attempt to contain the costs associated with workers' compensation, many of these programs are now provided through managed care plans from the private insurance market. Requiring pre-approval before services can be offered and working with case managers are common among workers' compensation programs. Some music therapists have received reimbursement from this type of coverage, specifically in the treatment of traumatic brain injury (TBI), physical rehabilitation, or pain management.

TRICARE

TRICARE is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors and certain former spouses worldwide. At this time, access to this funding is extremely rare and typically requires extensive advocacy to obtain approval for music therapy coverage.

EXHIBIT 4B

American Music Therapy Association

8455 Colesville Rd., Ste. 1000 • Silver Spring, Maryland 20910
Tel. (301) 589-3300 • Fax (301) 589-5175 • www.musictherapy.org

February 6, 2017

TO: Illinois Department of Financial and Professional Regulation
Music Therapy Advisory Board

FROM: Judy Simpson, MT-BC
Director of Government Relations
American Music Therapy Association

RE: Music Therapy Reimbursement Information

During the November 28, 2016 meeting, the Board expressed an interest in learning more about the current status of music therapy reimbursement. The attached document provides an overview of various payment systems that offer some form of coverage for music therapy services. As is true with most health services, coverage varies by payer, setting, and diagnosis.

The collaborative State Recognition initiative between AMTA and the Certification Board for Music Therapists is not focused on increasing reimbursement for music therapy. Our primary goals include:

Consumer protection-by requiring individuals to meet national standards if presenting themselves as music therapists.

Improving access to quality music therapy services-through inclusion in state regulations that outline qualifications for employment and inclusion in state programs. State recognition will help residents have access to music therapy services by personnel who are trained, equipped, held to high standards of ethics and professional practice, and demonstrate competency through board certification and continuing education.

It is important to note that establishing a state recognition program does not guarantee automatic inclusion in various funding streams. Board Certified Music Therapists across the country have obtained reimbursement from multiple sources for over 20 years by demonstrating medical necessity and documenting clients' functional outcome achievements. The music therapy community understands the need to provide research evidence to support reimbursement requests from different payment systems. AMTA and CBMT provide guidance to music therapists in differentiating between state recognition goals and benefits and the completely separate payer-based process to seek coverage for music therapy interventions.

Please feel free to contact me directly with any questions.

Simpson@musictherapy.org

301-589-3300 x105

August 2017
PE 17-01-595

SUNRISE REPORT

MUSIC THERAPY STATE TASK FORCE

AUDIT OVERVIEW

The Regulation of Music Therapists by the Certification Board for Music Therapists Provides Adequate Protection for Citizens of the State

WEST VIRGINIA LEGISLATIVE AUDITOR
PERFORMANCE EVALUATION & RESEARCH DIVISION

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WEST VIRGINIA LEGISLATIVE AUDITOR

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Justin Chapman, Referencer

Note: On Monday, February 6, 2017, the Legislative Manager/Legislative Auditor's wife, Ashley Summitt, began employment as the Governor's Deputy Chief Counsel. Most of the actions discussed and work performed in this report occurred prior to this date. Therefore, the Performance Evaluation and Research Division does not believe there are any threats to independence with regard to this report.

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EXECUTIVE SUMMARY

The West Virginia Music Therapy State Task Force submitted a Sunrise application to the Joint Standing Committee on Government Organization. Pursuant to West Virginia Code (W.Va.) §30-1A-3, the Performance Evaluation and Research Division is required to make a determination of whether state regulation of music therapists is or is not needed to adequately protect the public. **The Legislative Auditor concludes that there is no documented evidence of harm to the public caused by music therapists that rises to the level needed for state regulation.** A detailed analysis of this recommendation is provided within the report.

Frequently Used Acronyms in this Report:

PERD – Performance Evaluation and Research Division

CBMT – Certification Board for Music Therapists

AMTA – American Music Therapy Association

MT-BC – Music Therapist-Board Certified

Report Highlights:

Finding 1: The Regulation of Music Therapists by the Certification Board for Music Therapists Provides Adequate Protection for Citizens of the State.

- There is no documented harm to the public caused by music therapists in West Virginia.
- The Certification Board for Music Therapists and the West Virginia Office of the Attorney General provide a means for recourse should an individual believe a music therapist has caused harm or practiced unethically.
- The proposed fees would likely be sufficient to cover the increased cost of an advisory committee, but would also impose more costs to music therapists while adding minimal public safety.

Recommendations

1. *The Legislative Auditor does not recommend state licensure of music therapists.*

FINDING 1

The Regulation of Music Therapists By the Certification Board for Music Therapists Provides Adequate Protection for Citizens of the State.

Finding Summary

In accordance with West Virginia Code (W.Va.) §30-1A-3, a Sunrise application was submitted by the West Virginia Music Therapy State Task Force ("Task Force") seeking the Legislature's recognition of the profession of music therapy via individual special licensure through the West Virginia Department of Health and Human Resources (DHHR). Music therapy is not currently regulated in West Virginia, but a national certification is offered through the Certification Board for Music Therapists (CBMT). The Task Force proposes setting CBMT's education and training requirements as West Virginia's standards.

Music therapy is not currently regulated in West Virginia, but a national certification is offered through the Certification Board for Music Therapists.

The Task Force must show in its Sunrise application that if its proposal is not adopted by the Legislature, then there would be clear harm to the public health and welfare, and the potential for harm is easily recognizable and does not depend on remote or tenuous arguments per W.Va. §30-1A-3(c)(1). The Task Force states that there are a growing number of unqualified individuals claiming to practice music therapy and provides three examples of potential harm to the public. The Legislative Auditor found that two of the three examples represent potential harm; however, the regulation of music therapists would not prevent these examples from occurring. Furthermore, the Legislative Auditor found harm to the public throughout the nation from music therapy to be rare. **Consequently, the Legislative Auditor concludes that the Task Force does not provide sufficient evidence demonstrating harm to the general public if its proposal is not adopted.**

The Legislative Auditor found harm to the public throughout the nation from music therapy to be rare.

Background

According to the American Music Therapy Association (AMTA), "*music therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program.*" Music therapy, as a profession, has its beginnings from musicians who would help World War I and II veterans suffering from traumatic injuries. Today, music therapists treat individuals with a wide array of needs – from a child with autism to senior citizens with dementia. They do this by developing specialized treatment plans for the individual or group they are serving. Their work also takes place in a variety of settings – from in-home to hospitals. According to the scope of practice defined in the proposed regulation, music therapy interventions can include:

- music improvisation,
- song writing,
- lyric discussion,
- singing,
- music combined with other arts,
- music-assisted relaxation, and,
- electronic music technology.

The AMTA and the CBMT oversee and set standards for music therapists at the national level. The stated mission of the AMTA is *"to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world."* Besides advocating for the profession, one of the main responsibilities of the AMTA is to set education and clinical training requirements for music therapists who wish to obtain the Music Therapist-Board Certified (MT-BC) designation from the CBMT. The stated mission of the CBMT is *"to ensure a standard of excellence in the development, implementation, and promotion of an accredited certification program for safe and competent music therapy practice."* The CBMT provides a national certification and allows music therapists who meet eligibility requirements and pass the CBMT examination to use the title, MT-BC. Music therapists who wish to maintain their MT-BC credential must meet continuing education requirements and abide by the CBMT Code of Professional Practice.

The AMTA and the CBMT oversee and set standards for music therapists at the national level.

Music therapy is not currently regulated by the State of West Virginia. While there is not an official count of practitioners of music therapy, as of the time of this publication, there are 20 MT-BCs in the state. A 2016 survey by the AMTA found that a music therapist in West Virginia serves an average of 77 clients per year. Starting in Fall 2016, West Virginia University became the first university/college in the state to offer a degree in music therapy. The degree program is accredited by the National Association of Schools of Music and the AMTA. The degree program has 25 students and expects to have its first graduates in Spring 2018.

While there is not an official count of practitioners of music therapy, as of the time of this publication, there are 20 MT-BCs in the state. A 2016 survey by the AMTA found that a music therapist in West Virginia serves an average of 77 clients per year.

Applicant Does Not Document Harm to the Public from Unregulated Practice of Music Therapists

A primary concern in reviewing a Sunrise Application is to determine if the unregulated practice or current state of regulation clearly harms or endangers the health and safety of the public. In the Sunrise application, the Task Force supplied the following three examples of harm to clients from failure to provide appropriate service, or erroneous or incomplete service. These three examples are identical to the examples of harm submitted to the Minnesota House of Representatives in support of state regulation and are very similar to examples provided in the Washington State Department of Health Music Therapy Sunrise Review.

No empirical evidence was provided in either of those instances, and the Task Force did not clarify in its application if the examples actually occurred; therefore, PERD analyzed the three examples, which are listed below, as hypothetical scenarios.

Task Force's Examples of Harm:

> ***Example 1:*** *"An individual provided "relaxing" music at the bedside to a medically fragile patient, lowering the heart rate to a point that the patient became unstable and was transferred to a higher level of care in the coronary care unit. The individual, although a well-trained musician, had no training in reading and understanding patient telemetry monitors, thus putting the medically-fragile patient at-risk."*

The example above demonstrates an example of potential harm to the public; however, per the narrative, the individual never claimed to be a music therapist or to be providing music therapy services. Therefore, according to the Task Force's proposed legislation, this example would be legal and would not be prevented by regulations. Furthermore, within a hospital setting, a medically fragile patient would likely have a team of medically trained staff monitoring the patient – thus reducing the risk of harm as described.

> ***Example 2:*** *"Another example comes from a nurse at a long-term care facility, who claimed to do "music therapy" by playing the piano for sing-a-longs for the residents. While qualified to address a number of physical issues, she is not trained to select or manipulate particular musical elements to elicit specific desired responses, nor is she trained to handle the social or emotional responses that those individuals may have in response to musical stimuli; these types of social and emotional responses occur frequently and can be powerful."*

PERD has two main issues with the second example. First, it does not document the occurrence of harm. Instead, the Task Force implies that social and emotional responses to musical stimuli are examples of potential harm. The Task Force does not describe what negative social or emotional responses could occur from music stimuli. Therefore, PERD analyzed research from the *Journal of Music Therapy* and found that negative emotional/social responses to musical stimuli can include tension, fear, anger, sadness, and agitation, among other things. Given the fact that music therapists often work with vulnerable populations, these types of emotional/social responses can represent potential harm to the public.

Second, the proposed regulation states, *"No person without a license as a music therapist shall use the title 'music therapist' or similar title or practice music therapy."* Since the nurse in the second example

claimed to be performing music therapy, he/she would have violated the proposed regulation. The proposed regulation goes on to state,

"Nothing in this chapter may be construed to prohibit or restrict the practice, services, or activities of the following: (1) Any person licensed, certified, or regulated under the laws of this state in another profession or occupation or personnel supervised by a licensed professional in this State performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation, if that person does not represent himself or herself as a music therapist…"

Consequently, if the nurse would not have claimed to be performing music therapy, the nurse would not have violated the proposed regulation. Nursing is one of several professions regulated by the State, and music may be considered incidental to his/her practice while working at the long-term care facility.

The Consumer Protection and Antitrust Division of the Office of the Attorney General responded that it has not received any consumer complaints against MT-BCs or any other practitioner of music therapy in the last five years.

> ***Example 3:*** *"As a third example, a qualified music therapist working in the Neonatal Intensive Care Unit is trained to administer both live and recorded music interventions to assist both the infant and family. This training includes an understanding of acoustical principles (effected by the playing of music in an isolette), appropriate levels of sound (i.e., decibel levels), and amount of time exposed to music. Additionally, music therapists are trained to read behavioral and empirical (i.e., vital signs) cues of the infant that indicate infant distress. Without licensure of music therapists, it is difficult to identify music therapists who are in compliance with state regulations, which is essential for public protection."*

The third example lists competencies and skills that music therapists are expected to have, but does not provide any potential instances of harm taking place. Furthermore, the Task Force's statement, *"Without licensure of music therapists, it is difficult to identify music therapists who are in compliance with state regulations, which is essential for public protection,"* is misleading. The process through which a Neonatal Intensive Care Unit identifies a music therapist would minimally change under the proposed regulations. As will be discussed later, the Task Force's proposed regulation duplicates already established education and clinical training requirements set forth by the AMTA and the CBMT.

To find out whether there has been any harm caused by music therapists to West Virginians, PERD contacted West Virginia's Office of the Attorney General. The Consumer Protection and Antitrust Division of the Office of the Attorney General responded that it has not received any consumer complaints against MT-BCs or any other practitioner of music therapy in the last five years. The CBMT's Executive Director also confirmed to PERD that she has not received any complaints against

MT-BCs practicing in West Virginia. Furthermore, a legal search by the Office of Legislative Services did not find any civil or criminal cases involving music therapists in the state.

No Surrounding States Regulate Music Therapy, But a Growing Number of Other States Have Enacted Varying Forms of Regulation

None of the surrounding states regulate music therapists.

As shown in Table 1, none of the surrounding states regulate music therapists; however, MT-BCs in Pennsylvania can apply to become a Licensed Professional Counselor by meeting additional education and training requirements. Of the five surrounding states, Maryland, Ohio, and Pennsylvania have had bills introduced to regulate music therapists. None of those bills made it out of the committee level.

Table 1
Analysis of Surrounding States

Surrounding States	Number of MT-BCs	State Regulation of Music Therapists	Bills Introduced to Regulate Music Therapists
Kentucky	74	No	No
Maryland	119	No	Yes
Ohio	338	No	Yes
Pennsylvania	505	No*	Yes
Virginia	207	No	No

Sources: CBMT's "State Task Forces Map," CBMT's "Certified Music Therapist Search" for MT-BCs from surrounding states, and PERD's analysis of surrounding states legislative bills.
**Music Therapists in Pennsylvania can become a Licensed Professional Counselor by meeting additional education and training requirements set forth by the Pennsylvania State Board of Social Workers, Marriage & Family Therapists, and Professional Counselors.*

In total, nine states have regulation specifically over music therapists. As shown in Table 2, five states currently require licensure of practicing music therapists. One state offers practicing music therapists certification, two states provide a registry, and one state provides title protection.

In total, nine states have regulation specifically over music therapists.

Table 2 States With Regulation Over Music Therapists				
State	**Year Passed**	**Type of Regulation**	**Voluntary or Mandatory**	**Number Licensed, Certified, or Registered***
Connecticut	2016	Title Protection	-	-
Georgia	2012	License	Mandatory	124
Nevada	2011	License	Mandatory	19
North Dakota	2011	License	Mandatory	17
Oklahoma	2016	License	Mandatory	N/A
Oregon	2015	License	Mandatory	64
Rhode Island	2014	Registration	Mandatory	8
Utah	2014	Certificate	Voluntary	46
Wisconsin	1998	Registration	Voluntary	70

Sources: AMTA's "State Advocacy," CBMT's "State Licensure," University of Chicago Sunrise Review Music Therapy, PERD's review of individual state statutes, and PERD's analysis of individual state rules.
**As of May 25, 2017.*

In addition to states with regulation specifically over music therapists, four states have regulation over groups that can include music therapists. This fact is not to be construed to mean that music therapists in the four states are required to obtain the state licenses listed in Table 3. Instead, these states only place additional requirements on music therapists if they wish to practice in certain areas. For example, music therapists in Wisconsin are only required to obtain state licensure if they practice psychotherapy.

Four states have regulation over groups that can include music therapists.

Table 3 States With Alternative Licensure for Music Therapists		
State	**Licensure**	**Education**
New York	Creative Art Therapist	Masters
Pennsylvania	Professional Counselor License	Masters
Texas	Professional Counselor License	Masters
Wisconsin	License to Practice Psychotherapy	Masters

Sources: University of Chicago Sunrise Review Music Therapy and PERD's review of state statutes.

As part of this review, PERD reached out to all states that have had regulation of music therapists for at least one full year (Georgia, Nevada, North Dakota, Oregon, Rhode Island, Utah, and Wisconsin) to see how many complaints and what types of disciplinary actions have been taken since their state regulations were enacted. PERD received responses from each state except North Dakota and Oregon. Of the

states that replied, only Georgia and Wisconsin reported that they had received complaints. Georgia reported that it received a total of seven complaints since 2012. Six were for unlicensed practice and one was for unethical conduct. No disciplinary action has been taken in those cases. Wisconsin reported one complaint since 1999. The complaint was regarding unprofessional practice, but no disciplinary action was taken because of insufficient evidence.

PERD reached out to all states that have had regulation of music therapists for at least one full year. Only Georgia and Wisconsin reported that they had received complaints. No disciplinary action has been taken in those cases.

Establishing a Separate Licensing Board for Music Therapists Would Not Enhance the Level of Safety Beyond What Is Currently Being Provided

Although no West Virginia state agency has testing or oversight responsibilities over music therapists, there are two organizations/agencies that provide a means of recourse against bad practice.

1. Certification Board for Music Therapists

Music therapists who hold the MT-BC designation from the CBMT are required to provide services in an ethical manner in accordance with CBMT's Code of Professional Practice. Formal complaints against MT-BCs may be submitted to the CBMT and are referred to the Executive Director for disposition. The Executive Director is the first of three levels of potential review that a complaint may go through. The other two levels include the Disciplinary Review Committee, and the Disciplinary Hearing Committee. These are the only levels that issue sanctions. While the decisions made by the Disciplinary Review Committee may be referred to the Disciplinary Hearing Committee for a written review or oral hearing, all decisions made by the Disciplinary Hearing Committee are deemed final.

2. West Virginia Office of the Attorney General

The Consumer Protection and Anti-Trust Division of the Office of the Attorney General provides protection against fraud and ensures fair, safe business practices in West Virginia. If consumers of music therapy services in West Virginia feel they have been a victim of unlawful practice, they can file a consumer complaint report with the Office. Once a complaint is received by the Office, a staff member reviews the complaint to determine how the complaint can best be resolved. Methods used by the Office to resolve complaints include voluntary mediation, legal guidance, and conducting official investigations, which can lead to legal action (i.e. lawsuit).

The Task Force's Proposed Regulation Duplicates CBMT/AMTA Requirements

The Task Force application states, *"State licensure of music therapists would establish educational and clinical training requirements… [and] examination and continuing education requirements for music therapists."* As shown in Table 4, however, the Task Force did not propose any additional standards above what the CBMT and the AMTA already require. Licensure, as proposed, would simply set CBMT's and AMTA's requirements as West Virginia's standards.

The Task Force did not propose any additional standards above what the CBMT and the AMTA already require. Licensure, as proposed, would simply set CBMT's and AMTA's requirements as West Virginia's standards.

Table 4
CBMT/AMTA Requirements vs. Proposed Regulation

	CBMT/AMTA Requirements	Task Force's Proposed Regulation
Education Requirements	Bachelor's degree in music therapy or its equivalent from AMTA-approved college	Same as CBMT/AMTA
Continuing Education Requirements	100 recertification credits during the 5-year recertification cycle	Must show proof of maintenance of the applicant's status as a board certified therapist
Clinical Training Requirements	1,200 hours of clinical training; including, 180 hours of pre-internship experience and 900 hours in internship experiences	Same as CBMT/AMTA
Examination Requirement	CBMT Exam	Same as CBMT/AMTA
Disciplinary Power	Possible Sanctions: • Mandatory remediation through specific education, treatment, and/or supervision • Written reprimand • Suspension of MT-BC • Probation • Non-renewal of certification • Revocation of certification • Other corrective action	Possible Sanctions: • Suspension of license • Revocation of license • Denial of licensure • Refusal to renew license • Probation with condition • Reprimand • Fine between $100 and $1,000

Sources: AMTA Standards for Education and Clinical Training, CBMT Code of Professional Practice, CBMT "Recertification Credit Option," and Sunrise Application.

Lack of State Licensure Does Not Restrict Music Therapists from Receiving Third-Party Insurance Payments

One area that PERD must consider when reviewing a Sunrise application is whether the lack of regulation makes the professional

service ineligible for third-party insurance payments. In the application, the Task Force states, *"The current lack of regulation does not make its practitioners ineligible for third party insurance payments or federal grants."* DHHR confirmed to PERD that Medicaid reimburses music therapy services in the state; however, the number of individuals who can qualify for reimbursement is limited. First, Medicaid only reimburses the services through the Intellectual/Developmental (IDD) Waiver. Second, individuals who qualify for the IDD Waiver must choose to self-direct their services through the Participant Directed Goods and Services option. PERD was informed by DHHR that *"approximately 28 individuals were approved for Participant Directed Goods and Services for the use of music therapy"* from 2015 to 2017. It is important to note that there were 4,534 active individuals in the IDD Waiver Program at the end of FY 2016. DHHR also confirmed to PERD that the MT-BC credential from the CBMT or state board certification is required of music therapists wishing to have their services reimbursed by Medicaid. Therefore, the proposed state licensure of music therapists would have no effect on Medicaid coverage of music therapy services in the state since music therapists are already eligible to receive reimbursement as long as they have their MT-BC. PERD also reached out to the Public Employee's Insurance Agency (PEIA). PEIA confirmed that it does not cover music therapy services. When asked if the lack of state licensure/certification prevents music therapy from being a covered/reimbursable service, PEIA replied that it does not.

DHHR confirmed to PERD that Medicaid reimburses music therapy services in the state; however, the number of individuals who can qualify for reimbursement is limited to those on the IDD Waiver.

State Regulation Would Impose More Costs to Licensees

As authorized in W.Va. §30-1-6(c), a board may set fees by legislative rule that are sufficient to enable the board to effectively carry out its duties and responsibilities. In the Sunrise application, the Task Force proposed a $250 fee for initial licensure and a $75 fee for license renewal every two years. This is in addition to the cost associated to become a MT-BC. To become certified by the CBMT, music therapists must pass the CBMT exam. The CBMT exam costs $325 for first-time test-takers. To renew their MT-BC certification, music therapists must pay an annual maintenance fee of $68 and obtain 100 recertification credits during every five-year renewal cycle. The cost of the recertification credits varies. Table 5 shows a summary of the fees associated with certification and licensure.

PEIA confirmed that it does not cover music therapy services. When asked if the lack of state licensure/certification prevents music therapy from being a covered/reimbursable service, PEIA replied that it does not.

Table 5 **Cost of Music Therapy License**				
Current Fees for Music Therapists			**Proposed Fees Under State Licensure**	
CBMT Exam First-Time Certification	CBMT Annualized Maintenance Fee	CBMT Renewal Requirement	Initial Licensure	Biennial Renewal
$325	$68	Cost associated with obtaining 100 recertification credits	$250	$75
Sources: CBMT's Exam Candidate Handbook and Sunrise Application.				

With the small number of music therapists and the proposed fee structure, the music therapy licensing board would generate less revenue than any other professional licensing board in the state. Assuming all 20 current MT-BCs obtain state licensure, $5,000 in revenue would be generated the first year. Revenue would decrease significantly in following years, unless the state experiences significant growth in the number of music therapists. Table 6 shows the revenue from state licensure over the 2017-2021 period, assuming no growth in the number of music therapists.

With the small number of music therapists and the proposed fee structure, the music therapy licensing board would generate less revenue than any other professional licensing board in the state.

Table 6 **Analysis of Proposed Fees***					
	2017	**2018**	**2019**	**2020**	**2021**
Fees From Initial Licensure	$5,000	$0	$0	$0	$0
Fees From Licensure Renewal	$0	$0	$1,500	$0	$1,500
Total Fees	$5,000	$0	$1,500	$0	$1,500
Source: PERD's analysis of Sunrise Application. **Assuming no growth in the number of state-licensed music therapists.*					

In the application, the Task Force states that an advisory committee model under DHHR may be used for cost savings. As proposed, the advisory committee will consist of five members: three of whom are music therapists, one who is a health professional (other than a music therapist), and one who is a consumer of music therapy services. The proposed regulation states the five members of the advisory committee will serve without compensation and will be appointed by the "Director" or his or her designee. Although the Task Force does not clarify what position it is referring to, PERD assumes that the Director will be a department official within DHHR. The Director or designee would also be the main facilitator of the state license. His or her duties would include setting or changing fees with the consultation of the advisory committee, issuing licenses to applicants upon review of education and training credentials, and issuing sanctions for misconduct.

Even under the proposed model, the advisory committee would need to abide by W.Va. §30-1-6(c) – which requires regulatory boards to be self-sufficient. As proposed, it is not clear whether the music therapy advisory committee would be self-sufficient. First, the advisory committee would likely experience varying amounts of revenue year after year because of the small number of music therapists in West Virginia. Second, it is difficult to estimate expenses since the advisory committee will likely be using DHHR resources such as staff, equipment, and office space, to help with administration. While running the advisory committee would require staff time on the part of DHHR, PERD estimates that the time would likely be minimal. As the Task Force states, *"By using CBMT certification as the primary qualification for licensure, the state would only need to verify [certification] with CBMT."* Consequently, the majority of staff time would consist of setting fees, imposing sanctions, and conducting regular office functions (i.e. answering phone calls/emails and maintaining website).

As proposed, it is not clear whether the music therapy advisory committee would be self-sufficient.

Conclusion

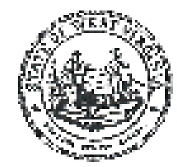
The Legislative Auditor finds that there is no documented evidence of harm to the public caused by music therapists that rises to the level needed for state regulation as stated by W.Va. §30-1A-3, and the hypothetical examples of harm provided by the applicant do not support the need for licensure. The AMTA and the CBMT are two national organizations that set standards of practice for music therapists throughout the United States. The regulatory responsibilities provided (i.e. ensuring competent education, training, and practice of music therapists) by these national organizations, in return, provides adequate protection to the public. Moreover, the Task Force does not propose any additional or enhancing criteria for licensure above what the CBMT and the AMTA already require. State licensure would duplicate what presently exists at the national level and additional costs would be imposed on West Virginia licensees while adding minimal public safety. Lastly, the CBMT maintains a database on its website where the general public is able to search for a certified music therapist by name or state. The public may also verify the board certification number and certification expiration date; therefore, state registration, the least restrictive form of regulation, would be largely redundant to what already exists.

State licensure would duplicate what presently exists at the national level and additional costs would be imposed on those licensed nationally while adding minimal public safety.

Recommendations

1. *The Legislative Auditor does not recommend state licensure of music therapists.*

Appendix A
Transmittal Letter



WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0610
(304) 347-4890
(304) 347-4939 FAX

John Sylvia
Director

April 28, 2017

Amy Rodgers-Smith, MMT, MT-BC
West Virginia Music Therapy State Task Force
714 Venture Drive #115
Morgantown, WV 26058

Dear Amy Rodgers-Smith:

This is to transmit a draft copy of the Sunrise Review of Music Therapists. This report has not yet been scheduled to be presented during interim meetings of the Joint Committee on Government Operations and the Joint Committee on Government Organization. We will inform you of the exact time and location once the information becomes available. It is expected that a representative from your task force be present at the meeting to orally respond to the report and answer any questions the committees may have during or after the meeting.

You have the option to provide a written response to this report. If you respond, please do so by Wednesday, May 10, 2017, in order for it to be included in the final report. Once an interim date has been established, if you intend to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 304-340-3192 to make arrangements.

We request that you do not disclose the report to anyone not affiliated with your task force. Thank you for your cooperation.

Sincerely,

John Sylvia

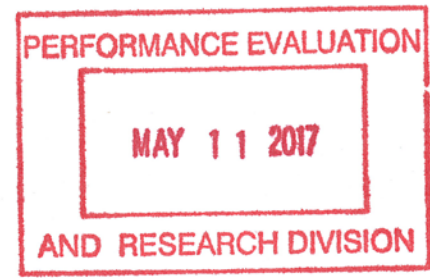
John Sylvia

Enclosure

Joint Committee on Government and Finance

Appendix B
Agency Response

714 Venture Dr. #115
Morgantown, WV 26508



5/10/2017

John Sylvia
Director
Performance Evaluation and Research Division
Building 1, Room W-314
1900 Kanawha Boulevard, East
Charleston, WV 25305-0610

Dear Mr. Sylvia:

Thank you for your review of our application. We appreciate your feedback and will take this under advisement as we continue to pursue professional recognition within the state.

Sincerely,

Amy Rodgers Smith, MMT, MT-BC
Chair, West Virginia Music Therapy Task Force

WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION & RESEARCH DIVISION

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2014 Sunrise Review:
Music Therapists

Office of Policy, Research and Regulatory Reform
October 15, 2014

October 15, 2014

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunrise reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed its evaluation of the sunrise application for regulation of music therapists and is pleased to submit this written report. The report is submitted pursuant to section 24-34-104.1, Colorado Revised Statutes, which provides that DORA shall conduct an analysis and evaluation of proposed regulation to determine whether the public needs, and would benefit from, the regulation.

The report discusses the question of whether there is a need for regulation in order to protect the public from potential harm, whether regulation would serve to mitigate the potential harm, whether the public can be adequately protected by other means in a more cost-effective manner and whether the imposition of any disqualifications for regulation based on criminal history serves public safety or consumer protection interests.

Sincerely,

Barbara J. Kelley
Executive Director

1560 Broadway, Room 1550, Denver, CO 80202 P 303.894.7855 F 303.894.7885 www.colorado.gov/dora

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Recommendation – There is no demonstrated public interest or need to warrant the creation of a new regulatory program or to protect the title, "music therapist" or "board-certified music therapist." 31

Background

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunrise Process

Colorado law, section 24-34-104.1, Colorado Revised Statutes (C.R.S.), requires that individuals or groups proposing legislation to regulate any occupation or profession first submit information to the Department of Regulatory Agencies (DORA) for the purposes of a sunrise review. The intent of the law is to impose regulation on occupations and professions only when it is necessary to protect the public health, safety or welfare. DORA must prepare a report evaluating the justification for regulation based upon the criteria contained in the sunrise statute:[1]

> (I) Whether the unregulated practice of the occupation or profession clearly harms or endangers the health, safety, or welfare of the public, and whether the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
>
> (II) Whether the public needs, and can reasonably be expected to benefit from, an assurance of initial and continuing professional or occupational competence;
>
> (III) Whether the public can be adequately protected by other means in a more cost-effective manner; and
>
> (IV) Whether the imposition of any disqualifications on applicants for licensure, certification, relicensure, or recertification based on criminal history serves public safety or commercial or consumer protection interests.

[1] § 24-34-104.1(4)(b), C.R.S.

Any professional or occupational group or organization, any individual, or any other interested party may submit an application for the regulation of an unregulated occupation or profession. Applications must be accompanied by supporting signatures and must include a description of the proposed regulation and justification for such regulation.

Methodology

DORA has completed its evaluation of the proposal for regulation of music therapists. During the sunrise review process, DORA performed a literature search; contacted and interviewed the applicant; reviewed licensure laws in other states; interviewed music therapy practitioners, mental health practitioners, health-care practitioners and administrators of the Colorado mental health boards; and contacted professional associations, the Colorado Department of Education, and the Colorado Department of Health Care Policy and Financing.

In order to determine the number and types of complaints filed against music therapists in Colorado, DORA contacted representatives of the Office of Occupational Therapy, the State Physical Therapy Board, the Office of Speech-Language Pathology Certification, and the Colorado mental health boards. To find additional reports of harm, DORA also contacted the Colorado Hospital Association, the Colorado Assisted Living Association, and the Colorado Health Care Association and Center for Assisted Living. To better understand the practice of music therapy, DORA staff observed nine music therapy sessions.

Profile of the Profession

After World War II, professional and amateur musicians traveled to hospitals throughout the United States to entertain war veterans who were suffering emotional and physical trauma. Recognizing the therapeutic benefit of music, doctors and nurses began to hire musicians to play for other patients, and the field of music therapy began to emerge.[2]

Music therapy is one of the creative arts therapies, which also include art therapy, dance therapy and drama therapy.[3] Music therapy involves listening to, creating, singing or moving to music.[4]

Music therapists use music in clinical or educational settings to treat individuals with cognitive, emotional, physical and social issues.[5] They often work with other health and educational professionals to assess an individual's needs and to develop a treatment plan.

Music therapists work with people who are mentally ill to develop coping and relaxation skills, increase self-esteem, decrease anxiety, enhance interpersonal relationships, improve group cohesiveness, increase motivation and help with catharsis.[6]

Music therapists also work with older people to enhance memory, reduce stress and anxiety, and improve mood.[7] For clients with Alzheimer's, they use music to ease depression, encourage social interaction, and decrease problem behaviors associated with agitation or aggression.[8]

Music therapists often work in hospice and hospital settings to help patients who are dying or coping with serious illnesses. For example, a music therapist may work with a child who has cancer in order to give voice to and validate the child's feelings of anger.[9]

---

[2] American Music Therapy Association. *History of Music Therapy.* Retrieved on April 9, 2014, from http://www.musictherapy.org/about/history/
[3] *See* National Coalition of Creative Arts Therapies Association. *About NCCATA.* Retrieved on June 23, 2014, from http://www.nccata.org/#!aboutnccata/czsv
[4] American Music Therapy Association. *Definitions and Quotes About Music Therapy.* Retrieved on April 9, 2014, from http://www.musictherapy.org/about/quotes/
[5] American Music Therapy Association. *Definitions and Quotes About Music Therapy.* Retrieved on April 9, 2014, from http://www.musictherapy.org/about/quotes/
[6] *See* American Music Therapy Association. *Music Therapy and Mental Health.* 2006.
[7] *See* American Music Therapy Association. *Music Therapy and Alzheimer's Disease.* 2006.
[8] American Music Therapy Association. *Personal Stories About Music Therapy.* Retrieved on June 18, 2014, from http://www.musictherapy.org/about/personal_stories/
[9] American Music Therapy Association. *Personal Stories About Music Therapy.* Retrieved on June 18, 2014, from http://www.musictherapy.org/about/personal_stories/

Music therapists may also work with people who are autistic in order to teach them to build relationships with peers, to express themselves verbally, to improve communication, and to participate with others in socially acceptable ways.[10]

Other professionals, such as psychologists, counselors and other health-care practitioners, may use music and other art forms therapeutically.[11]

Expressive art therapists are another group of practitioners who use music therapeutically. While creative arts therapists rely on one type of art for therapy, expressive arts therapists work with several different types of arts.

Expressive arts therapists may utilize painting, drawing, sculpture, dance, movement, music, drama, ritual, poetry or prose.[12]

Music thanatologists are another occupational group that uses music therapeutically. They sing and play the harp in hospice and palliative settings to ease suffering during the dying process.[13]

Musicians also play music in educational or clinical settings to entertain students or patients. While music by itself has therapeutic benefits, the American Music Therapy Association (AMTA) does not consider this to be music therapy.[14]

The AMTA establishes the educational and clinical training requirements of music therapists.[15] There are over 70 colleges and universities with music therapy programs approved by the AMTA.[16]

Music therapists must have a strong foundation in music. They must also have a basic knowledge of clinical and therapeutic practice. They must be able to apply the foundations and principles of music therapy, and they must be able to perform an assessment, plan treatment, and implement, document and evaluate treatment.[17]

[10] American Music Therapy Association. *Personal Stories About Music Therapy.* Retrieved on June 18, 2014, from http://www.musictherapy.org/about/personal_stories/
[11] *See* Cathy A. Malchiodi, *Expressive Therapies*, Guilford Publications, p. 2.
[12] California Institute of Integral Studies. *Expressive Arts Therapy.* Retrieved on June 23, 2014, from http://www.ciis.edu/Academics/Graduate_Programs/Expressive_Arts_Therapy.html
[13] Music-Thanatology Association International. *What Is Music-Thanatology?* Retrieved on June 23, 2014, from http://www.mtai.org/index.php/what_is
[14] American Music Therapy Association. *Definition and Quotes About Music Therapy. Retrieved on April 9, 2014, from* http://www.musictherapy.org/about/quotes/
[15] American Music Therapy Association. Frequently Asked Questions. Retrieved on March 28, 2014, from http://www.musictherapy.org/faq/
[16] American Music Therapy Association. *A Career in Music Therapy.* Retrieved on June 20, 2014, from http://www.musictherapy.org/careers/employment/
[17] *See* American Music Therapy Association. *A Career in Music Therapy.* Retrieved on June 20, 2014, from http://www.musictherapy.org/careers/employment/

According to the AMTA, a bachelor's degree in music therapy is made up of the following areas of study:[18]

- Music foundations (45 percent),
- Clinical foundations (15 percent),
- Music therapy (15 percent),
- General education (20 to 25 percent), and
- Electives (5 percent).

Music foundations may include the following courses:[19]

- Music Theory;
- Composition and Arranging;
- Music History and Literature;
- Applied Music Major;
- Ensemble;
- Conducting; and
- Functional Piano, Guitar and Voice.

Clinical foundations may include the following courses:[20]

- Exceptionality and Psychopathology,
- Normal Human Development,
- Principles of Therapy, and
- The Therapeutic Relationship.

Music therapy may include the following courses:[21]

- Foundations and Principles,
- Assessment and Evaluation,
- Methods and Techniques,
- Pre-Internship and Internship Courses,
- Psychology of Music,
- Music Therapy Research,
- Influence of Music on Behavior, and
- Music Therapy with Various Populations.

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[18] American Music Therapy Association. *A Career in Music Therapy.* Retrieved on June 20, 2014, from http://www.musictherapy.org/careers/employment/
[19] American Music Therapy Association. *A Career in Music Therapy.* Retrieved on June 20, 2014, from http://www.musictherapy.org/careers/employment/
[20] American Music Therapy Association. *A Career in Music Therapy.* Retrieved on June 20, 2014, from http://www.musictherapy.org/careers/employment/
[21] American Music Therapy Association. *A Career in Music Therapy.* Retrieved on June 20, 2014, from http://www.musictherapy.org/careers/employment/

A music therapy degree includes 1,200 hours of clinical training, which is gained through fieldwork experience in music therapy courses and an internship.[22]

Music therapists may also obtain a master's or a doctoral degree in music therapy.[23]

A music therapist may be designated as a Music Therapist — Board Certified (MT-BC), through the Certification Board for Music Therapists (CBMT). In order to become an MT-BC, a candidate must complete a bachelor's degree in music therapy and pass a national examination administered by the CBMT.[24]

Other professional credentials that music therapists may hold include the Advanced Certified Music Therapist (ACMT), Certified Music Therapist (CMT) or Registered Music Therapist (RMT). These credentials were previously granted by the National Association for Music Therapy and the American Association for Music Therapy before they merged to form the AMTA in 1998.[25]

Six states regulate music therapists. Two of these states only require music therapists to be licensed if they practice psychotherapy, and in another state, certification is voluntary.

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[22] American Music Therapy Association. *A Career in Music Therapy.* Retrieved on June 20, 2014, from http://www.musictherapy.org/careers/employment/#Bachelors_Degree_Requirements
[23] American Music Therapy Association. *A Career in Music Therapy.* Retrieved on June 20, 2014, from http://www.musictherapy.org/careers/employment/#Bachelors_Degree_Requirements
[24] American Music Therapy Association. *Professional Requirements for Music Therapists.* Retrieved on June 23, 2014, from http://www.musictherapy.org/about/requirements/
[25] Music Therapy Maven. *All You Need to Know About the Designations Behind a Music Therapist's Name.* Retrieved on June 23, 2014, from http://www.musictherapymaven.com/acronyms-and-specialized-training-designations-for-the-professional-music-therapist/

Proposal for Regulation

The American Music Therapy Association (AMTA) has submitted a sunrise application to the Department of Regulatory Agencies (DORA) for review in accordance with the provisions of section 24-34-104.1, Colorado Revised Statutes (C.R.S.). The application identifies state title protection of music therapists as the appropriate level of regulation to protect the public.

The sunrise application states that title protection is necessary to protect the public from the emotional, psychological, physical and financial harm from unqualified and incompetent music therapists.

It also states that title protection will help to protect personal health information from being shared with unqualified practitioners.

The sunrise application requests that only individuals who hold a professional designation, in good standing, through the Certification Board for Music Therapists (CBMT) or the National Music Therapy Registry be able to use the title "music therapist" or "board-certified music therapist."

The requirements to be board certified through CBMT are to:[26]

- Obtain a bachelor's degree in music therapy from a college or university program approved by the AMTA, and
- Pass a national examination created by CBMT.

A bachelor's degree in music therapy requires 1,200 hours of clinical training, which includes a supervised internship.[27]

In order to maintain certification, a music therapist must complete 100 hours of continuing education every five years.[28]

The National Music Therapy Registry includes music therapists who were credentialed before the creation of the AMTA.[29,30]

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[26] American Music Therapy Association. *Professional Requirements for Music Therapists.* Retrieved on June 23, 2014, from http://www.musictherapy.org/about/requirements/

[27] American Music Therapy Association. *Professional Requirements for Music Therapists.* Retrieved on June 23, 2014, from http://www.musictherapy.org/about/requirements/

[28] The Certification Board for Music Therapists. *CBMT Definition Fact Sheet.* Retrieved on September 26, 2014, from http://www.cbmt.org/fact-sheets/cbmt-definition-fact-sheet/

[29] American Music Therapy Association. *Professional Requirements for Music Therapists.* Retrieved on June 23, 2014, from http://www.musictherapy.org/about/requirements/

[30] Music Therapy Maven. *All You Need to Know About the Designations Behind a Music Therapists Name.* Retrieved on June 23, 2014, from http://www.musictherapymaven.com/acronyms-and-specialized-training-designations-for-the-professional-music-therapist/

Summary of Current Regulation

The Colorado Regulatory Environment

Music therapy is one of the creative arts therapies, which also include art therapy, dance therapy and drama therapy.[31] According to the National Institute of Mental Health, creative arts therapies and expressive arts therapy are forms of psychotherapy that are "based on the idea that people can heal themselves through art, music, dance, writing or other expressive acts."[32]

While there are no laws specific to "music therapy," anyone who practices psychotherapy must at a minimum be registered as a psychotherapist in Colorado.[33]

Under the Mental Health Practice Act, the following six boards regulate mental health providers:

- Addiction counselors,
- Licensed professional counselors,
- Marriage and family counselors,
- Psychologists,
- Registered psychotherapists, and
- Social workers.

The mental health boards have the authority to deny, revoke or suspend a license, certification or registration. They may also issue a letter of admonition, a confidential letter of concern or a fine, and they may place a licensee, certificate holder or registrant on probation.[34]

The grounds for discipline include, among other items:[35]

- A felony conviction;
- Habitually or excessively using or abusing alcohol, a habit-forming drug or a controlled substance;
- Failing to notify the relevant board of a physical or mental illness or condition that affects the person's ability to treat clients with reasonable skill and safety or that may endanger the client's health or safety;
- Acting or failing to act in a manner that meets the standards of practice;
- Performing services outside the person's area of training, experience or competence;

[31] National Coalition of Creative Arts Therapies Associations. *About NCCATA.* Retrieved on June 23, 2014, from http://www.nccata.org/#!aboutnccata/czsv
[32] National Institute of Mental Health. *Psychotherapies.* Retrieved on June 23, 2014, from http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml
[33] § 12-43-226(2), C.R.S.
[34] § 12-43-223(1), C.R.S.
[35] § 12-43-222(1), C.R.S.

- Exercising undue influence on the client, including the promotion of the sale of services, goods, property or drugs in such a manner as to exploit the client for the financial gain of the practitioner or a third party; and
- Engaging in sexual contact, sexual intrusion or sexual penetration with a client during the period of time in which a therapeutic relationship exists or for two years following the period in which such a relationship exists.

The Mental Health Practice Act provides a strong regulatory framework that protects the public against unprofessional conduct, incompetent practice and abuse.

The Colorado Department of Health Care Policy and Financing oversees the Medicaid program. In Colorado, there are three Home and Community-Based Services (HCBS) waivers through which music therapy is reimbursed through Medicaid:

- Children's Extensive Support,
- Supported Living Services, and
- Children with Life-Limiting Illness.

Each of these HCBS waivers require music therapists to be board certified through the Certification Board for Music Therapists (CBMT). For the most fragile and vulnerable persons who receive music therapy through HCBS waivers, the state government ensures that music therapists have demonstrated a certain level of professional competency.

Additionally, in the Consumer Protection Act, it is considered a deceptive trade practice to claim to possess a degree or a title associated with a particular degree unless the person has been awarded the degree from a school that is accredited or otherwise authorized to grant degrees as specified in statute.[36] Therefore, a person could not pose as a graduate of a music therapy program without first having a degree.

There are also numerous health-care practitioners that may use music as an intervention to treat patients:

- Nurses,
- Physical therapists,
- Occupational therapists,
- Speech language pathologists, and
- Mental health providers.

All of these practitioners are governed by their particular practice acts, and they are required to work within the boundaries of their education, skill and training. The professional boards that regulate them may investigate consumer complaints and discipline practitioners for unprofessional conduct.

[36] § 6-1-707(1)(a), C.R.S.

In addition to health-care professionals, musicians often enter into health-care settings to provide entertainment to patients. There are no laws regulating the professional conduct of these individuals.

Regulation in Other States

Six states regulate music therapists, and in each of these states the level of regulation is different. Four of these states regulate music therapists as a unique profession, and two states license music therapists as psychotherapists.

New York licenses music therapists as "creative arts therapists,"[37] which New York defines as practitioners who are trained in psychotherapy and specific art disciplines to address mental, emotional, developmental and behavioral disorders.[38] Wisconsin has a voluntary registration program, but it requires music therapists to be licensed in order to practice psychotherapy.

Only Georgia and North Dakota protect the title "music therapist." New York protects the title "creative arts therapist" and any of its derivatives.

Table 1 provides some basic information about the regulation of music therapists in other states.

Table 1
Regulation in Other States

	Georgia	Nevada	New York[39]	North Dakota	Utah	Wisconsin[40]
Year enacted	2012	2011	2007	2011	2014	1998
Type of regulation	License	License	License	License	Certificate	Registration/License
Voluntary or mandatory	Mandatory	Mandatory	Mandatory	Mandatory	Voluntary	Voluntary/ Mandatory
Title protected	Yes	No	Yes	Yes	No	No
Practice protected	No	No	Yes	No	No	Yes
Number licensed, certified or registered	91	12	1,575	6	None	38

[37] American Music Therapy Association. *How to Find a Music Therapist.* Retrieved on September 26, 2014, from http://www.musictherapy.org/about/find/
[38] New York State Education Department. *Consumer Information.* Retrieved on August 11, 2014, from http://www.op.nysed.gov/prof/mhp/catbroch.htm
[39] New York licenses music therapists as creative arts therapists along with other therapists who use art, dance, drama, movement, music or poetry.
[40] Wisconsin registers music therapists voluntarily but requires a license if music therapists practice psychotherapy. The number here includes both registered music therapists and those who are licensed to practice psychotherapy.

Analysis and Recommendations

Public Harm

The first sunrise criterion asks:

> Whether the unregulated practice of the occupation or profession clearly harms or endangers the health, safety or welfare of the public, and whether the potential for harm is easily recognizable and not remote or dependent on tenuous argument.

In order to determine whether the regulation of music therapists is necessary, the Department of Regulatory Agencies (DORA) requested that the sunrise applicant provide specific examples of harm to the public.

The examples of harm provided to DORA include:

- Emotional harm,
- Psychological harm,
- Physical harm, and
- Misuse of a title.

Each example of harm is summarized below along with DORA's analysis.

Emotional Harm

In 2004, a music therapist was working in a hospital in the suburbs of Chicago where music thanatologists[41] and music practitioners also provided services to patients in their rooms and in the waiting areas. The music therapist was called by a registered nurse to provide music therapy to a patient in the oncology unit. The patient was emotionally distraught following a visit from a music thanatologist, who played music that triggered feelings that were overwhelming for the patient. When the patient became distressed, crying and agitated, the thanatologist left the patient in this condition. The nurse was troubled by this and asked a music therapist to help the patient. The music therapist began a session which helped the patient to express and release her feelings in the context of a therapeutic relationship. By the end of the music therapy session, the patient was relaxed and calm.

[41] Music thanatologists: practitioners who sing and play the harp in hospice and palliative settings to ease suffering during the dying process.

__Analysis__

Clearly, the patient suffered temporary emotional distress due to the failure of the thanatologist to deal with the emotional response triggered by the music. However, the patient was under the care of nurses and other trained staff in the hospital, and the nurse responded to the emotional distress of the patient by calling in an appropriate person to handle the situation. The nurse could have also called a hospital chaplain or another mental health provider to help this patient. Therefore, any possible harm would likely be addressed without the need for additional regulation.

Emotional Harm

A music therapist in Oregon was working with a patient who was suffering from a terminal illness that had also killed her father. The patient was having a difficult week, and the health-care team decided that she needed to refocus on things that brought her happiness, so an intern that was working with the music therapist brought in a book and song. Halfway through the song, the patient broke down into uncontrollable sobbing. The intern did not know it, but the client's father used to sing that song to her at night. The patient had not grieved for the loss of her father, and because the intern was a trained music therapist she was able to help the patient grieve. The music therapy session developed into a cathartic experience for the patient. If the intern had simply been a music volunteer or someone without training, the patient may not have achieved catharsis and may have been left in a state of despair. The patient's psychologist thanked the music therapist for helping this patient to begin grieving the death of her father.

__Analysis__

While this case demonstrates the likelihood of an improved outcome by a board-certified music therapist, it is not clear evidence of harm.

Emotional Harm

A musician was brought into a state-run psychiatric hospital in Denver as a volunteer. During his tenure at the psychiatric hospital, the volunteer acted inappropriately on a number of occasions. First, the musician asked to be called a music therapist although he was not trained as a music therapist. The hospital denied this request. Second, the volunteer attempted to bring his friends into the hospital without processing them through volunteer services, which requires a fingerprint-based criminal history record check. They were not allowed in. Third, he also attempted to hold drum circles but was told to collaborate with the music therapist on staff. He decided not to collaborate and was not allowed to hold any drum circles. Fourth, the volunteer attempted to provide spiritual counsel to patients without understanding the client goals or working with Chaplain Services or collaborating with other appropriate staff. Finally, he attempted to sell compact discs of his music to indigent patients, resulting in emotional distress for some of the patients. His service was officially ended by the volunteer office after his visits became sporadic, and eventually he stopped coming to visit at all.

Analysis

A state-run psychiatric hospital is a sophisticated employer that should be able to assess the necessary qualifications of its staff and its volunteers. Attempts by the volunteer that could have resulted in harm to patients were prevented by hospital staff. The patients in this facility are under the care of qualified mental health providers, and this volunteer was supervised by trained staff. If this volunteer presented any real potential for harm to patients, the staff could have prevented him from continuing to volunteer. Even if music therapists were fully licensed, it would not prevent hospitals from enlisting volunteers to provide music to the patients. Therefore, any possible harm would likely be addressed without the need for additional regulation.

Emotional Harm

A psychiatric hospital in Colorado hosted a mental health fair for the community, staff from the facility and other similar facilities. Clients of the hospital also attended the fair. One of the options of the day was drum therapy. The leader of the drum therapy session was a psychologist and a member of the hospital staff but not a board-certified music therapist.

A board-certified music therapist who watched a drum therapy session and attended another reported the following problems. The drum therapy leader taught the group a rhythm and had the members repeat it for the duration of the session. According to the music therapist, this is inconsistent with research which shows that if a stimulus does not change, the behavior becomes rote and, therefore, does not improve aspects of cognition. The drum therapy leader also stopped the group and corrected anyone who was playing incorrectly. According to the music therapist, this is contrary to how music therapists are taught to approach mental health, which is to instill hope, focus on strengths and treat people with respect. Music therapy also focuses on allowing people to express themselves safely. Having people repeat the same rhythm without any aspect of individuality can damage self-esteem and the therapeutic relationship, and it discourages empowerment and independence. The drum therapy leader went back and forth between joining the group and soloing over the others. According to the music therapist, music therapy is client centered, but the music therapist considered the soloing to be attending to the needs of the drum therapy leader rather than the members of the group.

Finally, the drums were made of skin, which the music therapist said cannot be sanitized and should not be used in a medical or hospital setting.

After the drum therapy session, the music therapist approached the drum therapy leader and expressed concern that she was not trained to provide music therapy. The drum therapy leader declined to consult with a music therapist and responded that she had 30 years of experience in psychology and that she used drumming along with dialectical behavior therapy to teach mindfulness.

Analysis

Clearly, the drum therapy leader did not provide a drum therapy session the same way that the music therapist would have. However, music is an intervention that may be employed by psychologists and other health-care providers, and there is no evidence of actual harm to members of the community in this case.

Emotional Harm

A music therapist was working as a musician with a small ensemble in a kindergarten classroom and not as a music therapist when she noted a five-year-old boy who was behaving and reacting in the classroom in an atypical way. He seemed to be out of touch, screamed and had poor peer interactions with poor eye contact, and he did not follow directions well. Over a period of four weeks, it became clear that the child was sensitive to sound. He exhibited sudden episodes of high anxiety and self-talk, including covering his ears. This behavior was exacerbated by certain types of music and sounds. The music therapist made several attempts to remove the child from the group when he was having the most severe reactions, but the school did not have many alternatives for the child. After several months, the child was evaluated by the school, and it was determined that the child had special needs and probable childhood psychosis. In this case, music was contraindicated. The music therapist was not acting in her role as a music therapist, but as a musician. Her training, however, allowed her to advocate for the child given his negative reactions to music and certain sounds.

Analysis

According to the music therapist, music was not an appropriate form of treatment for this child. Music can be provided in almost any setting, and in this case, the music therapist was hired as a musician, not as a music therapist. Therefore, music was not being used to treat this individual. While this case demonstrates the likelihood of an improved outcome by a board-certified music therapist, it is not clear evidence of harm.

Psychological Harm

A hospital in Colorado hired two people to provide music therapy to patients in an adolescent psychiatric unit, an adult psychiatric unit and a pediatric unit. One person was a board-certified music therapist, and the other was a musician without any clinical training. The music therapist was holding a music therapy session when the musician entered into the room. The musician did not recognize the signs of acute hyper-sexuality in one of the patients, and she lacked therapeutic boundaries and clinical training. The musician engaged in a personal conversation in the presence of patients that triggered a patient to masturbate during the session. This patient and at least one other patient in the group were traumatized by the event. The music therapist immediately ended the session, asked everyone else to leave and called appropriate hospital staff to attend to the patients.

Analysis

This scenario is common in psychiatric units, and the music therapist reported to DORA that she has encountered it on other occasions in music therapy sessions. The hospital trains its staff and volunteers to respond to situations like this and other situations that could escalate into violence or be harmful to patients. The hospital could always hire musicians with or without clinical training to provide music to patients and call them music practitioners, music specialists or musicians. Therefore, neither title protection nor further regulation would address the alleged harm.

Physical Harm

During a music therapy session with a small group in Tucson, Arizona, a music therapist noted that a young boy — who had multiple developmental delays, was unable to walk or talk, and was on medication for epilepsy — was having *petit mal* seizure activity in response to higher frequency sounds and certain repetitive sounds. The music therapist addressed the high frequency sounds, bass rhythms and discernible tempos that were causing the seizures, and the following music therapy session was successful. Music therapy helped the child to stay alert and interact with her mother and her sibling. The music therapist provided the mother with information about music-induced seizures and how an advisory for the child's Individualized Education Program might be considered to prevent further seizures.

Analysis

This is one area where specialized training and education in music therapy clearly prepared this practitioner to help the client. While this case demonstrates the likelihood of an improved outcome by a board-certified music therapist, it is not evidence of harm.

Physical Harm

After several weeks of medical treatment, a 12-year-old oncology patient in Indiana had a stroke and was placed in a medically induced coma to protect her neurological functioning. After noting the physiological signs of agitation between doses of sedative medication, the attending physician requested music therapy. The board-certified music therapist assessed the patient and observed no behavioral responses to the music therapy intervention. The patient's mother asked for the session to continue because her child had received and loved music therapy before she had a stroke. As the session continued, the music therapist noted a drastic increase in the patient's heart rate, a decrease in her oxygen saturation levels, and an increase in her rate of respiration despite controlled, mechanical ventilation. The music therapist discontinued music therapy because of the potential strain on the child's heart, increased pressure on her brain, and strain on her compromised lungs.

Analysis

The board-certified music therapist acted appropriately by stopping the intervention and preventing the infliction of any harm. Even if the music therapist were not properly trained, the patient was under the care of an attending doctor and intensive care nurses, who were responsible for the patient, monitoring the patient's vitals and would act appropriately to prevent harm to the patient. Therefore, any possible harm would likely be addressed without the need for additional regulation.

Physical Harm

A music therapist from Oregon was working in a children's hospital when a doctor from the pediatric intensive care unit (PICU) called her in to consult on a case. A teenager ran his snowmobile into a tree and suffered a traumatic brain injury. He was in a stage of coma in which he was extremely agitated. The parents hired someone who claimed to be a music therapist, but who was not. The person programmed music to be played by the patient's bedside to help him relax. The patient became more agitated. His heart rate increased, and his oxygen saturation rates decreased. The PICU staff responded by increasing the sedatives, and the attending doctor called in a board-certified music therapist to consult on the case. When the music therapist entered the room, the music that was playing by the patient's bedside was a Mozart concerto. The music therapist noted that the child was writhing in his bed. The family told the music therapist that the patient did not like classical music and actually preferred gangster rap. When the music therapist set up a listening program that included the patient's preferred music, the patient sighed and visibly relaxed. His heart rate lowered to normal in less than three minutes, and his oxygen saturation rate went from 82 percent to 96 percent and remained stable. He was then able to relax without further medication, allowing his body and brain to heal.

Analysis

In this case, the patient was not harmed. The PICU staff was monitoring the vitals of the patient, and they responded to the situation appropriately. The hospital staff was sophisticated enough to recognize a potentially dangerous situation and assess the necessary qualifications of staff to consult on the case. Therefore, any possible harm would be addressed without the need for additional regulation.

Physical Harm

A music therapist from Colorado who provides music therapy to children and adults with intellectual and developmental disabilities was working with a 23-year-old man with Angelman syndrome. During the session, the man became extremely agitated and began throwing instruments across the kitchen and striking out at his parents and the music therapist. The music therapist assessed the situation and observed that he was frustrated because he had difficulty grasping an instrument. He was in immediate danger of harming himself and others, so the music therapist changed the tempo and volume of the music to reduce the auditory stimulation. She did this gradually but over a short period of time to settle him down and to avoid further distress.

Analysis

In this case, the patient was not harmed. Angelman syndrome is a genetic disorder that causes severe intellectual and developmental disabilities. This client is most likely receiving services through the Supported Living Services, Home and Community-Based Services Medicaid-waiver program, which requires music therapy to be provided by a board-certified music therapist. Also, the music therapist is an approved service provider through the Colorado Department of Health Care Policy and Financing, Division of Developmental Disabilities, which regulates the provision of therapeutic services provided to persons with developmental disabilities. Therefore, any possible harm would be addressed without the need for additional regulation.

Misuse of a Title

A registered nurse who is also a fitness instructor and a musician contacted a music therapist for some advice on how to improve the services she is providing to nursing homes in a small community in Colorado. The registered nurse promotes herself to the nursing homes as a music therapist. She provides 30-minute sessions, and she leads the residents in familiar songs and gives them instruments to play. Then she leads them in 30 minutes of gentle exercise therapy. She only provides these sessions once a week and otherwise works as a school nurse. According to the registered nurse, her clients appreciate the services she is providing.

Analysis

In this case, no consumer harm is reported or alluded to. The only possible harm is the misuse of a title, which is only harmful to the profession and is not evidence of consumer harm.

These cases do not demonstrate evidence that the unqualified practice of music therapy harms the public. In the cases presented in which clients were medically fragile, they were protected by other means.

DORA also contacted the Certification Board for Music Therapists (CBMT) to find additional cases of harm. CBMT provided several cases that resulted in disciplinary action. These cases occurred in other states and took place over a period of approximately 16 years.

Some of the cases provided by CBMT illustrate the following types of harm:

- Sexual assault,
- Sexual misconduct, and
- Financial exploitation.

Each example of harm is summarized below along with DORA's analysis.

Sexual Assault

CBMT revoked the certification of a music therapist following three cases of sexual assault, which all took place over the summer of 2008 in Arizona. The music therapist was reported to have locked the bedroom door where he was treating a 10-year-old non-verbal female with autism. When the mother unlocked the door, the child's underwear and pants were around her ankles. The child was unable to unbutton her pants by herself. The twin brother also alleged that the therapist touched his private parts and made him touch his. Another 10-year-old boy reported that he performed oral sex on the music therapist. The father of a 21-year-old non-verbal male with cerebral palsy walked in on a session, and found the therapist taking his hand out of his son's pull-up diaper. The music therapist was placed on lifetime probation and required to serve at least one year in county jail, and he will have to register as a sex offender.

Analysis

This case provides clear evidence of harm to people with developmental disabilities, who are especially vulnerable to abuse and exploitation. The individual was placed on a sex offender registry and his board certification was revoked, which would likely diminish his ability to find work as a music therapist, but it may not eliminate it.

Sexual Assault

A board-certified music therapist pleaded guilty to sexually molesting a child in Maryland in 1999, and he was given a suspended sentence and placed on probation. CBMT was not notified of this incident, so it did not revoke his certification. He then moved to Florida where he was working with terminally ill children in hospice and palliative care. He was subsequently arrested in 2008 for failing to register as a sex offender, which is a felony, and he was incarcerated. Following the music therapist's conviction, CBMT revoked his certification.

Analysis

This case provides evidence of harm to the public. Unfortunately, the requirement to register as a sex offender did not result in the revocation of the music therapist's board certification for nine years or reduce the sex offender's ability to work as a music therapist with terminally ill children during that time. Nine years later, he was convicted of a felony, incarcerated and CBMT revoked his certification, which would very likely diminish his ability to find work as a music therapist, but it may not eliminate it.

Sexual Assault

CBMT denied certification to an individual based on a history of sexual assault while in a position of trust in 1998. While working as a high-school band director at a high school in Virginia, the director was found guilty of sexually abusing more than one student by inappropriate touching, proposing sexual acts, exposing himself to students and asking a student to expose himself.

> ***Analysis***
>
> *This case provides evidence of harm to the public. However, the perpetrator was convicted and sentenced as a sex offender, and CBMT subsequently denied his application for board certification, which should reduce his ability to find work as a music therapist, but it may not completely eliminate it.*

Sexual Misconduct

In 2010, CBMT suspended the certification of a music therapist in Ohio who entered into a sexual relationship with a young male adult, who was an in-patient in psychiatric care. CBMT required the music therapist to take ethics classes and appeal for reinstatement, and the certification was then reinstated.

> ***Analysis***
>
> *This case provides evidence of harm to the public. While the music therapist was disciplined, consumers would have no way of knowing that any disciplinary action was taken. If the music therapist's board certification was revoked, consumers would be able to determine that the music therapist was no longer board certified. However, in this case, the music therapist's board certification was reinstated. CBMT is a private organization, so the misconduct would not be public. With state regulation, disciplinary actions are available to the public.*

Sexual Misconduct

In 1999, CBMT suspended the certification of a music therapist in Texas who entered into a sexual relationship with a young female adult, who was an in-patient in psychiatric care. CBMT required the music therapist to take ethics classes and appeal for reinstatement, and the certification was then reinstated.

Analysis

This case provides evidence of harm to the public. While the music therapist was disciplined, consumers would have no way of knowing that any disciplinary action was taken. If the music therapist's board certification was revoked, consumers would be able to determine that the music therapist was no longer board certified. However, in this case, the music therapist's board certification was reinstated. CBMT is a private organization, so the misconduct would not be public. With state regulation, disciplinary actions are available to the public.

Financial Exploitation

An individual used alias names and falsely advertised that he was a board-certified music therapist. While representing himself as a music therapist, the individual extorted money from nursing home residents and nursing homes in California. After he performed as a music therapist at a nursing home, he would collect signatures from residents and staff. Then after a lengthy period of time he would forge the signatures onto contracts. Once this was done, he would send demand letters for breach of contract. Due to the lapse of time, many agreed to pay him or they would hire him. If they didn't, he would sue them. He had 35 active lawsuits in a few years of time, and he acquired thousands of dollars through forged and fraudulent contracts. He was reported to CBMT in 2006 and 2009, and it ordered him to cease and desist representing himself as a board-certified music therapist.

Analysis

This case provides evidence of harm to the public. However, forgery and fraud are crimes that may be addressed by a criminal court. This individual was falsely representing himself as board certified. It is unlikely that title protection or government regulation could have prevented these crimes.

Financial Exploitation

A music therapist in Wisconsin became a primary caregiver for an elderly woman, who was a former client. The elderly woman subsequently left her estate to the music therapist upon her death. The daughter of the elderly woman contested the will, but the case was dismissed by two civil court judges and the Wisconsin Department of Regulation and Licensing. The music therapist maintained that there was no merit to the allegations of financial exploitation, but she voluntarily surrendered her certification in 2001 after the daughter filed a complaint with CBMT.

Analysis

It is unknown whether the music therapist in this case financially exploited her client since two civil courts dismissed the case. In this case, the music therapist was regulated in Wisconsin, and the state regulatory agency also dismissed the case. By surrendering her certification, the music therapist diminished her ability to find work as a music therapist, but she did not eliminate it entirely.

Most of these cases provide clear evidence of harm to the public by board-certified music therapists. The harm includes sexual abuse of children with developmental disabilities, sex with patients in psychiatric wards, and financial exploitation of elderly clients. While they represent only a few isolated cases, all of these events are reprehensible and some are heinous.

In nearly all of these cases, the board-certified music therapist was disciplined by the professional association. For those whose certification was revoked or surrendered, the chances of finding work as a music therapist has been significantly reduced.

However, the problem with private certification is that it cannot entirely prevent individuals from practicing music therapy without certification. Similarly, protecting the title "music therapist" would not prevent anyone from practicing music therapy as long as they did not represent themselves as a "music therapist." Only a regulatory program that requires a license in order to practice would prevent these individuals from practicing music therapy.

Unfortunately, government regulation does not prevent misconduct from taking place, but it could prevent individuals convicted of heinous crimes from practicing as music therapists in the future. While some of these music therapists received criminal sentences, they would still present a threat to the public if they continued to practice as music therapists.

That said, the harm identified in these cases is extremely rare, and none of these cases took place in Colorado. CBMT reported only five cases of harm throughout the entire country over a 16-year period, and there are currently about 6,000 board-certified music therapists throughout the United States.

The question is whether these few cases are sufficient to warrant government regulation of an entire occupational group.

In an attempt to identify harm in other states, DORA staff contacted the six states where music therapists are regulated. Wisconsin was the only state that reported having a record of any complaints filed against music therapists. In 16 years, Wisconsin reported only six complaints. No states, including Wisconsin, reported taking disciplinary action against a music therapist or denying any licenses, certificates or registrations.

DORA staff also contacted the following boards and offices in DORA to determine whether they have received any complaints against music therapists:

- The six boards that regulate mental health providers in Colorado,
- The Office of Occupational Therapy,
- The State Physical Therapy Board, and
- The Office of Speech-Language Pathology Certification.

Staff reported no records of complaints against music therapists.

DORA staff also contacted the Colorado Assisted Living Association and the Colorado Health Care Association and Center for Assisted Living. The facilities that these associations represent reported that some of them do hire or contract with board-certified music therapists, other clinicians and musicians to provide music to their patients. While the provision of music is different depending on the qualifications of the practitioner, these facilities state that the patients benefit therapeutically from music, and none of them reported any harm from the unqualified practice of music therapy.

DORA staff contacted the Colorado Hospital Association. One hospital reported that it hires musicians to provide entertainment, but it only hires board-certified music therapists to provide music therapeutically to improve functional outcomes with patients who have significant and severe neurologic injuries. In these cases, a physician writes an order for music therapy, and the hospital staff ensures the music therapist has a minimum of a Master's degree and board certification. However, no hospitals provided any evidence of harm from the unqualified practice of music therapy.

Community Centered Boards (CCB) also hire music therapists to provide treatment to persons who are developmentally disabled. Reimbursement for music therapy through a CCB is exclusively paid for by Medicaid through two HCBS waivers: Supported Living Services and Children's Extensive Support. Both of these HCBS waivers require music therapy to be provided by a board-certified music therapist.

DORA staff contacted Alliance, the association for agencies that serve persons with developmental disabilities, to determine if they have any evidence of harm by the unqualified practice of music therapy, but as of the writing of this report Alliance has not responded to any queries.

DORA staff also contacted the Division for Developmental Disabilities in the Colorado Department of Health Care Policy and Financing. The HCBS waivers that serve these populations require music therapists to be board certified, and staff did not provide any evidence of harm from the practice of music therapy.

DORA staff received numerous testimonials from other parties citing the need to regulate music therapists, but none of these parties could provide any evidence of harm. Most of these testimonials supported the regulation of music therapists because they consider client outcomes to be better with board-certified music therapists. However, this is difficult to quantify. Although DORA staff sought evidence to support this, it was not provided.

Overall, DORA staff utilized a variety of sources in an attempt to identify instances where unregulated music therapists were harming consumers. A comprehensive review of the information did not reveal harm resulting from the unqualified practice of music therapy.

DORA staff did uncover evidence of reprehensible and heinous crimes being committed by music therapists against their clients. While regulation would not prevent these crimes from taking place, it could prevent the individuals from practicing music therapy in the future. The cases reported are disturbing. However, they are also extremely rare.

Need for Regulation

The second sunrise criterion asks:

> Whether the public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional or occupational competence.

Since there is no clear evidence of harm by the unqualified practice of music therapy, an assurance of initial and continuing professional or occupational competence is unwarranted.

Alternatives to Regulation

The third sunrise criterion asks:

> Whether the public can be adequately protected by other means in a more cost-effective manner.

The applicant is seeking title protection, which is the least restrictive form of regulation. Since there is very little evidence of harm from the practice of music therapy, it is uncertain what public protection would be provided through title protection. There is even less evidence to support a more intrusive and costly regulatory scheme.

At this time, consumers have a choice in the marketplace. They may hire a music therapist who is board certified by CBMT or one who is not.

The Consumer Protection Act (CPA) makes it unlawful for anyone to claim to have a degree or use a title associated with a particular degree unless the person has been awarded the degree from a school that is accredited, or otherwise authorized to grant degrees as specified in statute.[42] Therefore, it is already unlawful for a person to pose as a graduate of a music therapy program without actually holding a degree.

Private certification is available to music therapists through CBMT. Only those individuals who hold this credential may represent themselves as board-certified music therapists, or place the initials MT-BC after their names. CBMT actively pursues individuals who falsely represent themselves as board-certified music therapists, and consumers can easily verify whether an individual is a board-certified music therapist.

Additionally CBMT has the authority to deny, revoke, suspend and require additional education of board-certified music therapists who are in violation of the certification standards. This includes gross or repeated negligence or malpractice in professional practice including a sexual relationship with a client, and sexual, physical, social or financial exploitation.[43]

Typically, private certification represents a high level of professional competency, beyond what is necessary for public protection. Unlike private certification, the purpose of state regulation is to ensure practitioners have the minimum standards necessary to protect the health, safety and welfare of the public.

Private certification provides a market advantage to those who have it. Anyone who does not have private certification must compete with those who do, and when it is important to consumers, professionals without it are at a competitive disadvantage.

A degree in music therapy and private board certification are credentials that offer consumers some assurance of professional competency.

While there is little evidence of harm from the unqualified practice of music therapy, there are some alternatives in place to provide consumers with some assurance of professional competency. However, none of these alternatives can entirely prevent someone from practicing music therapy or holding himself or herself out as a music therapist.

[42] § 6-1-707(1)(a), C.R.S.
[43] The Certification Board for Music Therapists. *CBMT Code of Professional Practice.* Revised October 4, 2011.

Collateral Consequences

The fourth sunrise criterion asks:

> Whether the imposition of any disqualifications on applicants for licensure, certification, relicensure, or recertification based on criminal history serves public safety or commercial or consumer protection interests.

The applicant did not propose any disqualifications based on criminal history.

Nevertheless, DORA staff uncovered some cases of music therapists committing reprehensible and heinous crimes against clients who are vulnerable to abuse and exploitation, and a regulatory program with the authority to disqualify individuals based on criminal history could serve to protect these consumers. However, considering the cases of harm are extremely rare, it is uncertain whether they demonstrate a need to regulate an entire occupational group.

Conclusion

The sunrise applicant identifies title protection of music therapists as the appropriate level of regulation to protect the public. The applicant states that title protection is necessary to protect the public from the emotional, psychological, physical and financial harm from unqualified and incompetent music therapists.

The sunrise application requests that only individuals who hold a professional designation, in good standing, through CBMT or the National Music Therapy Registry be able to use the title "music therapist" or "board-certified music therapist."

While the sunrise application states that the applicant is only seeking title protection, DORA must consider the consumer harm first and then determine the appropriate level of regulation.

Board-certified music therapists clearly demonstrate a certain level of professional competency and provide services that benefit clients in various settings. However, a comprehensive review of evidence from multiple sources demonstrated little evidence of harm to the public by the unqualified practice of music therapy.

According to the applicant, title protection would benefit the public by:

- Increasing access to music therapy, and
- Clarifying for the public and state government the qualifications necessary to work as a music therapist.

Title protection is unlikely to increase access to music therapy. Only 132 board-certified music therapists work in Colorado. While title protection would have less of an impact on the availability of services than a higher level of regulation would, it would restrict the market, and it is not clear that it would encourage qualified individuals to enter the market in Colorado.

Further, while the average consumer may not be able to determine the necessary qualifications for the provision of some types of music therapy, it seems relatively simple for the average consumer to find a music therapist who is board certified through CBMT.

If consumers search for a music therapist on their own, they would most likely search for one online. Since Google is the most widely used search engine, DORA staff performed four simple searches in Google for:

- Music therapists in Colorado,
- Music therapists in Denver,
- Music therapists in Greeley, and
- Music therapists in Grand Junction.

Overwhelmingly, these searches resulted in music therapists who are board certified through CBMT. Almost none of the online results were for music therapists without board certification. Any consumer who shops around would find that nearly all music therapists advertising their services online are board certified.

Individual consumers may also find music therapists from referrals. If they were referred by a health-care provider, an educator, a friend or a family member, then the music therapist referred most likely provides some benefit to consumers. A consumer may always request a resume outlining a music therapist's education, work history and references, and a consumer could perform a criminal history record check.

While some music therapists work in private practice, many others work in hospitals, nursing homes and assisted living facilities. These employers are sophisticated consumers with the ability to determine the appropriate qualifications necessary to hire staff.

According to the applicant, a large number of non-credentialed individuals are misrepresenting themselves as music therapists. Some of these people are musicians without any clinical training, and others are health-care providers, such as nurses and psychologists.

Music is a therapeutic intervention used by many different occupations and professions, and DORA staff found that some individuals who are not board certified are providing therapeutic music services in settings such as assisted living facilities, hospitals and nursing homes. However, many facilities find music to be beneficial and therapeutic whether provided by a musician, someone with clinical training, or a board-certified music therapist, and they reported no evidence of harm to patients.

The AMTA does not consider music that is provided by musicians or other health-care providers in health-care settings to be music therapy. While this may not be an appropriate use of the title, it is unlikely to harm consumers.

Additionally, the only consumer harm discovered through extensive research concerned criminal activity. Title protection could not have prevented this activity, and it would not prevent an individual from practicing music therapy.

For all of these reasons, there is little evidence to support protecting the title "music therapist" or "board-certified music therapist."

The applicant is also seeking state regulation so that board-certified music therapists may provide music therapy in public schools. However, the Colorado Department of Education (CDE) has its own licensing program distinct from professional licensure. Even if music therapists gained title protection or a professional licensing program, they would still be required to be licensed through CDE to work in the schools. In order to do this, the Colorado State Board of Education would have to include music therapists in the educational licensing category of Special Service Providers.

The Colorado Department of Health Care Policy and Financing currently requires music therapists to be board certified in order to provide services under three Home and Community-Based Services waivers. These waivers allow Medicaid reimbursement for therapeutic services to children and adults with developmental disabilities and to children with life-limiting illnesses. Therefore, title protection, in these cases, is unnecessary.

While music therapists have been successful in obtaining some level of regulation in a few states, most states do not recognize music therapy as a unique profession necessitating a separate regulatory program.

In conclusion, there is not sufficient evidence for Colorado to create a unique regulatory program for music therapists, or to protect the title, "music therapist" or "board-certified music therapist."

Recommendation – There is no demonstrated public interest or need to warrant the creation of a new regulatory program or to protect the title, "music therapist" or "board-certified music therapist."