2022 Packet I

Main Motions to the House of Delegates

May 25, 2022

Revised May 26, 2022

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Memo

FROM: Bill McGehee, PT, PhD, Speaker of the House

DATE: May 25, 2022

SUBJECT: 2022 House of Delegates Packet I

As delegates are aware, the 2022 session of the House of Delegates will begin on July 30, 2022, in a virtual format and continue August 14-15, 2022, in Washington, DC.

Packet I and additional information are attached to assist in your preparation.

Thank you for all that you do for this association. We are wishing you and yours good health.

APPENDIX A

MOTIONS TO THE HOUSE

Packet I
Packet I contains 22 motion and is being provided as the official notice of all motions, including bylaw amendments, that are coming before the 2022 House of Delegates. The packet may be downloaded from the House of Delegates Hub in the House Resources file library.

Individual motions in Word format will also be found in the House Resources, Packet I folder, to facilitate development and tracking of amendments. Line numbers may differ between the compiled PDF version of the Packet and the individual Word versions. In case of a conflict, the text and line numbering in the PDF version of a motion will be considered official.

There are several items the Speaker wishes to draw to your attention regarding the motions coming before the House.

- Amendment Submission Form
  All proposed amendments to motions published in Packet I, including replacement language from motion makers, must be submitted using the Amendment Submission Form, which will be posted to House Hub by May 27. Delegates contemplating amendments to motions should communicate with the motion maker and the Reference Committee liaison as soon as possible.

- Implications for motion language
  This document lists words that are appropriate for positions and for charges, and the definitions of those words. The goal is to provide consistency in use of terms and clarity of intent. Review this document as you read the motions, and particularly if you are contemplating amendments. Please refer to the APTA position Preferred Nomenclature for the Provision of Physical Therapist Services for definitions of the terms 'physical therapy services' and 'physical therapist services'. This will aid understanding of how and when these terms are used throughout the motions.

- Motions are placed into categories created by the Reference Committee to guide the order. Bylaw amendments are placed last since 2022 is not a bylaw year, and any motions not meeting main motion criteria, as delineated in APTA Standing Rule 9 are placed at the end of the agenda. The Speaker would like to thank all motion makers for their diligence as all motions met the Standing Rule 9 criteria.

- Some motions comprise several parts, indicated by 'Part A', 'Part B', etc. These motions have conforming amendments, which means, in order to maintain consistency, the question cannot be divided, and all parts will be debated and voted on with a single vote.

- Motion language has been edited and formatted to be consistent with standards for documents published by APTA. The same has not been done to support statements. These statements are the sole purview of the motion maker and have been presented as submitted. Support statements for each motion are preserved in the Archive section of the House of Delegates Community, and are readily accessible to all APTA members. The support statement format has been revised to respond to delegate requests for more background information provided by motion makers.

Business of the House is conducted through the introduction of main motions. Finding balance in the current climate is challenging. We suggest allotting time weekly if possible, to reading motions and support statements, reports, and delegate questions and information on the hub. The Parliamentary Motions Guide found in this packet offers guidance to help navigate the parliamentary rules of the House.

Questions about a motion should be directed to the maker of the motion on the discussion thread under Motion Information on the House hub. Delegates are encouraged to use this medium, and not social media, so that all delegates are aware of the information being shared. Hub discussion should not be used for debate of the motion. All delegates must abide by the following House Hub Standards shared with delegates earlier this year:

House Hub Standards

- To encourage collaboration within delegations, chief delegates, and delegates with permission of their chief, may post to the House hub.
- The Hub is a professional platform and not an extension of social media. Whether in or out of session, rules of decorum among delegates apply. Please be respectful.
- Hub posts will be clear and concise. Consider how long it will take someone to read your post.
- Debate is not allowed.
    - **What is debate?** Expressing opinion and trying to sway the opinion of others is debate and is not allowed.
    - **What is information sharing?** Asking and responding to clarifying questions and sharing proposed motion and amendment language is information sharing and is allowed.

No formal motion discussion groups will be arranged this year by the House officers. Motion makers wishing to convene a discussion group regarding their motion(s) may do so in whatever format they wish and may communicate that information on the House hub. Please see the Virtual Motion Discussion Facilitation Guide posted to the House Hub for more information and guidance.

Chief Delegates will use the Cosponsor Signup to indicate cosponsorship of a motion and the Consent Calendar Signup to register support for a motion to be placed on consent, which will be made available by Friday, May 27.

The House officers wish to thank delegates for their preparation thus far and for their timely submission of motions. We have the opportunity to work effectively and efficiently in a format that combines virtual meetings with in-person meetings. We are confident the House will complete high quality work. Early and frequent networking with delegates and motion makers will greatly improve our ability to resolve conflict and reach mutual understanding for the good of the association and the profession. Do not hesitate to contact us if you have questions, concerns, or suggestions for expediting the business of the House.

Implications for Motion Language

The following standardized language, developed by the Reference Committee, clarifies the implications of certain language that may be used in motions to be considered by the House of Delegates. Motion makers should refer to this standardized list to ensure that the words selected are consistent with the intent of the action or expected outcomes.

The first table applies to motions to create standards, positions, and guidelines. Motions in these categories will be included on the APTA Policies and Bylaws webpage.

The second table applies to motions that are designed to request specific action of the Board of Directors. Motions in this category, once passed, will be addressed by the Board to determine appropriate next steps.

A. Motions That Are Designed to Create Standards, Positions and Guidelines
There are no direct or immediate fiscal implications for any of these actions.

Word	Definition	Interpretation
Be/Is/Are	Used to describe the qualities or condition of a person or thing.	Describes expected behavior
Believe	A statement of opinion	Affirmative statement of values
Oppose	To disagree with	Affirmative statement of disagreement
Recommend	To counsel or advise (that something be done)	Only a suggestion; does not require action
Shall	Used to express duty or obligat	Obligates action and is preferred over “should” and stronger than “may”
Support	To agree with	Affirmative statement of agreement
Will	To decree; to resolve with a forceful will	Implies expectation, not action
Other verbs may be used as appropriate to describe the expected behavior of the targeted groups. However, the verbs listed below for use with charges should not be used in standards, positions, and guidelines.		

Last Updated: 2/17/2021
Contact: governancehouse@apta.org

B. Motions That Charge the Board of Directors to Take a Certain Action

Word	Definition	Interpretation	Fiscal Implication (monetary and human resources)
Advocate	To speak in favor of; recommend	Emphasize, raise awareness of. Not as strong as pursue and promote	Minimal to moderate
Develop	To bring into being; make active	Requires an end product	Usually significant
Encourage	To foster; to stimulate	Nonfinancial; to foster member action	None
Endorse	To give approval	General approval with minimal financial commitment	Minimal
Explore	To look at something in a careful way to learn more about it; research	The end product is information, rather than a recommendation	Minimal to significant
Evaluate	To determine or fix the value of; to examine carefully or appraise	Requires an end product	Minimal to significant
Identify	To find out the original nature or obligation	Requires an end product	Moderate to significant
Implement	To put into effect	Put into effect; make happen	Usually significant
Promote	To raise to a more important or reasonable rank; to contribute to the progress or growth of; to urge adoption of	Raise to a more important rank; emphasize; raise awareness; not as strong as “pursue”; stronger than advocate, endorse	Minimal to moderate
Provide	To furnish; supply; to make available	Requires an end product	Minimal to significant
Pursue	To strive to obtain or accomplish	Goal-directed activity with an identified end product	Moderate to significant

C. Inappropriate to Use in Charges

Word	Definition	Rationale for Not Using the Term
Charge		Unnecessary, since certain types of motions are charges
Consider	To think about seriously	Inappropriate for use in motions, as it does not provide clear direction
May	To be allowed or permitted	Inappropriate for use in motions, as it does not provide clear direction
Ought	Probability or likelihood; duty or obligation	Inappropriate for use in motions; use “shall”
Should	Used to express expectation	Implies expectation but no action

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (12th Edition)*

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:		YOU SAY:	INTERRUPT?	2ND?[1]	DEBATE?	AMEND?	VOTE?
§21	Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20	Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19	Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18	Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17	Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16	Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15	**Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14	**Postpone to a certain time**	I move to postpone the motion to ...	No	Yes	Yes	Yes	Majority
§13	**Refer** to committee	I move to refer the motion to …	No	Yes	Yes	Yes	Majority
§12	Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11	Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10	Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

[1] ***Some more formal requirements, likes seconds to motions, may not apply in smaller boards or any size committee.***

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Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (12th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority or tie sustains
§25 Suspend rules	I move to **suspend the rules** which …	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3 against consideration
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentary inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

§34	Take matter from table	I move to **take from the table** …	No	Yes	No	No	Majority
§35	Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	Varies
§37	Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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Main Motion to the 2022 House of Delegates

Required for Adoption: 2/3 Vote **Category**: 8

Motion Contact: Roger Herr, PT, MPA, Board of Directors
E-mail: rogerherr@apta.org

RC Contact: Janet Bezner, PT, DPT, PhD, FAPTA
E-mail: jb25@txstate.edu

PROPOSED BY: BOARD OF DIRECTORS

RC 1-22 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: J. KENT CULLEY, JD

Whereas, J. Kent Culley, JD, has engaged with APTA Pennsylvania (formally Pennsylvania Physical Therapy Association) since 1968, providing expert consultation to physical therapist members for the development of private practices, directing the development of the initial Pennsylvania Physical Therapy Practice Act, and crafting the legal strategy that allowed for physical therapists to perform EMG/NCV testing;

Whereas, He consulted in the preparation of at least 25 physical therapist practice acts with the first being in Pennsylvania;

Whereas, He successfully argued and secured a landmark decision with national implications, paving the way for physical therapists to be classified as exempt employees, thus separating the profession from nonexempt technical employees;

Whereas, He represented APTA Pennsylvania in the seminal Pennsylvania Supreme Court case that resulted in protection of the term "physical therapy," preventing the term from consideration as generic in Pennsylvania, and setting this precedent for multiple other jurisdictions;

Whereas, He served as the lead lobbyist in discussions with the Pennsylvania Chiropractic Association allowing physical therapists the ability to perform high-velocity low-amplitude thrust mobilization within the definition of manual therapy;

Whereas, He was instrumental in developing the language that permitted direct access to physical therapist services in Pennsylvania;

Whereas, He consulted in the successful litigation against the Pennsylvania Labor Bureau's attempt to devalue the physical therapist evaluation that led to the October 2021 9-0 court decision in favor of APTA Pennsylvania, which restored evaluation reimbursement retroactive to 2017;

Whereas, He served as the lead lobbyist with key legislators, proving to be invaluable in APTA Pennsylvania's efforts to define the state's physical therapist scope of practice while defending against unwarranted encroachment; and,

Whereas, He has been recognized for his accomplishments as the recipient of service awards from the APTA Pennsylvania, the APTA Private Practice Section, and the Federation of State Boards of Physical Therapy;

Resolved, That J. Kent Culley, JD, be elected as an Honorary Member of the American Physical Therapy Association.

SS: In his over 50 years as legal counsel to APTA Pennsylvania and to other physical therapy related organizations, Culley has been instrumental in key accomplishments to support our profession. He has provided consultation in the development of numerous chapter practice acts and supported private practitioners in actions that have had a positive impact on all therapists throughout the United States. He is a true leader in every aspect of his work. From the start of his engagement with the Pennsylvania chapter in 1968 to the present, J. Kent Culley has made ongoing contributions led by his sincere passion for the profession of physical therapy.

J. Kent Culley has served this profession in a highly skilled manner, with many of his accomplishments for Pennsylvania having a national reach. he has worked with six APTA Pennsylvania presidents over his many years of service, and his work has had influence beyond the chapter and to APTA nationally. He continues to be active in legislation and lobbying and is always advocating for physical therapy. Culley's wisdom and historical perspective is an invaluable asset to our profession, and he continues to serve each day with honor and dignity through a career-long commitment to improving the stature of the physical therapy profession.

Main Motion to the 2022 House of Delegates

Required for Adoption: 2/3 Vote **Category**: 8

Motion Contact: Roger Herr, PT, MPA, Board of Directors
E-mail: rogerherr@apta.org

RC Contact: Janet Bezner, PT, DPT, PhD, FAPTA
E-mail: jb25@txstate.edu

PROPOSED BY: BOARD OF DIRECTORS

RC 2-22 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: JESSE DEAN, PhD

Whereas, Jesse Dean, PhD, has made significant contributions to the profession of physical therapy;

Whereas, He has co-authored nearly 40 peer-reviewed articles with physical therapists;

Whereas, He has been instrumental in the instruction and mentorship of physical therapist students;

Whereas, He has been influential in the mentorship of physical therapist junior faculty;

Whereas, He has advanced the profession through national and international presentations on biomechanics; and,

Whereas, He has advocated for and secured increased funding for physical therapy research;

Resolved, That Jesse Dean, PhD, be elected as an Honorary Member of the American Physical Therapy Association.

SS: Jesse Dean, PhD, is core faculty at Medical University of South Carolina in the Division of Physical Therapy and the only member of the core faculty who is not a licensed clinician. His background in biomedical engineering gives him a unique perspective in research, translation of research into clinical practice, and in his approach as a member of the division. His unique background as a biomedical engineer creates balance, and his thoughtful introspection is appreciated by faculty. Dean is an integral member of the division's admissions committee, which has implemented changes to the admissions process that has led to increasing diversity within the field of physical therapy. Furthermore, he has worked diligently as an ally to increase diversity and inclusion through his work in the Diversity and Inclusion course in the MUSC PhD program and as an active member of the college DEI Committee.

Since Dean is not a clinician, he independently chose to audit multiple clinical physical therapy courses to gain a better understanding of the physical therapy profession. He supports the CARES Therapy Clinic, a student-run free clinic at MUSC, where he volunteers weekly.

Dean has mentored physical therapist students and assisted them in research that has led to student research awards, 15 student presentations at national and international conferences, and 12 student publications with students as first authors. These numbers exhibit his capacity to promote and develop students and future physical therapy researchers. He has made numerous presentations at APTA conferences at the state and national levels.

While his primary role is as a researcher, he is also an extraordinary teacher. He has numerous publications and invited presentations and is recognized locally, nationally, and internationally as an expert in the biomechanics of human movement. He has secured several large grants, including a recent R01 "Proactive

and Reactive Perturbation Training to Reduce Falls and Improve Gait Stability in People with Chronic Stroke." These grants are now funding his research on the stability and efficiency of walking in control subjects and in individuals who have experienced a stroke.

Dean's research spans the gap between engineering and physical therapy. His work is directly motivated by common clinical problems observed among people who have experienced a stroke. With his engineering background, Dean can approach these problems from a novel perspective, developing intervention strategies that focus on the underlying mechanisms at play. Through his research investigating perturbation training and sensory augmentation, Dean has helped to position the field of physical therapy for future breakthroughs to improve the quality of life of the millions of Americans who have experienced a stroke.

Main Motion to the 2022 House of Delegates

Required for Adoption: 2/3 Vote **Category**: 8

Motion Contact: Roger Herr, PT, MPA, Board of Directors
E-mail: rogerherr@apta.org

RC Contact: Janet Bezner, PT, DPT, PhD, FAPTA
E-mail: jb25@txstate.edu

PROPOSED BY: BOARD OF DIRECTORS

RC 3-22 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: MARC S. GOLDSTEIN, EdD

Whereas, Marc S. Goldstein, EdD, loyally served the American Physical Therapy Association with demonstrated passion in multiple roles related to both education and research from 1987 until his retirement in 2015, including staff liaison to the Advisory Panel on Physical Therapy Education and the Advisory Panel on Research;

Whereas, He served as an unwavering advocate for postbaccalaureate education during a critical time of change and transition in physical therapist education;

Whereas, He was instrumental in strengthening APTA's reputation as a leader in rehabilitation workforce analysis through his critical research over two decades that included development of the Practice Profile, obtaining external funding from the Agency for Health Care Research and Quality to convene the Conference on Workforce Issues in Physical Therapy, and advancing the Supply Demand Model published in PTJ: Physical Therapy & Rehabilitation Journal;

Whereas, He assumed a leadership role in developing the profession's research capacity as primary staff liaison to the National Center for Medical Rehabilitation Research, and other public and private funding agencies;

Whereas, He organized the process and conferences that resulted in the first and subsequent clinical research agendas of the association; and,

Whereas, He served the profession by his efforts to establish the Physical Therapy Outcomes Registry, developed clinically relevant instruments on patient outcomes and patient satisfaction, and conceptualized the Severity-Intensity Model as an alternative payment mechanism;

Resolved, That Marc S. Goldstein, EdD, be elected as an Honorary Member of the American Physical Therapy Association.

SS: For 28 years, Marc Goldstein, EdD, worked tirelessly on behalf of our members, first as assistant director of education, establishing critical outreach to stakeholder organizations during the tumultuous years that accompanied the decision to move to postbaccalaureate entry-level education. During that period, he also assumed responsibility for the annual Practice Profile, which has been critical to understanding the demographics of the profession.

Moving to the position of director of research in 1989, Goldstein further developed our understanding of physical therapist practice by leading all staff activities regarding workforce supply and demand, including organizing national and international conferences to address this critical issue that impacts both practice and education. Although we still grapple with this issue, we are fortunate that Goldstein had the vision to lay the groundwork for rigorous study of pertinent data.

His vision of the broad expanse of research pertinent to the profession also compelled him to tackle the critical issue of external funding for physical therapist researchers, particularly by the National Institutes of Health. Over many years of effort, Goldstein helped to establish the initiatives that spurred the proliferation of funding that gave an entire generation of physical therapists entry into the first ranks of scientists.

Throughout his tenure, Goldstein also contributed significantly to projects oriented toward practice and payment. Among these are the development and testing of two instruments for clinical practice and formulation of an alternative payment model.

Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 6

Motion Contact: Skye Donovan, PT, PhD, Board of Directors
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RC Contact: Janet Bezner, PT, DPT, PhD, FAPTA
E-mail: jb25@txstate.edu

PROPOSED BY: BOARD OF DIRECTORS

RC 4-22 ADOPT: DIGITAL HEALTH TECHNOLOGIES AND THERAPEUTICS IN PHYSICAL THERAPIST PRACTICE

That the following be adopted:

DIGITAL HEALTH TECHNOLOGIES AND THERAPEUTICS IN PHYSICAL THERAPIST PRACTICE

The American Physical Therapy Association believes digital health technologies and therapeutics have the potential to augment physical therapist practice by expanding access, enhancing care delivery models, promoting safety, and improving outcomes when all of the following criteria are met:

- **Patients and clients shall have the option to access physical therapist services in person and shall not be limited to digital care options exclusively.**
- **A physical therapist is responsible for all aspects of patient/client management.**
- **Physical therapist services shall be conducted in a manner that allows for patient and client engagement and supports the therapeutic alliance (i.e., fosters participation in the patient and client-provider relationship).**
- **The physical therapist and the physical therapist assistant adhere to scope of practice, including requirements that are based on the jurisdiction in which the patient or client is located when receiving physical therapist services.**
- **Physical therapist services shall be provided consistent with appropriate direction and supervision requirements of assistive personnel and other support personnel, as well as all relevant Association policies, positions, and binding ethical documents.**
- **Physical therapy is only represented, provided, and promoted when it meets term and title protections as defined in state law and in accordance with federal health, communications, and trade authorities.**

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?
The outcome of this motion is to contemporize APTA's policies to reflect the digital health technologies and therapeutics landscape and to align to recent statements made by the Association since the conclusion of the 2021 House of Delegates. According to the United States Federal Trade Commission, the broad scope of digital health includes categories such as mobile health (mHealth), health information technology (IT), wearable devices, telehealth and telemedicine, and personalized medicine. This motion would replace the current policy, which is limited to one component of digital health, telehealth, to be more expansive to the full scope and spectrum of applications of digital health technology and therapeutics to physical therapist practice.

APTA's Board of Directors is proposing this motion to the 2022 House of Delegates in addition to the current policy on telehealth HOD P06-19-15-09.

This is consistent with **APTA's Strategic Plan 2022-2025** and the Quality of Care Goal: Elevate the quality of care provided by PTs and PTAs to improve health outcomes for populations, communities, and individuals. Current and former APTA Presidents Roger Herr and Sharon Dunn each issued a statement on digital health during their terms on April 15, 2022 **Statement | Digital Health Technology and Physical Therapy | APTA** and on September 22, 2021 **Telehealth Physical Therapy Is Provided by Licensed Therapists, Not Technology | APTA**

In addition, this also addresses the Demand and Access Goal: Drive demand for and access to physical therapy as a proven pathway to improve the human experience.

B. How is this motion's subject national in scope or importance?

Following the pandemic and due to technology advances, digital health continues to evolve as a care delivery model for physical therapist directed services as well as for interventions that physical therapists direct, supervise or provide as part of a physical therapy plan of care. Digital health is broader in scope, services, and potential applications by physical therapists than past telehealth utilization and practices. Currently, at least 15 different companies are offering platforms to provide physical therapy or similar services direct to employers, in partnership with payers, as well as direct to consumers to address, evaluate and treat primarily musculoskeletal conditions.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

APTA primary policy and current activities have been focused on telehealth and not the broader definition of digital health (Telehealth | APTA). Foundational to this area of practice and care delivery is term and title protection. Stakeholders impacted by APTA action to determine a policy on digital health are primarily our members, the profession, state and federal policymakers and regulators and the public we serve through our practice, care and services. Due to the importance of term and title protection to the digital health technologies and therapeutics, the Federation of State Board of Physical Therapy would be a primary stakeholder, collaborator, and partner on this policy.

D. Additional Background Information.

The digital health landscape is at the forefront of innovative practice and is gaining attention from many entities including both health and non-health based corporations. Some select examples of digital health include wearables, telemedicine, digital therapeutics, health information technology, personalized healthcare, and mobile health. Additionally, digital platforms and technologies can range from client/patient facing, clinician facing to enterprise support. In response to numerous corporate and media reports, it is prudent for the APTA to create a position statement to assist both practitioners and consumers in understanding the role of digital health technologies and therapeutics as it pertains to the practice of physical therapy. This statement asserts that any physical therapy, whether provided in person or virtually, may only be performed by or under the supervision of licensed physical therapists.

Statement | Digital Health Technology and Physical Therapy | APTA – *April 15, 2022*

Telehealth Physical Therapy Is Provided by Licensed Therapists, Not Technology | APTA - *September 22, 2021*

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 8

Motion Contact: Susan Appling, PT, DPT, PhD, Board of Directors
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RC Contact: Janet Bezner, PT, DPT, PhD, FAPTA
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PROPOSED BY: BOARD OF DIRECTORS

RC 5-22 CHARGE: DISCONTINUE REPORT TO THE HOUSE OF DELEGATES FOR RC 16-10 COLLABORATIVE RELATIONSHIPS WITH PRIMARY CARE PROVIDER ORGANIZATIONS

That the report to the House of Delegates as specified in RC 16-10 Collaborative Relationships With Primary Care Provider Organizations be discontinued.

SS:
The Board has provided an annual report on RC 16-10 Collaborative Relationships with Primary Care Provider Organizations for more than 10 years. APTA continues its efforts to collaborate with external entities including standing up a partnership program, which guides the association's engagement with external entities and groups. APTA's external strategic alliances, and any information related to them, are managed and tracked in the Public Affairs Unit. There are avenues to communicate information on these efforts, including but not limited to APTA's magazine, news, and the APTA annual report.

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?
Discontinue the report to the House Delegates as per RC 16-10 Collaborative Relationships with Primary Care Provider Organizations. APTA continues its efforts to collaborate with external entities including a partnership program, which guides the association's engagement with external entities and groups. There are avenues to communicate information on these efforts, including but not limited to APTA's magazine, news, and the APTA annual report.

B. How is this motion's subject national in scope or importance?
Collaborative Relationships with Primary Care Provider Organizations are part of current interprofessional practice in the profession.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?
In 2021, APTA furthered its work to collaborate with primary care provider organizations by continuing to strengthen relationships with several entities. APTA's external collaboration efforts stretch across many arenas. Members and staff are interacting with other entities focused on initiatives such as quality, payment, practice, research, education, service, public health, and prevention. APTA continues proactive outreach to primary care provider organizations to continue to build impactful relationships that will support the association's strategic priorities. This work has been integrated into the work of the Association. In the future, APTA's external strategic alliances, and any information related to them, will be actively managed and tracked in the Public Affairs Unit.

D. Additional Background Information.

The report to the house is not specific to any house action at this time and the BOD has not had questions or responded to discussions in the House of Delegates.

Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 8

Motion Contact: Susan Appling, PT, DPT, PhD, Board of Directors
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RC Contact: Janet Bezner, PT, DPT, PhD, FAPTA
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PROPOSED BY: BOARD OF DIRECTORS

RC 6-22 CHARGE: DISCONTINUE REPORT TO THE HOUSE OF DELEGATES FOR RC 64-81 PHYSICIAN/PHYSICAL THERAPIST PRACTICE RELATIONSHIPS

That the report to the House of Delegates as specified in RC 64-81 Physician/Physical Therapist Practice Relationships be discontinued.

SS:
The Board has provided an annual report on RC 64-81 Physician/Physical Therapist Practice Relationships for more than 40 years. APTA continues its efforts at the state and federal levels to address self-referral and referral for profit. When activity occurs in these areas, there are avenues to communicate information on these efforts, including but not limited to APTA's magazine, news, and the APTA annual report.

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?
Discontinue the annual report to the House of Delegates as specified in RC 64-81 Physician/Physical Therapist Practice Relationships. APTA continues its efforts at the state and federal levels to address self-referral and referral for profit. When activity occurs in these areas, there are avenues to communicate information on these efforts, including but not limited to APTA's magazine, news, and the APTA annual report.

B. How is this motion's subject national in scope or importance?
APTA continues its efforts at the state and federal levels to address self-referral and referral for profit. The association has a clearly worded policy on its opposition to physician ownership of physical therapist services and self-referral, which guides association efforts on this topic (HOD P06-19-16-46).

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?
The 2021 Physician/Physical Therapist Practice Relationships (RC 64-81) Report includes three activities related to Physician/Physical Therapist Practice Relationships in Missouri, Delaware, and at the Federal level. APTA continues to work at the state and federal levels to address self-referral and referral for profit in an environment of increasing opposition to these efforts. This work is integrated into our advocacy initiatives in the Public Affairs unit.

Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 2

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RC Contact: Pamela White, PT, DPT
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PROPOSED BY: ARKANSAS

RC 7-22 AMEND: STANDING RULES OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, 9. MAIN MOTION CRITERIA

That Standing Rules of the American Physical Therapy Association, 9. Main Motion Criteria, be amended by inserting new numbers (3) and (4), and renumbering the remaining criteria, so that it would read:

9. MAIN MOTION CRITERIA

A. All main motions submitted by the established deadline shall meet the following criteria. It is the responsibility of the maker of the motion to:

(1) Provide a statement of the intended outcome of the motion.

(2) Demonstrate that the motion meets the object of the Association.

(3) Demonstrate that the motion advances or progresses the profession of physical therapy.

(4) Demonstrate that the motion directly supports (a) physical therapists, physical therapist assistants, or students in their roles within the profession, (b) physical therapy practices, (c) physical therapy education or research, or (d) professional development.

(~~3~~5) Demonstrate that the motion's subject is national in scope or importance.

(~~5~~6) Provide pertinent background information, in collaboration with the Board or staff, as necessary, including (a) a description of previous House, Board, or staff activity relating to the subject and (b) an identification of the stakeholders affected by the motion.

(~~6~~7) When possible, demonstrate that the motion concept has been disseminated to delegates of other delegations prior to the deadline for submission of main motions.

(~~7~~8) Provide a description of the potential resources needed to adopt and implement the motion.

B. The Reference Committee determines if criteria have been met. If it is determined that the criteria are not adequately met, the motion shall be placed at the end of the agenda of the House and shall not be considered unless a majority of the delegates vote, without debate, to consider the motion. The Reference Committee shall develop and make available to the delegates guidance designed to help delegates satisfy the foregoing criteria.

SS: The APTA rightfully markets the record number of physical therapy providers that are now members of the Association. However, the percent of licensed individuals that are members of the Association have been decreasing each year. One might conclude that we are not meeting the needs of these licensees and professionals. Before the last HOD, many mentions were submitted on the HUB and to delegates, emphasizing discontent with the direction of motions and the desire to have motions that would assist members in their practice settings. While many of the motions before the House of Delegates over the past few years have addressed pressing societal issues, the profession continues to face unaddressed barriers that limit the advancement and practice of physical therapy and may lead to the lack of interest in membership in

our Association. The Arkansas Board of Directors have asked our delegation to present a motion to develop and bring forth motions to improve support for services rendered, develop recognition in the public of the need for physical therapy intervention, improve efficacy and training opportunities for clinicians, and generally serve the needs of the members of our association in their everyday practice settings. In other words, how is the APTA working to improve the professional practice of clinicians in practice, consistency of professional education, and outcomes for our patients through House of Delegates activities? These are some of the issues that, if addressed directly by the HOD, may assist in increasing in the percentage of licensed PTs and PTAs that become part of our Association. The House is the most visible entity available to members.

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

We are a professional organization that is a community comprised of members whose mission is to advance the profession of physical therapy to improve the health of society. The best way to achieve this may be to advance the practice and work settings of the individual members. Our goals mentioned in the strategic plan include:

- "Improve the long-term sustainability of the profession by leading efforts to increase payment, improve provider health, and strengthen provider health...".
- "Elevate the quality of care provided by PTs and PTAs to improve health outcomes for populations, communities, and individuals."
- "Drive demand for and access to physical therapy as a proven pathway to improve the human experience."
- "Increase member value...".

The motion presented has potential to address each of these goals in the APTA Strategic Plan.

B. How is this motion's subject national in scope or importance?

This motion applies to all members and will improve their commitment to advancing their constituents and patients.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

This motion is intended to focus the actions of the HOD on advancing the profession through improving the ***member-therapist*** professional practice clinically and professionally. This motion will not interfere with any State or Federal laws. We intend this to focus House and Board activities as actions are taken.

D. Additional Background Information.

We intend this motion to amend the Standing Rules of the APTA.

Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 4

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PROPOSED BY: EDUCATION, PTA CAUCUS

RC 8-22 AMEND: DIRECTION AND SUPERVISION OF THE PHYSICAL THERAPIST ASSISTANT (HOD P06-18-28-35)

That Direction and Supervision of the Physical Therapist Assistant (HOD P06-18-28-35) be retitled and amended by substitution:

COLLABORATION, DIRECTION, AND SUPERVISION OF THE PHYSICAL THERAPIST ASSISTANT IN PHYSICAL THERAPIST PRACTICE AND INTERPROFESSIONAL TEAM-BASED CARE

~~Physical therapist practice and the practice of physical therapy are synonymous. Both phrases are inclusive of patient and client management, and direction and supervision. Direction and supervision apply to the physical therapist assistant, who is the only individual who assists a physical therapist in practice. The utilization of other support personnel, whether in the performance of tasks or clerical activities, relates to the efficient operation of the physical therapy service.~~

~~Physical therapists are responsible for providing safe, accessible, cost-effective, and evidence based services. Services are rendered directly by the physical therapist and with responsible utilization of physical therapist assistants. The physical therapist's practice responsibility for patient and client management includes examination, evaluation, diagnosis, prognosis, intervention, and outcomes. Physical therapist assistants may be appropriately utilized in components of intervention and in collection of selected examination and outcomes data.~~

~~Direction and supervision are essential in the provision of quality physical therapist services. The degree of direction and supervision necessary for ensuring quality physical therapist services is dependent upon many factors, including the education, experiences, and responsibilities of the parties involved, as well as the organizational structure where physical therapist services are provided.~~

The physical therapist assistant is the only individual who assists a physical therapist in physical therapist practice. The use of other support personnel, whether in the performance of tasks or clerical activities, relates to the efficient operation of the physical therapy service.

The PT is responsible for patient and client management including examination, evaluation, diagnosis, prognosis, intervention, and outcomes. Physical therapist assistants collaborate with the PT to perform components of intervention and collect selected examination and outcomes data.

Collaboration, direction, and supervision are essential when the PTA participates in the provision of physical therapist services, and are influenced by the education, experiences, and responsibilities of

the parties involved, as well as the organizational structure where physical therapist services are provided.

Collaboration refers to the interaction between the PT and PTA in physical therapist practice, as well as the interaction of the PT-PTA team in interprofessional team-based care.

Regardless of the setting in which the physical therapist service is provided, the following responsibilities must be borne solely by the physical therapist:

1. **Interpretation of referrals when available**
2. **Evaluation, diagnosis, and prognosis**
3. **Development or modification of a plan of care, which is based on the initial examination or reexamination and includes the physical therapy goals and outcomes**
4. **Determination of when the expertise and decision-making capability of the physical therapist requires the physical therapist to personally render services and when it may be appropriate to ~~utilize~~ collaborate with the physical therapist assistant**
5. **Revision of the plan of care when indicated**
6. **Conclusion of an episode of care**
7. **Responsibility for any "hand off" communication**
8. **Oversight of all documentation for services rendered to each patient or client**

~~Only the physical therapist performs the initial examination and reexamination of the patient and may utilize the physical therapist assistant in collection of selected examination and outcomes data.~~

The physical therapist is responsible for services provided when the physical therapist's plan of care involves the physical therapist assistant. Regardless of the setting in which the service is provided, the determination to ~~utilize~~ collaborate with physical therapist assistants requires the education, expertise, and professional judgment of a physical therapist as described by the Standards of Practice for Physical Therapy, the Code of Ethics for the Physical Therapist, and the APTA Guide for Professional Conduct.

In determining the appropriate extent of assistance from the physical therapist assistant, the physical therapist considers:

- **The physical therapist assistant's education, training, experience, and skill level**
- **Patient or client criticality, acuity, stability, and complexity**
- **The predictability of the consequences**
- **The setting in which the care is being delivered**
- **Federal and state statutes**
- **Liability and risk management concerns**
- **The mission of physical therapist services for the setting**
- **The needed frequency of reexamination**

~~Physical Therapist Assistant~~

~~Definition~~

The physical therapist assistant assists the physical therapist in the provision of physical therapy. The physical therapist assistant is a graduate of a physical therapist assistant program accredited by the Commission on Accreditation in Physical Therapy Education.

~~Utilization~~

The physical therapist is directly responsible for the actions of the physical therapist assistant in all practice settings. The physical therapist assistant may provide services under the direction and at least general supervision of the physical therapist. In general supervision, the physical therapist is not required to be on site for direction and supervision but must be available at least by telecommunication. The ability of the physical therapist assistant to provide services shall be assessed on an ongoing basis by the supervising physical therapist.

Services provided by the physical therapist assistant must be consistent with safe and legal physical therapist practice and shall be predicated on the following factors: complexity and acuity of the patient's or client's needs; proximity and accessibility to the physical therapist; supervision available in the event of emergencies or critical events; and type of setting in which the service is provided. The physical therapist assistant makes modifications to elements of the intervention either to progress the patient or client as directed by the physical therapist or to ensure patient or client safety and comfort.

When supervising the physical therapist assistant in any offsite setting, the following requirements must be observed:

1. **A physical therapist must be accessible by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is providing services to patients and clients.**
2. **There must be regularly scheduled and documented conferences with the physical therapist assistant regarding patients and clients, the frequency of which is determined by the needs of the patient or client and the needs of the physical therapist assistant.**
3. **In situations in which a physical therapist assistant is involved in the care of a patient or client, a supervisory visit by the physical therapist:**
   a. **Shall be made upon the physical therapist assistant's request for a reexamination, when a change in the plan of care is needed, prior to any planned conclusion of the episode of care, and in response to a change in the patient's or client's medical status**
   b. **Shall be made at least once a month, or at a higher frequency when established by the physical therapist, in accordance with the needs of the patient or client**
   c. **Shall include:**
      i. **An onsite reexamination of the patient or client**
      ii. **Onsite review of the plan of care with appropriate revision or termination**
      iii. **Evaluation of need and recommendation for utilization of outside resources**

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

The intended outcome of the amendments in this motion is to improve the quality of physical therapist services by explicitly identifying the physical therapist assistant as a partner in interprofessional collaborative team-based care. Widespread support among health care organizations for ***Core Competencies for Interprofessional Collaborative Practice: 2016 Update*** affirm that collaborative team-based care can contribute to achieving the Triple Aim.[1] As one of the supporting organizations, the American Physical Therapy Association (APTA) committed to the integration of the core competencies into both education and practice initiatives in **Commitment to Interprofessional Education and Practice** (HOD P06-19-69-33).[2] The proposed amendments to Direction and Supervision of the Physical Therapist Assistant (HOD P06-18-28-35) help realize that commitment, as well as furthering the relationship between this position and other key APTA documents identified in Section D of this support statement.

By recognizing the physical therapist assistant as part of interprofessional collaborative team-based care, we promote our **mission and the 2022-2025 Strategic Plan**.[3] By enhancing interprofessional team-based

collaboration in this another documents, the APTA mission ("Building a community that advances the profession of physical therapy to improve the health of society,") and the strategic goal to "Elevate the quality of care provided by PTs and PTAs to improve health outcomes for populations, communities, and individuals" are supported.[3]

B. How is this motion's subject national in scope or importance?

In **Guiding Principles to Achieve the Vision** (HOD P06-19-46-54), the House of Delegates (House) endorsed the terms "interprofessional," "team," and "collaboration" in describing "Collaboration" as one of the principles to be realized by the APTA **Vision** (see bulleted excerpts below).[4] The House, therefore, tied "interprofessional," "team," and "collaboration" to "…improv[ing] the human experience."[3]

- "The physical therapy profession will demonstrate the value of collaboration with other health care providers, consumers, community organizations, and other disciplines to solve the health-related challenges that society faces."
- "Education models will value and foster interprofessional approaches to best meet consumer and population needs and instill team values in physical therapists and physical therapist assistants."

By emphasizing physical therapist/physical therapist assistant team-based interprofessional collaboration in all relevant APTA positions, there is the potential to influence both practice and professional education. The proposed amendments to the policy may inform future changes to licensure laws and regulations, with this policy being a key document to which states might refer when revisions are being considered. Although some licensure laws and regulations may already identify the physical therapist and physical therapist assistant as collaborators in team-based care, many others do not. Thus, the policy as amended may improve alignment of physical therapy regulation and practice across the USA.

Lastly, and most controversially, additions to the policy may provide interrelated support to challenge differential payment for care provided by a physical therapist assistant. This amended position can contribute to the understanding of 3rd party payers (like the Centers for Medicare & Medicaid Services) that the physical therapist and physical therapist assistant serve a patient/client as a collaborative and indivisible team who, together, improve the quality of care. Because the physical therapist has a mandatory and ongoing collaboration with the physical therapist assistant, all physical therapy care provided by a PTA is guided by the physical therapist's expertise, thus provided by the PT/PTA team rather than by the PTA alone.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

We are not aware of previous or current House, Board or staff activities directly related to this motion beyond those cited in Sections A and B of the support statement.

D. Additional Background Information.

Revision to **Direction and Supervision of the Physical Therapist Assistant (HOD P06-18-28-35)** will align that policy with other APTA policies and documents, including but necessarily limited to those identified here.

In **Commitment to Interprofessional Education and Practice** (HOD P06-19-69-33), APTA expressed its support of **Core Competencies for Interprofessional Collaborative Practice: 2016 Update.**[1,2] The position cited the 4 core competency domains, with 2 of the domains directly supporting the proposed motion.[2]

- Competency 3: Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion

and maintenance of health and the prevention and treatment of disease. (Interprofessional Communication)

- Competency 4: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable. (Domain: Teams and Teamwork)

In 2021, the House passed **Core Values for the Physical Therapist and Physical Therapist Assistant** (HOD P09-21-21-09) wherein it is stated: "*Collaboration* [emphasis added] within the physical therapist-physical therapist assistant *team* [emphasis added] is working together, within each partner's respective role, to achieve optimal physical therapist services and outcomes for patients and clients."[5] These concepts are mirrored in the **Standards of Practice for Physical Therapy** (HOD S06-20-35-29).[6] In describing administration of the physical therapy service in that document, "coordination" stipulates: "Physical therapy personnel [thus including the physical therapist assistant] collaborate with all health services providers and with patients, clients, caregivers, and others as appropriate; and use a *team and person-centered approach* [emphasis added] in coordinating and providing physical therapist services."[6]

Given the cited House positions passed 2019 and 2021, the 2018 version of Direction and Supervision of the Physical Therapist Assistant (HOD P06-18-28-35) became outdated.[2,4,5] The terms "interprofessional," "team," and "collaboration" (in any form) do not appear in Direction and Supervision…. Yet, this is the logical document for physical therapists, licensure boards, legislators, and others to access when seeking guidance on the role of the physical therapist assistant in patient/client management. If "direct and supervise" (each arguably unidirectional in nature) remain unlinked to the multidirectional terms "collaborate," "team," and "interprofessional", a valuable opportunity is missed; further, compliance with APTA positions and progression toward the APTA mission, strategic goals, and the Triple Aim are jeopardized.

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2. American Physical Therapy Association House of Delegates. *Commitment to Interprofessional Education and Practice* (HOD P06-19-69-33). Alexandria, VA: American Physical Therapy Association; 2014. Updated: 09-20-19. **https://www.apta.org/apta-and-you/leadership-and-governance/policies/commitment-to-interprofessional-education-and-practice**. Accessed April 9, 2022.
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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 6

Motion Contact: Karen Goodlow, PT, DPT, MBA, Chief Delegate, Illinois Physical Therapy Association
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PROPOSED BY: ILLINOIS

RC 9-22 ADOPT: ROLE OF PHYSICAL THERAPY IN NONPHARMACOLOGIC BLOOD PRESSURE MANAGEMENT

That the following be adopted:

ROLE OF PHYSICAL THERAPY IN NONPHARMACOLOGIC BLOOD PRESSURE MANAGEMENT

The American Physical Therapy Association supports collaboration to promote education, research, and practice between physical therapists and other stakeholders regarding the nonpharmacologic management of blood pressure. Blood pressure management is a key component of primary, secondary, and tertiary prevention of many conditions managed by physical therapists throughout the lifespan and across the continuum of care. Physical therapist practice includes screening, educating, and providing nonpharmacologic management of blood pressure in individuals and communities.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?
The expected outcome of this motion is that the American Physical Therapy Association (APTA) supports collaboration at the association level and for physical therapists to promote education, research, and practice between physical therapists and other health professionals regarding the nonpharmacological management of blood pressure, consistent with APTA's Vision to improve the health and well-being of society, and the Strategic Plan goal to "elevate the quality of care provided by PTs and PTAs to improve health outcomes for populations, communities, and individuals."

B. How is this motion's subject national in scope or importance?
Hypertension (HTN) is the leading modifiable risk factor for cardiovascular disease (CVD) and other vascular-related conditions (e.g., stroke, kidney disease, and cognitive decline) and is present in approximately 47% of the US adult population.[1] Due to the asymptomatic nature of HTN, even at critical values, early detection and treatment is one of the most significant challenges facing the healthcare system.[2] It has been reported that every 10% increase in effective HTN treatment could prevent an additional 14,000 deaths per year in the US adult population.[3]

The prevalence of HTN is of concern to physical therapists across all settings due to the intersectional relationships between lifestyle factors and physical disability.[4–8] Individuals with physical disabilities demonstrate higher rates of HTN compared to those without.[9] Cardiometabolic risk factors, including HTN, are frequently observed in the most common clinical populations managed by physical therapists, even in

outpatient settings where the acuity of illness is much lower.[2] A study by Severin et al. demonstrated that the majority of outpatient orthopedic physical therapists report that at least one-half of their current caseload had a moderate or greater CVD risk profile and that they evaluated such patients at least twice per week.[10] Even higher prevalence of HTN and CVD risk factors have been reported in home health[11] and inpatient rehabilitation facilities.[12] Additionally, physical therapists are uniquely positioned to measure blood pressure response during and following exercise, which can assist with detecting various blood pressure disorders such as "masked HTN" and abnormal BP responses to exercise which possess strong prognostic value.[2] For example, an abnormally low BP response to exercise has been demonstrated to be a strong prognosticator of cardiovascular events and all-cause mortality independent of clinical presentation or exercise intensity.[13] Furthermore, individuals who demonstrate an exaggerated BP response to exercise, possess a 1.4 to 3.0-fold higher relative risk for cardiovascular events compared with individuals with a normal BP response to exercise.[14]

The available evidence suggests that physical therapists' BP screening behaviors have improved over the past 20 years. A study by Frese et al. in 2002 reported that BP screening rates across settings were approximately 4%.[15] However, more recent work demonstrates this has improved to approximately 15% in outpatient settings[10], and in settings such as home health, the rates are close to 100%.[12] Several actionable guidelines for measurement and interpretation of BP measured at rest and during exercise have also been provided for both inpatient,[16] and outpatient physical therapists.[2]

While assessment and interpretation of blood pressure response to inform treatment for a patient's primary complaint is recognized as part of the physical therapist scope of practice and accordingly a reimbursed service as part of the physical therapy examination, referral specific for the management of blood pressure is not. Management of blood pressure disorders such as HTN is not a reimbursable diagnostic code for skilled physical therapy services, and improvements in blood pressure are not considered to be acceptable physical therapy goals by most third-party payers. However, physical therapists do possess the necessary skills, knowledge, and training to include nonpharmacological blood pressure management as part of the physical therapist scope of practice. Theoretically, this would be done through a combination of exercise testing, exercise prescription, physical activity counseling, sleep health promotion, and nutritional education which have all been recognized as part of the physical therapist scope of practice.[17]

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

There are no current House policies or positions that directly address nonpharmacologic management of blood pressure by physical therapists. Previous activities of the House of delegates that touch on the physical therapist's role in disease management are:

- HOD P06-19-27-12: Physical Therapists' Role in Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability
- HOD P06-19-26-11: Association's Role in Advocacy for Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability
- HOD P06-19-74-40: Communicable and Infectious Diseases/Conditions: Rights of Patients and Providers in Physical Therapy

Key stakeholders include, but are not limited to, physical therapists, physical therapist assistants, patients and clients, Medicare/Medicaid, commercial insurers and other payers, communities, and PT/PTA education programs.

D. Additional Background Information.

While this motion is written to include nonpharmacologic blood pressure management of all measures, recent work has been done regarding the specific management of hypertension. The American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines considered exercise

training for the treatment of HTN a class I recommendation, with evidence level A.[18] However, only 15% of US adults with HTN have been reported to meet exercise training recommendation.[19] The well-established effects of exercise training for improving blood pressure outcomes and the widespread usage of exercise training by physical therapists present a promising opportunity for the physical therapy profession to address the growing HTN crisis.

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 6

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PROPOSED BY: PELVIC HEALTH, COLORADO, TENNESSEE

RC 10-22 ADOPT: ACCESS TO PHYSICAL THERAPIST SERVICES IN THE PRENATAL AND FOURTH TRIMESTER PERIODS

That the following be adopted:

ACCESS TO PHYSICAL THERAPIST SERVICES IN THE PRENATAL AND FOURTH TRIMESTER PERIODS

The American Physical Therapy Association supports access to physical therapist services in the prenatal and fourth trimester periods as the standard of care to improve health outcomes and prevent comorbidities and health disparities.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

This motion is in alignment with APTA Strategic Plan improving the health of society and improving the human experience specifically related to the prenatal care and "4th trimester" postpartum population. Many people receive insufficient healthcare during both the prenatal and postpartum time periods as they recover from pregnancy and birth. They seek rehabilitation with the goal of returning to prior levels of function and optimizing their movement. Prenatal and "4th trimester" physical therapy care includes creating and implementing individualized interventions based upon the best available evidence to help people improve mobility, rehabilitate from injury, prevent future harm, manage pain and chronic medical conditions.[13,14,15,16,17]

Pregnancy-related deaths and the significant racial disparities that exist are a public health crisis.[1] A commitment to improving maternal health outcomes includes educating members, physical therapy education stakeholders, and our communities about the role of physical therapist services along the continuum of maternal care.[2,3] The expected outcomes of this motion are:

1) to elevate the quality of care provided by PTs and PTAs during the pregnancy and postpartum period
2) to drive access to perinatal screening, preventative, and restorative services provided by PTs and PTAs in the hospital, home, and outpatient care settings
3) to drive the development of new APTA evidence-based resources that impact maternal health at all levels.

Demonstrating awareness and commitment to improving the experience and health outcomes of the maternal population directly aligns with the Vision. Through engagement and recognition of the maternal health crisis, the APTA will expand avenues that promote the profession as reflected in the current Strategic Plan.[4] Stakeholders in the APTA community will have broader access to collaborate with public health officials and

interdisciplinary organizations to justify our services as a standard component of maternal care and improve both physical and mental health outcomes in this population.

B. How is this motion's subject national in scope or importance?

Mortality and morbidity during prenatal and 4th trimester periods are a public health crisis in the United States. The American Physical Therapy Association supports the inclusion of physical therapy care as a standard of care in the prenatal and 4th trimester periods to address client goals and needs related to optimizing physical function, movement, performance, health, quality of life, well-being, healing, and disability status. This includes using the best available evidence and standards of practice to evaluate and treat, including a pelvic health assessment.

In the US 2020, the population of women ages 15-44 was 64,543,832. The demographic distribution of women and children in a state, county or city can have an impact on the rates of birth outcomes in that area, according to the March of Dimes.[20] There were only 21,570 gynecologists and obstetricians to evaluate and treat.[21] 5 Million women live in "maternity care desert" with inadequate or insufficient healthcare options for pregnancy and postpartum care.[20]

ACOG supports increased engagement and reports, "currently, as many as 40% of women do not attend a postpartum visit. Underutilization of postpartum care impedes management of chronic health conditions and access to effective contraception, which increases the risk of short interval pregnancy and preterm birth. Attendance rates are lower among populations with limited resources, which contributes to health disparities."[13]

The United States has the highest maternal mortality rate of all developed nations in the world and is currently the only country where maternal deaths are increasing.[5] It is estimated that the majority of deaths are preventable with over 50% of maternal-related deaths occurring after birth, during fourth trimester recovery in the hospital, and within the first 12 months postpartum.[6] The racial differences in outcomes are significant with Black women being 2.9 times more likely to die from maternal-related causes than their white counterparts.[7] Of those who survive their pregnancies, over 60,000 individuals per year suffer from impairments associated with severe maternal morbidity (SMM).[8] Blood transfusion is the most common marker of severe morbidity and is associated with the most performed surgery in the US, the cesarean section, which accounts for one-third of all deliveries.[9,10] The effects of a major, open abdominal surgery, significant blood loss, and other traumatic delivery experiences result in longer hospital stays, dysfunctional movement patterns, increased risk factors for cardiopulmonary impairments, and gastrointestinal dysfunction.[2,9-11] The unexpected length of recovery from delivery-related complications and functional impairments significantly impact both maternal-infant bonding and mental health outcomes.[9-11] Physical therapists in all settings that care for the pregnant and postpartum population can screen for risk factors related to activity tolerance, mobility, and wound healing to identify and reduce the risk factors of mortality and severe, long-term morbidity.[11,12]

Pelvic health physical therapists treat all individuals for pelvic health related conditions that include but are not limited to urinary dysfunction, bowel dysfunction, musculoskeletal dysfunction, sexual dysfunction, and other prenatal and 4th trimester related issues.[17]

The Postpartum period alone can be broken in three phases that impact each person who gives birth and the people around them. These are phases when physical therapy care can be most impactful.

1. The initial, rapid change, period in the first 6-12 hours, is when potential for hemorrhage, uterine inversion, amniotic fluid embolism and eclampsia risk are greatest.
2. The second, less rapid, phase lasting 2-6 weeks, is when the body changes in terms of hemodynamics, genitourinary recovery, metabolism, and emotional status. This subacute phase may include perineal discomfort, peripartum cardiomyopathy or postpartum depression. With prior patient education, from a physical therapist, the patient is often able to self-identify problems.

3. The third, more gradual, phase lasting up to 6 months or the duration of lactation, is when muscle tone and connective tissue is restored.[18,19]

Improving maternal health and function regardless of race, socioeconomic status, or birth setting is a human rights priority and a driving force to ensure equitable access to perinatal care and obstetric physical therapist services. By passing this motion, the APTA and its members demonstrate their dedication to elevate a higher standard of maternal care by expanding physical therapist services across all settings, including birth centers and hospitals. The APTA's commitment to improving maternal health outcomes will support the organization's vision of transforming society with greater access to services that enhance perinatal function and improve the fourth trimester experience. This also aligns with strategic plan priorities of "Quality of Care," and "Demand and Access."

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

The Academy of Pelvic Health Prenatal and 4th Trimester Legislative Task Force is currently working with APTA to increase efforts to provide meaningful support for pregnancy, birth and post-partum mothers and birthing individuals.[14]

The Academy of Pelvic Health Prenatal and 4th Trimester Legislative Task Force is currently working diligently on this topic including collaborating in the development of clinical practice guidelines for the provisions of postpartum care stipulated in the 2022 National Defense Authorization Act. In addition, the General Assembly of Pennsylvania passed a Resolution designating May 26, 2021 as "Fourth Trimester Care Day" and the New Mexico Legislature passed House Memorial 4/Senate Memorial declaring February 14, 2022 '4th Trimester Care Day". There are other regulatory efforts underway including a bill instructing CMS to issue guidance on coverage under Medicaid and CHIP for pelvic health services performed during the postpartum or neonatal period. In addition to CMS, other internal and external stakeholder opportunity efforts are being initiated with the CDC, NIH, AUGS, and AAFP, for instance.

Previous or current activities of the House, Board, or staff that address this topic are:

- In 2021, PTJ published: Segraves RL, Segraves JM. Reducing maternal morbidity on the frontline: acute care physical therapy after cesarean section during and beyond the COVID-19 pandemic. *Phys Ther*. 2021;pzab093. doi:10.1093/ptj/pzab093.
- In response to the role of physical therapists on maternal health outcomes, the Academy of Pelvic Health released two webinars in 2022 titled: 4th Trimester Care Around the World and How Acute Care Therapists are Transforming Cesarean Section Recovery.
- In 2018, the APTA released a newsletter titled: OB-GYN Group Embraces 'Fourth Trimester' Concept, Acknowledges Role of Physical Therapy in Postpartum Care

Stakeholders that will be affected by this motion are:

- Internal: APTA BOD, APTA staff, APTA members, clients/patients served now or in the future by PTs and PTAs, PT/PTA current and future students,
- External: physical therapy education stakeholders, public health officials (i.e. Centers for Disease Control and Prevention, National Institutes of Health), maternity care providers and organizations including midwives, Maternal-Fetal-Medicine specialists, the American College of Obstetricians and Gynecologists (ACOG), and perinatal quality care organizations that collaborate with our association, profession, and society.

More Specifically, state and federal laws or regulations that address this topic are:

- Black Maternal Health Momnibus Act of 2021
- Colorado Birth Equity Bill Package
- Maternal CARE Act

D. Additional Background Information.

The APTA is committed to increasing diversity, equity, and inclusion in the association, profession, and society and transforming society by optimizing movement to improve the human experience.[4] By committing to improving maternal health outcomes, the APTA is bringing awareness to significant racial inequality and public health crisis affecting the pregnant and postpartum population.

Tennessee, Colorado, New Mexico, Pennsylvania, and many others have legislation, regulations, and/or are bringing up this motion concept to their constituents and patients to support prenatal and post-partum physical therapy visits. It would support the current national efforts to have a position statement supported by the APTA HOD.

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Main Motion to the 2022 House of Delegates

Required for Adoption:	Majority Vote	**Category**: 6
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RC Contact:	Venita Lovelace-Chandler, PT, PhD, FAPTA E-mail: vlc.phd.pt.pcs@gmail.com	

PROPOSED BY: ORTHOPAEDICS

RC 11-22 ADOPT: PHYSICAL THERAPISTS AS ENTRY-POINT PRACTITIONERS FOR PRIMARY CARE AND CLEARANCE FOR ACTIVITY PARTICIPATION

This is a motion with three conforming amendments - Parts A–C.

PART A

That the following be adopted:

PHYSICAL THERAPISTS AS ENTRY-POINT PRACTITIONERS FOR PRIMARY CARE AND CLEARANCE FOR ACTIVITY PARTICIPATION

The American Physical Therapy Association supports unrestricted access to physical therapists as entry-point primary care practitioners to determine fitness, activity limitations, clearance for participation, disability, and necessary accommodations.

Physical therapists are primary health care practitioners who make unique contributions as an entry-point to the health care system to optimize movement, fitness, activity, and participation. Doctoral-level education prepares physical therapists to render a differential diagnosis, using relevant diagnostic classification labels, to establish the cause and nature of an individual's injuries, emergent conditions, movement impairments, activity limitations, and participation barriers.

Physical therapists deliver a broad range of primary care services to optimize movement, including, but not limited to, triage, examination, evaluation, diagnosis, prognosis, intervention, coordination of care, prevention, wellness, and referral to other health care practitioners when indicated.

Physical therapists have unique qualifications for evaluating an individual's fitness for activity participation and disability in all aspects of life (health, recreation, employment, daily living, and transportation) and to prescribe physical activity and participation restrictions. Physical therapists coordinate care and justify the need for accommodations to alleviate disability.

PART B

That the following position be rescinded:

~~**SOCIETAL ACCESS TO AND RECOGNITION OF PHYSICAL THERAPISTS FOR DISABILITY EVALUATION AND DETERMINATION (HOD P06-17-08-06)**~~

~~The American Physical Therapy Association supports increased societal access to and recognition of physical therapists for disability evaluation and determination for health, recreation, employment, legal, regulatory, transportation, and insurance purposes.~~

PART C

That the following position be rescinded:

~~**PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS (HOD P06-18-28-22)**~~

~~**Physical therapists make unique contributions as individuals or members of primary care teams and are entry-point providers into the health care system.**~~

~~**Physical therapists provide a broad range of services to optimize movement, including screening, examination, evaluation, diagnosis, prognosis, intervention, coordination of care, prevention, wellness and fitness, and, when indicated, referral to other providers.**~~

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

This language will replace "PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS" (HOD P06-18-28-22) and "SOCIETAL ACCESS TO AND RECOGNITION OF PHYSICAL THERAPISTS FOR DISABILITY EVALUATION AND DETERMINATION" *HOD P06-17-08-06) with a new position statement that further clarifies the role and qualifications of physical therapists as entry-point practitioners for primary care and determination of clearance for activity participation, disability, or necessary accommodations. Its intent is to inspire advocacy and serve as a model for stakeholder education to remove access barriers for physical therapists to provide a broad range of primary care services, with emphasis on qualification to provide participation-focused physical examinations throughout the lifespan of individuals and disability determination.

Although direct access to physical therapy is permitted in all states, regulatory and policy barriers exist that limit access and opportunities for physical therapists to practice as an entry-point to the healthcare system and to conduct physical examinations to determine clearance for physical activity participation or disability, within their full scope of education and training. The motion supports expanded access to physical therapists to promote activity participation and bridge gaps that exist between therapy programs and activity participation in all aspects of life (health, recreation, employment, daily living, and transportation).

Direct access to physical therapists for participation-focused physical examinations supports early detection of movement disorders, cost savings, improved functional outcomes, and can improve quality of life. This motion is consistent with APTA's Vision Statement of "transforming society by optimizing movement to improve the human experience", and Strategic Plan initiatives to maximize stakeholder awareness of the value of physical therapy and expand access to physical therapy in primary care settings, schools, and workplace health promotion and well-being programs.

We originally intended to pursue physical therapist involvement in participation exams as a stand alone concept. As we dug into existing policy, we found insufficiencies in closely related positions that do not capture participation exams and other future models of PT primary care that have not yet been imagined. This new language aims to improve existing policy, include participation exams, and allow room for PT growth into new areas of primary care and direct access practice.

Finally, the language of this proposal favors consistent use of the term “health care practitioner” rather than the term “provider” that was used in HOD P06-18-28-22 when referring physical therapists. The term “health care practitioner” or “practitioner” is defined in the *Guidebook* for the National Practitioner Data Bank as the individual who is licensed or otherwise authorized by a state to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized.[10] The term “health care provider” has a broader organization context in the *Guidebook* to mean:

- A provider of services as defined in Section 1861(u) of the Social Security Act
- Any organization (including an HMO, preferred provider organization, or group medical practice) that provides health care services and follows a formal peer review process for the purpose of furthering quality health care, or
- Any other organization that, directly or through contracts, provides health care services

Since this motion is about the unique expertise and contributions of physical therapists to deliver services as an entry point to the health care system, the term “practitioner” is more specific to the physical therapist and consistent with use of this term “practitioner” in the Model Practice Act in reference to our role as licensed healthcare professionals. Although the previous HOD P06-18-28-22 position used the term “provider” rather than “practitioner” in reference to physical therapists, the makers of this motion recommend consistent application of the term “health care practitioner” when referring to physical therapists rather using the broader “provider” term that includes an organization business entity for group practice or billing. One of the barriers for acceptance of physical therapists as entry point of care providers in state workers’ compensation jurisdictions such as Ohio is that physical therapists have not taken the initiative to apply for an individual provider number. Instead the organization’s provider number is used to bill for services. Not having an individual provider number results in dependence on physicians or other healthcare professionals to request services. This is not consistent with the example set by other health care practitioner types such as physicians and nurse practitioners.

B. How is this motion’s subject national in scope or importance?

Participation-focused physical examinations at the entry point of care are underutilized in most physical therapist practice settings in the United States. Although every state permits some form of physical therapist evaluation and treatment without referral, regulation, and policy barriers exist that prevent or discourage physical therapists from conducting participation-focused physical examinations for health, recreation, employment, daily living, and transportation within the full extent of their education and expertise. The Guide to PT Practice, Standards of Practice for Physical Therapy, and the FSBPT Model Practice Act for Physical Therapy all contain inadequate language to describe the role of physical therapists in participation-focused physical exams for health, recreation, employment, daily living, and transportation. As a result, concise model language is not presented to assist with education of stakeholders to remove access barriers to physical therapists as an acceptable medical source for conducting participation-focused physical exams for health, recreation, employment, daily living, and transportation.

Currently, many youth sports organizations do not recognize physical therapists as acceptable sources for determining fitness for activity participation, because the physical examination form required for sports participation by state high school athletic associations fails to communicate that physical therapists are qualified to perform a sports preparticipation physical exam. For example, the Ohio High School Athletic Association has a form (https://ohsaaweb.blob.core.windows.net/files/Sports-Medicine/PPE_2021-22.pdf) that indicates “MD, DO, DC, NP, or PA” as appropriate credentials for the types health care professional who are permitted to complete this form. This form contains a 2019 copyright reference to a listing of physician associations and the American College of Sports Medicine. An identical form without “DC” listed is contained in the appendix of forms in a book of consensus based guideline for PPE Preparticipation Physical Evaluation 5th Edition that is published by the American Academy of Pediatrics.[1]

This PPE guideline book is authored entirely by physicians who state that responsibility for conducting and determining medical eligibility should be completed by physicians (MD or DO), nurse practitioners (NP) or physician assistants (PA). It acknowledges that some state associations allow a doctor of chiropractic (DC) to perform the evaluation. The book acknowledges that PPE was not developed as an evidence-based process, and that most PPE forms used in high schools and colleges do not follow the American Heart Association (AHA) recommendations regarding cardiac screening and physical exam. A systematic review by Stickler (2000) of over 2000 sports participation exams found that only 3 participants were excluded from sports participation.[2] Corrente (2021) conducted a survey of 616 physicians who perform preparticipation physical examinations and found that although 52% of physicians reported using a musculoskeletal movement screen recommended in the PPE Monograph, 26% said that they don't perform a physical exam at all.[3] We are hopeful that our motion will prompt APTA state chapters to advocate with athletic associations to include physical therapists as acceptable sources for performing sports pre-participation evaluations. This will provide an entry point of care opportunity for therapy practices to improve community awareness of physical therapist services and gather more objective pre-injury baseline data that would benefit fitness training and encourage return to the same therapy provider for care after injury.

There is precedent for authorizing physical therapists to provide safety-sensitive physical examinations for commercial motor vehicle drivers in six states that should be expanded to all states. The Federal Motor Carrier Safety Association (FMCSA) recognizes physical therapists as qualified to perform Department of Transportation (DOT) Physical Examinations of Commercial Vehicle Drivers in AR, LA, KY, OH, ND, and TX. To authorize physical therapists in other states, FMCSA must receive a letter from the physical therapy state licensing board to confirm that a DOT physical examination is within the scope of practice for licensed physical therapists for each state. DOT physical examinations are highly standardized and may only be performed by examiners who complete mandatory continuing education and pass a national certification examination to be designated as a "Certified Medical Examiner".[5] We hope that the discussion around our concept will inspire physical therapists from other states to become authorized to provide DOT physical exams. This would provide supporting evidence to leverage advocacy for physical therapists to perform simpler sports pre-participation evaluations and other types of participation exams.

Although physical therapists face no barriers to performing employment screens of new hires as a direct-to-employer service, physical therapists are not afforded with the same privileges as physicians, physician assistants, nurse practitioners, and chiropractors to perform participation exams and related coordination of care in most State Workers' Compensation Programs . Precedent has been set in states such as Washington and North Dakota to authorize physical therapists to perform work participation exams of injured workers for return to work, based on the physical therapist's expertise with performance-based testing as a more accurate method for determination of fitness-for-duty. In August of 2021, North Dakota was the first state to authorize physical therapists to function as the primary treating provider. The APTA State Resources page indicates that 14 states do not require physician referral for authorization of services. States often impose regulatory or policy barriers that prevent physical therapists from providing opinions about the cause of injury, impairments, and disability because this language is described inadequately in state practice acts. We hope our motion inspires other state chapters to follow the example of North Dakota to get physical therapists authorized to function as the primary treating provider for coordination of care, clearance of an injured worker to work without restriction, or to work with prescribing functional limitations.

Finally, the inclusion of physical therapists as DOT examiners for work clearance purposes in all states would support a future petition by APTA to the Social Security Administration to include physical therapists as qualified to provide evidence to substantiate the need for disability benefits from Social Security Administration and other disability insurance programs.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

The HOD has previously established in 2018 a general position statement on "PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS" (HOD P06-18-28-22). [6] However, this position does not address PTs ability to determine the cause and nature of an injury or to appropriately use various diagnostic taxonomies that are required by regulators including workman's compensation carriers. These concepts are central missing pieces in current APTA policy that have motivated our work.

> *Physical therapists make unique contributions as individuals or members of primary care teams and are entry-point providers into the healthcare system.*
>
> *Physical therapists provide a broad range of services to optimize movement, including screening, examination, evaluation, diagnosis, prognosis, intervention, coordination of care, prevention, wellness and fitness, and, when indicated, referral to other providers.*

The HOD has previously established and more recently revised (in 2019) a general position statement "SOCIETAL ACCESS TO AND RECOGNITION OF PHYSICAL THERAPISTS FOR DISABILITY EVALUATION AND DETERMINATION" *HOD P06-17-08-06).[7] It originally focused on the sole issue of PTs qualifying individuals for handicap placards. It was later amended to include PTs in other disability determinations. However, this position is still narrow in its scope and does not address the concerns of the barriers to PT assuming their role as the practitioners of choice in participation examination and will likely not support future practice areas that have not yet emerged:

> *The American Physical Therapy Association supports increased societal access to and recognition of physical therapists for disability evaluation and determination for health, recreation, employment, legal, regulatory, transportation, and insurance purposes.*

This new motion concept leans in to describe and clarify the unique qualifications of physical therapists and process for performing participation physical examinations for the purpose of determining fitness to perform functional activities; provide a differential diagnosis of the cause, nature and extent of disability; and identify need for accommodation. Having the ability to perform participation physical exams would promote achievement of healthy physical activity guidelines for school-age students and workers.

The Federal Motor Carrier Safety Administration (FMCSA) allows physical therapists to certify fitness-for-duty of commercial truck/bus (CMV) drivers (DOT Physical Exams) if applicable State laws and regulations allow physical therapists to perform physical examinations. All eligible healthcare providers must also successfully complete DOT specific training from an accredited training program that meets the requirements of § 390.105, and pass the medical examiner certification test provided by the FMCSA and administered by a testing organization that meets the requirements of § 390.107.[5] Given that this exam is more complex and has public safety implications, the precedent established for including physical therapists as "Certified Medical Examiners" in these states could be leveraged in advocacy to state athletic associations to gain similar privileges for physical therapists to conduct sports preparticipation physical examinations.

The Social Security Administration published revisions to their medical evidence rules in 2017 (20 CFR Parts 404 and 416). In the revised rules, the SSA added advanced practice registered nurses, physician assistants, and audiologists to the list of acceptable medical sources within their scope of practice for the purpose of providing opinions to the SSA regarding the severity of a patient/client's physical limitations and how those physical limitations interfere with the patient/client's ability to participate in work activities. The SSA determined that physical therapists were not qualified to serve as acceptable medical sources based

on the presumption that licensing requirements for physical therapists were not at a similar level of consistency or rigor in terms of education, training, certification, and scope of practice. https://www.ssa.gov/disability/professionals/bluebook/documents/Medical Evidence Final Published.1.18.17.pdf

D. Additional Background Information.

The Guide to PT Practice, Standards of Practice for Physical Therapy, and the FSBPT Model Practice Act for Physical Therapy all contain inadequate descriptions about the role of physical therapists in participation exams. There is inadequate language in these documents describing a physical therapist's role in establishing the cause and nature of an individual's injury, emergent condition, and impairment. There are no statements referencing the physical therapist's role in analyzing the performance demands of jobs. These areas of missing language create problems for advocacy to provide entry point care by physical therapists of sports and work injuries. For example, there is model language being propagated by the National Athletic Trainers' Association to reform state practice acts in a manner that positions athletic trainers as an entry point provider in schools and work settings. The athletic trainers established a collaborative agreement with physicians for scope of practice expansion that is similar to physician supervisory arrangements with nurse practitioners and physician assistants. Athletic trainers in Ohio were successful in reforming their practice act to expand the definition of athletic training diagnosis to mean the "the judgment made after examining, evaluating, assessing, or interpreting symptoms presented by a patient to establish the cause and nature of the patient's injury, emergent condition, or functional impairment and the plan of care for that injury, emergent condition, or functional impairment within the scope of athletic training." https://searchrod.lis.state.oh.us/solarapi/v1/general_assembly_134/bills/hb176/EN/05/hb176_05_EN?format=pdf We hope that our motion will encourage state chapters to modify terminology for diagnosis to include language such as "to establish the cause and nature of the patient's injury, emergent conditions…" Determination of the cause and nature of an injury or emergent condition is critical to serving at the entry point of care in Workers' Compensation programs, as well as to make triage decisions in home health, sports, or workplace.

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8. PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS HOD P06-18-28-22
9. SOCIETAL ACCESS TO AND RECOGNITION OF PHYSICAL THERAPISTS FOR DISABILITY EVALUATION AND DETERMINATION (HOD P06-17-08-06)

Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 8

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PROPOSED BY: CONNECTICUT

RC 12-22 CHARGE: APTA TO PURSUE DIRECT-TO-EMPLOYER PHYSICAL THERAPIST SERVICES

That the American Physical Therapy Association develop a coordinated approach to enable members to pursue direct-to-employer physical therapist services.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

APTA to pursue Direct to Employer Physical Therapist Services. This charge is a call for APTA to evaluate the feasibility of developing collaborative initiatives among national, component, and grassroots levels for sustaining work to pursue Direct to Employer Physical Therapist Services. The initiative is focused on building upon the strong foundation of resources the APTA has developed on Direct-to-Employer services while mobilizing our members at all levels of the organization to create an impact on demand for PT services by employers. A broader value proposition for rehabilitative services, along with population health strategies, is needed to cut costs, improve access, and improve quality of care. This charge has greater potential for creating a critical mass of Direct-to-Employer services provided by physical therapists to increase our market demand and transform society.

Over the years, the APTA Academy of Orthopaedic Physical Therapy Occupational Health Special Interest Group, along with an APTA Workgroup has made substantial contributions to developing and promoting resources for population health programs and Direct-to-Employer Physical Therapy Services. More recently the Private Practice Section has been collaborating on the development Direct-to-Employer resources for bridging the gap in developing partnerships with employers to provide PT services. Resources developed by APTA can be found easily by searching the website, for instance: https://www.apta.org/patient-care/public-health-population-care/healthy-workforce-promotion. Resources outside of the APTA, such as the NIOSH Total Workers Health Program and white papers produced by the Institute for Healthcare Improvement, provide valuable insight to further our productivity on this charge. Likewise, a quick literature review provides evidence-based research on how PT services can cut employee health costs and improved well-being. However, we lack the evidence to know the extent of current PT services being provided direct-to-employers. In addition, we only have anecdotal evidence from private practices and hospital systems that demonstrates the extent of PT services being provided direct to employers. The evidence on direct to employer physical therapy services is sparce, transient, and not substantial enough for employers to amass substantive market power to successfully negotiate with providers and third-party payers to reduce cost and improve access to PT services. We need to develop a collaborative effort at all levels of the APTA for organized, sustaining work to drive demand for our services in this space. With a centralized charge we can provide better data regarding the state of relationships with employers and focus efforts to gain market share, conduct further research, establish PT as the primary provider of preventative, rehabilitative, and return to work programs for

employers. The APTA CT Delegation requests the House of Delegates consider this charge to close the gap in knowledge translation of evidence to practice in providing direct to employer PT services.

This charge is in direct alignment with the APTA Strategic Plan 2022-2025 regarding "The APTA community will collaborate to reach more consumers, drive demand for physical therapy, and expand the markets and venues that promote the profession," as well as the desired outcome of increasing the "use of and access to physical therapist services as a primary entry point of care for consumers."

B. How is this motion's subject national in scope or importance?

Given:

- Member groups are making great strides in educating both PTs and Employers on the physical therapy (PT) services needed to get patients better quicker with less cost.
- There is evidence that going directly to PT for care of musculoskeletal injuries is more effective in improving function and reducing cost to employers.
- Direct to Employer services (PT providers contracting directly with employers) has not gained enough traction to substantially improve the health of society. This includes preventative, rehabilitative, and performance enhancement initiatives.
- Insurance companies control our care of patients and create substantial barriers to necessary care of patients.
- More Research is needed to improve services and gain access to employers; there is a paucity of research being conducted onsite with employers for better buy-in and outcomes.

However:

- Building individual competencies through educating PTs and Employers is necessary but insufficient to address the contextual factors that are barriers to accessing employers.
- Without coordinated efforts in support, advocacy, and implementation of direct-to-employer services, from APTA national to grassroots efforts, we will be inefficient and ineffective in improving the health of and transforming society.
- Empowering employers with direct services that reduce risk, decrease lost workdays, and cost-effective contractual agreements with providers can increase negotiating power of the employer in securing insurance plans.

Therefore, the motion is a request to work "Better Together" by requesting:

- **APTA to pursue Direct to Employer Physical Therapy Services**: The American Physical Therapy Association evaluate the feasibility of developing collaborative initiatives at national, component, and grassroots levels for sustaining work to pursue Direct to Employer Physical Therapy Services.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

All members are internal stakeholders and previous APTA resources include:

Better Together: Resources for Component Leaders; Last updated 1/24/22. Contact: memberengagment@apta.org.

Perspective on Direct-to-Employer Population Health Services by Physical Therapists; Last updated 6/14/20. Contact: practice@apta.org.

Direct-to-Employer Services: How to Engage in Employer Outreach; Last updated 6/7/21. Contact: email@apta.org

How PTs Can Cut Your Employee Health Care Costs and Improve Well-Being; Last updated 6/7/21. Contact: advocacy@apta.org

Tools for Establishing Direct-to-Employer Relationships. Found at: https://www.apta.org/patient-care/public-health-population-care/healthy-workforce-promotion/direct-to-employer-relationships. 4/23/22

Direct-to-Employer Services: Why PTs Should Work with Employers to Manage Population Health. White Paper found at: https://www.apta.org/patient-care/public-health-population-care/healthy-workforce-promotion/why-pts#

APTA Public Policy Goals 2021-2022 found at: https://www.apta.org/advocacy/issues/apta-public-policy-priorities

APTA Strategic Plan 2022-2025 found at: https://www.apta.org/apta-and-you/leadership-and-governance/vision-mission-and-strategic-plan/strategic-plan

Clinical Guidance to Optimize Work Participation after Injury or Illness: The Role of Physical Therapist. Found at: https://www.apta.org/patient-care/evidence-based-practice-resources/cpgs/clinical-guidance-to-optimize-work-participation-after-injury-or-illness-the-role-of-physical-therapists

External Stakeholders are all employers, other health professionals, and third-party payers. Some relevant external resources include:

Center for Disease Control and Prevention: National Institute of Occupational Safety and Health (NIOSH) *Total Worker Health* Program. Found at: https://www.cdc.gov/niosh/twh/default.html

Institute for Healthcare Improvement. Found at: https://www.ihi.org.

Self-Insurance Educational Foundation: Found at: http://www.siefonline.org/

Self-Insurance Institute of America, Inc. Found at: https://www.siia.org/i4a/pages/index.cfm?pageid=1

Past House of Delegates related motions include:

RC 3-19 (HOD P06-06-12-08) Evidence-Based Practice

RC 14-19; 15-19 (HOD P06-17-06-05): Association's Role in Advocacy for Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability.

RC 20-19 (HOD P06-15-20-11): Health Priorities for Populations and Individuals

RC 25-19 APTA Efforts to Address Social Determinants of Health and Achieving Health Equity.

RC 63-19 Position on Research

RC 21-18 (HOD P06-13-24-17): Public Policy Efforts to Improve Consumer Access to Physical Therapist Services.

RC 29-18 (HOD P06-14-07-11): Entry Point into Health Care

RC 39-18 APTA Statement in Support of Essential Health Benefits

RC 47-18 Adjustments in Documentation Requirements for Prevention and Wellness interactions.

RC 8-17 Transformational Innovations in Physical Therapist Practice

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2. APTA, Perspective on Direct-to-Employer Population Health Services by Physical Therapists. Last updated 6/14/20. Contact: practice@apta.org.
3. APTA. Direct-to-Employer Services: How to Engage in Employer Outreach. Last updated 6/7/21. Contact: email@apta.org
4. APTA. How PTs Can Cut Your Employee Health Care Costs and Improve Well-Being. Last updated 6/7/21. Contact: advocacy@apta.org
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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 6

Motion Contact: Christopher L. Petrosino, PT, PhD, Chief Delegate, APTA Connecticut
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PROPOSED BY: CONNECTICUT

RC 13-22 ADOPT: DIRECT-TO-EMPLOYER PHYSICAL THERAPIST SERVICES

That the following be adopted:

DIRECT-TO-EMPLOYER PHYSICAL THERAPIST SERVICES

The American Physical Therapy Association supports direct-to-employer physical therapist services to improve access, increase quality of care, and decrease health care costs.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?
APTA Statement in support of Direct-to-Employer Physical Therapist Services. This Position Statement is needed to drive demand for physical therapy, expand our market, and promote the profession. This position statement is supported by the 2020 APTA publication, "Perspectives on Direct-to-Employer Population Health Services by Physical Therapists," yet broadens the scope beyond population health to all PT services. The position on Direct-to-Employer Population Health Services addresses many reasons we need a broader position statement on Direct-to-Employer Services. The background information presented in the "Perspectives on Direct-to-Employer Population Health Services by Physical Therapists" is relevant and appropriate but not sufficient to gain market share. The focus on population health strategies has not gained enough traction with employers to impact the value proposition of PT services. A broader statement which encompasses a focus on increasing access, decreasing cost, and increasing quality care for individuals through rehabilitative services, as well as the health of populations, is needed for advocacy, relationship building and contract negotiation with employers. This position emphasizes not only population health initiatives but the full intent of the APTA Strategic Plan 2022-2025 regarding demand, access, and quality of care. Strategies to improve access and provide PT as the primary entry point of care has produced evidence of reduced cost for individuals and employers. Earlier return to work from receiving physical therapy first is a measure of quality of care. With strong evidence to support the value of physical therapist Direct-to-Employer Services the APTA can influence the expansion of our market through advocating for prevention, wellness, fitness, health promotion, management and rehabilitation of disease and disability, safe work practices, safe return to work, leisure, and activities of daily living.

B. How is this motion's subject national in scope or importance?
Revitalizing focus on Direct to Employer Services to impact the "Iron Triangle" of Access, Cost, and Quality, while continuing the promotion and advocacy for population health initiatives is at the foundation of this position statement. Employers in a capitalist market have little interest in focusing on the Quadruple Aim (aka: population health, experience of care, per capita cost, and healthcare provider wellbeing) until

they control the Iron Triangle. Collaborative initiatives encourage ideas, innovation, and new solutions that can leverage resources for an impact on desired outcome, so we must consider:

Given:

- Member groups are making great strides in educating both PTs and Employers on the physical therapy (PT) services needed to get patients better quicker with less cost.
- There is evidence that going directly to PT for care of musculoskeletal injuries is more effective in improving function and reducing cost to employers.
- Direct to Employer services (PT providers contracting directly with employers; D2E) has not gained enough traction to substantially improve the health of society. This includes preventative, rehabilitative, and performance enhancement initiatives.
- Insurance companies control our care of patients and create substantial barriers to necessary care of patients.
- More Research is needed to improve services and gain access to employers; there is a paucity of research being conducted onsite with employers for better buy-in and outcomes.

However:

- Building individual competencies through educating PTs and Employers is necessary but insufficient to address the contextual factors that are barriers to accessing employers.
- Without coordinated efforts in support, advocacy, and implementation of direct-to-employer services, from APTA national to grassroots efforts, we will be inefficient and ineffective in improving the health of and transforming society.
- Empowering employers with direct services that reduce risk, decrease lost workdays, and cost-effective contractual agreements with providers can increase negotiating power of the employer in securing insurance plans.

Therefore:

- The APTA supports Direct-to-Employer Physical Therapist Services to increase access, decrease healthcare costs, and increase quality of care.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

All members are internal stakeholders and previous APTA resources include:

Better Together: Resources for Component Leaders; Last updated 1/24/22. Contact: memberengagment@apta.org.

Perspective on Direct-to-Employer Population Health Services by Physical Therapists; Last updated 6/14/20. Contact: practice@apta.org.

Direct-to-Employer Services: How to Engage in Employer Outreach; Last updated 6/7/21. Contact: email@apta.org

How PTs Can Cut Your Employee Health Care Costs and Improve Well-Being; Last updated 6/7/21. Contact: advocacy@apta.org

Tools for Establishing Direct-to-Employer Relationships. Found at: https://www.apta.org/patient-care/public-health-population-care/healthy-workforce-promotion/direct-to-employer-relationships. 4/23/22

Direct-to-Employer Services: Why PTs Should Work with Employers to Manage Population Health. White Paper found at: https://www.apta.org/patient-care/public-health-population-care/healthy-workforce-promotion/why-pts#

APTA Public Policy Goals 2021-2022 found at: https://www.apta.org/advocacy/issues/apta-public-policy-priorities

APTA Strategic Plan 2022-2025 found at: https://www.apta.org/apta-and-you/leadership-and-governance/vision-mission-and-strategic-plan/strategic-plan

Clinical Guidance to Optimize Work Participation after Injury or Illness: The Role of Physical Therapist. Found at: https://www.apta.org/patient-care/evidence-based-practice-resources/cpgs/clinical-guidance-to-optimize-work-participation-after-injury-or-illness-the-role-of-physical-therapists

External Stakeholders are all employers, other health professionals, and third-party payers. Some relevant external resources include:
Center for Disease Control and Prevention: National Institute of Occupational Safety and Health (NIOSH) *Total Worker Health* Program. Found at: https://www.cdc.gov/niosh/twh/default.html
Institute for Healthcare Improvement. Found at: https://www.ihi.org.
Self-Insurance Educational Foundation: Found at: http://www.siefonline.org/
Self-Insurance Institute of America, Inc. Found at: https://www.siia.org/i4a/pages/index.cfm?pageid=1

Past House of Delegates related motions include:
RC 3-19 (HOD P06-06-12-08) Evidence-Based Practice
RC 14-19; 15-19 (HOD P06-17-06-05): Association's Role in Advocacy for Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability.
RC 20-19 (HOD P06-15-20-11): Health Priorities for Populations and Individuals
RC 25-19 APTA Efforts to Address Social Determinants of Health and Achieving Health Equity.
RC 63-19 Position on Research
RC 21-18 (HOD P06-13-24-17): Public Policy Efforts to Improve Consumer Access to Physical Therapist Services.
RC 29-18 (HOD P06-14-07-11): Entry Point into Health Care
RC 39-18 APTA Statement in Support of Essential Health Benefits
RC 47-18 Adjustments in Documentation Requirements for Prevention and Wellness interactions.
RC 8-17 Transformational Innovations in Physical Therapist Practice

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 6

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PROPOSED BY: WASHINGTON, PENNSYLVANIA

RC 14-22 ADOPT: ADVOCACY FOR IMPROVED ACCESS TO PHYSICAL THERAPIST SERVICES FOR MEDICAID BENEFICIARIES

That the following be adopted:

ADVOCACY FOR IMPROVED ACCESS TO PHYSICAL THERAPIST SERVICES FOR MEDICAID BENEFICIARIES

The American Physical Therapy Association supports national and state efforts to improve access to physical therapist services for Medicaid beneficiaries. APTA advocates for physical therapist services as a mandatory benefit in all state Medicaid programs, authorized without administrative delays and barriers, and paid commensurate with Medicare.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?
This motion encourages national APTA and state chapter efforts to improve access to physical therapist services for Medicaid beneficiaries. Consistent with the Vision, this motion directly supports access to physical therapist services which aim to optimize movement for vulnerable members of society who have historically lacked access to necessary and beneficial care. This motion supports the APTA Strategic Plan goals of “Improving Demand and Access” and “Sustainable Profession” by supporting efforts to increase payment and reduce barriers to physical therapy access for Medicaid beneficiaries.

Possible outcomes of this motion include, but are not limited to:

National Efforts

- Inclusion of Medicaid advocacy as one of the national APTA 2023-2024 Public Policy priorities and as a key issue for APTA Advocacy Days on Capitol Hill
- Inclusion of Medicaid-specific outputs and outcomes in the APTA strategic plan metrics
- National APTA advocacy efforts to achieve Medicaid parity with Medicare payment rates for physical therapist services, similar to efforts achieved under the Mental Health Parity and Addiction Equity Act
- Increased encounters with national legislators to advocate for Medicaid parity
- PTPAC fundraising efforts to support national Medicaid advocacy
- National media campaigns to highlight physical therapists who prioritize and successfully treat Medicaid patients
- Increased resources for state-specific Medicaid programs in the State Payer Advocacy Resource Center (SPARC)
- Increased collaboration with state chapter leadership and lobbyists to assist in state advocacy efforts

State Efforts

- Increased coordination between state chapters to allow states targeting Medicaid issues for the first time to learn from chapters with a history of Medicaid engagement and lobbying
- Increased knowledge sharing amongst state chapter members, which could include strategies, best practices, and success stories by physical therapists, administrators, and business owners who successfully access Medicaid payment
- Increased State chapter advocacy activity, including encounters with state legislators, focusing on Medicaid legislation to improve payment rates and reduce unnecessary administrative burdens
- State chapter collaboration with patient advocacy groups and other stakeholders to magnify advocacy efforts
- Inclusion of Medicaid administrative burden and/or payment parity issues in training to members prior to state chapter Legislative Impact/Advocacy days
- Increased state chapter collaboration with national APTA staff to utilize national advocacy resources and policy knowledge to help chapters make progress on state Medicaid issues
- State political action committee fundraising efforts to support state chapter Medicaid advocacy and lobbyist time

B. How is this motion's subject national in scope or importance?

Medicaid is the largest health insurer in the United States, covering over 85 million Americans who qualify due to low income or due to significant medical needs, such as chronic disability. Nearly half of Medicaid enrollees (46%) are children living under the federal poverty line enrolled in the Children's Health Insurance Program (CHIP).[1]

Physical therapist services are beneficial for Medicaid beneficiaries with various musculoskeletal, developmental, and neurologic diagnoses.[2–4] However, barriers to access to physical therapist services have been documented for Medicaid beneficiaries, including children, patients recovering from musculoskeletal surgeries, and patients with rehabilitation-sensitive neurologic conditions, including spinal cord injury, brain injury, and stroke.[5–8] For patients with neurologic impairments, the most commonly cited reasons for difficulty accessing services were that the provider did not accept Medicaid or that Medicaid did not cover the service.[6]

While the federal government sets mandatory benefits that must be covered in all Medicaid programs, individual states administer Medicaid. Physical therapy is not currently a federal mandatory benefit. Each state sets additional eligibility criteria for the Medicaid program and optional benefits, such as physical therapist services.

Administrative burdens to receiving payment are higher for Medicaid patients than Medicare and commercial insurers. On average, physicians lose 17% of Medicaid revenue due to billing issues, compared to only 5% for Medicare and 3% for commercial insurers.[9] Coverage, payment, and administrative processes surrounding physical therapist services for Medicaid beneficiaries also vary widely across states. Across the country, there is wide variability in regulations on copays, prior authorization, visit limits, utilization review requirements and timelines, and other administrative burdens on providers.[10]

For example, in a study on Medicaid coverage in North Carolina, Medicaid beneficiaries aged 21+ are entitled to just one evaluation per year between physical, occupational and speech therapy.[11] After musculoskeletal surgeries including conditions requiring lengthy rehabilitation such as rotator cuff repairs, a patient on Medicaid is entitled to only one evaluation and three treatment sessions. After joint arthroplasties, the patient receives two therapy evaluations and eight treatment sessions split amongst therapy disciplines. Prior authorization for rehabilitative care is needed 100% of the time, and Direct Access is generally not permitted, which results in unnecessary delays in receiving care and added costs of the required physician visit.

Adding to administrative burdens, 40 states and the District of Columbia also deliver Medicaid through third-party Managed Care Organizations (MCOs) for at least a proportion of Medicaid enrollees, which receive a capitated monthly rate per beneficiary to administer Medicaid services.[12] Around 70% of Medicaid beneficiaries receive have their care managed by an MCO. There may also be multiple Medicaid MCOs used by a single state, which vary broadly in services they cover, utilization management, quality reporting, and other programmatic features.[13] There are 16 companies who manage Medicaid programs in two or more states. Of those, seven are publicly traded for-profit companies, and six are on the Fortune 500 list (United Healthcare, Centene, Anthem, Molina, Aetna, and Wellcare).

The proliferation of MCOs leads to increased administrative burden for providers. In a state such as Pennsylvania which contracts with 10 different MCOs to manage care for Medicaid enrollees, a physical therapy clinic that wishes to treat patient with Medicaid would potentially need to enter into 10 different contracts, one with each separate MCO.[14] Four of the MCOs operating in Pennsylvania are for-profit companies, many known for rationing of care. Denials of physical therapist services for the largest Medicaid MCO in Pennsylvania (Gateway Health) are managed by case reviewers who are Licensed Practical Nurses, which require only an associate degree, not physical therapists. Physicians who manage appeals for denials of rehabilitative services are not physiatrists or from a rehabilitation-related discipline.

Finally, payment to health providers under Medicaid is also typically well below Medicare rates. The ten worst states for Medicaid payment parity to Medicare rates are:[15]

1. Rhode Island (38% of Medicare)
2. New Jersey (42% of Medicare)
3. California (52% of Medicare)
4. Florida (56% of Medicare)
5. New York (56% of Medicare)
6. New Hampshire (58% of Medicare)
7. Missouri (60% of Medicare)
8. Illinois (61% of Medicare)
9. Hawaii, Wisconsin (62% of Medicare)

Due to the heterogeneity in Medicaid payment and barriers to accessing Medicaid reimbursement across the country, improving access to physical therapist services for Medicaid beneficiaries across states requires a two-pronged approach to advocacy. Both national and individual state-level efforts must be prioritized and coordinated to achieve real progress. The three primary areas of focus for advocacy efforts were specifically included in the motion language to help guide advocacy actions to address remaining barriers to accessing physical therapist services for Medicaid beneficiaries.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

According to the APTA strategic plan assessment, the APTA includes Medicaid as an advocacy issue, but has not made significant progress or efforts towards Medicaid-specific advocacy. Medicaid is not currently listed as an APTA Public Policy Priority. The APTA is currently hiring for a State Government Affairs Specialist staff position. This motion aims to encourage state chapters to increase dialogue and collaboration with national APTA staff to make progress on Medicaid policy.

In 2019, the Private Practice Section of the APTA wrote to the Center for Medicare & Medicaid Services with concerns regarding administrative burdens for physical therapists.[16] This letter focused to barriers to accessing physical therapy for beneficiaries covered by Medicare Fee-for-Service and Medicare Advantage plans, but did briefly mention burdensome prior authorization requirements of Medicaid MCOs.

This motion encourages similar advocacy actions specific to Medicaid beneficiaries by the APTA and individual state chapters.

The APTA and the Private Practice Section have also recently collaborated to create **SPARC- the State Payer Advocacy Resource Center**. However, this excellent resource focuses on clinician-payer communication, not state chapter advocacy efforts. Additionally, SPARC includes just two Medicaid-specific form letters for clinicians and consumers, which are not tools for improving state policy on Medicaid access.

Three previous House of Delegates actions support the intent of this motion while leaving room for additional work towards reducing barriers to accessing physical therapist services for Medicaid beneficiaries, which this motion attempts to address.

1. APTA Position statement **HOD P06-13-27- 26, THE ROLE OF PHYSICAL THERAPY IN HEALTH MANAGEMENT FOR PEOPLE WITH CHRONIC DISABILITY** reads (in part):
"That the American Physical Therapy Association support and advocate for timely and regular access to physical therapist services, rehabilitation equipment, and assistive/adaptive devices for children and adults with severe chronic physical disability, with particular attention to the health needs of the population who are disabled and are dual eligible under Medicare and Medicaid, so that all people with chronic disability will experience better health and improved life participation."

This motion takes the HOD P06-13-27-26 a step further in two important ways. First, this motion encourages both national and state advocacy efforts to improve access to physical therapist services. Second, this motion focuses on improving access for all Medicaid beneficiaries, not just for dually eligible Medicare/Medicaid beneficiaries with disabilities. This motion also suggests three important advocacy targets pertinent to national and state efforts: physical therapy as a mandatory benefit, reduced administrative burden, and improved payment parity.

2. The **APTA STATEMENT IN SUPPORT OF ESSENTIAL HEALTH BENEFITS HOD P06-18-37-5** also supports inclusion of rehabilitative services as essential health benefits in all insurance plans. HOD P06-18-37-5 demonstrates previous House of Delegates support for inclusion of physical therapy as a mandatory benefit under insurance plans such as Medicaid. However, the term "essential health benefit" is used by the Center for Medicare & Medicaid services to apply to benefits to be included in plans on state health exchanges and this term is not used when discussing a federally required benefit for a state Medicaid plan. This motion intentionally uses terminology specifically applicable to Medicaid for clarity in all potential advocacy actions that may result from this motion. This motion also extends the intent of HOD P06-18-37-5 to include advocacy towards payment parity with Medicare and reduced administrative barriers in addition to including physical therapist services as a mandatory benefit.

3. **PRINCIPLES AND OBJECTIVES FOR HEALTH SERVICES IN THE UNITED STATES HOD P06-19-17-66** demonstrates previous House of Delegate support for the principle of access to high-quality physical therapist services to meet the needs of individuals, patient and client populations, and communities. HOD P06-19-17-66 also includes language that supports coverage that is free of arbitrary restrictions that impede access to payment for physical therapist services. However, HOD P06-19-17-66 does not discuss acknowledge the unique barriers faced by Medicaid beneficiaries specifically (as discussed above in Section B), nor does it suggest specific advocacy actions at both the national and state levels towards reducing these unique barriers.

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 6

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PROPOSED BY: TEXAS

RC 15-22 ADOPT: EQUITABLE DISABILITY ACCOMMODATIONS IN PHYSICAL THERAPY

That the following be adopted:

EQUITABLE DISABILITY ACCOMMODATIONS IN PHYSICAL THERAPY

The American Physical Therapy Association supports the full inclusion of individuals with disabilities within the profession of physical therapy through the provision of equitable accommodations. Support includes advocacy for reasonable accommodations for students and practitioners on all applications, coursework, and examinations, as well as within the workplace.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

The expected outcome of this motion is a unified statement of support from the APTA as it relates to disability accommodations in the field of physical therapy. Our vision is for the APTA to adopt a position statement that we support the provision of equitable accommodations in physical therapy education, practice, advocacy, and research. This includes, but is not limited to, reasonable accommodations on the National Physical Therapy Examination, through the specialty board certification and re-certification process, for students applying to physical therapy and physical therapy assistant school, for those in physical therapy school, and equitable workplace accommodations.

This motion contributes to achieving the vision of the APTA by ensuring that all individuals have the opportunity to transform society by optimizing movement to improve the human experience. It supports the mission of the APTA to build an inclusive community that advances the profession of physical therapy the improved the health of society. Finally, this supports the APTA Strategic Plan ("the profession will realize improvement in diversity and representation") as well as the forthcoming Diversity, Equity, and Inclusion Action Plan.

B. How is this motion's subject national in scope or importance?

This motion's subject is national in its scope and importance because this issue impacts individuals with disabilities all over the nation. The disability community has been critical of the role that physical therapy professionals play in conceptualizing and treating disability[1] and one of the main reasons why is due to a lack of representation from the disability community within the field of physical therapy.[2] According to latest data from the CDC, 20% of the United States population has a disability of some type.[3] The percentage of PTs/PTAs/SPTs/SPTAs with disabilities (reported to be as low as 5%)[4,5] is not reflective of the percentage of adults with disabilities in the US, nor is it consistent with the percentage of graduate students with disabilities in the US (approximately 11%).[6] We will be unable to move the needle forward on fully embracing disability in physical therapy until we have reasonable and equitable accommodations for all within the field. While the

profession is gaining speed in thinking and speaking critically on these issues,[7,8] it is time that we translate intention into action. The proposed motion provides an avenue for the American Physical Therapy Association (and the profession as a whole) to do so.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

The following house positions, standards, guidelines, policies, and/or procedures apply to this motion: HOD Y06-19-43-52: APTA opposes discrimination on the basis of race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status.

HOD P06-04-12-1: Outlines the role of APTA as an advocate for full inclusion of people with disabilities in all aspects of community life and within the profession of physical therapy.

HOD P09-21-21-09: Outlines core values that guide the behavior of PTs and PTAs to provide the highest quality of physical therapy services.

HOD P06-19-46-21: Describes the association's role and position regarding health and social issues.

BOD Y08-21-01-01: APTA is committed to increasing diversity, equity, and inclusion in the association, profession, and society.

HOD P06-20-27-23: Defines the term "underrepresented" in relation to physical therapy education.

Additional stakeholders who may be impacted by this motion include:

- NPTE candidates
- ABPTS specialty exam candidates
- Prospective SPTs/SPTAs
- PT/PTAs with disabilities
- The American Physical Therapy Association Academy of Education
- The American Council of Academic Physical Therapy
- The Academy of Leadership & Innovation Disability Justice & Anti-Ableism Catalyst Group
- The FSBPT
- The ABPTS

State/Federal Laws Include:

- The Americans with Disabilities Act[9–11]

D. Additional Background Information.

Currently, there are inconsistencies experienced by National Physical Therapy Examination (NPTE) candidates with disabilities who request testing accommodations. Approximately half of jurisdictions require testing candidates to apply directly to the Federations of State Boards of Physical Therapy (FSBPT) for testing accommodations, while the other half use an independent review process. Anecdotally, many students are reporting difficulties in navigating this process due to these state-by-state differences. Additionally, many students who have received reasonable accommodations through undergraduate and graduate school are denied the same testing accommodations for the NPTE. Some candidates even report having to sit for the licensure exam outside of their home state and then later apply for their home state licensure.

Technical standards required by PT/PTA programs for admission into PT school are frequently written in ways that exclude prospective students with disabilities. The process of applying for and receiving reasonable

accommodations is arduous, and students are often left to navigate this process without the full support of their program. Once in the clinic, students as well as clinicians with disabilities frequently face inequities and discrimination from clinical instructors and employers, with a majority reporting a negative impact on their job.[12] These instances are examples of the "disability tax," where individuals with disabilities have to take multiple additional steps beyond what non-disabled individuals do in order to have equitable access to resources.

On April 7, 2022, the APTA as part of the Disability Rehab Research Coalition (DRRC) Submitted comments to the National Institutes of Health (NIH) requesting NIH to consider designating people with disabilities as a "health disparity population" for purposes of federal research conducted at the National Institute on Minority Health and Health Disparities (NIMHD) and across the National Institutes of Health. The comments noted the lack of a health disparities population designation for people with disabilities fails to recognize the significant health disparities people with disabilities face on a daily basis. By revising this omission, research conducted through the NIMHD and NIH will better prioritize research into the causes of these disparities and how they interact and intersect with the disparities faced by other already recognized health disparity populations. Further, and perhaps most importantly, such action will help develop and inform critical policy solutions to reduce and eliminate health disparities and advance health equity for all populations.

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 6

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PROPOSED BY: WASHINGTON, HEALTH POLICY ADMINISTRATION

RC 16-22 ADOPT: AMERICAN PHYSICAL THERAPY ASSOCIATION'S COMMITMENT TO BEING INCLUSIVE OF LGBTQIA+ POPULATIONS

That the following be adopted:

AMERICAN PHYSICAL THERAPY ASSOCIATION'S COMMITMENT TO BEING INCLUSIVE OF INDIVIDUALS WITHIN LGBTQIA+ POPULATIONS

The American Physical Therapy Association is committed to being an organization inclusive of individuals within Lesbian, Gay, Bisexual, Transgender, Questioning or Queer, Intersex, and Asexual populations, plus people of other sexual orientations and gender identities. APTA and its members, collectively and individually, are obligated to promote inclusivity while also addressing policies and practices that perpetuate the exclusion of LGBTQIA+ people in our association, the profession, and society.

SS:
This motion promotes accountability from APTA and the profession in its diversity, equity, and inclusion (DEI) policies, including explicit demonstration of support for the LGBTQIA+ community and takes steps toward achieving APTA's Vision and Strategic Plan goals.

This motion resolves to create an inclusive environment and uplift LGBTQIA+ stakeholders, including APTA members, non-member Physical Therapists and Physical Therapist Assistants, physical therapist and physical therapist assistant students, patients/clients, and society. This motion will encourage support of internal and external policies that advocate for equitable and inclusive treatment of all while working against policies that impact the rights of any individual.

Background:
According to the **2021 Gallup poll**, 7.1% of Americans (and rising) identify as LGBTQIA+[1]. These numbers are representative of the profession's patient/client stakeholders. APTA membership data identifying members as LGBTQIA+ is currently unavailable, which limits opportunities for engagement and membership. With over 100,000 members, if APTA has a comparable composition, 7100 physical therapists and physical therapist assistants would identify as LGBTQIA+, including the many student APTA members. Taking the above numbers into consideration, APTA needs to engage in a self-assessment exercise to determine internal and external challenges concerning the LGBTQIA+ community as this can greatly impact many of its members.

According to the American Civil Liberties Union (ACLU), over 175 anti-LGBTQIA+ bills have been introduced across 39 state legislatures in 2022[2]. Specifically, there are currently 20 states considering legislation to limit health care to LGBTQIA+ individuals. If the proposed bills are passed in these states, the provision of medical

services may result in criminal punishment or loss of medical licenses from health care providers.[3] These discriminatory legislative efforts provide a widespread opportunity for APTA to expand on previous advocacy efforts and explicitly express support for the LGBTQIA+ community.

Many patients/clients seeking physical therapy services are pursuing or utilizing hormone therapies and may also be considering or rehabilitating from surgical intervention for gender-affirming care. Current and emerging legislation across multiple states restricts access to or criminalizes these services. Thus, it is imperative that APTA explicitly express and advocate for support for our LGBTQIA+ patients/clients and colleagues. A 2021 survey from The Trevor Project revealed the unique challenges faced by LGBTQIA+ youth: higher rates of suicidal ideation (42%) and attempt (20%), depression (62%), anxiety (72%), food insecurity (30%), and discrimination based on their identity (75%)[4]. The survey also showed that transgender youth, affirmed in their identity and given access to spaces that affirm their sexual orientation or gender identity, have their pronouns respected, and are allowed to change legal documents experience a dramatic (up to 50%) reduction in rates of attempted suicide. Harmful and restrictive legislation has an enormous impact on the community, while anti-discriminatory and protective legislation will save lives.

Research investigating physical therapy services for LGBTQIA+ patients/clients and experiences of LGBTQIA+ physical therapists is limited. In 2022, Ross et al published "An Exploration of the Experiences of Physical Therapists Who Identify as LGBTQIAIA+: Navigating Sexual Orientation and Gender Identity in Clinical, Academic, and Professional Roles," a qualitative study that identified the need for inclusivity across the profession[5]. A broader search demonstrates the need for increased clinician education to provide appropriate care for LGBTQIA+ patients/clients. In 2021, Bass et al wrote "Cultural Competence in the Care of LGBTQIA Patients," which outlined specific considerations for this population including understanding proper terminology and use of appropriate pronouns, considerations for psychologically-informed care, and understanding of available hormonal and surgical interventions[6].

APTA has historically demonstrated support of the LGBTQIA+ population through various publications. In 2016, APTA Magazine published "Managing Patients who are Transgender", which acknowledged the unique health care needs of LGBTQIA+ patients/clients. The article provided evidence that LGBTQIA+ people are accessing physical therapy services more frequently than in previous years, but that physical therapy education does not include specific curricular standards to prepare students to demonstrate adequate cultural competency[7]. In 2019, Ross et al published several suggestions that would reduce discrimination and improve physical therapy experiences for the LGBTQIA+ population, including provider awareness and education-related reforms that this motion can facilitate[8].

The efforts stated above are steps in the right direction, but are insufficient. As the nation's physical therapy association, there is a responsibility to advocate for the interests of all its stakeholders. APTA must now rise to the occasion of diminishing the discrepancy between APTA's expression of intended support and actionable demonstrations of advocacy for the LGBTQIA+ community. For example, in the current 117th session of the United States Congress, H.R.5, "The Equality Act" was passed by the United States House of Representatives[9]. An identical version, S.393 has been introduced in the United States Senate[9]. This bill will protect health care services for all people by prohibiting discrimination based on sex, sexual orientation, and gender identity. An opportunity exists to diminish the discrepancy between APTA's expression of intended support and actionable advocacy for the LGBTQIA+ community. Over 140 national organizations, including APTA, are listed in **this letter** of support for the Equality Act, shared by the American Academy of Family Physicians[10]. Additionally, multiple national organizations have published statements in opposition to anti-transgender legislation, including the **American Medical Association**[11], **American Psychological Association**[12], and **American Association for Pediatrics**[13]. Meanwhile, APTA's website and social media show no indication that APTA supports these efforts.

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

The expected outcome of this motion is for APTA to commit to inclusiveness of the LGBTQIA+ community by addressing policies and practices within and beyond our Association that impacts our members, association staff, patients/clients, and LGBTQIA+ community. Recognizing and taking actionable steps to improve diversity and equity and facilitate inclusion of all members contributes to achieving APTA's Vision and Strategic Plan Goals.

To achieve the expected outcome, APTA will consider taking the following action steps to improve the inclusiveness of the Association:

1. APTA Membership: Updating APTA member profile webpage to be gender inclusive beyond female/male options. This action is an opportunity to reduce gender binary structures.
2. APTA Membership: APTA representation and participation in local, state, and national LGBTQIA+ sponsored events.
3. APTA Membership: Consider safety, logistics, and access for individuals of all gender identities and sexual orientations when selecting conference locations.
4. APTA Membership: Updating registration forms and identification badges for conferences and events to allow participants and speakers to list personal pronouns. Consideration of inclusion from under-represented groups in the selection of speakers.
5. APTA Membership: Updating APTA.com Web pages "Diversity, Equity, Inclusion Resources for Educators" and "Diversity, Equity, and Inclusion" to include resources specific to the LGBTQIA+ population14-15.
6. APTA Stakeholders: Improve communication processes between APTA Board, Chapters, and Academy/Section Leadership with groups within and outside APTA to facilitate collaboration for inclusion. APTA will utilize consultation and expertise from existing groups such as PT Proud and the DEI Committee to improve outcomes for unrepresented groups within the Association.
7. APTA in Society: Sponsor LGBTQIA+ advocacy efforts by empowering and collaborating with stakeholders to publish statements that support health care legislation for the LGBTQIA+ community and denounce discriminatory laws that create barriers to care. Members can be encouraged to participate in activities that promote social justice for all and contribute to APTA's Vision to transform society.
8. APTA in Society: Educate clinicians in academia, research, and clinical practice on best practices for care for LGBTQIA+ patients/clients so they may serve as role models and educate students and colleagues regarding APTA's Vision to transform society.
9. Resources: Develop and distribute an evidence-based Clinical Practice Guideline for best practice in working with patients/clients pursuing gender-affirming medical care.
10. Resources: Develop and distribute resources to educate physical therapists and physical therapist assistants in clinical practice about optimal care for all patients/clients regardless of sexual orientation or gender identity. This may include recommendations for practice sites to adopt non-discriminatory statements that protect transgender rights, updating intake paperwork containing inclusive gender identity and sexual orientation options, guidelines for physical therapy services for LGBTQIA+ patients/clients undergoing gender-affirming care, clinician education regarding proper language and terminology, and tools for facilities to promote an inclusive and welcoming environment.
11. Research: Develop APTA-supported initiatives to increase publications, including research on physical therapy treatment for the LGBTQIA+ population and examine clinical practice challenges for our LGBTQIA+ colleagues.
12. Physical Therapy Education: Update PTCAS data collection information to be more reflective of LGBTQIA+ applicants and student admissions. This would improve PTCAS reporting structure to examine inequities for LGBTQIA+ students.
13. Physical Therapy Education: Support research efforts to develop curricular content standards related to the sexual and gender diverse population in physical therapy education programs.
14. Physical Therapy Education: Development of financial resources to support scholarships and facilitate career opportunities for members of the LGBTQIA+ community.

Engaging in the above action steps will, therefore, require the APTA as an organization to recognize, publicly acknowledge and oppose legislation that is discriminatory towards the LGBTQIA+ community, demonstrate specific action steps in support of the LGBTQIA+ community and educate and train staff and members on their stance in this respect. Supporting the LGBTQIA+ community in this manner sends a strong message to its membership on APTA's and the profession's stance of inclusivity of the LGBTQIA+ community. It will allow APTA to advocate for and act on behalf of LGBTQIA+ patients/clients and colleagues by following APTA policies and documents, including the Strategic Plan, Vision, Code of Ethics, and Core Values.

APTA Strategic Plan highlights four essential target areas to meet the needs of the profession: Member Value, Sustainable Profession, Quality of Care, and Demand/Access16. One target goal in the Plan is to "increase member value by ensuring that APTA's community delivers unmatched opportunities to belong, engage, and contribute." Inclusivity of all, including LGBTQIA+ people, is key to achieving this goal and align with the four targets of the Strategic Plan.

B. How is this motion's subject national in scope or importance?

Over 7% of the US Population belongs to the LGBTQIA+ community, but it is unknown if that percentage is paralleled in APTA (a national organization), physical therapy practice and education, and in patients/clients seeking physical therapy services. Even though the demographic data of APTA's LGBTQIA+ community is unknown, what is apparent is the large extent to which the national LGBTQIA+ community has and continues to suffer discrimination.

Discriminatory rhetoric is also accelerating nationwide at state government levels at a rate that was not anticipated. Thus far in 2022, over twenty states have introduced and/or passed anti-LGBTQIA+ legislation restricting health care and criminalizing medical providers who provide care to LGBTQIA+ individuals, especially to transgender youth. For comprehensive list of anti-LGBTQIA+ legislature, both https://www.aclu.org/legislation-affecting-LGBTQIA-rights-across-country and https://freedomforallamericans.org/legislative-tracker/medical-care-bans/ are regularly updated sources that link to the specific language of each law and how individual states are working to impact health care for LGBTQIA+ people[2-3].

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

There are minimal resources available through the APTA that specifically relate to the LGBTQIA+ population and their identified needs. In fact, APTA's efforts thus far have only globally supported DEI as recognized in the following motions:

1. HOD P09-21-21-09 APTA Core Values for the Physical Therapist and Physical Therapist Assistant.
2. HOD S06-20-28-25 APTA Code of Ethics for the Physical Therapist, Principle 1A, 1B, 8B.
3. HOD P06-19-43-16: APTA's Commitment to Diversity, Equity, and Inclusion: APTA supports efforts to increase diversity, equity, and inclusion to better serve the Association, the profession, and society.
4. HOD P09-21-24-11: APTA Commitment to being an Anti-Racist organization. The American Physical Therapy Association is committed to being an anti-racist organization. APTA and its members, collectively and individually, have an obligation to address policies and practices that perpetuate systemic racism and inequity in our Association, the profession, and society. For additional background information, RC 9-21 in 2021 Packet I.
5. HOD P06-20-43-38 World Confederation for Physical Therapy Congress Location Selection. APTA Board of Directors proposed RC 5-21 rescind, but the motion was defeated.
6. HOD P06-98-14-05: Affirmative Action: APTA is committed to serving the needs of all people who require physical therapy and to meeting the needs of all its members.

7. HOD Y06-19-43-52: Nondiscrimination. APTA opposes discrimination based on race, creed, color, sex, gender, gender identity, gender expression, age, national or ethnic origin, sexual orientation, disability, or health status.
8. BOD Y08-21-01-01: APTA Commitment to Increasing Diversity, Equity, and Inclusion. APTA is committed to increasing diversity, equity, and inclusion in the Association, profession, and society.
9. RC 32-20, RC 33-20, and RC 34-20 collection of three related motions regarding World Confederation for Physical Therapy Congress's selection of Dubai for Conference location. Archived in House of Delegates 2020 Packet 1
10. RC 4-21 Process for prioritization of diversity, equity, inclusivity, and vulnerable health populations in site selection of National events.

Stakeholders: The stakeholders for this current motion include all APTA members, all LGBTQIA+ patients/clients, families, physical therapists, and individuals in society. Specific APTA groups internally that may be interested as stakeholders are the Diversity, Equity, and Inclusion Committee; the Academy of Pelvic Health Physical Therapy; the Academy of Leadership and Innovation, and its PT Proud community.

D. Additional Background Information.

APTA Website does include "Cultural Competence Resources: Gender Identity and Expression," but the resources are limited, outdated, and non-specific to physical therapy services[17]. APTA Website also has "Seven Resources to Inform Your Practice with LGBTQIA+ Patients and Clients" from 2020 that directly links to this Delaware Public Health Issue focusing on LGBTQIA+ Health Equity[18-19]. The Delaware Public Health Issue includes multiple papers that demonstrate the need for growth in health care for LGBTQIA+ people. One paper concludes "Gender expansive youth are at significantly heightened risk of suicide compared to their cisgender peers. Non-binary youth are the most vulnerable of all subgroups." "Current suicide rates of young people reflect a large public health problem. Sadly, suicide rates for gender-expansive individuals are several times higher. Between 2015 and 2016, 7.2% of the general population of high school students in Delaware reported attempting suicide. In contrast, over one-third (35%) of gender-expansive high school students reported attempting suicide in 2018. In Delaware, 1,100 youth are estimated to be gender-expansive. Approximately 2% of high school students surveyed throughout the US reported being transgender. Even though the gender-expansive community is a small minority, they are disproportionately affected by suicide that specific consideration is warranted."

Another paper in the Delaware Issue authored by Physical Therapist Karla Bell entitled "Part of the Solution to Address Sexual and Gender Minority Health and Health Care Disparities: Inclusive Professional Education" concludes[19]**.** "Based on pedagogical principles in education and literature suggesting positive associations between the impact on health disparities and health professional education, it is concluded that health professional education - regardless of discipline - should be inclusive of sexual and gender minority content to address this significant gap in knowledge, awareness, and skill in health delivery for these populations."
On March 31, 2022, the Department of Health and Human Services (HHS) released statements to firmly stand in support of transgender individuals in recognition of International Transgender Day of Visibility[20]. The statements convey the HHS commitment to protect and advance the rights of the LGBTQIAI+ population and directly condemn discrimination against transgender and LGBTQIAI+ individuals. APTA must take a similar stance to protect the interests of its members and the communities they serve.

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 8

Motion Contact: Wendy Colley, PT, DPT, Delegate, APTA Kentucky
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PROPOSED BY: KENTUCKY

RC 17-22 CHARGE: FEASIBILITY OF EXPANDING PRESCRIPTIVE AUTHORITY WITHIN PHYSICAL THERAPIST SCOPE OF PRACTICE.

That the American Physical Therapy Association evaluate the feasibility of expanding prescriptive authority within physical therapist scope of practice.

SS: The Evolution of the Doctor of Physical Therapy (DPT) as entry level for the profession established the profession as a doctoring profession however a missing component is expanded prescriptive authority. Expanded prescriptive authority would allow physical therapists to prescribe specific medications, including controlled substances. Expanded prescriptive authority would also allow physical therapists to prescribe devices, health care services, durable medical equipment and other equipment and supplies essential to providing timely, cost-effective, quality health care (14). Physical therapists with expanded prescriptive authority will help meet the needs of primary care, improve ratios of care, and improve the health of society. Installing the needed movement expert as a foundation in primary care with expanded prescriptive authority will improve patient outcomes through the evaluation of movement and the effects of medication on movement which at times is the missing component in best practice patient care with prescribing and deprescribing medications and prescribing regarding other health care needs.

Due to shortages of primary care physicians in many locations, patients have long wait times to be seen by a physician. This may delay essential care. In Kentucky, the projected shortages from 2010 census for primary care physicians indicate a 24% increase is needed by 2030 to maintain the current ratio of care (6). This ratio is currently insufficient at 1721:1 physician to patient ratio in Kentucky, national average physician to patient ratio is 1463:1(6).

Although physical therapist practice has not moved forward with achieving expanded prescriptive authority yet, primary care advancements do include the advancements of the professions of physician assistant and nurse practitioner (NP).

Physician assistant (PA) “There are over 114,201 physician assistants currently employed in the United States. 66.4% of all physician assistants are women, while 33.6% are men. The average age of an employed physician assistant is 38 years old. The most common ethnicity of physician assistants is white (70.7%), followed by Asian (10.8%) and Hispanic or Latino (9.8%). Physician assistants are paid an average annual salary of $130,021”(11).

Nurse Practitioners (NP): “There are more than 325,000 nurse practitioners (NPs) licensed in the US. More than 36,000 new NPs completed their academic programs in 2019–2020. 88.9% of NPs are certified in an area of primary care, and 70.2% of all NPs deliver primary care. 81.0% of fulltime NPs are seeing Medicare patients and 78.7% are seeing Medicaid patients. 42.5% of full-time NPs hold hospital privileges, 12.8% have

long-term care privileges. 96.2% of NPs prescribe medications, and those in full-time practice write an average of 21 prescriptions per day. NPs hold prescriptive privileges, including controlled substances, in all 50 states and DC. In 2020. The median base salary for full-time NPs was reported as $110,000" (3).

With the advancements of the PA and NP why is there still a need to advance the physical therapist profession by expanding prescriptive authority? Because movement experts are needed with expanded prescriptive authority. physical therapists trained and credentialed with expanded prescriptive authority could also play a greater role in consultative support for deprescribing medications as well as to provide lifespan (non-episodic) following of patients regarding medications and other health care needs to help improve health care and the health of society.

2018 and 2019, the Committee on Ways and Means began investigating the overuse of antipsychotics in nursing homes across the country (8). Information from this report indicated that; "In the fourth quarter of 2019, approximately 20 percent of all skilled nursing facility (SNF) residents in the United States (US) about 298,650 people every week received some form of antipsychotic medication. Most patients received these medications without any psychosis diagnosis for which the drugs are indicated. Nursing homes continue to give these powerful drugs to residents despite the Food and Drug Administration's (FDA) issuing a black box warning specifically stating that the use of off-label antipsychotics among seniors with dementia can result in injuries, hospitalizations, and even death". This report indicated;" patients over 70 years old are 3.5 times more likely than younger patients to be admitted to the hospital due to adverse drug reactions associated with psychotropic medications" (8). The Ways and Means investigation cited a recent study that found a 50 percent increased risk of a serious fall-related bone fracture with the use of antipsychotic medications (8).

It is frequently the movement expert, the physical therapist or physical therapist assistant who recognizes a change in the mobility skills of the patient which is caused by the overuse of antipsychotic medication. Having movement experts trained and credentialed with expanded prescriptive authority available for consultative support for deprescribing and following patients regarding these medications will improve outcomes, prevent decline and at times prevent death. Problems in nursing homes are not limited to antipsychotic overuse. Nursing home issues also include problems associated with the Opioid epidemic (10). Polypharmacy in general is a clinical challenge because the health care system is geared toward starting medications, not reducing, or stopping medications (4,7). physical therapists and physical therapist assistants care deeply about helping patients meet mobility goals. physical therapists with expanded prescriptive authority for the profession would help patients meet these goals. Polypharmacy can be a significant barrier to patients meeting mobility goals and a barrier to optimum recovery. Frequently patients are prescribed medications that have significant side effects, adverse drug interactions and at times do more harm than good. With many older adults, medications may accumulate over time and the original prescribing practitioner may no longer be involved in the patient's care. A medication may have worked well for the patient initially, however, as the patient moves from one care environment to another, medications may become problematic and need reevaluation for the potential for deprescribing. The observations of the physical therapist assessing for decline in mobility can be a vital component in optimizing care regarding medications.

The devastating loss of life associated with Covid-19 in nursing homes indicates that change is needed to improve nursing home care. physical therapists with expanded prescriptive authority could play a larger role in emergency preparedness. Prescribing credentialed therapists as primary care providers would improve outcomes not only for emergency preparedness and oversight but for many health care and medication concerns and not just in nursing homes but in all environments where physical therapy is currently provided.

Due to shortages of primary care providers, high productivity standards for primary care providers, poor patient to provider ratios and the lack of movement experts with expanded prescriptive authority in primary care, many patients in a variety of health care environments frequently do not receive proper follow-up and consultations in a timely manner. The evolution of the profession with solid physical therapist and physical therapist assistant education, a broad research infrastructure and a strong national association (APTA) as well as multi-

generational collective knowledge of clinical experience has provided the optimum platform for patient care. With expanded prescriptive authority, training and credentialling, physical therapists will improve the health of society and help support other primary care providers by becoming a cornerstone in primary care as the needed movement expert regarding medication prescribing and other health care prescribing needs. Now is the time to honor our APTA vision and mission and explore the feasibility of expanding prescriptive authority for physical therapist scope of practice.

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

The expected outcome is that the American Physical Therapy Association (APTA) will make a focused effort to evaluate the feasibility of expanding prescriptive authority as a pathway to advance physical therapist practice to improve the health of society The expected outcome of this motion is for the APTA to provide an executive summary highlighting the scope of work along with the benefits and challenges associated with expanding prescriptive authority for the physical therapist's scope of practice. In addition to the executive summary, bringing this motion forward to the House of Delegates will initiate an important discussion regarding the expansion of physical therapist practice to improve population health.

B. How is this motion's subject national in scope or importance?

Expanding prescriptive authority is of national importance because it will require a plan for developing national guidelines to coordinate this shift in practice as uniformly as possible.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

John Heick: presented a similar motion, RC 16-15 Management of the Movement System which did not pass. RC 16-15 addressed prescribing as physical therapists prescribe in the military.

This Kentucky motion intends to examine the feasibility of expanding prescriptive authority similar to that of the nurse practitioner or physician assistant which is different from that of the physical therapists in the military.

There is an existing position statement, DIAGNOSIS BY PHYSICAL THERAPISTS HOD P06-12-10-09 which is a position statement that includes prescriptive authority description for imaging and other studies as follows; "When indicated, physical therapists order appropriate tests, including but not limited to imaging and other studies, that are performed and interpreted by other health professionals. Physical therapists may also perform or interpret selected imaging or other studies" (13).

Stakeholders include but are not limited to: physical therapists and physical therapist assistants, researchers, American Council of Academic Physical Therapy (ACAPT), Commission on Accreditation in Physical Therapy Education (CAPTE), APTA Ethics and Judicial Committee (EJC), physicians, physician assistants (PAs), nurse practitioners (NPs), payors, educators, legislators)

Further legal research and counsel is needed regarding state and federal laws and regulations.

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 8

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PROPOSED BY: WASHINGTON, MICHIGAN, SOUTH CAROLINA

RC 18-22 CHARGE: EXPLORE OPPORTUNITIES TO ENHANCE ENGAGEMENT, COLLABORATION, AND KNOWLEDGE-SHARING IN PHYSICAL THERAPIST PRACTICE

That the American Physical Therapy Association explore opportunities outside the currently established framework of sections/academies to enhance engagement, collaboration, and knowledge-sharing in physical therapist practice.

SS: While Physical Therapists and Physical Therapist Assistants practice in various settings and care for diverse patient populations, there are practice topics, patient themes, and clinical interests that encompass most, if not all, of patient care. The current Academy/Section Special Interest Group (SIG) structure assumes that there are subspecialties within our current classification of practice areas. However, some topics transcend practice areas and are relevant across the profession such as balance and falls, pain, imaging, and health promotion and wellness. The current structure of APTA could be improved so that members can find community, engagement, knowledge-sharing, and collaborative opportunities related to cross-profession topics through member networks that are not isolated within the current framework of SIGs and Engagement Groups.

Currently, APTA has 18 Academies/Sections. Within this structure, SIGs connect members with similar interests or career paths. Even when a topic is applicable to most, if not all, members of the Association, there are distinct benefits for only those members that belong to a specific Academy/Section. There are Academies/Sections that have duplicated SIG topics for that reason. For example, APTA Geriatrics, the Academy of Neurologic Physical Therapy, and APTA Oncology all have Balance and Falls SIGs. Another example is the Health Promotion and Wellness SIG of APTA Geriatrics, the Health Promotion and Wellness Practice Committee of the Neurology Academy, and the APTA Health Promotion and Wellness Council. Multiple groups with a single topic results in duplication of services, fractionation of members, and the potential of differing practice patterns. There are also some SIGs that are solely housed within one Academy/Section, but the topic could be considered appropriate and beneficial to any member, such as the Imaging SIG and the Pain SIG, which are only in the Academy of Orthopaedic Physical Therapy (AOPT).

APTA has over 100,000 members. Approximately 70% of those members belong to an Academy/Section. The largest Academy/Section is the AOPT with 17,000 members, whereas the smallest has less than 1000 members. At best, only 17% of the membership has access to beneficial communities within SIGs that are focused on these cross-profession topics. There is a potential for larger Academies/Sections to have more Special Interest Groups because there are more members to take on this work, and consequently, smaller Academies/Sections may not attract members that are specifically interested in a SIG topic. The current model restricts collaboration between members and potentially prevents advancement of the profession. A solution

to this identified problem could significantly benefit members, our profession's practice, and most importantly, the individuals and communities we serve.

The proposed motion will contribute to the mission by building a collective community that advances the profession of physical therapy. The motion will also contribute to the strategic plan by delivering opportunities to belong, engage, and contribute for at least 80% of members that are outside the current framework of a SIG or Engagement Group.

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

The expected outcome of this motion is a report to the House of Delegates followed by Bylaws, Standing Rules, or policy changes (if needed) that will allow for general member engagement in cross-professional practice topics.

The proposed motion will contribute to the mission by building a collective community that advances the profession of physical therapy. The motion will also contribute to the strategic plan by delivering opportunities for at least 80% of members that are outside the current framework of a SIG or Engagement Group. The framework may also encourage more members because there is not a potential barrier to joining these networks.

Quality of Care would be improved by increased knowledge-sharing and collaborative opportunities, better dissemination of evidence-based resources, and increased availability of experts. Increasing the depth and breadth of member access may lead to improved standardization of care.

B. How is this motion's subject national in scope or importance?

APTA is the national organization. Many of APTA's members do not have access to SIGs but may have interests in cross-profession topics. Therefore, this motion is national in its scope.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

The current structure of SIGs within Academies/Sections is defined in the Bylaws, Standing Rules, and policies. There have been the formation of councils and engagement groups, but it is unclear how these structures meet the needs as outlined in the current motion.

People affected by this motion include all APTA members, Sections/Academies, and people who may be considering joining the APTA.

There are no state or federal laws or regulations which address this topic.

Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 8

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PROPOSED BY: ARIZONA

RC 19-22 CHARGE: EVALUATION OF CONTINUING COMPETENCE REQUIREMENTS

That the American Physical Therapy Association, in collaboration with relevant stakeholders, evaluate continuing competence requirements as the preferred method for maintenance of licensure and develop recommendations for a uniform evaluation process of educational and professional activities that could be implemented by components and jurisdictions.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

The expected outcome of the present motion is the formation of a task force that will generate a report on standards for continuing competence and continuing education (CE) course review for physical therapists. These standards should establish a universal method for reviewing CE courses that could be followed by state associations and jurisdictions that administer such approvals. This motion would support the American Physical Therapy Association's (APTA) Strategic Plan by aiming to improve the overall quality of care delivered by physical therapists and ensuring the public's confidence in physical therapy remains high.

B. How is this motion's subject national in scope or importance?

The APTA has **defined continuing competence** as, "The ongoing possession and application of contemporary knowledge, skills, and abilities commensurate with an individual's (physical therapist or physical therapist assistant) role within the context of public health, welfare, and safety and defined by a scope of practice and practice setting." Continuing competence requirements are regulated by state boards of physical therapy. In order to ensure physical therapists remain competent and the public is protected, most (but not all) state boards have adopted continuing competence requirements as part of their licensing process. The intent of these requirements is that physical therapists shall update their knowledge of the evidence. These courses are usually reviewed for approval by state components of the APTA.

However, data suggests that physical therapists have not improved their adherence to clinical practice guidelines over the past several decades.[1] Recent research estimates that clinicians adhere to evidence about half the time in their treatments.[2] Finally, a recent review of orthopedic and sports CE courses showed that less than half of courses approved by state chapters of the APTA were supported by high-level evidence—and some courses blatantly contradicted current evidence.[3] In the later scenario, there exists the potential to harm through perpetuating ineffective interventions in clinical practice.

Concern about the CE review process is an issue that has been raised by others in the past. In his McMillan Lecture, Stanley Paris warned that states might be tempted toward leniency when reviewing physical therapy CE courses, since it represented non-dues income.[4] In her 2017 Maley Lecture, Tara Jo

Manal also expressed concern about unwarranted variability in practice and the physical therapy profession's lack of a consistent plan for postprofessional education.[5] Just this year, authors have put forth an argument that our current approach to continuing competence in physical therapy is one potential source of the unwarranted variability in practice[6] –something Manal called "the greatest threat to the value of physical therapy."[5]

At the current time, the physical therapy profession leans on continuing competence requirements to ensure the health, welfare and safety of the public. However, the current approach to continuing competence through CE is widely variable and inconsistent. For example:

1. Continuing competence requirements are not universal. Some states (Maine and Massachusetts) do not have continuing competence requirements.
2. States that review CE courses have vastly different requirements for course approval. For example, some states do not appear to have a requirement that a course be evidence-based (ie, West Virginia), while some have a highly operationalized definition (ie, Nevada).
3. Some states only grant CE units to authorized providers, while many states place little scrutiny on the provider.
4. Many state boards recognize approvals by outside state associations even though vastly different policies are in place for course approval in those states. As a result, a course could be rejected by "State A," but still provide credit for licensees in "State A" because it was approved by "State B."
5. There is no standard, operationalized method of CE course review among states.
6. There is no method of providing consumer-facing information about a CE course. For example, a badge system that could show whether a course is highly supported by guidelines or only supported by clinical experience.
7. There are no standard qualifications for CE course reviewers.
8. Most courses have limited, if any, methods to ensure actual learning has occurred.
9. Larger questions exist, such as whether state associations are the best-equipped to review courses or whether an alternative approach to continuing competence would be more suitable to the physical therapy profession.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

The APTA has **recognized** its responsibility to "develop or encourage the development of policies that address the current and future needs of…the profession…in relation to career and professional development." It has also codified its values and definitions of concepts related to professional development in the following statement, from 2007: (**PROFESSIONAL DEVELOPMENT, LIFELONG LEARNING, AND CONTINUING COMPETENCE IN PHYSICAL THERAPY (HOD P05-07-14-14**). A joint paper was later published by the Federation of State Boards of Physical Therapy (FSBPT) and the APTA entitled "Continuing Competence in Physical Therapy: An Ongoing Discussion."[7] The 2009 paper was intended to review the continuing competence in physical therapy and create dialogue about its many questions, but intentionally provided no recommendations.[7] It is unclear what feedback was received, but the paper now appears to be over 10 years old.

Relevant stakeholders impacted by this motion would include accrediting agencies, employers, licensees, professional associations, the public, and regulators/licensing boards.

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 8

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PROPOSED BY: COLORADO

RC 20-22: CHARGE: DEVELOP A PLAN TO PROMOTE EQUITY IN PAY ACROSS GENDERS IN THE PHYSICAL THERAPY PROFESSION

That the American Physical Therapy Association develop a plan to promote equity in pay across genders among physical therapists and among physical therapist assistants, no later than June 2024.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?

The goals of this motion are to compose research to gain a better understanding of the factors that led to the pay disparity on the basis of sex and identify actionable ways to make pay equal across gender. In the early days of the profession, “reconstruction aides" helped to rehabilitate US soldiers in the First World War. This led to the advancement of the profession and the development of the Physiotherapy Department at Walter Reed General Hospital. From there, 16 of the 18 original aides formed the American Women's Physical Therapeutic Association that eventually became the APTA.[1] In a profession that was pioneered by women and consists predominantly of women, a pay gap should not still exist. Additionally, as we have students facing higher debt burdens, equal pay is crucial. The mission of the APTA is, “Building a community that advances the profession of physical therapy to improve the health of society.” By addressing factors related to pay inequity, this will advance the profession’s sustainability and growth. This sustainability falls under the strategic plan in the realms of “Member Value,” and “Sustainable Profession.”[12]

B. How is this motion’s subject national in scope or importance?

Equal pay is consistently in the spotlight because across all occupations, industries, and forms of employment; this is not a problem which is unique to PT, rather it is a widespread problem in which female-dominated professions such as PT continue to feed into the inequity. According to the Bureau of Labor Statistics, women earn approximately 82 cents per every one dollar men earned in 2020.[2] This is only nine cents higher than the reported wage difference in 2000 and 22 cents higher than the difference in 1980.[3] According to research performed by The Institute for Women’s Policy Research, women will not receive equal pay until the year 2059.[3] When considering how our nation has evolved in the past forty years and the possibilities of where we will be in the future, it is astounding to think that the gender pay gap still persists today. These statistics show that the gender pay gap is rooted in deep societal norms, as the traditional role of a woman’s place in the workforce is still viewed secondary to her obligations to her family and home. In the past forty years, as these traditional views are becoming less widespread and more women find themselves focusing on a career, society must accept this shift by honoring a woman’s work with equal compensation.

When it comes specifically to health care and physical therapy, an APTA Practice Profile Survey completed in 2016 reported that over the past two decades, women have earned on average $10,000 less than their male counterparts.[4] Physical therapy continues to be a female dominated profession as the U.S. Bureau of Labor Statistics in 2019 reported that 67.9% of the nation's estimated 304,000 physical therapists were women.[5] With the combination of the 2016 APTA report and 2019 USBL statistics, there is a clear need for an update on salary breakdown and its inequity towards women. In 2019, Business News Daily reported that for every 100 men that get promoted to a manager position, only 79 women are also promoted.[6]

More recently, Chevan et al in an article printed in PTJ in March of 2022, find that the wage gap continues, concluding that females earning ~10% less than their age-matched male counterparts.[13] An APTA article, examining work from the Washington post highlighted this discrepancy by stating that female PTs “work for free,” after December 2nd of each year. While the article states that this problem is less in the PT profession than others, we can and should do better.[14]

In addition to pay discrepancy, women also face less opportunities for promotions and less time in the clinic compared to their male counterparts due to childbearing and familial responsibilities. Less time in the clinic decreases opportunities for pay raises and leadership advancements solely due to the fact that women have the ability to carry children. One could argue that due to less time in the clinic, women therefore have not earned equal pay for less work. But, according to a 2021 YouGov survey of 21,000 US adults, 68% of Americans believe companies should offer both mothers and fathers paid parental leave.[7] Additionally, according to a Department of Labor Policy Brief, 9/10 fathers took at least some time off work for the birth or adoption of a child.[8] Therefore, with gaining popularity of parental leave, for both mothers and fathers alike, the idea of pay equity is only further solidified and needed.

When it comes to diversity within the workplace, varying ethnic and cultural backgrounds are often at the forefront of those conversations, but gender diversity in the workplace is just as important according to a 2018 McKinsey & Company study.[9] They found that gender and ethnic diversity are positively correlated with profitability, yet women and minorities are still underrepresented. Additionally, gender diversity on executive teams, where women are on the front lines of decision making, was strongly correlated with profitability and value creation. Therefore, by promoting women in the physical therapy workforce, not only will a more diverse workforce be created, but also increased cognition, creation, and overall improved innovation with well-rounded colleagues.

The APTA has clearly identified the pay gap across factors such as gender, ethnicity and degree status based on the 2016 Practice Profile Survey. Since then, the COVID-19 pandemic has swept across the United States and the world, leaving millions without jobs and parents to care for their kids at home whilst continuing to work and care for their families. According to a 2020 Qualtrics study that looked at career progression and the inequitable effects of the pandemic, the study found that women with children are two to three times less likely than men with children to be promoted, get a pay raise, gain leadership, take responsibility for important projects, receive praise or recognition from the company, and receive positive formal reviews.[10] Additionally, men were twice as likely to say that working from home has positively affected their career and productivity.[10] These staggering effects of the pandemic show that there are many factors which have changed since the 2016 APTA Practice Profile Survey was published. Additionally, a PayScale 2021 DEI Report revealed that “when unemployed women do return to the workforce, they could face a disproportionate wage penalty from being unemployed compared to men, suggesting that the gender pay gap could widen again in subsequent years.” [11] It is clear that since the onset of the pandemic, women have been unsupported for their work and will continue to be when they return to the workplace once the pandemic subsides. Due to the nature of the argument for equal pay and the effects the pandemic has had, it is imperative that we address the gender pay discrepancy immediately. Therefore, we are calling on the APTA to evaluate and review the existing data on salary transparency and then take proper action based on those discrepancies.

By taking on this charge, the APTA has an opportunity to be at the forefront of the fight for equal pay in healthcare. In many cases, people and companies say they support equal pay but have yet to actually act on their statements. The paradox comes into play "when men enter female-dominated sectors like nursing or education, the job begins **paying more**… when women enter male-dominated spaces, they don't get paid more than men" according to C. Nicole Mason of the Institute for Women's Policy Research.[12] If the APTA were to evaluate, report, and develop a plan to address the gender pay gap within the physical therapy profession, support and respect for the field would only continue to bolster physical therapy.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

Activities of the House and Board include policies. See **APTA Policies and Bylaws** page on the APTA website. See the **House Hub Archive** for previous House actions. Inquiries about APTA initiatives underway related to this motion concept should be directed to **governancehouse@apta.org**. Please note that responses will focus solely on information not readily available via a search of the APTA website including the APTA policies page, and the House of Delegates Hub archive.

D. Additional Background Information.

American Physical Therapy Workforce Analysis
APTA Median Income of Physical Therapist Summary
Remembering the Reconstruction Aides
5 Facts About the State of the Gender Pay Gap

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Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: 8

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PROPOSED BY: VIRGINIA

RC 21-22 CHARGE: ASSOCIATION HEALTH CARE PLAN

That the American Physical Therapy Association pursue member access to an association health care plan.

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?
The expected outcome of this motion is that the Board of Directors pursues the development of an Association Healthcare Plan (AHP) to better serve the needs of its members. This motion helps contribute to the APTA Vision by directly improving the access to quality healthcare, reducing much of the financial burdens of quality coverage, and increasing member retention through higher perceived value of membership. This motion supports the current strategic plan and address multiple priorities that the Board of Directors has identified in their plan.

B. How is this motion's subject national in scope or importance?
This motion will have national scope in that it will allow for healthcare coverage for all members within the United States. Providing affordable, high-quality healthcare is paramount to improving member value within the association and will undoubtedly increase recruitment and retention efforts.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?
To the best of my knowledge there have been no efforts to address this topic by the House, Board, or staff. The internal stakeholders affected by this motion include all members of the association that are in good standing and reside within the United States. Externally, the stakeholders would include the company that provides the health insurance benefits.

There are several laws and regulations surrounding Association Healthcare Plans (AHPs). These include (at the federal level): The Employment Retirement Income Security Act of 1974 (ERISA), The Health Insurance Portability and Accountability Act of 1996 (HIPAA), The Public Health Service Act (PHS), The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), The Affordable Care Act (ACA), The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), The Civil Rights Act, The Women's Health and Cancer Rights Act, and The Genetics Information Nondiscrimination Act. There is also some regulation at the state level with laws governing Multiple Employer Welfare Arrangements (MEWAs).

D. Additional Background Information.

In 2010, President Obama signed into law the Affordable Care Act (ACA). This was intended to help improve the quality of healthcare coverage, reduce costs, and make it easier for people to sign up for coverage. Unfortunately, the regulations surrounding this law caused employer costs to skyrocket which in turn caused a significant drop in coverage being offered. In fact, the Small Business Administration has released data showing that only half of employers with under 200 employees offer health insurance. This number has been continuing to steadily decrease over the past few years.[1] A side effect of this reduction has been an increase in the number of uninsured employees. The cost of individual insurance is prohibitive when not offered through an employer. The Department of Labor (DOL) released a statement expressing this, sharing that the individual health insurance market saw premiums more than double between 2013 and 2017 and deductibles increasing even more than that.[2]

The regulations and restrictions that are in place currently are much stricter on smaller businesses than larger ones. This allows for larger organizations to offer more robust coverage at a more affordable rate because their leveraging power is much higher. To put this in perspective, the average small business pays 18 percent more than large firms for the same health insurance policy.[3] The current health insurance offerings to APTA members are restricted to their employers and the expensive open healthcare market. A great way to increase the potential offerings would be for APTA to pursue an Association Healthcare Plan (AHP).

AHPs are simply a type of group health insurance for people with a “commonality of interest” – in our case, physical therapy. Providing health insurance to members would allow for greater quality coverage at a much more affordable rate because the leveraging power would be significantly increased. From a cost savings perspective, this would translate to an average of 13-49%.[4] That equates to $1,900 to $4,100 in yearly savings on premiums for small group market plans and $8,700 to $10,800 in yearly savings for individual market plans.[5] That is a significant reduction in cost. There are many advantages of AHPs beyond the cost savings, however. These include the compatibility with a health savings account (HSA), avoiding many of the expensive requirements for ACA plans, not having to pay for unnecessary care, and of course expanding health coverage options. Additionally, one of the nice features of AHPs is that they are not restricted to the Open Enrollment Period for plans under the ACA. That means that you can join the plan at any time.[6]

The ACA had many great features including the prevention of denial of coverage due to health status and preexisting conditions. This resulted in an adjustment of the cost of claims, making it so all claims were spread among everyone in the plan. By not being subject to this stipulation of the ACA, an AHP would allow for more flexibility on premiums making coverage effectively less expensive for healthier individuals.[6] AHPs are still not able to deny coverage based on race or religion and can’t charge people more for pre-existing conditions or for being sick. An oversimplification would be to equate this to a pay-as-you-go type of model. Your cost is associated with how much you use it.[6]

47% of workers in the United States are employed in a small business (or self-employed).[7] Access to healthcare for half of these individuals is cost prohibitive. The National Federation of Independent Business (NFIB) conducted a survey and found that 52% of small business owners found the “cost of health insurance” a critical problem for their company.[5] Similarly, another survey found that from the employee perspective, health insurance is the most important benefit offered, beating out flexible hours, vacation time, and many others.[7] Even though health insurance is clearly valued highly, it remains out of reach of many workers due to cost. This is especially true for the APTA with many members working in small private practices, those that are self-employed, and even our student members. An Association Healthcare Plan (AHP) provides a unique opportunity for the APTA to provide its members with affordable, high-quality health insurance. This offering would significantly increase membership value and would undoubtedly improve recruitment and retention efforts. We would not be the first professional member

association to do this, as the American Medical Association has offered health insurance options since 1988.[8]

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Main Motion to the 2022 House of Delegates

Required for Adoption: 2/3 to Consider, 2/3 to Adopt **Category**: 1

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PROPOSED BY: CALIFORNIA

RC 22-22 AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE VII. COMMITTEES, SECTION 2: COMMITTEES OF THE HOUSE OF DELEGATES, A. NOMINATING COMMITTEE

That Bylaws of the American Physical Therapy Association, Article VII. Committees, Section 2: Committees of the House of Delegates, A. Nominating Committee, (3), be amended by striking out the words "serve concurrently as delegates to the House or" so that it would read:

ARTICLE VII. COMMITTEES OF THE ASSOCIATION

Section 2: Committees of the House of Delegates

A. Nominating Committee
- **(1) The Nominating Committee, elected by the House, shall consist of five Physical Therapists.**
- **(2) Members shall serve three-year terms starting at the beginning of the calendar year following the close of the annual session of the House at which they were elected, or until their successors are elected. The terms of two members shall expire each year, except that every third year the term of only one member shall expire. No member shall be elected to successive complete terms.**
- **(3) Members of the committee may not ~~serve concurrently as delegates to the House or~~ be slated for national office during their term.**
- **(4) The chair shall be elected by the committee annually.**
- **(5) Vacancies on this committee shall be filled by appointment by the Nominating Committee until the next session of the House, when an election shall be held to fill the unexpired term.**
- **(6) This committee shall:**
  - **a. Foster activities that maintain and promote a pool of qualified nominees.**
  - **b. Prepare a slate of at least two qualified candidates, if possible, for each position from those consenting to serve if elected for officers, directors, and members of the Nominating Committee to meet the responsibilities of their positions. The slate of candidates shall be distributed to the members as soon as available, but no later than three months before the annual session.**

SS:

A. What is the expected outcome of this motion? How does it contribute to achieving the Vision? Does it support APTA priorities (as reflected in the current Strategic Plan), and if so, how?
If passed, this amendment would allow members of components the option of electing as a Delegate whomever they feel best represents their component, including a current member of the Nominating Committee. If previously elected, this revision would allow an individual to serve the remainder of their term as Delegate, completing the commitment they made to represent the members of their component. This revision is consistent with the Vision and our Strategic plan in that it reduces a potential barrier to Member choice thus increasing Member Value.

B. How is this motion's subject national in scope or importance?

Members may be elected to APTA's Nominating Committee from all corners of our Association. If chosen by their component to serve as a Delegate, a group of Members has spoken and has stated that they want that particular individual to carry their voice in the House. Depending on the depth and breadth of the individual's knowledge, any conversation of the House could suffer for lack of that individual's unique and duly elected perspective.

C. What previous or current activities of the House, Board, or staff address this topic? Who are the stakeholders that might be affected by this motion (internal to APTA as well as relevant groups external to APTA)? Are there any state or federal laws or regulations which also address this topic; if so, what are they?

The current Bylaw language originated with the Special Committee on Bylaws. Relevant stakeholders include members of the Nominating Committee and members of components participating in the election process within those components.

D. Additional Background Information.

Following the 2021 House of Delegates, a group of former Nominating Committee members engaged in robust discussion over this concept. There were former members in favor of rescinding this newly instituted restriction while others expressed concern over potential conflicts of interest. Conflict could be real or perceived when a member of the Nominating Committee recuses themselves from a delegation's discussion of candidates. In the past when a member of the Nominating Committee simultaneously served as delegate, the member would excuse themselves from any conversations regarding current candidates. However, the requirement of this recusal is not specifically written in available documents.

During the election cycle, candidates for national office must follow the APTA Candidacy Rules and Processes document. Similarly, sitting Board members adhere to their own Code of Conduct as well as additional documents including Integrity in Serving the Association and APTA Board Member Participation in Elections for National Office. Those two groups have more available guidance for their behavior than do current members of the Nominating Committee. In the absence of specific, guiding language and with the precedent of many recent members serving both as a Delegate and on the Committee, the group of former Nominating Committee members felt that this question deserves to be heard by the House of Delegates. If amended as proposed, our Bylaws would allow as many as five consultants to the House the ability to simultaneously serve as voting Delegates. This privilege would only be available to the members of the Nominating Committee and would not to any other consultants.

It should also be noted that there is a precedent for a partial forgoing of delegate privileges and responsibilities when one looks at guidance for the behavior of Campaign Managers. As stated in APTA Candidacy Rules and Processes, a delegate serving as a Campaign Manager may not participate in discussion of candidates for any national office.

For reference, two members of the current Nominating Committee were obligated to resign from their delegate roles immediately at the close of the 2021 House vacating seats to which their components had elected them.