2023 Packet I

Main Motions to the House of Delegates

May 3, 2023

Table of Contents

RC #	CAT	TITLE	CONTACT	PAGE
RC 00-23	ZO-0	RC 00-22 CONSENT CALENDAR – PACKET I	HO	9
RC 1-23	ID-4	RC 1-23 AMEND: PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS (HOD P06-18-28-22)	HI	11
RC 2-23	ID-8	RC 2-23 CHARGE: PROMOTION OF PHYSICAL THERAPISTS AS PROVIDERS FOR TREATMENT OF POST-ACUTE SEQUELAE OF COVID-19	FL	14
RC 3-23	QU-4	RC 3-23: AMEND: CLINICAL SPECIALIZATION IN PHYSICAL THERAPY (HOD P06-19-66-30)	BOD	19
RC 4-23	QU-4	RC 4-23 AMEND: APTA CLINICAL SPECIALIZATION POLICY (HOD Y06-19-67-31)	BOD	22
RC 5-23	QU-4	RC 5-23 AMEND: AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION RECOGNITION (HOD P06-18-40-43)	KY	25
RC 6-23	QU-6	RC 6-23 ADOPT: SUPPORT FOR EDUCATION THAT INCLUDES IDENTIFYING SIGNS OF HUMAN TRAFFICKING	TX	27
RC 7-23	QU-6	RC 7-23 CHARGE: PROVIDE RESOURCES FOR SIGNS OF HUMAN TRAFFICKING	TX	30
RC 8-23	QU-8	RC 8-23: ADOPT: AUTONOMY IN DETERMINING QUALIFICATIONS OF CORE DOCTOR OF PHYSICAL THERAPY FACULTY	WI	33
RC 9-23	QU-8	RC 9-23: CHARGE: EXPLORE ALTERNATE MODELS FOR PHYSICAL THERAPIST ASSISTANT EDUCATION AND PRACTICE	AZ	36
RC 10-23	QU-8	RC 10-23: CHARGE: NATIONAL CONFERENCE ON PTA SCOPE OF WORK AND SUPERVISION REQUIREMENTS	AZ	38
RC 11-23	CO-4	RC 11-23 RESCIND: OPPOSITION TO PHYSICIAN OWNERSHIP OF PHYSICAL THERAPIST SERVICES AND SELF-REFERRAL BY PHYSICIANS (HOD P06-19-16-46)	IL	40

RC 12-23	CO-8	RC 12-23 CHARGE: SOCIAL MEDIA MARKETING STRATEGIES FOR COMPONENTS	AR	44
RC 13-23	CO-8	RC 13-23 CHARGE: DEVELOP A PROCESS FOR CREATION AND DISSEMINATION OF GUIDELINES FOR REFERRAL TO A PHYSICAL THERAPIST	AZ	45
RC 14-23	CO-8	RC 14-23 CHARGE: DEVELOP A SEARCHABLE SYSTEM FOR HOUSE BUSINESS FROM 2018 FORWARD	AZ	47
RC 15-23	IN-8	RC 15-23 CHARGE: RESOURCES RELATED TO SCREENING, REFERRALS, AND AUTHORIZATION FOR PARTICIPATION IN COMMUNITY-BASED HEALTH PROMOTION, INJURY PREVENTION, AND PHYSICAL ACTIVITY PROGRAMS	MI	49
RC 16-23	CC-4	RC 16-23 AMEND: CONSUMER PROTECTION THROUGH LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS (HOD P06-19-51-57)	AZ	52
RC 17-23	AE-6	RC 17-23 ADOPT: PAY EQUITY ON THE BASIS OF SEX ASSIGNED AT BIRTH/GENDER/GENDER IDENTITY	CT/MA	55
RC 18-23	AE-8	RC 18-23 CHARGE: DEVELOP A PLAN TO PROMOTE PAY EQUITY ON THE BASIS OF SEX ASSIGNED AT BIRTH/GENDER/GENDER IDENTITY IN THE PHYSICAL THERAPY PROFESSION	CO	57
RC 19-23	AE-6	RC 19-23 ADOPT: SUPPORT FOR INITIATIVES TO IMPROVE RURAL HEALTH	HI	60
RC 20-23	AE-8	RC 20-23 CHARGE: PROMOTING THE IMPROVEMENT OF HEALTH IN RURAL COMMUNITIES	HI	63
RC 21-23	AE-6	RC 21-23 ADOPT: PAY TRANSPARENCY BY EMPLOYERS OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS	TX	65
RC 22-23	AE-8	RC 22-23 CHARGE: ADVOCACY FOR STREAMLINED CREDENTIALING PROCESSES THAT EMPHASIZE PORTABILITY	AR	68
RC 23-23	ZO-8	RC 23-23 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: DEAN JACKS, PhD	BOD	69
RC 24-23	ZO-8	RC 24-23 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: RICHARD F. MACKO, MD	BOD	70

RC 25-23	ZO-1	RC 25-23 AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION TO PERMIT COMPONENTS THE RIGHT TO SEAT ONE PHYSICAL THERAPIST ASSISTANT AS A DELEGATE TO THE HOUSE OF DELEGATES	OR/TX/WA/ PTA	72
RC 26-23	ZO-1	AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE VII. COMMITTEES OF THE ASSOCIATION, SECTION 2: COMMITTEES OF THE HOUSE OF DELEGATES, A. NOMINATING COMMITTEE	Sports/Leadership/Pelvic Health/IA/TN	76

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.***

Jim Slaughter, Attorney, Certified Professional Parliamentarian-Teacher, Professional Registered Parliamentarian
e-mail: jim@jimslaughter.com **web site: www.jimslaughter.com**

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

Jim Slaughter, Attorney, Certified Professional Parliamentarian-Teacher, Professional Registered Parliamentarian
e-mail: jim@jimslaughter.com **web site:** www.jimslaughter.com

Memo

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

DATE: May 3, 2023

SUBJECT: 2023 House of Delegates Packet I

As delegates are aware, the 2023 session of the House of Delegates will begin on July 8, 2023, in a virtual format and continue July 23 - 24, 2023, 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 26 motions and is being provided as the official notice of all motions, including bylaw amendments, that are coming before the 2023 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 be found in the House Resources, Packet I folder, by May 5 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 5. Delegates contemplating amendments to motions should communicate with the motion maker and the Reference Committee liaison as soon as possible.

- Motion Language
  The Speaker would like to call your attention to the following resources to assist with preparation of language for motion amendments:
  - 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.
  - Preferred Nomenclature for the Provision of Physical Therapist Services provides 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.
  - Advancing Health Equity: A Guide to Language, Narrative and Concepts, a document prepared by the American Medical Association's Center for Health Equity, provides guidance and promotes a deeper understanding of equity-focused, person-first language and why it matters.

- New this year, motions have been organized by a category and subcategory. The category identifies the guiding principle that best defines the motion concept as found in Guiding Principle to Achieve the Vision. Subcategories created by the Reference Committee are provided to further guide the order. Please see the key below for all motion categories. Bylaw amendments are placed last since 2023is 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.

Motion Categories
ID- Identity
QU- Quality
CO- Collaboration
VL- Value
IN- Innovation
CC- Consumer Centricity
AE- Access/Equity
AD- Advocacy
ZO- Other New Business

Motion Subcategories
The Reference Committee has adopted the following categories as a guide for ordering the business of the House.

0 Consent Calendar
1 Bylaws
2 Standing Rules
3 Adoption or Amendment of Mission, Vision, or Goals
4 Amending or Rescinding Previously Adopted Positions, Standards, Guidelines, Policies, Procedures
5 Motions in Response to Previous House Referrals
6 Association Positions, Standards, Guidelines, Policies, Procedures — New items
7 New Business Related to APTA Vision Statement for the Physical Therapy Profession
8 Other New Business

- The Consent Calendar is a group of motions that will be adopted as a package by general consent of the House. The Consent Calendar is the first motion found in Packet I.
- Categories 1-6 consist of motions that can only be handled by the House of Delegates.
- Category 7 provides information about activities the House of Delegates would like to debate and potentially direct the Board of Directors to accomplish.
- In non-bylaws years, bylaw amendments will be ordered at the end of the agenda.
- Motions included on the consent calendar include identification of the appropriate category, in the event the motion is removed from the consent calendar.

- 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 was revised in 2022 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 on the House Hub.

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.

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 available on May 5 to indicate cosponsorship of a motion.

The Preliminary Consent Calendar is included in Packet I. Per APTA Standing Rules, the authority for development of the Consent Calendar rests with the House Officers. This year we are asking Chief Delegates to indicate no later than June 9 via a SignUp Genius provided on May 5, that they would like to **remove a motion** from the consent calendar. Prior to the June 9 deadline, five chief delegates are required to remove a motion from consent. After that deadline 1/3 of the assembly voting in the affirmative is required to remove an item from consent. The final consent calendar will be available on June 16 via Packet II.

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. Collaboration is key for the House to function at its highest capacity and make impactful decisions that will continue to move the profession forward. Key areas that play an important role in the quality and efficacy of our collaboration include communication, coordination, transparency, accountability, and trust. Embracing these key elements of collaboration will greatly improve our ability to resolve conflict and reach mutual understanding to make decisions that are in the best interests of the profession and the members we represent. Do not hesitate to contact us with questions, concerns, or suggestions for expediting the business of the House.

Main Motion to the 2022 House of Delegates

Required for Adoption: Majority Vote **Category**: ZO-0

Motion Contact: Officers of the House of Delegates

PROPOSED BY: OFFICERS OF THE HOUSE OF DELEGATES

RC 00-23 CONSENT CALENDAR

That the following motions be adopted by general consent:

Title	Proposed by
RC 2-23 CHARGE: PROMOTION OF PHYSICAL THERAPISTS AS PROVIDERS FOR TREATMENT OF POST-ACUTE SEQUELAE OF COVID-19	FL
RC 3-23: AMEND: CLINICAL SPECIALIZATION IN PHYSICAL THERAPY (HOD P06-19-66-30)	BOD
RC 4-23 AMEND: APTA CLINICAL SPECIALIZATION POLICY (HOD Y06-19-67-31)	BOD
RC 12-23 CHARGE: SOCIAL MEDIA MARKETING STRATEGIES FOR COMPONENTS	AR
RC 13-23 CHARGE: DEVELOP A PROCESS FOR CREATION AND DISSEMINATION OF GUIDELINES FOR REFERRAL TO A PHYSICAL THERAPIST	AZ
RC 14-23 CHARGE: DEVELOP A SEARCHABLE SYSTEM FOR HOUSE BUSINESS FROM 2018 FORWARD	AZ
RC 17-23 ADOPT: PAY EQUITY ON THE BASIS OF SEX ASSIGNED AT BIRTH/GENDER/GENDER IDENTITY	CT/MA
RC 18-23 CHARGE: DEVELOP A PLAN TO PROMOTE PAY EQUITY ON THE BASIS OF SEX ASSIGNED AT BIRTH/GENDER/GENDER IDENTITY IN THE PHYSICAL THERAPY PROFESSION	CO
RC 19-23 ADOPT: SUPPORT FOR INITIATIVES TO IMPROVE RURAL HEALTH	HI
RC 20-23 CHARGE: PROMOTING THE IMPROVEMENT OF HEALTH IN RURAL COMMUNITIES	HI
RC 21-23 ADOPT: PAY TRANSPARENCY BY EMPLOYERS OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS	TX
RC 22-23 CHARGE: ADVOCACY FOR STREAMLINED CREDENTIALING PROCESSES THAT EMPHASIZE PORTABILITY	AR

RC 23-23 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: DEAN JACKS, PhD	BOD
RC 24-23 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: RICHARD F. MACKO, MD	BOD

Main Motion to the 2023 House of Delegates

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

Motion Contact: Douglas M. White, DPT, Chief Delegate, APTA Hawaii
E-mail: dr.white@miltonortho.com

RC Contact: Venita Lovelace-Chandler, PT, PhD, FAPTA
E-mail: vlc.phd.pt.pcs@gmail.com

PROPOSED BY: HAWAII

RC 1-23 AMEND: PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS (HOD P06-18-28-22)

That Physical Therapists as Primary Care and Entry-Point Providers (HOD P06-18-28-22), be amended by substitution.

PRIMARY CARE PHYSICAL THERAPISTS SERVICES ~~AS PRIMARY CARE AND ENTRY-POINT PROVIDERS~~

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.~~ long-term and lifelong person-centered primary care services including screening for health risk, injury, and disease; obtaining medical history; physical examination; diagnostic testing; determining a diagnosis(es) and prognosis; and developing a management plan. The management plan includes, providing therapeutic intervention, education, coordination of care, referrals for testing and consultations, monitoring response, and adjusting the management plan. Physical therapists provide services such as prenatal and postpartum care, and child development monitoring and management; promotion of physical fitness and wellness; and prevention of the onset or the progression of health conditions such as but not limited to hypertension, prediabetes mellitus and diabetes mellitus, and respiratory disease.

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 will have a position on Primary Care (PC) which describes in detail those aspects of Physical therapist (PT) practice which directly relate to PC care as it is commonly provided. The current position is too broad and ill-defined to provide readers with a clear understanding of PT practice in PC settings, this can lead to ineffectual use of the position. A detailed and clearly articulated position on PC care will enable the profession to more effectually advocate for inclusion of, and payment for, PTs in PC. This will expand access to PTs in underserved areas and improve health with more timely and more frequent PT management. The adopted position will foster clearer and more robust educational curriculum and professional development of PT students and PTs in the PC practice area.

This motion perfectly aligns with APTA Strategic Plan by addressing the **Goals**: *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.* Facilitating the **Outcomes**: *Use of and demand for physical therapist services as a primary entry point of care for consumers will increase. The APTA community will collaborate to reach more consumers, drive demand for physical therapy, and expand the markets and venues that promote the profession.*

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

It clearly defines an area of practice with implications in all jurisdictions. See above.
Five of the top ten reasons for visits (RFV) to primary care are conditions PTs can help manage.[1]

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 House of Delegates first adopted this position in 2002. APTA currently uses this position in advocacy efforts. The 2022 House of Delegates had an early version of a motion which would have watered down and subsumed the current position on PC into another position. While the existing position was retained it became clear the language was not optimally defining PTs in PC settings. Stakeholders are the entire profession, payers, regulators, Congress, legislatures, DPT programs, residencies and fellowships, and society as a whole.

No state or federal laws which directly address this issue have been identified.

D. Additional Background Information.

Since 2002 APTA has had a position addressing primary care. In 1996 the Institute of Medicine acknowledged physical therapists (PT) ability to contribute to primary care (PC)[2]. PTs in the US Army have been practicing PC since 1971[3]. Also, Kaiser Permanente and the Veterans Administration have PTs in PC roles. There other scattered settings where PTs practice some level of PC. However, overall, in the ensuing 21 years since APTA adopted a position on PC there has not been widespread advancement of PTs in PC environments. Most outpatient PTs practice in secondary or tertiary settings. As a result, the profession is not optimally meeting the needs of society. When individuals are able to access a PT in a PC setting their time to definitive management can be shorter than care that is delivered in secondary or tertiary settings. PT care in PC is integrated with the whole PC team which can lead to more effective and efficient communication and coordination of patient management. Additionally, PTs, particularly in PC, can often avoid the need for unnecessary diagnostic work up and medications.

The reasons for the limited participation of PTs in PC are many. Tens of millions of Americans receive PC in Federally Qualified Health Centers and Federal Health Clinics. PTs are not identified as providers in these settings[1]. As a result, it is not economically feasible to provide access to PTs in these settings. Most outpatient PT care is provided as episodic care. As a result, there is often a lack of long-term therapeutic relationships with patients to manage their health on an ongoing basis. This is largely due to third party payment policies and state practice acts which do not permit or pay for care by PTs in the model of PC and do not allow for the full scope of PT services. Doctor of Physical Therapy education programs typically do not have robust curriculum of PTs in the PC setting. There is also a shortage of healthcare workers in rural settings where access to PTs is limited.
One barrier to greater involvement of PTs in PC is the existing APTA policy[3] which lacks specificity and clarity of the value of PTs in PC.

REFERENCES

1. PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS HOD P06-18-28-22

2. Institute of Medicine (US) Committee on the Future of Primary Care; Donaldson MS, Yordy KD, Lohr KN, et al., editors. Primary Care: America's Health in a New Era. Washington (DC): National Academies Press (US); 1996. 2, Defining Primary Care. Available from: https://www.ncbi.nlm.nih.gov/books/NBK232631/ Accessed 1.28.23
3. Murphy BP, Greathouse D, Matsui I. Primary care physical therapy practice models. J Orthop Sports Phys Ther. 2005 Nov;35(11):699-707. doi: 10.2519/jospt.2005.35.11.699. PMID: 16355912. Accessed 1.28.23
4. https://www.aha.org/system/files/content/11/09AprilFQHCfactsheet.pdf Accessed 1.28.23
5. PHYSICAL THERAPISTS AS PRIMARY CARE AND ENTRY-POINT PROVIDERS HOD P06-18-28-22

Main Motion to the 2023 House of Delegates

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

Motion Contact: Jamie Dyson PT, DPT, Delegate, Florida Physical Therapy Association
E-mail: jamiedyson224@gmail.com

RC Contact: Pamela White, PT, DPT
E-mail: pwhite5577@aol.com

PROPOSED BY: FLORIDA

RC 2-23 CHARGE: PROMOTION OF PHYSICAL THERAPISTS AS PROVIDERS FOR TREATMENT OF POST-ACUTE SEQUELAE OF COVID-19

That the American Physical Therapy Association promote physical therapists as providers for the treatment of post-acute sequelae of COVID-19 through interprofessional education, advocacy efforts, and public-facing education.

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 American Physical Therapy Association (APTA) promotes practice, reimbursement, education, and research regarding the effects of Post-Acute Sequalae of COVID-19 (PASC) on human movement. The long-term symptoms of PASC are well documented. These involve one or more of the body systems that integrate to perform movement. Physical therapists are uniquely trained to work with patients who have disorders of multiple body systems which have a direct effect on human movement. The scope of physical therapy practice includes screening for these disorders, educating and providing intervention to individuals as well as larger populations.

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

The global pandemic of COVID-19 has resulted in more than 500 million confirmed cases and 6.1 million deaths.[1] The emergence of new SARS-cov-2 variants of higher transmissibility (eg, Omicron and Delta), has resulted in the number of confirmed cases to constantly increase..[2,3] Although most SARS-cov-2–infected patients recover from the acute phase, some patients may experience long-lasting health problems, including physical, cognitive, and psychological sequelae, affecting their social participation and health-related quality of life.[4-6] A burden exists of self-reported post-acute symptom clusters and possible sequelae, notably fatigue and neurocognitive impairment, six to 12 months after acute SARS-cov-2 infection, even among young and middle aged adults after mild infection, with a substantial impact on general health and working capacity[26]

Greater than 50 long-term effects have been classified [6]; even though the most common signs and symptoms reported are both physical, such as dyspnea, fatigue, pain, and psychological, such as anxiety and depression [symptoms can be combined in different ways, fluctuating over time, and lead to an overall impairment of mobility, reduced independence in everyday life activities and Quality of Life [29] A recent cross-sectional study suggested the presence of at least 1 PASC symptom in 59.7% of hospitalized patients and 67.5% of nonhospitalized patients 2 years after infection.[15] The prevalence of PASC pain symptoms was 42.7% (n = 176) and 36.2% (n = 149) at 6.8 and 13.2 months after hospital discharge [7] was demonstrated in a separate study. A third study showed that exercise capacity was reduced more than 3 months after SARS-cov-2 infection among individuals with symptoms consistent with PASC compared with

individuals without symptoms, Potential mechanisms for exertional intolerance other than deconditioning include altered autonomic function, endothelial dysfunction, and muscular or mitochondrial pathology.[5] A recent meta-analysis shows that PASC symptoms are present in more than 60% of patients infected by SARS-cov-2. Fatigue and dyspnea were the most prevalent PASC symptoms, particularly 60 and ≥90 days after.[14] About 38% of survivors seeking care for their persistent symptoms suffered from severe anxiety, 31.8% from severe depression, 43% experiencing moderate to severe PTSD symptomology, and 17.5% had cognitive impairment. Their health-related quality of life was substantially lower than that of the general population (-26%) and of persons with other chronic conditions[2]. Therefore, systematic follow-up of patients with COVID-19 discharged from the hospital is necessary to identify the trajectory of symptom burden, to understand the long-term health outcomes of this disease.[34] The follow up should include consultation and examination by physical therapy. The syndrome should be recognized as billable for physical therapy which would allow clients to seek care directly from physical therapists. Since the sequalae extend beyond the musculoskeletal system there would need to be education regarding physical therapies role in neurological, cardiovascular, and pulmonary disorders as well.

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 has been no previous house activity regarding this motion The APTA has been involved with advocacy regarding having Physical Therapy involved as part of the solution for this population. There has been no activity as far as reimbursement or recognition of PASC as having a direct effect on human movement. It should be recognized as a billable condition that is treatable by physical therapists. Doing so would allow clients to seek care directly from physical therapists. Since the sequalae extend beyond the musculoskeletal system there would need to be education of the public and providers/health systems regarding physical therapists' role in neurological, cardiovascular, and pulmonary disorders as well.

The APTA board did send a well written to the Biden administration regarding the need for APTA to be involved with the solution to the COVID pandemic.

There are multiple resources located throughout the APTA website as well as the websites of multiple sections and academies. There is a robust amount of information available for members.

- Coronavirus (COVID-19) Resources for the Physical Therapy Profession | APTA
- Long COVID | APTA
- Resource | Long COVID Patient and Client Resources | APTA
- COVID-19 Updates and Resources - Academy of Acute Care Physical Therapy
- COVID-19 Resources
- COVID-19 Resources for APTA Academy of Education Members - APTA Academy of Education

Unfortunately, this information is inward facing and public education as well as legislative actions should also be a priority.

D. Additional Background Information.

COVID-19 survivors have a progressive decrease in their symptom burden, but those with severe disease during hospitalization, especially those who required intensive care unit admission, have higher risks of persistent symptoms.[34] Patients with PASC have a high amount of resource utilization, and there are several demographic features and comorbidities that were associated with greater rehabilitation utilization. A combination of higher BMI, dyslipidaemia, and lower physical endurance 180 days after COVID-19 is suggestive of a higher risk of developing metabolic disorders and possible cardiovascular complications.[4] Clinical profiles of PASC differ between groups of people. The incidence of muscle weakness is more prevalent in the ICU survivors but patients who had not needed ICU admission have worse anxiety. Many

patients who did not required mechanical ventilation have respiratory muscle weakness [25] Severely obese ICU survivors with COVID-19 experience more long-term physical and mental symptoms than patients in lower BMI categories, whereas no significant differences were present before ICU admission The long-term impact of COVID-19 may be more pronounced in obese patients and they may require greater utilization of rehabilitative services after their hospital stay.[22] Comprehensive rehabilitation management effectively improved muscle mass, muscle strength, and physical performance in severe-to-critical COVID-19 patients. Dose-response relationship of rehabilitation and functional improvement emphasizes the importance of intensive post-acute inpatient rehabilitation in COVID-19 survivors.[32]

Evidence suggests that PASC pain can be categorized as nociceptive (i.e., pain attributable to the activation of the peripheral receptive terminals of primary afferent neurons), neuropathic (i.e., pain associated with a lesion or disease of the somatosensory nervous system), nociplastic (i.e., pain arising from altered nociception despite no clear evidence of actual or threatened tissue damage), or mixed type (when two pain phenotypes co-exist). Each of these pain phenotypes may require a different treatment approach to maximize treatment effectiveness. Accordingly, the ability to classify PASC pain patients into one of these phenotypes would likely be critical for producing successful treatment outcomes.[8] 10% of individuals infected by SARS-cov-2 will suffer from musculoskeletal PASC pain symptomatology at some time during the first year after the infection.[11]

In a study involving 154,068 people who had COVID-19, 5,638,795 contemporary controls and 5,859,621 historical controls, which altogether correspond to 14,064,985 person-years of follow up, showed that beyond the first 30 days of infection, people with COVID-19 are at increased risk of an array of neurologic disorders spanning several disease categories including stroke (both ischemic and hemorrhagic), cognition and memory disorders, peripheral nervous system disorders, episodic disorders, extrapyramidal and movement disorders, mental health disorders, musculoskeletal disorders, sensory disorders and other disorders including Guillain– Barré syndrome, and encephalitis or encephalopathy.[33] The fact that neurological and psychiatric outcomes are similar during the delta and omicron waves indicates that the burden on the health-care system might continue even with variants that are less severe in other respects. [31] Deconditioning can explain part of the reductions but there are most likely other factors involved. A combination of COVID19-induced and inactivity-induced processes might be responsible for the alterations in cardiac, vascular, and muscular but also pulmonary function[21]. In addition, psychological factors may contribute substantially to the prolonged symptoms fostering exercise intolerance [28]

REFERENCES

1. Abdelwahab, N., Ingraham, N. E., Nguyen, N., Siegel, L., Silverman, G., Sahoo, H. S., ... & Ikramuddin, F. (2022). Predictors of Post-Acute Sequelae of COVID-19 Development and Rehabilitation: A Retrospective Study. *Archives of physical medicine and rehabilitation*.
2. Abramoff, B. A., Dillingham, T. R., Brown, L. A., Caldera, F., Caldwell, K. M., McLarney, M., ... & Pezzin, L. E. (2023). Psychological and Cognitive Functioning Among Patients Receiving Outpatient Rehabilitation for Post-COVID Sequelae: An Observational Study. *Archives of Physical Medicine and Rehabilitation*, *104*(1), 11-17.
3. Cuenca-Zaldivar, J. N., Monroy Acevedo, Á., Fernández-Carnero, J., Sánchez-Romero, E. A., Villafañe, J. H., & Barragán Carballar, C. (2022). Effects of a Multicomponent Exercise Program on Improving Frailty in Post-COVID-19 Older Adults after Intensive Care Units: A Single-Group Retrospective Cohort Study. *Biology*, *11*(7), 1084.
4. Deuel, J. W., Lauria, E., Lovey, T., Zweifel, S., Meier, M. I., Züst, R., ... & Schlagenhauf, P. (2022). Persistence, prevalence, and polymorphism of sequelae after COVID-19 in unvaccinated, young adults of the Swiss Armed Forces: a longitudinal, cohort study (LoCoMo). *The Lancet Infectious Diseases*, *22*(12), 1694-1702.
5. Durstenfeld, M. S., Sun, K., Tahir, P., Peluso, M. J., Deeks, S. G., Aras, M. A., ... & Hsue, P. Y. (2022). Use of Cardiopulmonary Exercise Testing to Evaluate Long COVID-19 Symptoms in Adults: A Systematic Review and Meta-analysis. *JAMA network open*, *5*(10), e2236057-e2236057.
6. Fernández-de-Las-Peñas, C., Rodríguez-Jiménez, J., Cancela-Cilleruelo, I., Guerrero-Peral, A., Martín-Guerrero, J. D., García-Azorín, D., ... & Pellicer-Valero, O. J. (2022). Post–COVID-19 Symptoms 2 Years After SARS-CoV-2 Infection Among Hospitalized vs Nonhospitalized Patients. *JAMA Network Open*, *5*(11), e2242106-e2242106.

7. Fernández-de-Las-Peñas, C., Ryan-Murua, P., de-la-Llave-Rincón, A. I., Gómez-Mayordomo, V., Arendt-Nielsen, L., & Torres-Macho, J. (2022). Serological biomarkers of COVID-19 severity at hospital admission are not related to long-term post-COVID pain symptoms in hospitalized COVID-19 survivors. *Pain*, *163*(11), 2112-2117.
8. Fernández-de-Las-Peñas, C., Nijs, J., Neblett, R., Polli, A., Moens, M., Goudman, L., ... & Arendt-Nielsen, L. (2022). Phenotyping Post-COVID Pain as a Nociceptive, Neuropathic, or Nociplastic Pain Condition. *Biomedicines*, *10*(10), 2562.
9. Fernández-de-Las-Peñas, C. (2022). Are patients exhibiting post-coronavirus disease (COVID) symptoms at 12 months the same at 5 or 9 months? The fluctuating nature of post-COVID. *Clinical Infectious Diseases*, *75*(1), e1208-e1208.
10. Fernandez-de-Las-Penas, C., Fuensalida-Novo, S., Ortega-Santiago, R., Valera-Calero, J. A., Cescon, C., Derboni, M., ... & Barbero, M. (2022). Pain Extent Is Not Associated with Sensory-Associated Symptoms, Cognitive or Psychological Variables in COVID-19 Survivors Suffering from Post-COVID Pain. *Journal of Clinical Medicine*, *11*(15), 4633.
11. Fernández-de-Las-Peñas, C., Navarro-Santana, M., Plaza-Manzano, G., Palacios-Ceña, D., & Arendt-Nielsen, L. (2022). Time course prevalence of post-COVID pain symptoms of musculoskeletal origin in patients who had survived severe acute respiratory syndrome coronavirus 2 infection: a systematic review and meta-analysis. *Pain*, *163*(7), 1220-1231.
12. Fernández-de-Las-Peñas, C., Herrero-Montes, M., Cancela-Cilleruelo, I., Rodríguez-Jiménez, J., Parás-Bravo, P., Varol, U., ... & Valera-Calero, J. A. (2022). Understanding sensitization, cognitive and neuropathic associated mechanisms behind post-COVID pain: A Network Analysis. *Diagnostics*, *12*(7), 1538.
13. Fernandez-de-Las-Penas, C., Cancela-Cilleruelo, I., Moro-Lopez-Menchero, P., Rodriguez-Jimenez, J., Pellicer-Valero, O. J., Martin-Guerrero, J. D., & Arendt-Nielsen, L. (2022). Exploring the trajectory curve of long-term musculoskeletal post-COVID pain symptoms in hospitalized COVID-19 survivors: A multicenter study. *Pain*, 10-1097.
14. Fernández-de-Las-Peñas, C., Palacios-Ceña, D., Gómez-Mayordomo, V., Florencio, L. L., Cuadrado, M. L., Plaza-Manzano, G., & Navarro-Santana, M. (2021). Prevalence of post-COVID-19 symptoms in hospitalized and non-hospitalized COVID-19 survivors: A systematic review and meta-analysis. *European journal of internal medicine*, *92*, 55-70.
15. Fernández-de-Las-Peñas, C., Martín-Guerrero, J. D., Cancela-Cilleruelo, I., Moro-López-Menchero, P., Rodríguez-Jiménez, J., Navarro-Pardo, E., & Pellicer-Valero, O. J. (2022). Exploring the recovery curves for long-term post-COVID functional limitations on daily living activities: The LONG-COVID-EXP-CM multicenter study. *Journal of Infection*, *84*(5), 722-746.
16. Fernández-de-Las-Peñas, C., Martín-Guerrero, J. D., Cancela-Cilleruelo, I., Moro-López-Menchero, P., & Pellicer-Valero, O. J. (2022). Exploring the recovery curve for long-term post-COVID dyspnea and fatigue. *European Journal of Internal Medicine*.
17. Fernández-de-Las-Peñas, C., Cancela-Cilleruelo, I., Moro-López-Menchero, P., Rodríguez-Jiménez, J., Gómez-Mayordomo, V., Torres-Macho, J., ... & Arendt-Nielsen, L. (2022). Prevalence of Musculoskeletal Post-COVID Pain in Hospitalized COVID-19 Survivors Depending on Infection with the Historical, Alpha or Delta SARS-CoV-2 Variant. *Biomedicines*, *10*(8), 1951.
18. Fiest, K. M., Krewulak, K. D., Jaworska, N., Spence, K. L., Mizen, S. J., Bagshaw, S. M., ... & Parsons Leigh, J. (2022). Impact of restricted visitation policies during COVID-19 on critically ill adults, their families, critical care clinicians, and decision-makers: A qualitative interview study. *Canadian Journal of Anesthesia/Journal canadien d'anesthésie*, *69*(10), 1248-1259.
19. Fischer, A., Zhang, L., Elbéji, A., Wilmes, P., Oustric, P., Staub, T., ... & Fagherazzi, G. (2022, August). Long COVID symptomatology after 12 months and its impact on quality of life according to initial coronavirus disease 2019 disease severity. In *Open forum infectious diseases* (Vol. 9, No. 8, p. ofac397). Oxford University Press.
20. Greer, N., Bart, B., Billington, C. J., Diem, S. J., Ensrud, K. E., Kaka, A., ... & Wilt, T. J. (2022). COVID-19 postacute care major organ damage: a systematic review. *BMJ open*, *12*(8), e061245.
21. Hall, P. A., Meng, G., Hudson, A., Sakib, M. N., Hitchman, S. C., MacKillop, J., ... & Fong, G. T. (2022). Cognitive function following SARS-CoV-2 infection in a population-representative Canadian sample. *Brain, behavior, & immunity-health*, *21*, 100454.
22. Kooistra, E., Heesakkers, H., Pickkers, P., Zegers, M., & van den Boogaard, M. (2022). Long-Term Impairments are Most Pronounced in Critically Ill COVID-19 Patients with Severe Obesity. *Am. j. respir. crit. care med*.
23. Moss, S. J., Rosgen, B. K., Lucini, F., Krewulak, K. D., Soo, A., Doig, C. J., ... & Fiest, K. M. (2022). Psychiatric Outcomes in ICU Patients With Family Visitation: A Population-Based Retrospective Cohort Study. *Chest*.
24. Peluso, M. J., Sans, H. M., Forman, C. A., Nylander, A. N., Ho, H. E., Lu, S., ... & Deeks, S. G. (2022). Plasma markers of neurologic injury and inflammation in people with self-reported neurologic postacute sequelae of SARS-CoV-2 infection. *Neurology-Neuroimmunology Neuroinflammation*, *9*(5).

25. Perrot, J. C., Segura, M., Beranuy, M., Gich, I., Nadal, M. J., Pintor, A., ... & Güell-Rous, M. R. (2022). Comparison of post-COVID symptoms in patients with different severity profiles of the acute disease visited at a rehabilitation unit. *Plos one*, *17*(9), e0274520.
26. Peter, R. S., Nieters, A., Kräusslich, H. G., Brockmann, S. O., Göpel, S., Kindle, G., ... & Kern, W. V. (2022). Post-acute sequelae of covid-19 six to 12 months after infection: population based study. *bmj*, *379*.
27. Sankar, K., Gould, M. K., & Prescott, H. C. (2022). Psychological Morbidity After COVID-19 Critical Illness. *Chest*.
28. Schwendinger, F., Knaier, R., Radtke, T., & Schmidt-Trucksäss, A. (2022). Low cardiorespiratory fitness post-COVID-19: a narrative review. *Sports Medicine*, 1-24.
29. Straudi, S., Manfredini, F., Baroni, A., Milani, G., Fregna, G., Schincaglia, N., ... & Lamberti, N. (2022). Construct Validity and Responsiveness of the COVID-19 Yorkshire Rehabilitation Scale (C19-YRS) in a Cohort of Italian Hospitalized COVID-19 Patients. *International Journal of Environmental Research and Public Health*, *19*(11), 6696.
30. Taniguchi, L. U., Aliberti, M. J., Dias, M. B., Jacob-Filho, W., Avelino-Silva, T. J., & CO-FRAIL Study Group and EPICCoV Study Group, for COVID HCFMUSP Study Group. (2022). Twelve Months and Counting: Following Clinical Outcomes in Critical COVID-19 Survivors. *Annals of the American Thoracic Society*, (ja).
31. Taquet, M., Sillett, R., Zhu, L., Mendel, J., Camplisson, I., Dercon, Q., & Harrison, P. J. (2022). Neurological and psychiatric risk trajectories after SARS-CoV-2 infection: an analysis of 2-year retrospective cohort studies including 1 284 437 patients. *The Lancet Psychiatry*, *9*(10), 815-827.
32. Woo, H., Lee, S., Lee, H. S., Chae, H. J., Jung, J., Song, M. J., ... & Beom, J. (2022). Comprehensive Rehabilitation in Severely Ill Inpatients With COVID-19: A Cohort Study in a Tertiary Hospital. *Journal of Korean Medical Science*, *37*(34).
33. Xu, E., Xie, Y., & Al-Aly, Z. (2022). Long-term neurologic outcomes of COVID-19. *Nature medicine*, *28*(11), 2406-2415.
34. Yang, X., Hou, C., Shen, Y., Zhang, M., Zhang, K., Wang, F., ... & Li, L. (2022). Two-Year Health Outcomes in Hospitalized COVID-19 Survivors in China. *JAMA Network Open*, *5*(9), e2231790-e2231790.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Kim Nixon-Cave, PT, PhD, FAPTA, Board of Directors
E-mail: kimnixoncave@apta.org

RC Contact: Ami Elizabeth Ross Faria, PT, DPT
E-mail: drfariapt@gmail.com

PROPOSED BY: BOARD OF DIRECTORS

RC 3-23: AMEND: CLINICAL SPECIALIZATION IN PHYSICAL THERAPY (HOD P06-19-66-30)

That Clinical Specialization in Physical Therapy (HOD P06-19-66-30) be amended by substitution.

CLINICAL SPECIALIZATION IN PHYSICAL THERAPY

The American Physical Therapy Association supports the recognition of physical therapists who have attained voluntary specialization of practice.

Specialization is the process by which a physical therapist builds on a broad base of professional education and practice to develop greater depth of knowledge and skills related to a particular area of practice. Clinical specialization in physical therapy responds to a specific area of patient need and requires knowledge, skill, and experience that exceeds ~~entry-level~~ professional physical therapist practice and is unique to the specialized area of specialty or subspecialty practice.

Specialty is an explicit practice focus on a patient or client population or a set of conditions within physical therapy.

Subspecialty is a distinct subset of knowledge and skills within one or more physical therapy specialties.

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 amendments to this House position are being proposed to include reference to subspecialty practice. In support of the efforts related to RC 10-21, a reactor group, comprising key member group representatives, was identified to provide member reactions and perceptions to statements, positions, models, and definitions. This group responded to a written survey, and a subset of this group participated in a series of focus discussions that added depth and context to the survey findings. The collected data indicated a strong desire (91%) for options to advance knowledge and skills in specialty and subspecialty practice.

Expanding the opportunities for formal recognition of physical therapists engaged in subspecialty practice allows for increased education, training, and demonstration of knowledge. This amendment will support the APTA Strategic Plan's commitment to quality of care and supports the plan's outcome measure for achieving a record number of members seeking career advancement through specialization, residency, fellowship, continuing education, and/or certifications.

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

APTA's specialist certification program, governed by the American Board of Physical Therapy Specialties, was established to advance the profession of physical therapy by establishing, maintaining, and promoting standards of excellence for clinical specialization, and by recognizing the advanced knowledge, skills, and experience by physical therapist practitioners through specialist credentialing. These efforts would continue through the expansion of this recognition to physical therapists engaged in subspecialty practice.

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 House of Delegates adopted the initial position Clinical Specialization in Physical Therapy (HOD P06-16-10-11) in 1978. In 2019 the House separated this into the following policy and position documents focused on specialization:

    - Clinical Specialization In Physical Therapy HOD P06-19-66-30.
    - APTA Clinical Specialization Policy HOD Y06-19-67-31.

- Board of directors policy describes the charge to ABPTS.
- The Board of Directors adopted Specialty and Subspecialty Definitions BOD P05-21-02-05, which defines the terms specialty and subspecialty as formally recommended by ABPTS and the American Board of Physical Therapy Residency and Fellowship Education.
- With RC 10-21, APTA was charged to examine the history and current status of specialization and advanced clinical practice within the physical therapy profession and from that analysis create a long-term strategy to enhance the evolution and integration of specialization, and potentially sub-specialization, into the advanced practice of physical therapy, with a report submitted to the House of Delegates in 2023.
- Stakeholders that would be impacted by this motion include:
    - Physical therapists seeking increased recognition for their subspecialty practice, including but not limited to those completing an accredited fellowship program.
    - ABPTS, which has committed to supporting certification efforts at the subspecialty area if approved.
    - Postprofessional education providers who contribute to a physical therapist's continued advanced knowledge, skills, and practice experience.
    - Clinical practices that provide care at the subspecialty level.

D. Additional Background Information.

If approved, ABPTS is committed to the development of petition and review processes that align specialty and subspecialty practices (certification, certificates, residency, fellowship) with contemporary practice and societal needs. This would also require coordination with ABPTRFE as well, as they already recognize subspecialty areas of practice through fellowships. ABPTRFE fellowship accreditations are currently offered in ten different subspecialty areas:

- Critical Care
- Hand Therapy
- Higher Education Leadership
- Neonatology
- Neurologic Movement Disorders
- Orthopaedic Manual Physical Therapy
- Performing Arts

- Spine
- Sports Division 1
- Upper Extremity Athlete

Based on the development processes required, the anticipated timeframe for the first subspecialty certification examination(s) would be no earlier than seven years.

REFERENCES

1. The Future of Specialization and Advanced Clinical Practice in Physical Therapy (RC 10-21) Special Report to the House of Delegates
2. Glossary of Terms Related to Certification and Assessment

Main Motion to the 2023 House of Delegates

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

Motion Contact: Kim Nixon-Cave, PT, PhD, FAPTA, Board of Directors
E-mail: kimnixoncave@apta.org

RC Contact: Ami Elizabeth Ross Faria, PT, DPT
E-mail: drfariapt@gmail.com

PROPOSED BY: BOARD OF DIRECTORS

RC 4-23 AMEND: APTA CLINICAL SPECIALIZATION POLICY (HOD Y06-19-67-31)

That APTA Clinical Specialization Policy (HOD Y06-19-67-31) be amended by substitution.

APTA CLINICAL SPECIALIZATION POLICY

Clinical specialization in physical therapy is a voluntary and unrestricted process. Participation is initiated at the request of the individual, and no attempt is made to prohibit others from practicing in a specified area, nor is it required that physical therapists who are certified restrict their practice to the area in which they are certified. However, physical therapists shall not purport to be a "board-certified clinical specialist" unless they have successfully completed the certification process as developed by the American Board of Physical Therapy Specialties.

The purposes of the association's Clinical Specialization Program can best be achieved through a centralized organization ~~which~~ that provides reasonable uniformity in the level and type of standards adopted as the basis for ~~certification~~ each specialty and subspecialty. ~~and~~ The program provides for the participation of consumer representatives in the decision-making process. The organizational body that guides the American Physical Therapy Association Clinical Specialization Program is ABPTS and its appointed specialty councils.

~~Criteria for establishment of a new specialty area are established by ABPTS and guide the development of all new specialty areas. The APTA House of Delegates approves all new specialty areas. The approved specialty areas are:~~ ABPTS establishes criteria for each specialty and subspecialty, and the APTA House of Delegates approves all specialties in physical therapist practice, which are:

Cardiovascular and Pulmonary Physical Therapy	**1981**
Orthopaedic Physical Therapy	**1981**
Pediatric Physical Therapy	**1981**
Sports Physical Therapy	**1981**
Clinical Electrophysiologic Physical Therapy	**1982**
Neurologic Physical Therapy	**1982**
Geriatric Physical Therapy	**1989**
Women's Health Physical Therapy	**2006**
Oncologic Physical Therapy	**2016**
Wound Management Physical Therapy	**2019**

ABPTS approves certification of clinical specialists in each specialty ~~area~~ and subspecialty. The specialty councils define, develop, and modify the requirements for certification and recertification ~~in their specialty areas~~. The APTA Board of Directors directs funding for the specialist certification program~~,~~ and serves as an appeal body for certification petitioners and candidates.

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 amendments to this House position are being proposed to include reference to subspecialty practice. In support of the efforts related to RC 10-21, a reactor group, comprising key member group representatives, was identified to provide member reactions and perceptions to statements, positions, models, and definitions. This group responded to a written survey, and a subset of this group participated in a series of focus discussions that added depth and context to the survey findings. The collected data indicated a strong desire (91%) for options to advance knowledge and skills in specialty and subspecialty practice.

Expanding the opportunities for formal recognition of physical therapists engaged in subspecialty practice allows for increased education, training, and demonstration of knowledge. This amendment will support the APTA Strategic Plan's commitment to quality of care and supports the plan's outcome measure for achieving a record number of members seeking career advancement through specialization, residency, fellowship, continuing education, and/or certifications.

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

APTA's specialist certification program, governed by the American Board of Physical Therapy Specialties, was established to advance the profession of physical therapy by establishing, maintaining, and promoting standards of excellence for clinical specialization, and by recognizing the advanced knowledge, skills, and experience by physical therapist practitioners through specialist credentialing. These efforts would continue through the expansion of this recognition to physical therapists engaged in subspecialty practice.

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 House of Delegates adopted the initial position Clinical Specialization in Physical Therapy (HOD P06-16-10-11) in 1978. In 2019 the House separated this into the following policy and position documents focused on specialization:

- Clinical Specialization In Physical Therapy HOD P06-19-66-30.
- APTA Clinical Specialization Policy HOD Y06-19-67-31.

Board of directors policy describes the charge to ABPTS.

The Board of Directors adopted Specialty and Subspecialty Definitions BOD P05-21-02-05, which defines the terms specialty and subspecialty as formally recommended by ABPTS and the American Board of Physical Therapy Residency and Fellowship Education.

With RC 10-21, APTA was charged to examine the history and current status of specialization and advanced clinical practice within the physical therapy profession and from that analysis create a long-term strategy to enhance the evolution and integration of specialization, and potentially sub-specialization, into the advanced practice of physical therapy, with a report submitted to the House of Delegates in 2023.

Stakeholders that would be impacted by this motion include:

- Physical therapists seeking increased recognition for their subspecialty practice, including but not limited to those completing an accredited fellowship program.
- ABPTS, which has committed to supporting certification efforts at the subspecialty area if approved.
- Postprofessional education providers who contribute to a physical therapist's continued advanced knowledge, skills, and practice experience.
- Clinical practices that provide care at the subspecialty level.

D. Additional Background Information.

If approved, ABPTS is committed to the development of petition and review processes that align specialty and subspecialty practices (certification, certificates, residency, fellowship) with contemporary practice and societal needs. This would also require coordination with ABPTRFE as well, as they already recognize subspecialty areas of practice through fellowships. ABPTRFE fellowship accreditations are currently offered in ten different subspecialty areas:

- Critical Care
- Hand Therapy
- Higher Education Leadership
- Neonatology
- Neurologic Movement Disorders
- Orthopaedic Manual Physical Therapy
- Performing Arts
- Spine
- Sports Division 1
- Upper Extremity Athlete

Based on the development processes required, the anticipated timeframe for the first subspecialty certification examination(s) would be no earlier than seven years.

REFERENCES

1. The Future of Specialization and Advanced Clinical Practice in Physical Therapy (RC 10-21) Special Report to the House of Delegates
2. Glossary of Terms Related to Certification and Assessment

Main Motion to the 2023 House of Delegates

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

Motion Contact: Margaret Elaine Lonnemann, PT, DPT, Delegate, APTA Kentucky
E-mail: elonnemann@usa.edu

RC Contact: Pamela White, PT, DPT
E-mail: pwhite5577@aol.com

PROPOSED BY: ELAINE LONNEMANN

RC 5-23 AMEND: AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION RECOGNITION (HOD P06-18-40-43)

That American Board of Physical Therapy Residency and Fellowship Education Recognition (HOD P06-18-40-43) be amended by substitution.

AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION RECOGNITION

The American Physical Therapy Association recognizes the American Board of Physical Therapy Residency and Fellowship Education as the financially supported agency for the accreditation of physical therapy residency and fellowship education programs. APTA also recognizes the Accreditation Council on Orthopaedic Manual Physical Therapy Education as an accreditation body for orthopedic manual physical therapy fellowship education.

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 report to the House of Delegates followed by Bylaws, Standing Rules, or policy changes (if needed) that will allow for recognition of all Fellows of AAOMPT and Fellowship Programs who have met the international OMPT Standards.

The proposed motion supports the strategic initiative to elevate the quality of care provided by PTs to improve health outcomes for populations, communities, and individuals. The guiding principles quality and collaboration are reinforced with the recognition of programs required to meet international standards. It contributes to the mission by adding to the area of member value and ensuring that APTA's community delivers unmatched opportunities to belong, engage, and contribute. In addition the results of this motion will contribute to the vision for excellence in physical therapy education to ensure core faculty of all programs have the qualifications necessary to oversee and initiate both educational and practice aspects of a program's fellowship curriculum and includes more clinical partners for the development of clinical academic partnerships. The motion may also encourage more members to maintain specialty certification because of the benefits of receiving category 2 credit for completion of an ABPTRFE accredited fellowship. It may also enhance the recruitment of site reviewers for ABPTRFE for all fellowship programs as they also receive credit toward the maintenance of specialty certification (MOSC).

B. How is this motion's subject national in scope or importance?
The motion is national in scope because of the value of the close collaboration between AAOMPT and the APTA related to the accreditation of OMPT Fellowships to meet the Internationally developed standards as created by IFOMPT. IFOMPT is a recognized subgroup of the World Physiotherapy (WPT). There are 37

manual therapy member organizations in the world representing 23,000 PTs within this subspecialty. The APTA recognizes AAOMPT as the US representative member organization to IFOMPT and IFOMPT is a subgroup of WCPT.

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 not state or federal laws or regulations pertaining to this topic.

People affected by this motion include APTA members who are involved with or are considering all fellowship training.

D. Additional Background Information.

In 1992 the Academy of Orthopaedic Physical Therapy recognized AAOMPT as the Organization that sets standards for OMPT education in the United States. AAOMPT is still an active partner and collaborates with the AOPT.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Brady Holcomb, PT, DPT, Delegate, Texas Physical Therapy Association
E-mail: Bholcomb8820@gmail.com

RC Contact: Pamela White, PT, DPT
E-mail: pwhite5577@aol.com

PROPOSED BY: TEXAS

RC 6-23 ADOPT: SUPPORT FOR EDUCATION THAT INCLUDES IDENTIFYING SIGNS OF HUMAN TRAFFICKING

That the following be adopted:

SUPPORT FOR EDUCATION THAT INCLUDES IDENTIFYING SIGNS OF HUMAN TRAFFICKING

The American Physical Therapy Association supports physical therapist and physical therapist assistant education that includes identifying signs of human trafficking.

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 for American Physical Therapy Association (APTA) to recommend that content in physical therapist and physical therapist assistant student education programs include content to identify signs of human trafficking. Content should also include evidence-based screening tools and resources to assist survivors of human trafficking.

This motion directly addresses two of the four goals of the Strategic Plan.
Quality of Care: Elevate the quality of care provided by physical therapists and physical therapist assistants to improve health outcomes for populations, communities, and individuals. Promotion of human trafficking training could be part of the outcome: A portfolio of new APTA evidence-based resources will drive quality of care evolutions to impact health at all levels.
Demand and Access: Drive demand for and access to physical therapy as a proven pathway to improve the human experience. This motion could help meet the outcome: Use of and demands for physical therapist services as primary entry point of care for consumers will increase.

The motion promotes the Vision and commitment to diversity, equity, and inclusion by potentially promoting health care equity and diversity and inclusivity of groups marginalized by human trafficking to enhance the human experience. Results could have significant effects on populations marginalized by human trafficking who have access to the profession of physical therapy.

This motion also addresses current Commission of Accreditation of Physical Therapist Education (CAPTE) criteria:[1]

7D2 Report to appropriate authorities suspected cases of abuse of vulnerable populations.
7D4 Practice in a manner consistent with the APTA Code of Ethics
7D5 Practice in a manner consistent with the APTA Core Values.

7D6 Implement, in response to an ethical situation, a plan of action that demonstrates sound moral reasoning congruent with core professional ethics and values.

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

Human trafficking is a national and global problem with an estimated 40.3 million victims worldwide and 800,000 victims in the United States each year. It occurs in all states and communities and impacts individuals of all ages, races, gender, and nationality and includes trafficking for sex and labor.[2]

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 any current activities of the House, Board, or staff that have addressed this topic.

Internal stakeholders may include all Academies and Sections as human trafficking affects people of all ages.

External stakeholders may include CAPTE and the American Council of Academic Physical Therapy (ACAPTE). Additional external stakeholders are individuals and groups that are marginalized in society and may be victims of human trafficking.

Federal laws include the Trafficking Victims Protection Act of 2000.[3]

State laws: Some states, including Texas and Florida, require training to recognize and prevent human trafficking as part of licensure or the renewal of a license.

Texas HB 2059 Relating to required human trafficking prevention training as a condition of registration permit or license renewal for certain health care practitioners. 2019-2020, 86th Legislature.[4]

D. Additional Background Information.

Human trafficking is pervasive, yet health care providers including physical therapists and physical therapist assistants may lack an understanding of risk factors, signs and symptoms, and knowledge of how to offer assistance. Survivors of human trafficking often present to health care providers while still in control of their traffickers. Physical therapists are often first-contact health professionals and as such can identify and assist those being trafficked.[5] Common screening questions ask about work conditions, living conditions, physical health, mental health trauma, and travel and immigration history.[6]

In general, the healthcare educational system does not provide the knowledge of basic concepts related to the healthcare needs of individuals experiencing human trafficking. All members of the healthcare team should be educated to meet the needs of patients who are being trafficked. There are many educational strategies to teach and increase awareness for signs of human trafficking and how to respond when needed.[7] This motion requests American Physical Therapy Association collaborate with CAPTE and ACAPT to support that education without endorsing any strategy or method.

REFERENCES

1. Accreditation Handbook. Commission on Accreditation in Physical Therapy Education. https://www.capteonline.org/globalassets/capte-docs/capte-pt-standards-required-elements.pdf
2. U.S. Department of State. About Human Trafficking. https://www.state.gov/humantrafficking-about-human-trafficking.
3. Victims of Trafficking and Violence Protection Act of 2000. Public Law 106-386. 106th Congress. https://www.govinfo.gov/content/pkg/PLAW-106publ386/pdf/PLAW-106publ386.pdf
4. Texas HB 2059 Relating to required human trafficking prevention training as a condition of registration permit or license renewal for certain health care practitioners. 2019-2020, 86th Legislature. https://legiscan.com/TX/bill/HB2059/2019

5. Rapoza S. Sex trafficking: a literature review with implications for health care providers. Adv Emerg Nurs J. 2022;44(3):248-261. DOI: 10.1097/TME. 0000000000000419
6. Macy RJ, Klein LB, Shuck CA, Rizo CF, Van Deinse TB, Wretman CJ, Luo J. A scoping review of human trafficking screening and response. Trauma, Violence, & Abuse. 2021;0(0):1-18. DOI: 10.1177/15248380211057273
7. Johnson LA, Patterson A, Begley K, Ryan-Haddad A, Pick AM, Todd M, Sedillo T, Dawson AM. Development and implementation of violence across the lifespan (VAL) interprofessional education modules for health sciences students addressing human trafficking, child maltreatment, and intimate partner violence. J Inter Educ Pract. 2022;29:100535. https://doi.org/ 10.1016/j.xjep.2022.100535

Main Motion to the 2023 House of Delegates

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

Motion Contact: Derrick F Campbell, PT, DPT, ScD, Delegate, Texas Physical Therapy Association
E-mail:dcampbell@usa.edu

RC Contact: Arie van Duijn, PT, EdD
Email: duijn101@gmail.com

PROPOSED BY: TEXAS

RC 7-23 CHARGE: PROVIDE RESOURCES FOR SIGNS OF HUMAN TRAFFICKING

That the American Physical Therapy Association provide access to compiled resources for physical therapists and physical therapist assistants about signs of human trafficking, including access to screening tools.

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?
Physical therapists are accepted as primary points of contact for patients and as such have a duty to screen for health conditions associated with human trafficking.

The expected outcomes of this motion would be to promote training of physical therapists and physical therapist assistants to recognize signs of human trafficking and to screen for individuals marginalized by human trafficking. Promotion of training could include a list of already available training programs to recognize and address human trafficking. These programs also include steps that should be taken to help an individual who is experiencing trafficking.
This motion directly addresses two of the four goals of the Strategic Plan.
Quality of Care: Elevate the quality of care provided by physical therapists and physical therapist assistants to improve health outcomes for populations, communities, and individuals. Promotion of human trafficking training could be part of the outcome: A portfolio of new APTA evidence-based resources will drive quality of care evolutions to impact health at all levels.
Demand and Access: Drive demand for and access to physical therapy as a proven pathway to improve the human experience. This motion could help meet the outcome: Use of and demands for physical therapist services as primary entry point of care for consumers will increase.

The motion promotes the Vision and commitment to diversity, equity, and inclusion by potentially promoting health care equity and diversity and inclusivity of groups marginalized by human trafficking to enhance the human experience. Results could have significant effects on populations marginalized by human trafficking who have access to the profession of physical therapy.

B. How is this motion's subject national in scope or importance?
Human trafficking is a national and global problem with an estimated 40.3 million victims worldwide and 800,000 victims in the United States each year. It occurs in all states and communities and impacts individuals of all ages, races, gender, and nationality and includes trafficking for sex and labor.[2]

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 any current activities of the House, Board, or staff that have addressed this topic.

Internal stakeholders may include all Academies and Sections as human trafficking affects people of all ages.

External stakeholders may include populations that are marginalized in society and may be victims of human trafficking.

Federal laws include the Trafficking Victims Protection Act of 2000.[2]
https://www.govinfo.gov/content/pkg/PLAW-106publ386/pdf/PLAW-106publ386.pdf

State laws: Some states, including Texas and Florida, require training to recognize and prevent human trafficking as part of licensure or the renewal of a license.

Texas HB 2059 Relating to required human trafficking prevention training as a condition of registration permit or license renewal for certain health care practitioners. 2019-2020, 86th Legislature.[3]

D. Additional Background Information.
Human trafficking is pervasive, yet health care providers including physical therapists and physical therapist assistants may lack an understanding of risk factors, signs and symptoms, and knowledge of how to assist and refer. Survivors of human trafficking often present to health care providers while still in control of their traffickers. Physical therapists are often first-contact health professionals and as such can identify and assist victims of trafficking. To do this physical therapists and physical therapist assistants need to know risk factors, recognize signs of trafficking, and be trained to offer appropriate assistance.[4]

Trafficking screening tools and responses are available, but not in a centralized location with easy access for physical therapists and physical therapist assistants. Common screening questions ask about work conditions, living conditions, physical health, mental health trauma, and travel and immigration history.[5]

According to the Department of Homeland Security, “Human trafficking involves the use of force, fraud, or coercion to obtain some type of labor or commercial sex act.” Millions of men, women, and children are trafficked worldwide and in the United States. Survivors of human trafficking are of any age, race, gender, or nationality. Language barriers, fear of traffickers and of law enforcement may keep individuals from seeking help.[6]

In 2021, the International Labour Organization, the Walk Free Foundation, and the International Organization for Migration, estimated that there were 27.6 million people in forced labor.[6,7] The Trafficking Victims Protection Act of 2000 define human trafficking as forced labor requiring the trafficker’s acts, means, and purpose.[6]

There are no official policy statements on human trafficking by physical medicine and rehabilitation organizations, such policies are needed for appropriate patient management.[7] Many trafficked persons present to clinical settings with a variety of impairments within the scope of practice of physical therapists. Physical therapists and physical therapist assistants should employ a patient-centered, trauma-informed approach emphasizing the patient’s freedom of choice.[7]

REFERENCES

1. Accreditation Handbook. Commission on Accreditation in Physical Therapy Education. https://www.capteonline.org/globalassets/capte-docs/capte-pt-standards-required-elements.pdf
2. U.S. Department of State. About Human Trafficking. https://www.state.gov/humantrafficking-about-human-trafficking.

3. Victims of Trafficking and Violence Protection Act of 2000. Public Law 106-386. 106th Congress. https://www.govinfo.gov/content/pkg/PLAW-106publ386/pdf/PLAW-106publ386.pdf
4. Texas HB 2059 Relating to required human trafficking prevention training as a condition of registration permit or license renewal for certain health care practitioners. 2019-2020, 86th Legislature. https://legiscan.com/TX/bill/HB2059/2019
5. Rapoza S. Sex trafficking: a literature review with implications for health care providers. Adv Emerg Nurs J. 2022;44(3):248-261. DOI: 10.1097/TME. 0000000000000419
6. Macy RJ, Klein LB, Shuck CA, Rizo CF, Van Deinse TB, Wretman CJ, Luo J. A scoping review of human trafficking screening and response. Trauma, Violence, & Abuse. 2021;0(0):1-18. DOI: 10.1177/15248380211057273
7. Johnson LA, Patterson A, Begley K, Ryan-Haddad A, Pick AM, Todd M, Sedillo T, Dawson AM. Development and implementation of violence across the lifespan (VAL) interprofessional education modules for health sciences students addressing human trafficking, child maltreatment, and intimate partner violence. J Inter Educ Pract. 2022;29:100535. https://doi.org/ 10.1016/j.xjep.2022.100535

Main Motion to the 2023 House of Delegates

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

Motion Contact: Susan Griffin, PT, DPT, MS, Registered Parliamentarian, Delegate, APTA Wisconsin
E-mail: suegriffin@aptawi.org

RC Contact: Arie J. Van Duijn, PT, MSPT, EdD
E-mail: duijn101@gmail.com

PROPOSED BY: WISCONSIN

RC 8-23: ADOPT: AUTONOMY IN DETERMINING QUALIFICATIONS OF CORE DOCTOR OF PHYSICAL THERAPY FACULTY

That the following be adopted:

AUTONOMY IN DETERMINING QUALIFICATIONS OF CORE DOCTOR OF PHYSICAL THERAPY FACULTY

The American Physical Therapy Association supports allowing doctor of physical therapy programs autonomy in determining the percentage of their core faculty who must have academic doctoral degrees.

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 Commission on Accreditation in Physical Therapy Education (CAPTE) criterion 4K stipulates that at least 50% of core faculty in a Doctor of Physical Therapy (DPT) education program must hold an academic doctorate. This may include a PhD, an EdD, 'or other doctoral degree that requires advanced work beyond the master's level, including the preparation and defense of a dissertation based on original research, or the planning and execution of an original project demonstrating substantial scholarly achievement.'[1] An entry-level DPT degree does not meet this requirement. The aim of the motion is to create a formal statement indicating that educational institutions and physical therapist education programs should be allowed by CAPTE to determine the appropriate mix of credentialed faculty to meet the expectations of the institution, the goals of the program, and the needs of the students. CAPTE is currently accepting input on revisions to the Standards and Required Elements for Accreditation of Physical Therapist Education Programs, though no change in the 50% threshold in 4K has been proposed. The majority of input CAPTE receives is understandably from the educational community. A statement by the American Physical Therapy Association (APTA) House of Delegates (HOD) would provide CAPTE with timely and important feedback from delegates representing all areas of the profession. By making a statement related to faculty qualifications in DPT education programs, this motion addresses the guiding principles of quality, collaboration, and innovation in the Guiding Principles to Achieve the Vision (HOD P06-19-46-54). It also continues the collaborative efforts to drive excellence in physical therapy education that were formalized when the Educational Leadership Partnership (ELP) was in existence.

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

CAPTE is the only agency recognized by CAPTE for the accreditation of physical therapy education programs. Providing input on the standards developed by CAPTE impacts the quality of physical therapy education throughout the country.

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 Association activities focused specifically on criterion 4K of the CAPTE Standards and Required Elements for Accreditation of Physical Therapist Education Programs. However, as noted above, CAPTE is currently accepting input to revisions of the entire document, so there are certainly CAPTE staff who are working to gather that input, some of which may apply to criterion 4K. In August 2021, the ELP published 'A Vision for Excellence in Physical Therapy Education'[2], and one of the guiding principles they developed is that 'Educators continually advance their knowledge, skills and attitudes to deliver evidence-based educational and practice aspects of curricula, and to serve as leaders and mentors.'. There is no mention of faculty credentials required to achieve those aims.

The primary stakeholders affected by this motion are the educational institutions and DPT programs. The goal of this motion is to allow those stakeholders complete autonomy in determining the optimal faculty mix to meet the needs of their institution, their program, and their students. Secondary stakeholders affected by the decision of the institution and program include potential and current faculty, students, patients served by those students/graduates, and the profession as a whole. Allowing DPT programs to lower the number of academic doctoral prepared faculty has been posited to have many potential consequences, including decreasing financial barriers for DPTs to enter academia; decreasing time barriers for DPTs to enter academia; increasing the number of women and minorities in academia; allowing more flexibility in educational programming[3]; decreasing the production of physical therapy research[4]; increasing production of clinically-focused PT research; lowering tuition; raising tuition; and allowing for development of too many DPT programs. Each of these potential consequences should be carefully weighed. However, they should be weighed by the DPT programs as they are determining optimal faculty mix for their needs. The role of CAPTE is to determine quality standards for physical therapy education and to assess whether programs have met those standards, not to dictate how the programs must meet those standards.

No state or federal laws or regulations address criterion 4K of the CAPTE Standards and Required Elements for Accreditation of Physical Therapist Education Programs.

D. Additional Background Information.

The main question posed by this motion is not whether at least 50% of DPT faculty should hold academic doctoral degrees. The question is which entity should determine the optimal mix of faculty 'to meet program goals and expected program outcomes as related to program mission, institutional expectations and assigned program responsibilities'.[1] With the exception of the Occupational Therapy Doctorate5 (which appears to be modeled after CAPTE standards), no other clinical doctoral programs delineate the percentage of core faculty required to hold academic doctoral degrees. Delegates who believe the responsibility for this determination lies with the DPT program should vote yes on this motion.

REFERENCES

1. The Commission on Accreditation in Physical Therapy Education Standards and Required Elements for Accreditation of Physical Therapist Education Programs.
2. A Vision for Excellence in Physical Therapy Education. https://journals.lww.com/jopte/Fulltext/2021/12001/A_Vision_for_Excellence_in_Physical_Therapy.1.aspx
3. Dickson, T., Taylor, B. Faculty Staffing Patterns: Breadth and Flexibility in Professional Physical Therapy Programs. Innov High Educ 46, 499–518 (2021).

4. Myers, Bradley J. PT, DPT, DSc; Tudini, Frank T. PT, DSc; Sawyer, Scot M. PT, DPT. Scholarly Productivity Among Doctor of Physical Therapy Faculty in the United States. Journal of Physical Therapy Education 34(2):p 172-178, June 2020.
5. **Accreditation Council for Occupational Therapy Education (ACOTE®) Standards and Interpretive Guide.** https://acoteonline.org/accreditation-explained/standards/

Main Motion to the 2023 House of Delegates

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

Motion Contact: James R. Roush, PT, PhD, ATC, Delegate, APTA Arizona
E-mail: jroush@atsu.edu

RC Contact: Venita Lovelace-Chandler, PT, PhD, FAPTA
E-mail: vlc.phd.pt.pcs@gmail.com

PROPOSED BY: ARIZONA AND APTA ACADEMY OF EDUCATION

RC 9-23: CHARGE: EXPLORE ALTERNATE MODELS FOR PHYSICAL THERAPIST ASSISTANT EDUCATION AND PRACTICE

That the American Physical Therapy Association explore alternate models of education and practice in other health care professions to identify best practices toward developing a consistent scope of work for the PTA, as discussed in "The Physical Therapist Assistant Education Summit Report: Prioritized Recommendations for the Future," published by the Journal of Physical Therapy Education in 2022.

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?

It is our hope that the American Physical Therapy Association may follow some of the recommendations from the Physical Therapy Assistant Education Summit. The first recommendation from the conference was an examination of models of education and practice in other health care professions that may influence possible changes to more effectively utilize of physical therapy assistants in the delivery of physical therapy services. Perhaps the physical therapy profession is not using the physical therapist assistant at the most optimal capability.

This is related to the Strategic Plan for Sustainable Profession: "Improve the long-term sustainability of the profession by leading efforts to increase payment, reduce the cost of education, and strengthen provider health and well-being," and "Physical therapists and physical therapist assistants will be paid fairly and will spend more time with patients than with paperwork."

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

In 2021, the Bureau of Labor Statistics published the ratios of separation for trades, occupations, and professions. A separation occurs when an individual leaves a trade, occupation, or profession for any reason; whether is through death, retirement, or just changing what the individual does for a living. The published separation rate for Physical Therapist Assistants is 14% PER year. That means 14% of Physical Therapist Assistants are leaving physical therapy every year. That ratio is unsustainable. Some steps need to be made to reduce this ratio. We are hoping this is a first step.

In 2022 a paper was published in Journal of Physical Therapy Education reporting on work of a taskforce that advanced recommendations for the future of PTA education. (Giffin K, Levangie P. The Physical Therapist Assistant Education Summit Report: Prioritized Recommendations for the Future, al of Physical Therapy Education 36(4s1):p 1-13, December 2022.) From this paper, we believe that there are a couple of concepts for motions that can begin immediately (specific recommendations can be found in Table 12 of the article). The first recommended strategy from the paper is: "That the American Physical Therapy

Association examine alternate models of education and practice, as well as jurisdictional differences, in other health care professions (eg, nursing, respiratory, OT, MD, etc) to better inform the most effective utilization of the physical therapist assistant in the delivery of physical therapist services." What we think is that we need to look at what other professions (eg, nursing, respiratory, OT, MD, etc) are doing in terms of the work of their assistive personnel. By learning from the other health professions, we may learn avenues to better utilize the physical therapist assistant in physical therapy practice. Perhaps the physical therapy profession is not using the physical therapist assistant at the most optimal capability.

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 unaware of any further activities related to this motion by the House, Board, or staff. We are aware of the work published related to the PTA Education Summit. Roger Herr was a participant in the summit planning committee. Important stakeholders for this motion include the Academy of Physical Therapy Education, the Private Practice Section, and the PTA Engagement Group. They have been contacted and it is hope they will contribute to the discussion.

REFERENCES

1. Giffin KA, Levangie PK. The Physical Therapist Assistant Education Summit Report: Prioritized Recommendations for the Future. Journal of Physical Therapy Education. 2022 (12);36(4s1):p 1-13.
2. US Bureau of Labor Statistics. Occupational separations and openings. https://www.bls.gov/emp/tables/occupational-separations-and-openings.htm. Accessed March 15, 2023.

Main Motion to the 2023 House of Delegates

Required for Adoption:	Majority Vote	**Category**: QU-8
Motion Contact:	James R. Roush, PT, PhD, ATC, Delegate, APTA Arizona E-mail: jroush@atsu.edu	
RC Contact:	Venita Lovelace-Chandler, PT, PhD, FAPTA E-mail: vlc.phd.pt.pcs@gmail.com	

PROPOSED BY: ARIZONA AND APTA ACADEMY OF EDUCATION

RC 10-23: CHARGE: NATIONAL CONFERENCE ON PTA SCOPE OF WORK AND SUPERVISION REQUIREMENTS

That the American Physical Therapy Association explore opportunities to conduct a national conference to develop model regulatory language on PTA scope of work and supervision requirements, as discussed in "The Physical Therapist Assistant Education Summit Report: Prioritized Recommendations for the Future," published by the Journal of Physical Therapy Education in 2022.

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?

That the American Physical Therapy Association would collaborate with other interested parties to conduct a national conference to develop model regulatory language on PTA scope of work and supervision requirements that reflect the highest evidence-based expectations found across jurisdictions and settings. The other interest parties may include the Federation of State Boards of Physical Therapy and regulatory boards.

A question could be what is the potential for such a conference to be convened and what is the potential for some positive recommendations from the conference. Recent history has shown that physical therapists have come together to form the Physical Therapy Compact, which is having a positive effect on physical therapy practice. The House of Delegates passed a motion supporting the PT Compact in 2014. Within 5-7 years it was up and running. Perhaps in 5-7 years, the role of the physical therapist assistant will change. If changes in the role of the physical therapist assistant are not made, there is a potential that there will be no physical therapist assistants in the not so distant future.

This is related to the Strategic Plan for Sustainable Profession: "Improve the long-term sustainability of the profession by leading efforts to increase payment, reduce the cost of education, and strengthen provider health and well-being," and "Physical therapists and physical therapist assistants will be paid fairly and will spend more time with patients than with paperwork."

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

In 2021, the Bureau of Labor Statistics published the ratios of separation for trades, occupations, and professions. A separation occurs when an individual leaves a trade, occupation, or profession for any reason; whether is through death, retirement, or just changing what the individual does for a living. The published separation rate for Physical Therapist Assistants is 14% PER year. That means 14% of Physical

Therapist Assistants are leaving physical therapy every year. That ratio is unsustainable. Some steps need to be made to reduce this ratio. We are hoping this is a first step.

In 2022 a paper was published in Journal of Physical Therapy Education reporting on work of a taskforce that advanced recommendations for the future of PTA education. (Giffin K, Levangie P. The Physical Therapist Assistant Education Summit Report: Prioritized Recommendations for the Future, al of Physical Therapy Education 36(4s1):p 1-13, December 2022.) From this paper, we believe that there are a couple of concepts for motions that can begin immediately (specific recommendations can be found in Table 12 of the article). The second recommended strategy from the paper is: “Conduct a national consensus conference to develop model regulatory language on PTA scope of work and supervision requirements that reflect the highest evidence-based expectations found across jurisdictions and settings.”

Physical therapist assistants are licensed or certified in all regulatory jurisdictions in the United States. Therefore, there is substantial importance nationally 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?

We are unaware of any further activities related to this motion by the House, Board, or staff. We are aware of the work published related to the PTA Education Summit. Roger Herr was a participant in the summit planning committee. Important interest parties for this motion may include the Academy of Physical Therapy Education, the Private Practice Section, the PTA Engagement Group, and Federation of State Boards of Physical Therapy. They have been contacted and it is hope they will contribute to the discussion.

REFERENCES

1. Giffin KA, Levangie PK. The Physical Therapist Assistant Education Summit Report: Prioritized Recommendations for the Future. Journal of Physical Therapy Education. 2022 (12);36(4s1):p 1-13.
2. US Bureau of Labor Statistics. Occupational separations and openings. https://www.bls.gov/emp/tables/occupational-separations-and-openings.htm. Accessed March 15, 2023.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Karen Goodlow, PT, DPT, MBA, Chief Delegate, Illinois Physical Therapy Association
E-mail: kgoodlow@comcast.net

RC Contact: Arie J. Van Duijn, PT, MSPT, EdD
E-mail: duijn101@gmail.com

PROPOSED BY: ILLINOIS

RC 11-23 RESCIND: OPPOSITION TO PHYSICIAN OWNERSHIP OF PHYSICAL THERAPIST SERVICES AND SELF-REFERRAL BY PHYSICIANS (HOD P06-19-16-46)

That Opposition to Physician Ownership of Physical Therapist Services and Self-Referral by Physicians (HOD P06-19-16-46) be rescinded.

~~**RESCIND OPPOSITION TO PHYSICIAN OWNERSHIP OF PHYSICAL THERAPIST SERVICES AND SELF-REFERRAL BY PHYSICIANS**~~

~~**Whereas, The American Physical Therapy Association advocates for a healthy society, for patient and client engagement in health services, and for direct access to physical therapist services;**~~

~~**Whereas, Physical therapists and physicians collaboratively provide patient-centered services in practice models that may include mutual referral, co-management, and consultation;**~~

~~**Whereas, Physician self-referral to physical therapist services in which an ownership interest by the physician is an avoidable conflict of interest that may restrain patient choice in services;**~~

~~**Whereas, Federal law prohibits, with some exceptions, physician self-referral for various designated health services1;**~~

~~**Whereas, Evidence suggests that there is greater cost per patient encounter and for the entire episode of care in self-referral situations2; and**~~

~~**Whereas, Evidence also suggests that patients in self-referral situations receive more passive treatment that is performed by persons not licensed as physical therapists and that non-self-referred physical therapist services include more active, hands-on, and one-to-one services that promote greater patient independence and a return to performing routine activities without pain3;**~~

~~**Resolved, That the American Physical Therapy Association opposes ownership of and self-referral to physical therapist services by physicians, and supports federal and state laws and regulations that prohibit physician ownership of 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?

The expected outcome of this motion is to rescind HOD P06-19-16-46 (Opposition to Physician Ownership of Physical Therapist Services and Self-Referral by Physicians), originally passed in 2003 and amended in 2019. One of the ways that this Position Statement has been operationalized is to limit the ability of members of the APTA who work in physician owned practices from fully participating as a part of the organization. There have been several instances where members were not allowed to participate at the component level with a posting on a job board for a physician owned entity. There has also been an instance where members were not allowed to participate as a vendor in the exhibit hall at CSM because they were physician owned. These exclusionary acts do not move the association towards creating member value for all members.

The APTA Strategic Plan has a primary goal of “Increasing member value by ensuring that APTA’s community delivers unmatched opportunities to belong, engage, and contribute”. The current operationalization and interpretation of this position statement by APTA staff has led to members feeling they are not valued and are not a full part of the professional organization. At the end of the APTA Better Together Statement it reads: “to improve the health of society, we believe every stakeholder in the APTA community has a role to play.” This position statement, as it is currently interpreted, does not allow all members full participation and does not demonstrate our Core Value of Inclusion. By passing this motion and rescinding the Position Statement, the organization would allow more global statements to speak to ethical practice and business arrangements while also removing this barrier to participation in the organization based on employer category.

The overall goals of autonomous, patient centered practice and appropriate business practices/referrals are clearly delineated in multiple other documents of this professional body such as Autonomous Physical Therapist Practice (HOD P06-06-18-12), Practice and Business Financial Arrangements for Physical Therapists (HOD P06-20-39-31), and the Code of Ethics for the Physical Therapist (HOD S06-20-28-25) on a more global level. This position statement is specific to one type of practice arrangement/ownership model, whereas we do not have other position statements that speak to other practice models, which present similar concerns. If the concern is ethical and legal practice, allowing choice of practitioner, best practice, and managing ultimate cost to the system then these other documents speak to those across settings/practice models. These more global documents would still be able to provide APTA members insight into decisions on employment without a focus on a single model. There is pressure for referral and patient recruitment and/or retention in a large number of practice arrangements. Unethical practice and business arrangements are unethical no matter who owns the practice.

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

Since this original position statement came from the House of Delegates, the need to rescind this statement is national in scope. The biggest impact would be on members who are employed by physician owned entities who would then be allowed to participate fully within the association. The association would also benefit from being “better together” by welcoming a group who have previously been excluded based on their employment.

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 IL delegation does not want to minimize the concerns of the original motion makers of this position statement, which in 2003 were the IL delegation and Private Practice Section. Concerns regarding ethical practice, therapist autonomy, patient choice, cost of healthcare services, and best practice are paramount for our profession. However, as the healthcare environment has continued to shift over the 20 years since this was originally passed by the House, there have been immense changes with regards to ownership models across the profession. There are now many companies that are owned by private equity groups or hospital systems, or are publicly traded. These owners present the same ethical concerns as physician

owned groups-if not to a larger degree, as these other owners may not even be healthcare professionals who have ethical training specific to patient care. They may also not have any type of professional licensure. The IL delegation contends that we have strong, global statements regarding these concerns and the current position statement HOD P06-19-16-46 Opposition to Physician Ownership of Physical Therapist Services and Self-Referral by Physicians isolates a single business arrangement and limits member participation in the professional organization.

The key areas of concern addressed by the original motion are ethical, autonomous practice, and financial relationships. These concerns are addressed by documents that exist within the APTA and the House of Delegates, including the Code of Ethics for the Physical Therapist (HOD S06-20-28-25), Practice and Business Financial Arrangements for Physical Therapists (HOD P06-20-39-31), and Autonomous Physical Therapist Practice (HOD P06-06-18-12).

The Code of Ethics for the Physical Therapist (HOD S06-20-28-25) has multiple items that speak to autonomous decision making, complying with laws and regulations, avoiding of conflicts of interest, and refraining from arrangements that prevent the therapist from fulfilling the obligations to patient:

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's or client's best interest in all practice settings.

3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.

5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients and clients.

These statements speak to ethical principles for all professionals, regardless of ownership of the practice. In HOD P06-20-39-31 Practice and Business Financial Arrangements for Physical Therapists, three significant components of the position statement address on a more global level the concerns raised as part of the Opposition of Physician Owned Practice Position statement. Namely, the APTA supports practice and business models that:

- Prioritize best clinical practice above business and financial aims.
- Provide value and choice for the consumer
- Comply with laws and regulations, such as antitrust and Stark laws.

In addition, Autonomous Physical Therapist Practice (HOD P06-06-18-12) states that "Physical Therapists have the responsibility to practice autonomously in all settings, practice environments, and employment relationships."

In addition to documents internal to the profession, there are federal and state laws that speak to self-referral, such as the Physician Self-Referral Law, commonly referred to as Stark law and Anti-Kickback statutes. There are a small number of states that have laws that speak to physician self-referral.

There are many stakeholders that could be impacted by this motion. Physical therapists who work for physician owned practice would be the stakeholder most impacted by this motion. These therapists may not feel valued or equal to other members of the organization based on the current position statement as it stands, and this motion to rescind it could create/improve member value and possibly membership from

this group. Patients/clients are a primary stakeholder of concern due to the concerns related to cost and patient choice. Public (Medicare/Medicaid) and private payor source insurance are stakeholders as this motion and various business models can impact cost of healthcare. Hospital and healthcare systems, private practice companies, and larger healthcare corporations are stakeholders. Another primary stakeholder in this are physical therapists, members and non members.

D. Additional Background Information.

The Government Accountability Office released a report in 2014 titled “Medicare Physical Therapy” which looked at self-referring providers from 2004 to 2010. They reported that while there were more referrals to beneficiaries, there were fewer services to each beneficiary. They also reported that referrals from self-referring providers stayed steady, while referrals to PT by non-self referring providers increased by 41%.[1]

It should be noted that the APTA/House do not currently have position statements which oppose any other ownership models for physical therapy, although several other ownership models do exist with similar ethical concerns.

REFERENCES

1. U.S. Government Accountability Office. Medicare Physical Therapy: Self-Referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary. GAO-14-270. April 2014.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Steve Forbush, PT, PhD, OCS, Chief Delegate, APTA Arkansas
E-mail:steve@orthomti.com

RC Contact: Pamela White, PT, DPT
E-mail: pwhite5577@aol.com

PROPOSED BY: ARKANSAS

RC 12-23 CHARGE: SOCIAL MEDIA MARKETING STRATEGIES FOR COMPONENTS

That the American Physical Therapy Association provide resources, support, and instruction to components on social media marketing strategies to promote consumer recognition of the profession of physical therapy and promote member recruitment and engagement.

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?
We would expect the APTA staff and resources to be used to train and mentor the respective components on how to effectively use social media marketing, the costs of using this type of marketing, and to better understand the potential return on investment.

B. How is this motion's subject national in scope or importance?
All Components have in their interest to promote the Brand of APTA and to increase potential membership which should include social media marketing along with other means of marketing.

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 a Social Media marketing director, who should not only be well-versed in proper social media marketing strategies but should understand how to educate others on the use of this strategy to influence licensees, members, and the customers they serve. We have not asked the APTA to instruct Components in this area.

REFERENCES

1. Florence CS, Bergen G, Atherly A, et al. Medical costs of fatal and nonfatal falls in older adults. JAGS. 2018;66(4):693-698.
2. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed January 14, 2019.
3. Carroll NV, Slattum PW, Cox FM. The cost of falls among the community-dwelling elderly. J Manag Care Pharm. 2005;11(4):307-16.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Seth Peterson, PT, DPT, Delegate, APTA Arizona
E-mail: srpeterson01@atsu.edu

RC Contact: Arie J. Van Duijn, PT, MSPT, EdD
E-mail: duijn101@gmail.com

PROPOSED BY: ARIZONA

RC 13-23 CHARGE: DEVELOP A PROCESS FOR CREATION AND DISSEMINATION OF GUIDELINES FOR REFERRAL TO A PHYSICAL THERAPIST

That the American Physical Therapy Association, in collaboration with interested parties, develop a process for creation and dissemination of guidelines for referral to a physical therapist.

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 the generation of a process to identify and facilitate referral guidelines. The role of the APTA in this process would likely be similar to its role in the generation of clinical practice guidelines. In fact, it could likely use an identical process to clinical practice guidelines, and exist in parallel, thereby reducing the burden on the APTA. Additionally, the APTA's involvement may help facilitate interprofessional collaboration on referral guideline development.

This motion would address the APTA Strategic Plan in several ways. First, successful referral guidelines would help drive more demand for physical therapist services, particularly for underutilized conditions. Additionally, interprofessional collaboration on these guidelines may help strengthen care continuity and therefore patient satisfaction and outcomes.

B. How is this motion's subject national in scope or importance?
Referral guidelines have the potential to improve understanding of the best ways to access and refer to physical therapists for underutilized conditions, such as peripartum pelvic floor physical therapy. They also may be good resources for physical therapists on how to collaborate and communicate with other health professionals.

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?
Referral guidelines have not been attempted by the APTA. As far as we can tell, they have also not been discussed in the House of Delegates. As previously stated, other specialty associations have developed referral guidelines. However, these typically refer to referring to their own profession, thus none have been explicitly developed for referring to physical therapists.

There are a few adjacent actions taken by the House of Delegates. One of these is clinical practice guidelines. Although clinical practice guidelines are typically headed by Sections/Academies (ie, APTA

components) the APTA does assist with opportunities for funding, implementation, evaluation, and dissemination of appropriate guidelines.[12]

D. Additional Background Information.

This motion concept has been discussed within the Arizona Delegation and inquiries have been sent to select Association representatives. It will be discussed with the Reference Committee, shared on the Hub, and (time permitting) attempts will be made to share it during other meetings prior to the deadline for main motions.

REFERENCES

1. Chen AH, Yee HF Jr. Improving the primary care-specialty care interface: getting from here to there. *Arch Intern Med*. 2009;169(11):1024-1026. doi:10.1001/archinternmed.2009.140
2. Forrest CB. A typology of specialists' clinical roles. *Arch Intern Med*. 2009;169(11):1062-1068. doi:10.1001/archinternmed.2009.114
3. Morris AA, Khazanie P, Drazner MH, et al. Guidance for Timely and Appropriate Referral of Patients With Advanced Heart Failure: A Scientific Statement From the American Heart Association. *Circulation*. 2021;144(15):e238-e250. doi:10.1161/CIR.0000000000001016
4. Avidor Y, Still CD, Brunner M, Buchwald JN, Buchwald H. Primary care and subspecialty management of morbid obesity: referral patterns for bariatric surgery. *Surg Obes Relat Dis*. 2007;3(3):392-407. doi:10.1016/j.soard.2006.12.003
5. Oliveria SA, Yood MU, Campbell UB, Yood SM, Stang P. Treatment and referral patterns for colorectal cancer. *Med Care*. 2004;42(9):901-906. doi:10.1097/01.mlr.0000135820.44720.89
6. Im SS, Gordon AN, Buttin BM, et al. Validation of referral guidelines for women with pelvic masses. *Obstet Gynecol*. 2005;105(1):35-41. doi:10.1097/01.AOG.0000149159.69560.ef
7. Shaw BA, Segal LS; SECTION ON ORTHOPAEDICS. Evaluation and Referral for Developmental Dysplasia of the Hip in Infants. *Pediatrics*. 2016;138(6):e20163107. doi:10.1542/peds.2016-3107
8. Shaw I, Smith KM, Middleton H, Woodward L. A letter of consequence: referral letters from general practitioners to secondary mental health services. *Qual Health Res*. 2005;15(1):116-128. doi:10.1177/1049732304270725
9. Kones R, Morales-Salinas A, Rumana U. Cardiac rehabilitation underutilization: Missed opportunities in comprehensive cardiac care. *Int J Cardiol*. 2019;292:39-40. doi:10.1016/j.ijcard.2019.05.068
10. Cheville AL, Kornblith AB, Basford JR. An examination of the causes for the underutilization of rehabilitation services among people with advanced cancer. *Am J Phys Med Rehabil*. 2011;90(5 Suppl 1):S27-S37. doi:10.1097/PHM.0b013e31820be3be
11. Stubblefield MD. The Underutilization of Rehabilitation to Treat Physical Impairments in Breast Cancer Survivors. *PM R*. 2017;9(9S2):S317-S323. doi:10.1016/j.pmrj.2017.05.010
12. *APTA Clinical Practice Guideline Process Manual, Revised*. Alexandria, VA: American Physical Therapy Association; 2022.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Kimberly Varnado, PT, DPT, DHSc, Delegate, APTA Arizona
E-mail: kvarnado@csm.edu

RC Contact: Venita Lovelace-Chandler, PT, PhD
E-mail: vlc.phd.pt.pcs@gmail.com

PROPOSED BY: ARIZONA

RC 14-23 CHARGE: DEVELOP A SEARCHABLE SYSTEM FOR HOUSE BUSINESS FROM 2018 FORWARD

That the American Physical Therapy Association develop a searchable system for accessing all business noticed to the House of Delegates from 2018 forward.

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 brought forward to aid delegates and members in engaging in the business of the APTA House of Delegates. Currently, delegates must locate archived documents or rely on the institutional memory of experienced delegates to access information on past activities of the House. The proposed system will have a search function to expedite finding motions. The digital system will allow for a search of all business noticed to the House, including information on motions that were not adopted but were presented to the House as business. The purpose of including unsuccessful or other motions is to inform delegates of the work done by the members. Including this information will provide delegates with additional data to expedite future motion concept development.

If the APTA aims to increase member value by ensuring the APTA community provides opportunities to belong, engage, and contribute, this digital system supports the strategic plan of the APTA by increasing member engagement and value. In addition, by increasing transparency and communication between leadership and members, the APTA tracking system would help facilitate the process.

B. How is this motion's subject national in scope or importance?
The motion impacts how delegates can access information and develop future policies. The APTA digital system would expedite the motion development process and improve the efficiency of the House. Increasing efficiency reduces delegates' time away from work and the required resources to conduct House business annually.

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?
Currently, no activities are noted in the House or Board policies addressing this motion concept. Delegates can access motions through a search function on the APTA website. However, the search function does not provide information on all business noticed to the House.

D. Additional Background Information.

The motion intends to increase the House's efficiency and provide transparency to members regarding motions noticed to the House. Annually, delegates from 51 state chapters come together to create policies and make decisions on issues that affect the association and physical therapy profession. The current process of finding motions involves logging onto the APTA website. After a series of clicks, members can access a motion (>APTA and You>Leadership & Governance>APTA House of Delegates>Board and House Policies). APTA members can search for motions that have passed through this search function. Members of the association not in attendance at the House may be unfamiliar with or lack access to House documents and are not privy to this information expeditiously.

In addition, searching for motions that did not pass in the House is inefficient. Members must search through archived motion packets to access motions not passed. Delegates wishing to develop concepts from previously submitted motions must start from scratch. It would be more efficient to build on motion concepts from past submissions. Delegates could learn from past challenges and make adjustments to support more robust policy development.

Furthermore, the APTA digital system could help succession planning as new delegates join the House. For example, it would be helpful not to always rely on experienced delegates' institutional memories to recall past motions presented in the House. Instead, in real-time, delegates could learn about the work done in the past to help chart a clear path for the future. Another benefit of the APTA digital system is it will communicate to the membership opportunities in leadership and the governance process to increase engagement.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Chris Wilson PT, DPT, DScPT, Delegate, APTA Michigan
E-mail: cwilsondpt@gmail.com

RC Contact: Arie J. Van Duijn, PT, MSPT, EdD
E-mail: duijn101@gmail.com

PROPOSED BY: MICHIGAN

RC 15-23 CHARGE: RESOURCES RELATED TO SCREENING, REFERRALS, AND AUTHORIZATION FOR PARTICIPATION IN COMMUNITY-BASED HEALTH PROMOTION, INJURY PREVENTION, AND PHYSICAL ACTIVITY PROGRAMS

That the American Physical Therapy Association develop clinical and advocacy resources for physical therapists and physical therapist assistants, and educational materials for interested parties related to screening, referrals, and providing authorization, as components of physical therapist practice, for participation in community-based health promotion, injury prevention, and physical activity programs.

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 intent of this motion is to begin to adjust public perception of physical therapists being able to provide safe and appropriate referrals and authorization for individuals who wish to participate in community-based health promotion, injury prevention, and physical activity programs, inclusive of those which have historically required "physician clearance" to exercise. As a doctoring profession, physical therapists are extensively qualified to determine the scope and safe parameters for appropriate exercise performance in all settings.

This motion and its intent directly applies to two of the APTA's 2022-2025 Goals.

- Goal 3: Elevate the quality of care provided by PTs and PTAs to improve health outcomes for populations, communities, and individuals.
- Goal 4: 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?

Health promotion, injury prevention, and physical activity programs have national implications due to the widespread burden of management of chronic diseases and injuries from falls. One common way that individuals seek to address health and wellness issues as well as reducing fall risk is through community-facing exercise programs. Some community-based programs require written notification from a medical professional that a person is safe to participate in physical activity and exercise programs. As programs traditionally have required a physician to provide this written notification, this has created a limitation to access to community-based health promotion, injury prevention, and physical activity programming.

As physical therapists are experts in exercise and movement and skilled in exercise testing and differential diagnosis, they are well positioned and highly trained to determine the amount and type of exercise and physical activity as well as identifying when exercising at certain levels is not safe without further diagnostic or medical assessment. This charge will provide physical therapists with resources and

community education materials toward this purpose; this will improve individuals' access to another health professional to provide guidance and screening related to exercise programming, thereby positively contributing to the health and well-being of individuals, communities, and society as well as assisting in containing healthcare costs through the reduction of the health impact of sedentary lifestyles and fall-related injuries.

As all jurisdictions within the United States have some form of evaluation and treatment with direct consumer access, improved access to physical therapists as well as increased awareness by all interested parties regarding the physical therapist's role in providing referral or authorization for participation in community-based health promotion, injury prevention, and physical activity programs will help to improve the human experience through access and promotion of these community based resources.

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?

HOD P08-22-12-14 [Position] Access to Physical Therapists as Entry-Point Practitioners For Activity Participation, Wellness, Health, And Disability Determination

Now that this position has been amended in 2022 to include "Prescribe or recommend physical activity, accommodations, adaptive and assistive technology, diagnostic tests, and other interventions to optimize functioning and participation in society", there exists a need to provide concise, evidence-based resources for physical therapists to provide this needed service. In addition, educational resources are needed to let these community-based organizations know about our training and education regarding our role in providing this service related to providing a safe and appropriate referral/authorization to community programming. This will help to increase awareness that physical therapists are widely available and expertly trained as a healthcare professional who is able to provide this assessment and if necessary, authorization.

HOD P06-18-19-29: APTA supports physical therapists as authorized prescribers of durable medical equipment.

This motion is similar in concept to providing authorization that individuals for services well within the scope of physical therapist practice is endorsed. In this case it would be related to authorization to participate in physical activity and exercise programming.

In a similar analog, after lobbying efforts and past APTA positions, the Michigan government included physical therapists as one of the listed providers who, by law, are allowed to prescribe disability placards (e.g., handicap parking permits) and this is now in practice but anecdotally not widely utilized because of awareness issues and limited training available to Michigan physical therapists.

D. Additional Background Information.

The public is CONSISTENTLY coached to speak to their physician before starting exercise, but not similarly coached to consult with physical therapists for appropriate guidance on safe exercise. Within the below articles is no mention of physical therapists as professionals able to authorize, refer, or provide advice about the safety and level or type of exercise. This demonstrates that the public perception of physical therapists in providing this service remains scant and poorly understood. This is the aim of this motion.

Examples of Physician-centric language related to exercise and physical activity:

- "Are you considering adding exercise to your daily routine or significantly increasing your level of activity? Talk with your doctor about the exercises and physical activities that are best for you."[1]

- "If you are not sure if exercise is safe for you or if you are currently inactive, ask your doctor."[2]

- "If your physician has not cleared you for independent physical activity, you should exercise only under the supervision of a certified professional. The American College of Sports Medicine has two groups of certified fitness professionals that could meet your needs."[3]

Furthermore, guidance on needing "medical clearance" for individuals with chronic conditions have evolved over the past 15 years, with the overall result being more liberal and less restrictive. This trend logically would include other qualified professionals who would be able to provide screening for exercise guidance and safety. For example, the CDC now states that "Older adults with chronic conditions should understand whether and how their conditions affect their ability to do regular physical activity safely. When older adults cannot do 150 minutes of moderate-intensity aerobic activity a week because of chronic conditions, they should be as physically active as their abilities and conditions allow."[4]

In a 2015 ACSM Expert Consensus Roundtable Special Communication, the authors stated "A possible barrier to becoming physically active is the requirement for exercise preparticipation health screening, which may involve a visit to a health care provider and/or diagnostic testing to potentially identify underlying CAD and other occult CVD. Unnecessary referral to health care providers for screening may lead to a high rate of false-positive exercise test responses in some populations, necessitating medical follow-up and additional noninvasive/ invasive studies when they are not needed. Such studies can place unnecessary financial and other burdens on the individual and health care system."[5] As physical therapists are easily accessible and qualified to provide assessment and guidance, our role within providing exercise guidance and authorization can improve access as a provider to exercise screening to reduce the cost and burden of referral.

The ACSM's Exercise Pre-participation Health Screening Questionnaire for Exercise Professionals provides guidance for healthcare professionals to determine if additional assessment is necessary before starting exercise based on the patient's medical history and exercise history.[5] As this tool is freely available and recommended for use by medical professionals, an assessment such as this is easily applied within physical therapist clinical practice but does not likely capture the physical therapist's unique training and role. Physical therapist-centered resources and materials will increase the confidence and uptake of physical therapists providing this vital service and further lowering the barrier to safe community exercise performance.

REFERENCES:

1. National Institutes of Aging. How Older Adults Can Get Started With Exercise. National Institutes of Aging website. https://www.nia.nih.gov/health/how-older-adults-can-get-started-exercise. Updated April 03, 2020. Accessed March 14, 2023.
2. American Academy of Family Physicians. Exercise and Seniors. American Academy of Family Physicians website. https://familydoctor.org/exercise-seniors/. Updated May 2022. Accessed March 14, 2023.
3. American College of Sports Medicine. Starting an Exercise Program. American College of Sports Medicine Website. https://www.exerciseismedicine.org/assets/page_documents/8_StartingExProgram.pdf. Accessed March 14, 2023.
4. U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition. Washington, DC: U.S. Department of Health and Human Services; 2018. https://health.gov/sites/default/files/201909/Physical_Activity_Guidelines_2nd_edition.pdf
5. Magal M, Riebe D. New Preparticipation Health Screening Recommendations: What Exercise Professionals Need to Know ACSM's Health & Fitness Journal. 2016; 20(3): 22-27. https://www.exerciseismedicine.org/wp-content/uploads/2021/04/EIM-exercise-preparticipation-screening.pdf
6. Riebe D, Franklin BA, Thompson PD, Garber CE, Whitfield GP, Magal M, Pescatello LS. Updating ACSM's Recommendations for Exercise Preparticipation Health Screening. Med Sci Sports Exerc. 2015 Nov;47(11):2473-9. doi: 10.1249/MSS.0000000000000664. Erratum in: Med Sci Sports Exerc. 2016 Mar;48(3):579. PMID: 26473759.

Main Motion to the 2023 House of Delegates

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

Motion Contact: James R. Roush, PT, PhD, ATC, Delegate, APTA Arizona
E-mail: jroush@atsu.edu

RC Contact: Arie J. Van Duijn, PT, MSPT, EdD
E-mail: duijn101@gmail.com

PROPOSED BY: ARIZONA

RC 16-23 AMEND: CONSUMER PROTECTION THROUGH LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS (HOD P06-19-51-57)

That Consumer Protection Through Licensure of Physical Therapists and Physical Therapist Assistants (HOD P06-19-51-57) be amended by adding a new Principle IX., so that it would read:

PRINCIPLE IX. PRIMACY OF REGULATORY STATUTES AND REGULATIONS

The American Physical Therapy Association is opposed to policies or rules of third-party payers being used or substituted for regulatory purposes. Those licensed or certified under jurisdictional statutes and regulations governing physical therapist practice are regulated only by their jurisdictional practice acts that contain the statutes and regulations, along with the inclusion of or reference to APTA binding ethical documents for the physical therapy profession.

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?
That the current position on CONSUMER PROTECTION THROUGH LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS HOD P06-19-51-57 be amended by adding a new principle entitled " Primacy of Regulatory Statutes & Regulations" and reads "The American Physical Therapy Association opposes the policies or rules of third-party payers being used or substituted for regulatory purposes. Those licensed or certified under jurisdictional statutes and regulations governing physical therapist practice are regulated only by their jurisdictional practice acts that contain the statutes and regulations, along with the inclusion of or reference to the recognized ethical standards of the physical therapy profession."

This supports the Strategic Plan related to the goal for Quality of Care which states: "Elevate the quality of care provided by PTs and PTAs to improve health outcomes for populations, communities, and individuals." The agenda forwarded by third-party payers may not always be in line with this goal.

B. How is this motion's subject national in scope or importance?
All physical therapist and physical therapist assistant are licensed or certified in all US jurisdictions. All physical therapist services are subject to regulatory standards and are impacted by payer policies and rules. This topic is clearly of national 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?

CORE VALUES FOR THE PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT (**HOD P09-21-21-09)**

Duty - Duty is the commitment to meeting one's obligations to provide effective physical therapist services to patients and clients, to serve the profession, and to positively influence the health of society.

ACCESS TO, ADMISSION TO, AND PATIENT/CLIENT RIGHTS WITHIN PHYSICAL THERAPY SERVICES (HOD P06-18-20-17): In providing physical therapy services, the physical therapist is accountable first and foremost to the individual receiving physical therapy. The physical therapist is also accountable for abiding by professional standards and ethics and the laws governing the practice of physical therapy in the jurisdiction where the service is rendered.

Code of Ethics for the Physical Therapist (HOD S06-20-28-25):

- **Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients and clients.** 2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients and clients over the interests of the physical therapist. 2B. Physical therapists shall provide physical therapist services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients and clients.
- **Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients and clients and society.** 7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.
- **Principle #5: Physical therapists shall fulfill their legal and professional obligations.** 5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.

D. Additional Background Information.

Slowly over years and even decades, we are witnessing an insidious creep and influence of payer policy on practice. It is gaining an outsized influence over the practice of physical therapy. This has grown to the point where physical therapists and physical therapist assistants and practice administrators are influenced in practice patterns as much, and sometimes more, by payer policy and rules than by the statutory laws and regulations within jurisdictional practice acts. We are concerned that licensure boards may make decisions that set precedent based on insurance rules that are not part of the statutes and regulations of a practice act.

Practice acts generally include a reference to, or in some cases explicit inclusion of, the recognized ethical standards of the profession that are promulgated by the professional association. Principle #5A of APTA's *Code of Ethics for the Physical Therapist* (with identical language in the *Standards of Ethical Conduct of the Physical Therapist Assistant*) states, "Physical therapists shall comply with the applicable local, state, and federal laws and regulations." Payer policies and rules are not laws and regulations. Insurers and payers are not regulatory agencies.

To be clear, participation in various payment plans does include compliance with requirements based on the specific payer policies and rules. Providers have the option to participate or not in various plans. Violating such policies and rules can have consequences including being excluded from participating. In extreme cases, violations may be considered insurance fraud. In such situations it is the payer's prerogative to pursue any adjudication of legal penalties through the legal system. There should not be an expectation that regulatory agencies, i.e., jurisdictional licensing boards, be the enforcers of payer policies. If, through this process of legal adjudication, a physical therapist or physical therapist assistant is found guilty of insurance fraud, then and only then, would Principle 5A apply and the person regulated be subject to potential regulatory discipline including practice restrictions as specified in a practice act based on violation of law.

Examples of insurance policies and rules that could become items of regulatory scrutiny include the 8-minute rule and limits on number of evaluations done or patients seen within a specific timeframe. Such restrictions are rarely if ever found in the language of practice acts. Further, payer decisions on which procedures and their billing codes may or may not be reimbursed, are often arbitrary and can have no relation to what is authorized by a practice act and determined as medically necessary by providers.

Adoption of this motion raises the awareness of the entire profession to a gradually developing problem that impacts the ability of physical therapist and physical therapist assistants to provide quality services. It also informs advocacy efforts of APTA, its components, and members with federal, state, and local governments, regulatory agencies, and payers.

REFERENCES

1. American Physical Therapy Association. Consumer Protection Through Licensure of Physical Therapists and Physical Therapist Assistants APTA [online]. Accessed March 15, 2023.
2. American Physical Therapy Association. APTA Strategic Plan 2022-2025. APTA [online]. Accessed March 15, 2023.
3. American Physical Therapy Association. Code of Ethics for the Physical Therapist. APTA [online]. Accessed March 15, 2023.
4. American Physical Therapy Association. Core Values for the Physical Therapist and Physical Therapist Assistant. APTA [online]. Accessed March 15, 2023.
5. American Physical Therapy Association. Access to, Admission to, and Patient/Client Rights within Physical Therapy Services. APTA [online]. Accessed March 15, 2023.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Stefanie Bourassa PT, DPT, Delegate, APTA Connecticut
Email: stefanie.bourassaaptact@gmail.com

RC Contact: Kathleen K. Mairella, PT, DPT, MA
E-mail: kkmairella@gmail.com

PROPOSED BY: CONNECTICUT and MASSACHUSETTS

RC 17-23 ADOPT: PAY EQUITY ON THE BASIS OF SEX ASSIGNED AT BIRTH/GENDER/GENDER IDENTITY

That the following be adopted:

PAY EQUITY ON THE BASIS OF SEX ASSIGNED AT BIRTH/GENDER/GENDER IDENTITY

The American Physical Therapy Association supports pay equity on the basis of sex assigned at birth/gender/gender identity within the physical therapy profession and society.

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 a statement of support for pay equity on the basis of sex assigned at birth, gender, gender identity, and sex assigned at birth, and gender, gender identity, and sex assigned at birth identity within the physical therapy profession and in society at large. Our centennial celebration highlighted that ours is a profession founded by women. Yet, the recent findings by Chevan and Chevan1 highlight that despite this foundation, women physical therapists are paid 10% less than male physical therapists. This discrepancy not only has implications for women, but the profession as a whole. Given that women make up a majority of the physical therapy profession,2 this discrepancy significantly drives down the average pay across the profession. If we wish to attract the best and brightest to our profession, increasing our pay is critical. This motion supports and aligns with the current Strategic Plan. The 2022-2025 Strategic Plan includes efforts towards achieving a sustainable profession.3 “Improve the long-term sustainability of the profession by leading efforts to increase payment, reduce the cost of education, and strengthen provider health and well-being. Specifically, the strategic plan asserts that “Physical therapists and physical therapist assistants will be paid fairly.3” This is precisely the intent of this motion. While equality might seem like the correct wording, equal resources does not equate to equitable resources. Equity, as defined by Oxford dictionary, is a noun, and is the quality of being fair and impartial; it is also defined as the value of the shares issued by a company. Equity, as defined by the National Association of Colleges and Employers, refers to the fairness and justice that is distinguished from equality. Equality means providing the same to all, while equity means that there is a recognition that we do not all start from the same place and must acknowledge and make adjustments to the imbalances.

B. How is this motion’s subject national in scope or importance?
Pay equity on the basis of gender, gender identity, and sex assigned at birth, gender, gender identity, and sex assigned at birth identity and sex assigned at birth, is an issue of national scope. The support statement for RC 20-22 provides a comprehensive review of the implications of and potential causes of pay inequity on the basis of gender, gender identity, and sex assigned at birth, gender, gender identity,

and sex assigned at birth identity, and sex assigned at birth as an issue of national significance both outside of and within the physical therapy profession. Evidence of a gender, gender identity, and sex assigned at birth pay gap is not unique to the physical therapy profession. Among physicians, women are paid 24.6% less than men,4 while female Registered Nurses make 15.5% less than their male counterparts.5 The recent publication by Chevan and Chevan in our profession's top journal highlights a 10% pay discrepancy between male and female physical therapists.1 In our profession which was founded by women, this is troubling. Our profession fares better than average as the collective pay discrepancy for women across the nation is 18%.6 While we must support pay equity on the basis of gender, gender identity, and sex assigned at birth within our profession, we are well positioned to lead in this effort and support pay equity on the basis of gender, gender identity, and sex assigned at birth across society as well.

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?

As published in Packet I for the 2022 House of Delegates, the House is to consider RC 20-22, a charge to the APTA Board of Directors to develop a plan to promote equity in pay across gender, gender identity, and sex assigned at births among physical therapists and among physical therapist assistants. This position serves as a statement of support for pay equity on the basis of gender, gender identity, and sex assigned at birth within the profession of physical therapy and in society as a whole. While the charge directs efforts of the Board of Directors towards this important issue, this statement of support is intended for a broader audience in the healthcare community and society at large.

REFERENCES

1. Chevan J, Chevan A. Mind the gap: an analysis of physical therapist earnings in the united states by male/female sex. Phys Ther. 2022;102(3):pzab306. doi:10.1093/ptj/pzab306
2. Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Physical Therapists, at https://www.bls.gov/ooh/healthcare/physical-therapists.htm Accessed: June 19, 2022.
3. APTA Strategic Plan 2022-2025.
4. Whaley CM, Koo T, Arora VM, Ganguli I, Gross N, Jena AB. Female physicians earn an estimated $2 million less than male physicians over a simulated 40-year career: study examines estimated career gap in pay between female physicians and male physicians. Health Aff (Millwood). 2021;40(12):1856-1864. doi:10.1377/hlthaff.2021.00461
5. Nursing Salary Research Report 2022. https://www.nurse.com/blog/wp-content/uploads/2022/05/2022-Nurse-Salary-Research-Report-from-Nurse.com_.pdf Accesed: July 7, 2022.
6. United States Census Bureau. Income and poverty in the United States: 2019 https://www.census.gov/library/publications/2020/demo/p60-270.html. Accessed: July 5, 2022

Main Motion to the 2023 House of Delegates

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

Motion Contact: Rebekah Griffith PT, DPT, Chief Delegate, APTA Colorado
E-mail: rgriffithdpt@gmail.com

RC Contact: Kathleen K. Mairella, PT, DPT, MA
E-mail: kkmairella@gmail.com

PROPOSED BY: COLORADO

RC 18-23 CHARGE: DEVELOP A PLAN TO PROMOTE PAY EQUITY ON THE BASIS OF SEX ASSIGNED AT BIRTH/GENDER/GENDER IDENTITY IN THE PHYSICAL THERAPY PROFESSION

That the American Physical Therapy Association develop and implement a plan to promote pay equity on the basis of sex assigned at birth/gender/gender identity among physical therapists and among physical therapist assistants.

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 gain a better understanding of the factors that led to the pay disparity on the basis of gender and identify actionable ways to make pay equitable across genders along with solutions to promote equity. While much of the research that exists on this topic is gender binary specific, the intention is equity across the gender spectrum. 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 across all genders 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.”

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

According to the AMA guide to advancing Health Equity glossary of terms, equity “refers to fairness and justice and is distinguished from equality. While equality means providing the same to all, equity requires recognizing that we do not all start from the same place because power is unevenly distributed. The process is ongoing, requiring us to identify and overcome uneven distribution of power as well as intentional and unintentional barriers arising from bias or structural root causes.”[19] Equality means providing the same to all, while equity means that there is a recognition that we do not all start from the same place and must acknowledge and make adjustments to the imbalances. Equitable pay is consistently in the spotlight 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 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 earn ~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 13 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 the 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, on the front lines of decision-making, was strongly correlated with profitability and value creation. Therefore, by promoting gender diversity 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 equitable 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.

In addition to the disparities described above, the disparities impacting those who identify across the gender spectrum are also stark. According to Forbes, transgender individuals are paid up to 32% less than their cisgender peers.[15] The gap may be even wider amongst those who are female, transgender individuals.[18] The 2015 U.S. Transgender Survey identified many intersectional factors impacting this population including difficulty obtaining employment.[16] The Human Rights Campaign organization shares that LGBTQ+ individuals may only earn $0.90 for every dollar earned by peers.[17]

Data for those outside of binary designations of gender continues to be lacking in the field of physical therapy. As part of developing a plan for addressing the pay gap for all genders, this must be considered to ensure all those in our profession are not marginalized due to gender. Pay includes so many factors, many that are intersectional. This motion focuses on gender, not to discount those other critical factors, but as a key first step to achieving equity within our profession.

By taking on this charge, the APTA has an opportunity to be at the forefront of the fight for equitable pay in healthcare. In many cases, people and companies say they support equitable 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.

REFERENCES

1. https://www.americanprogress.org/issues/women/reports/2020/03/24/482141/quick-facts-gender-wage-gap/
2. https://www.pay-equity.org/info-time.html
3. APTA Median Income of Physical Therapist Summary
4. https://www.bls.gov/ooh/healthcare/physical-therapists.htm
5. https://www.businessnewsdaily.com/4178-gender-gap-workplace.html
6. https://today.yougov.com/topics/economy/articles-reports/2021/04/15/mothers-fathers-parental-leave-poll
7. https://www.dol.gov/sites/dolgov/files/OASP/legacy/files/PaternityBrief.pdf
8. https://www.mckinsey.com/business-functions/organization/our-insights/delivering-through-diversity
9. https://www.qualtrics.com/blog/inequitable-effects-of-pandemic-on-careers/
10. https://www.payscale.com/data/gender-pay-gap?tk=genderwidget-ps-rc-degree
11. https://www.nytimes.com/2021/03/24/us/equal-pay-day-explainer.html
12. https://www.apta.org/apta-and-you/leadership-and-governance/vision-mission-and-strategic-plan/strategic-plan
13. Chevan J, Chevan A. Mind the Gap: An Analysis of Physical Therapist Earnings in the United States by Male/Female Sex. Phys Ther. 2022;102(3): pzab306. doi:10.1093/ptj/pzab306
14. https://www.apta.org/news/2017/11/07/washington-post-female-pts-will-spend-last-4-weeks-of-2017-working-for-free
15. https://www.forbes.com/sites/jamiewareham/2021/11/17/transgender-pay-gap-revealed-cisgender-people-paid-32-more/?sh=6965b2917b2c
16. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.
17. https://www.hrc.org/resources/the-wage-gap-among-lgbtq-workers-in-the-united-states
18. https://www.macleans.ca/society/for-transgender-women-the-pay-equity-gap-is-even-wider/

Main Motion to the 2023 House of Delegates

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

Motion Contact: Douglas M. White, DPT, Delegate, APTA Hawaii
E-mail: dr.white@miltonortho.com

RC Contact: Venita Lovelace-Chandler, PT, MA, PhD, FAPTA
E-mail: vlc.phd.pt.pcs@gmail.com

PROPOSED BY: HAWAII

RC 19-23 ADOPT: SUPPORT FOR INITIATIVES TO IMPROVE RURAL HEALTH

That the following be adopted:

COMMITMENT TO IMPROVING HEALTH IN RURAL COMMUNITIES

Whereas, Rural health content in physical therapist and physical therapist assistant education can be enhanced, the number of physical therapist internships, fellowships, and residencies in rural health settings can be increased, and optimal practice in rural health settings requires capabilities that can be addressed with specialized training;

Whereas, Including physical therapists as essential providers in rural health settings will expand access to physical therapist services;

Whereas, Improving access to care requires payment reform to include:

- **The full range of services provided by physical therapists and physical therapist assistants, and**
- **Addressing the higher costs of delivering health care in under-resourced communities;**

Whereas, Increasing the inclusion of physical therapists and physical therapist assistants in student scholarships and loan modification and forgiveness will help reduce rural workforce shortages;

Whereas, Collecting data regarding physical therapists' role and impact in rural health settings will inform policy on rural health needs;

Whereas, Enhancing physical therapist scope of practice will allow physical therapists and physical therapist assistants to better meet the needs of individuals in rural areas;

Whereas, Collaborating with other health care professions and interested parties to optimally integrate physical therapists and physical therapist assistants as part of rural health care teams will improve rural health;

Whereas, The expanded use of technology in physical therapy will improve rural health; and

Whereas, Innovative and extended care delivery models can improve rural heal health;

Resolved, That the American Physical Therapy Association supports initiatives to improve rural health.

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 will adopt a position addressing and promoting physical therapist (PT) practice in Rural Health (RH) settings. Individuals living in rural areas generally have poorer health when compared to urban areas. The mortality rate for all ten of the leading causes of death in the United States is higher in rural areas. The document ***Advancing Rural Health Equity*** articulates the national scope of health needs of which PTs should be playing a larger role.

Currently, APTA lacks a single source document which describes multiple ongoing initiatives, and initiatives needed, to improve access to PTs and improve the practice environment for PTs in RH. There are multiple policy and payment barriers to overcome to optimally meet society's need for PTs in RH settings. PTs are not included as qualified providers in Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Rural by definition indicates low-density population and low-density services. Most outpatient physical therapy is provided in secondary and tertiary settings which are either not available or not readily accessible in many rural areas. Therefore, much of the healthcare provided in rural settings is in FQHC/RHCs without PTs. For a detailed description of the CMS policy landscape readers are encouraged to review ***Advancing Rural Health Equity***. There are many initiatives by CMS, states, and other entities seeking to advance rural health, a glaring omission is a lack of how PTs can be part of the solutions.

A position which outlines APTA's commitment is needed to meet the PT needs in rural communities will provide a touchstone for all stakeholders. This document will demonstrates the profession's alignment with many of the strategies advocated for improving health in rural communities. The adopted motion will assist advocacy efforts to improve RH.

This motion perfectly aligns with APTA Strategic Plan by addressing the **Goals**: *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.* Facilitating the **Outcomes**: *Use of and demand for physical therapist services as a primary entry point of care for consumers will increase. The APTA community will collaborate to reach more consumers, drive demand for physical therapy, and expand the markets and venues that promote the profession.*

The adoption of this motion will support the goals of APTA's public policy priorities[1] The initiatives described in the motion address many of aspects of the goals.

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

The profession of physical therapy is dedicated to meeting the needs of society. Approximately 60 million people live in rural areas across the United States. There are 3143 counties in the United States. There are 1889 rural or mostly rural counties.

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 has multiple advocacy efforts which address some elements of the RH issue including:

- Medicaid advocacy
- Position Paper: Primary Health Services Enhancement Act
- Medicare Physician Fee Schedule advocacy
- Health Information Technology Advocacy
- Direct Access Advocacy

- Rural Health Care Presents Needs and Opportunities

Stakeholders internal to the profession include all components, all DPT and PTA education programs, and all PTs and PTAs involved in RH. External stakeholders include Congress, CMS, HHS, all state, territorial, and tribal health policy bodies.

There are many laws and regulations which apply to RH. A major law impacting RH is: Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990

D. Additional Background Information.

The United States Public Health Service Commissioned Corps has physical therapists providing some services in rural health.

REFERENCES

1. https://www.apta.org/advocacy/issues/apta-public-policy-priorities-2023-2024
2. https://www.usphs.gov/about-us

Main Motion to the 2023 House of Delegates

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

Motion Contact: Douglas M. White, DPT, Delegate, APTA Hawaii
E-mail: dr.white@miltonortho.com

RC Contact: Venita Lovelace-Chandler, PT, MA, PhD, FAPTA
E-mail: vlc.phd.pt.pcs@gmail.com

PROPOSED BY: HAWAII

RC 20-23 CHARGE: PROMOTING THE IMPROVEMENT OF HEALTH IN RURAL COMMUNITIES

That the American Physical Therapy Association pursue improvements in rural health as outlined in the position Support for Initiatives to Improve Rural Health,

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 will further its initiatives addressing and promoting physical therapist (PT) practice in Rural Health (RH) settings. There are multiple policy and payment barriers to overcome to optimally meet society's need for PTs in RH settings. PTs are not included as qualified providers in Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Rural by definition indicates low-density population and low-density services. Most outpatient physical therapy is provided in secondary and tertiary settings which are either not available or not readily accessible in many rural areas. Therefore, much of the healthcare provided in rural settings is in FQHC/FHCs without PTs. For a detailed description of the CMS policy landscape readers are encouraged to review ***Advancing Rural Health Equity***. There are many initiatives by CMS, states, and other entities seeking to advance rural health, a glaring omission is a lack of how PTs can be part of the solutions.

This motion perfectly aligns with APTA Strategic Plan by addressing the **Goals**: *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.* Facilitating the **Outcomes**: *Use of and demand for physical therapist services as a primary entry point of care for consumers will increase. The APTA community will collaborate to reach more consumers, drive demand for physical therapy, and expand the markets and venues that promote the profession.*

The adoption of this motion will support the goals of APTA's public policy priorities[1] The initiatives described in the motion address many of aspects of the goals.

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

The profession of physical therapy is dedicated to meeting the needs of society. Approximately 60 million people live in rural areas across the United States. There are 3143 counties in the United States. There are 1889 rural or mostly rural counties. Individuals living in rural areas generally have poorer health when compared to urban areas. The mortality rate for all ten of the leading causes of death in the United States is higher in rural areas. The document ***Advancing Rural Health Equity*** articulates the national scope of health needs of which PTs should be playing a larger role.

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 has multiple advocacy efforts which address some elements of the RH issue including:

- Medicaid advocacy
- **Position Paper: Primary Health Services Enhancement Act**
- Medicare Physician Fee Schedule advocacy
- Health Information Technology Advocacy
- Direct Access Advocacy
- **Rural Health Care Presents Needs and Opportunities**

Stakeholders internal to the profession include all components, all DPT and PTA education programs, and all PTs and PTAs involved in RH. External stakeholders include Congress, CMS, HHS, all state, territorial, and tribal health policy bodies.

There are many laws and regulations which apply to RH. A major law impacting RH is: **Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990**

D. Additional Background Information.

The United States Public Health Service Commissioned Corps[2] has physical therapists providing some services in rural health.

REFERENCES

1. https://www.apta.org/advocacy/issues/apta-public-policy-priorities-2023-2024
2. https://www.usphs.gov/about-us

Main Motion to the 2023 House of Delegates

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

Motion Contact: Matthew Huey, PT, MPT, Delegate, Texas Physical Therapy Association
E-mail: matt.the.pt.contact@gmail.com

RC Contact: Kathleen K. Mairella, PT, DPT, MA
E-mail: kkmairella@gmail.com

PROPOSED BY: TEXAS

RC 21-23 ADOPT: PAY TRANSPARENCY BY EMPLOYERS OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

That the following be adopted:

PAY TRANSPARENCY BY EMPLOYERS OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

The American Physical Therapy Association supports pay transparency by employers of physical therapists and physical therapist assistants.

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 position statement motion is to provide support to physical therapists and physical therapists assistants who wish to advocate for pay transparency and negotiate better pay for themselves.

This motion supports APTA Vision by addressing a societal issue - pay inequity. Support for pay transparency can help create a workplace culture where PT/PTAs are paid fairly for their work This motion does support the Sustainable Profession priority area of the APTA Strategic Plan 2022-2025. This motion will improve the Sustainable Profession priority area's goal of "improving the long-term sustainability of the profession by strengthening provider health and well-being" by supporting pay transparency among PT/PTA employers to ensure pay equity, job satisfaction, and the long-term health of the profession.

B. How is this motion's subject national in scope or importance?
This motion is national in scope because more states are requiring greater transparency through labor laws referred to as pay transparency, salary transparency, or anti-secrecy laws.

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 any current activities of the House of Delegates, Board of Directors, or staff that address this topic, nor are we aware of previous policies on pay transparency. Stakeholders that might be affected by this motion are physical therapists and physical therapist assistants, as well as their employers.

D. Additional Background Information.

"Pay transparency is the employer practice of disclosing information about employee compensation standards to others --- internally, externally or both."[1] It refers to a pay communications policy in which a company voluntarily provides pay-related information to employees that is: (1) about the process of the pay system, (2) the actual pay levels or ranges and/or (3) an open policy for employees to freely share information about their pay. Pay transparency is different from pay parity or pay equity in that pay parity or pay equity is the concept of being paid fairly for performing the same job regardless of the person's race, gender identity or age. Globally, companies are adopting pay transparency policies and practices to narrow the pay inequities and create a positive work environment that builds trust, fairness and job satisfaction .[1] Evidence suggests that by increasing the level of public information available around competitive pay ranges, there is a positive impact on the employees' perceptions of trust, fairness, and job satisfaction.[2] Pay transparency can also improve pay equity.[3,4,5]

There are a growing number of state laws and ordinances in localities across the US that address pay transparency. Since 2019 several states (Colorado, California, New York, Washington) have pay transparency laws in place that requires employers to include salary ranges in job postings. Additional states (Nevada, Rhode Island, Connecticut, Maryland) require employers to provide salary range at some point in the hiring process or employee's tenure. Currently, there is movement to enact pay transparency laws in more states (Hawaii, Illinois, Kentucky, Massachusetts, Montana, New Jersey, Oregon, South Dakota, Vermont, Virginia, and West Virginia).[3,4,5]

By the end of 2021, at least eight cities or states had enacted such laws.80% of respondents on a survey by ResumeLab stated they would not apply for a job posting if salary information was lacking[6] and according to PayScale,[7] if the process is not transparent, employees, particularly younger ones may be more likely to leave the company within six months. Thus, salary transparency in job postings on Indeed is growing and has more than doubled since 2020.[8]

The topic of pay transparency is a growing policy in the United States. Several states and cities have passed laws requiring that employers either post or make available the wage range for positions.[9,10] The goal of pay transparency is to allow job applicants to negotiate better wages by having this information when applying for a position. It also allows wage gaps to be closed and employers to engage in more fair compensation for workers.

Pay transparency laws have been enacted in the European Union since 2000 and in the United Kingdom since 2018 Their data indicate that pay transparency has decreased wage gaps between men and women employees. Groups who have largely experienced unfair wages apply to companies who make public their wage ranges. This is also a benefit to employers by protecting them against gender, racial, and sexual orientation bias in terms of wages.[3,4,5]

Adopting this motion will demonstrates that APTA supports initiatives to reduce the wage gap in physical therapy.[11] APTA's support of pay transparency can promote fairness and equity in the workforce and can foster a culture of trust and transparency within employers that is in line with the APTA's commitment to diversity, equity, and inclusion. Employers also benefit from pay transparency with the ability to recruit and retain a talented and diverse workforce.

REFERENCES

1. Beppel H. Pay equity vs pay transparency: defining the difference and unscrambling the jargon. https://www.adp.com/spark/articles/2023/02/pay-equity-vs-pay-transparency-defining-the-difference-and-unscrambling-the-jargon.aspx
2. Collela A, Paetzold RL, Zardkoohi A, Wesson MJ. Exposing pay secrecy. *Acad Manage Rev*. 2007. 32(1). https://doi.org/10.5465/amr.2007.23463701
3. Duchini, Emma, Stefania Simion, and Arthur Turrell. Pay transparency and gender equality. *Competitive Advantage in the Global Economy (CAGE)*. 2020, No. 482.

4. Ramachandran, Gowri. "Pay transparency." *Penn St. L. Rev*. 2011;116: 1043.
5. Baker, Michael, et al. Pay transparency and the gender gap. National Bureau of Economic Research. 2019. No. w25834.
6. Goldschmitt D. New data on financial transparency at work [2023 report]. ResumeLab. https://resumelab.com/career-advice/financial-transparency
7. Payscale. How your paise raise practices affect employee turnover. https://www.payscale.com/research-and-insights/employee-turnover-pay-raises/
8. Stahl C. Pay transparency in job postings has more than doubled since 2020. https://www.hiringlab.org/2023/03/14/us-pay-transparency-march-2023/
9. Spark Team. Pay transparency: what it is and laws by state. SPARK. https://www.adp.com/spark/articles/2023/03/pay-transparency-what-it-is-and-laws-by-state.aspx
10. Wallace L. Four predictions for pay transparency laws in 2023. Forbes EQ. 2023. https://www.forbes.com/sites/forbeseq/2023/02/01/four-predictions-for-pay-transparency-laws-in-2023/?sh=3a2f89fa7b72
11. Chevan J, Chevan A. (2022). Mind the gap: an analysis of physical therapist earnings in the United States by male/female sex. *Phys Ther.*2022;102(3), pzab306. https://doi.org/10.1093/ptj/pzab306

Main Motion to the 2023 House of Delegates

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

Motion Contact: Steve Forbush, PT, PhD, Delegate, Arkansas
E-mail:steve@orthomti.com

RC Contact: Pamela White, PT, DPT
E-mail: pwhite5577@aol.com

PROPOSED BY: ARKANSAS

RC 22-23 CHARGE: ADVOCACY FOR STREAMLINED CREDENTIALING PROCESSES THAT EMPHASIZE PORTABILITY

That the American Physical Therapy Association, along with interested parties, advocate for streamlined processes for credentialing physical therapists and physical therapist assistants that emphasize portability with changes in job or location of practice setting.

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 credentialing of PTs and PTAs takes a considerable length of time even though the therapy providers have previously been credentialed and approved. Hopefully, the APTA can develop a better method of professional credentialing that will lower this burden on individual and corporate practice settings and thus alleviate administrative burdens on physical therapist providers and their employers.

B. How is this motion's subject national in scope or importance?
The APTA, through this action, can alter and expediate the credentialing process for all PTs, PTAs, and their employers.

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 is the only national organization with enough political capital to initiate this change in the credentialing process and this has not been previously explored and implemented.

REFERENCES

1. Florence CS, Bergen G, Atherly A, et al. Medical costs of fatal and nonfatal falls in older adults. JAGS. 2018;66(4):693-698.
2. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed January 14, 2019.
3. Carroll NV, Slattum PW, Cox FM. The cost of falls among the community-dwelling elderly. J Manag Care Pharm. 2005;11(4):307-16.

Motion Development and Main Motion Template

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

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

RC Contact: Ami Faria PT, DPT
E-mail: drfariapt@gmail.com

PROPOSED BY: BOARD OF DIRECTORS

RC 23-23 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: DEAN JACKS, PhD

Whereas, Dean Jacks, PhD, has made a significant contribution to the practice of physical therapy;

Whereas, He has been an active teacher since he graduated from The University of Toledo in 1998 with a doctor of philosophy degree in exercise physiology;

Whereas, He has helped develop the curriculum and was on the committee for accreditation at Hanover College for the doctor of physical therapy program;

Whereas, He is a member of six committees, each with a unique science background in research and developing student learning programs;

Whereas, He has been in 19 published research articles pertaining to physical therapy rehabilitation and more;

Whereas, He has 38 published abstracts, 10 from local/state conferences, seven regional, 17 national, and four international;

Whereas, He has completed 28 research projects of which 16 were fully funded, all contributing to improving overall health nationally and to improving youth development; and,

Whereas, He is continuing his education years after being fully vested in his teaching career;

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

SS: Dean Jacks, PhD, was instrumental in the accreditation from Higher Learning Commission for graduate programs and DPT, which was approved in summer of 2020 as well as the curriculum development at Hanover College for the launch of the Doctor of Physical Therapy Program and has made substantial contributions to the development and implementation of the inaugural cohort of the Hanover College Doctor of Physical Therapy program. He is a mentor for physical therapy students, teaches several courses, and serves as a secondary faculty member for several others. He is an advocate for APTA and wants all his students to succeed.

Motion Development and Main Motion Template

Required for Adoption:	2/3 Vote	**Category**: ZO-8
Motion Contact:	Roger Herr, PT, MPA, Board of Directors E-mail: governancehouse@apta.org	
RC Contact:	Ami Faria PT, DPT E-mail: drfariapt@gmail.com	

PROPOSED BY: BOARD OF DIRECTORS

RC 24-23 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: RICHARD F. MACKO, MD

Whereas, Richard F. Macko, MD, has made significant contributions to the practice of physical therapy;

Whereas, He has co-authored over 150 peer-reviewed articles that contribute to the field pf physical rehabilitation of individuals post-stroke;

Whereas, He was at the forefront of and instrumental in conducting research that focused on higher-intensity walking training, and has contributed to understanding the mechanisms underlying such improvements and developing programs that can facilitate these positive changes in the community; and,

Whereas, He has advocated for and achieved increased funding for physical rehabilitation research;

Resolved, That Richard F. Macko, MD, be elected as an Honorary Member of the American Physical Therapy Association.

SS: Richard F. Macko, MD, obtained his medical degree from the Ohio State University Medical School, completed his neurology residency at the University of California, Los Angeles School of Medicine, and subsequently completed a Stroke Fellowship at the University of Southern California School of Medicine. His current research and clinical interests include development of exercise training models and combine motor learning principles with exercise rehabilitation in patients with neurological injury; potential adaptations in neural, muscular, and metabolic physiological processes following these interventions and more recent interest focus on the use of robotic technologies to potentially enhance the benefits of exercise training paradigms. His research accomplishments include more than 150 published manuscripts, with the large majority focused on recovery following neurological injury, with grant activity of greater than $17 million in the last 10 years.

While the details of Macko's record delineate the breadth and depth of his contributions to neurological rehabilitation, related specifically to the physical therapy field, Macko pioneered the idea of providing large amount of task-specific practice to individuals with neurological impairments post-stroke. In a few seminal articles published from 1997-2001, Macko's group described the potential utility of graded exercise testing and training in individuals post-stroke to improve aerobic capacity, efficiency, and gait kinematics and function. These studies were followed by a number of publications focused on both improving functional capacity post-stroke and the physiological mechanisms and/or benefits for improving locomotor function as well as the potential relationships between real-world community mobility and clinical measures. In 2005, Macko

published the first randomized trial demonstrating a clinically significant improvement in locomotor function after attempting to target higher aerobic training thresholds with subsequent work in identifying specific neural activation changes and the consistency of this intervention in different contexts. These latter articles were the basis for additional researchers attempting to target higher intensities during walking interventions, which was a strategy recommended by recently published clinical practice guidelines funded by APTA and published by the Academy of Neurologic Physical Therapy.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Leigh Reece, PT, DPT, Chief Delegate, APTA Oregon
E-mail: reec1958@pacificu.edu

RC Contact: Kathleen K. Mairella, PT, DPT, MA
E-mail: kkmairella@gmail.com

PROPOSED BY: OREGON, TEXAS, WASHINGTON, AND PTA CAUCUS

RC 25-23 AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION TO PERMIT COMPONENTS THE RIGHT TO SEAT ONE PHYSICAL THERAPIST ASSISTANT AS A DELEGATE TO THE HOUSE OF DELEGATES

This is a motion with two conforming amendments: Parts A and B. Triple asterisks (* *) indicate language that is not being amended and therefore has not been included in order to make the document more concise.*

PART A

That Bylaws of the American Physical Therapy Association, Article III. Members, Section 2: Rights of Members, C., (2), be amended by inserting the words "serve as a component delegate to the House" after the words "Physical Therapist Assistant Engagement Group to the House;" so that it would read:

* * *

(2) Physical Therapist Assistant: subject to component bylaws, to make motions and vote at component meetings; serve on a component's board of directors except as defined in these bylaws; serve as a delegate from the Physical Therapist Assistant Engagement Group to the House; serve as a component delegate to the House; serve on the Nominating Committee of a component; and serve on committees as permitted in these bylaws.

* * *

PART B

That Bylaws of the American Physical Therapy Association, Article V. House of Delegates, Section 6: Voting Delegates, B. Qualifications of Voting Delegates, (1), be amended by inserting the words "and, subject to component bylaws, one Physical Therapist Assistant member in good standing per delegation," after the words "in good standing" so that it would read:

* * *

B. Qualifications of Voting Delegates
(1) Chapter and section/academy delegates: Only Physical Therapist members in good standing and, subject to component bylaws, one Physical Therapist Assistant member in good standing per delegation may serve as component delegates.

* * *

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 to provide chapters and sections the opportunity to seat 1 physical therapist assistant as a delegate within their delegation with full voting rights in the House of Delegates. If a chapter or section decides to provide this opportunity (it is not mandated), it would require amending their bylaws, including the means to s/elect the physical therapist assistant.
This motion directly supports the Vision Statement For The Physical Therapy Profession: “Transforming society by optimizing movement to improve the human experience.” Including physical therapist assistants, as representatives of their components with decision-making authority in the House of Delegates, aligns with the APTA Brand Strategy “to move to a unified association” to better address the health needs of society.

The motion also supports several APTA priorities in the APTA Strategic Plan 2022-20251, including Goals and Outcomes of Member Value (see below). By expanding opportunities to “belong, engage, and contribute” (Goals), it promotes additional and sustained membership (Outcomes). This provides expanded representation and leadership opportunities for physical therapist assistant members.

Member Value
GOALS
Increase member value by ensuring that APTA’s community delivers unmatched opportunities to belong, engage, and contribute.

OUTCOMES
APTA will grow membership market share to extend the reach and impact of the APTA community.

B. How is this motion’s subject national in scope or importance?
The House of Delegates is the highest policy making body in our association, and therefore, addresses issues of national importance. Allowing chapters and sections the option to include physical therapist assistants with decision-making authority provides the opportunity for the PTA community to better engage in these significant issues and influence the outcome in collaboration with either their chapter or section.

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?
Highlights of historical and current actions of the House, Board, and staff that involve the representative structure and voting rights of physical therapist assistant members are presented below.

1989: The Affiliate Assembly, composed of all PTA members, was created by the House of Delegates. Affiliate members may serve as a delegate for chapter or section with 2 votes for Affiliate Assembly delegates and ½ vote for affiliate members in chapters and sections.
1998: The House adopted motions to dissolve the Affiliate Assembly and created the National Assembly and Representative Body of the National Assembly (RBNA). It also removed voting privileges for PTAs and allowed two non-voting PTA delegates from the RBNA.
2005: House adopted bylaw changes to dissolve the National Assembly and RBNA, and established the PTA Caucus with 5 non-voting delegates in the House.
2015: House granted components the option to provide full vote for PTAs at the component level.
2021: House adopted bylaw changes to allow the PTA Engagement Group to have 2 voting delegates.
2023: APTA Board of Directors and staff presented a new structure, roles, and leadership to represent PTAs (see attached APTA PTA Council Job Description and APTA PTA Member Engagement Group Delegate Job Description, both current as of 2/15/23). The following transitions and actions will occur in 2023, with full implementation by January 1, 2024:

- The current Physical Therapist Assistant Caucus, consisting of 1 representative from each chapter, will become the **Physical Therapist Assistant Council**. The Council will be responsible for engagement of PTA members across the association.
- The Council will select and be led by a **PTA Council Steering Group,** consisting of 7 members in addition to a chair. Council Steering Group members will have one-year terms, and may serve two years consecutively, then must take ≥1 year intermission.
- The current PTA Caucus Nominating Committee and PTA Delegates will continue to serve in their roles through the end of 2023.
- A **PTA Member Engagement Group delegation** to the House of Delegates will begin operation. This delegation will consist of a chief delegate, a chief delegate-elect, who serves as the second delegate, both with full voting rights, and the chair of the PTA Council Steering Group who will serve as an alternate delegate. Candidacy is open to all PTA members who are association members in good standing. Other than the chair of the PTA Council Steering Group, other members of the Steering Group are excluded to serve.
- By the end of February 2023, APTA will provide guidance to components with new model bylaws to align with these changes, including striking references to the PTA Caucus.

Stakeholders affected by this motion will be all members, chapters, and sections/academies of the association. This motion will not affect any state or federal laws or regulations.

D. Additional Background Information.

Section C above reveals an evolution of the structure of a representative body of the physical therapist assistant. Following the comprehensive revision of the APTA Bylaws in 2021, it was timely for the APTA Board of Directors to continue that evolution and design a new structure for the Physical Therapist Assistant Engagement Group that aligns with those bylaws. We commend the Board for its actions. The new role of the PTA Council promotes a focus on the broad issues that confront the PTA community in our profession and organization and continues the opportunity for PTAs to engage in component leadership. The title, definition, and fee structure of the PTA Council is appropriate and further aligns it with similar bodies in the APTA. Further, the creation of the Physical Therapist Engagement Group delegation allows that body to focus on governance and engagement in the House of Delegates.

Given that component bylaws must be amended to remove any references to the PTA Caucus, it is timely to adopt this motion to permit a concurrent amendment to allow a component to seat 1 PTA delegate in their delegation. Bylaw amendments at the component level must be approved by both the component and the APTA Board of Directors, a process that can take a year to complete. Addressing both concepts concurrently achieves both outcomes more efficiently and allows for continued engagement of PTA leaders, signifying value in PTA membership. Additionally, the proposed restructuring of the PTA Engagement Group indicates that only the 2 elected PTA delegates plus an alternate will have the opportunity to be involved in governance, whereas previously all PTA representatives were engaged in the process. This bylaw amendment will allow components the option to continue to engage their PTA leaders as delegates.

Consideration of this motion concurrent with the introduction of the restructure is logical as an inherent part of the transition. With the new PTA Council structure, components are given flexibility regarding their PTA Council Representative. This includes the method of s/election, length of term, and whether to impose term limits. These same prerogatives would apply if this motion were adopted. If a component chooses to create a position for a PTA delegate, the component can decide to seat their PTA Council Representative as the PTA delegate within their delegation or engage other PTA leaders within their chapter or section as the PTA delegate. For example, in a recent revision of the APTA Oregon Bylaws, a new position, PTA Director, was created to seat this person on the chapter Board of Directors separate from the PTA Caucus Representative who serves as a member of the delegation. This provides a more equitable distribution of workload and expands the opportunity for engagement of multiple PTA leaders rather than a singular PTA

leader who serves as the PTA Caucus Representative and as a member of the Board of Directors. The proposed amendment would continue the Board's intention of broader engagement of PTA leaders within the component, but also retain the opportunity for direct engagement in the component delegation with a PTA delegate.

In recent years, physical therapist assistants have expanded their contributions through expanded rights and leadership opportunities at the component level, yet continue to have restrictions as a component delegate at the national level. This results in inconsistencies. For example, at the component level, most chapter delegations include their PTA Caucus reps in discussions and decisions within their delegations, have them track motions, and in the past, conduct phone interviews with candidates. Additionally, physical therapist assistants carry a full vote in 47 chapters and 12 sections and serve on the Board of Directors with full voting rights in 45 chapters. In the regulatory arena, PTAs are appointed as members of state physical therapy licensing boards with full voting rights in 33 states. Moreover, many PTAs own and/or manage a physical therapy service, which employs or oversees physical therapists. These are examples of how the input of PTAs informs decisions at the component level and on state licensing boards, and yet they are restricted from serving as a delegate in their component delegations. Although their clinical roles are distinctly different from those of the physical therapist, whenever they, or any other delegate is confronted with issues outside of their knowledge base or skills, they review appropriate resources and consult with colleagues. This results in making informed decisions on motions, irrespective of their individual educational backgrounds or clinical roles.

It is timely to provide voting rights for 1 physical therapist assistant in their chapter or section delegations as an inherent component of the restructure of their representative body and operation. We are clearly better together as a transformative and inclusive organization that values all of our members.

REFERENCES

1.American Physical Therapy Association. APTA Strategic Plan 2022-2025. https://www.apta.org/apta-and-you/leadership-and-governance/vision-mission-and-strategic-plan/strategic-plan. Accessed February 20, 2023.

Main Motion to the 2023 House of Delegates

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

Motion Contact: Scott Euype, PT, DPT, Chief Delegate, American Academy of Sports Physical Therapy
E-mail:euypes@ccf.org

RC Contact: Kathleen K. Mairella, PT, DPT, MA
E-mail: kkmairella@gmail.com

PROPOSED BY: SPORTS, LEADERSHIP AND INNOVATION, PELVIC HEALTH, INDIANA, TENNESSEE

RC 26-23 AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE VII. COMMITTEES OF THE ASSOCIATION, SECTION 2: COMMITTEES OF THE HOUSE OF DELEGATES, A. NOMINATING COMMITTEE

Triple asterisks (* *) indicate language that is not being amended and therefore has not been included in order to make the document more concise.*

That Bylaws of the American Physical Therapy Association, Article VII. Committees of the Association, Section 2: Committees of the House of Delegates, A. Nominating Committee, (2), be amended by striking out the words "at the beginning of the calendar year" and inserting the word "immediately" so that it would read:

A. Nominating Committee

* * *

(2) Members shall serve three-year terms starting ~~at the beginning of the calendar year~~ immediately following the close of the annual session of the House at which they were elected, or until their successors are elected.

* * *

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 for a mechanism that would permit newly elected APTA Nominating Committee (NOM-COM) members to immediately following close of the APTA House of Delegates (HOUSE) participate in confidential conversations and meetings related to the work of NOM-COM with current nominating members without violating the oath of office; and would allow for a smooth transition initially intended in the House motion a few years ago. This revision is also consistent with APTA Vision and Strategic plan of increasing member value because it will ensure that there is a more efficient process to gain the perspective of newly elected NOM-COM members early on to recruit and determine the "right" slate of candidates for future elected APTA national positions.

B. How is this motion's subject national in scope or importance?
The subject of this motion is of national importance because the current process is hindering the work of NOM-COM. If this amendment is passed it will eliminate the existing barrier of delay in communication between newly elected and current members of the NOM-COM thereby allowing for a more efficient process for transition of information between committee members and participation of newly elected NOM-

COM members in the work of the committee. APTA is a large multi-million business organization whose management rests in the hands of its elected officials who must be carefully recruited and vetted for office, the burden of which is directly borne by the members of NOM-COM. Each newly elected NOM-COM member has valuable insight to offer in the recruitment & vetting of APTA candidates for office based on the depth and breadth of their individual skills and experiences that currently is being lost as it cannot be incorporated soon enough in the vetting process owing to the existing communication impediment.as was intended.

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 is to honor the previous House motion (RC 3-20 Amend: Bylaws of the American Physical Therapy Association and Standing Rules of the American Physical Therapy Association to Change the Date that National Elected Leaders Assume Office) that was passed by the HOUSE in 2020. However, the impact of the motion is yet to be realized because since the newly elected NOM-COM members take office on January 1 of the year following their elections. According to the APTA staff & the HOUSE officers, because of the confidential nature of the work of the NOM-COM, the newly elected NOM-COM members are not permitted to have access to the work of the NOM-COM between the close of the HOUSE in which they were elected and January 1 of the year following. This impacts every member of NOM-COM, the current members and future members and their ability to bring forth the best slate of candidates for national office. This also impacts candidates for APTA national office as the candidates would have abrupt changes and lesser opportunity to communicate with the newly elected NOM-COM members.

D. Additional Background Information.

The process of production of a slate of candidates for national office (the Board and NOM-COM) who will be elected by delegates at the annual meeting of the House is at issue here. Nominations for APTA national office are submitted each fall by any APTA member as per HOD Y06-19-71-35 for review by NOM-COM. New NOM-COM members to fill open positions on NOM-COM are also elected each year at the annual meeting of the HOUSE; but they start their term of office at the beginning of the calendar year following the close of the annual session of the House at which they were elected (APTA Bylaws Art. VII Sec.2(A)(2)). Consequently, in the interim time from being elected (close of House in fall of election year) to Jan1 of following year, the newly elected NOM-COM members are not being permitted to participate in NOM-COM work to prepare the most qualified slate of candidates for APTA office positions.

The House previously passed a motion (RC 3-20) to allow for newly elected members of the APTA Board of Directors (Board) and APTA Nominating Committee (NOM-COM) to overlap so as to create an improved process for transition of office. However, due to the confidential nature of the work of the NOM-COM, this participation and collaboration is currently not allowed. The calendar and work of the Nominating Committee has created situations where current NOM-COM members are not permitted to share information (such as noted in BOD Y04-20-05-06) that may be imperative to the candidate selection process with the newly elected NOM-COM members which is an undue hardship not just for the newly elected NOM-COM member eager to perform the work for which they were elected but also for the Association members who do not get the benefit of the input from skill and expertise of their newly elected representatives on NOM-COM in the preparation of the most qualified slate of candidates for national office.

In order to ease the transition of knowledge, a member of the NOM-COM recently resigned their position to allow for a newly elected member to the NOM-COM to onboard sooner than their elected term. By doing so, the newly elected NOM-Com member was able to fill the vacated term to be able to participate in the critical work of NOM-COM since there was no other mechanism available to accomplish this. Allowing this process to repeat itself in future years is a band-aid approach which should not be permitted as it is unjust

to the elected member who must sacrifice a portion of their elected term to achieve a just outcome. Therefore, the APTA bylaws must be amended as stated above so that the elected NOM-COM members are immediately available to fully participate in preparing the next slate of candidates for national office which is a minimum expectation of the members who elect them to office.

REFERENCES

1. Florence CS, Bergen G, Atherly A, et al. Medical costs of fatal and nonfatal falls in older adults. JAGS. 2018;66(4):693-698.
2. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed January 14, 2019.
3. Carroll NV, Slattum PW, Cox FM. The cost of falls among the community-dwelling elderly. J Manag Care Pharm. 2005;11(4):307-16.