AMERICAN PHYSICAL THERAPY ASSOCIATION

73rd SESSION OF THE HOUSE OF DELEGATES

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IN MEMORIAM

The list below reflects the names of APTA members who died between January 1 and December 31, 2016.

John Allis, PT
Marilyn Anderson, PT
Doris Aubry, PT
Emma Buehlmann, PT, DPT
Elizabeth Burridge, PT
Tzena Carpenter, PTA
Toni Chiara, PT, PhD
Otto Cordero, PT
Joshua Dombo, PT
August Dorando, PT
Kristen Ellers, PT, DPT,
Certified Athletic Trainer
Kristy Esporo, PT
Carl Forrest, PT
Cecilia Graham, PT, PhD
Anoton Krasilnikov, PTA
Bruce Lamb, PT
Charles Magistro, PT, FAPTA
Bella May, PT, EdD,
Certified Exercise Expert for Aging Adults
Nancy McClure, PT
George McCluskey, PT
Diana McDonald, PT, DPT
John McGrail, PT, MSPT
Herman Meadows, PT
Margaret Moore, PT, EdD, FAPTA
Virginia O’Connell, PT
Jane Okubo, PT, DPT
Ryan Patton, SPTA
Anthony Sarola, PT,
Geriatric Certified Specialist
Matthew Schmitz, PT
Sharon Shaw, PT, PhD
Mary Singh, PTA
Caryl Sircus, PT
David Taylor, PT
Vinson Varghese, SPT
Will Wiggins, PT
Mildred Wood, PT, PhD
Donna Woodson, PT
Helen Ziler, PT
AMERICAN PHYSICAL THERAPY ASSOCIATION
BOARD OF DIRECTORS

President
Sharon L. Dunn, PT, PhD, OCS 2018
Vice President
Lisa K. Saladin, PT, PhD, FASAHP 2018
Secretary
Roger A. Herr, PT, MPA, COS-C 2019
Treasurer
Elmer R. Platz, PT 2017
Speaker
Susan R. Griffin, PT, DPT, MS, GCS, RP 2017
Vice Speaker
Stuart H. Platt, PT, MSPT 2019

Directors
Susan A. Appling, PT, DPT, PhD, OCS 2018
Jeanine M. Gunn, PT, DPT 2018
Matthew R. Hyland, PT, PhD, MPA 2017
Kathleen K. Mairella, PT, DPT, MA 2017
Sheila K. Nicholson, PT, DPT, JD, MBA, MA 2017
Carolyn M. Oddo, PT, MS, FACHE 2016
Robert H. Rowe, PT, DPT, DMT, MHS, FAAOMPT 2018
Kip Schick, PT, DPT, MBA 2019
Susan L. Whitney, PT, DPT, PhD, NCS, ATC, FAPTA 2019

PAST PRESIDENTS

Mary McMillan, PT* 1921 – 1923
Inga Lohne Brauner, PT* 1923 – 1924
Dorothea M. Beck, PT* 1924 – 1926
Gertrude Beard, PT* 1926 – 1928
Hazel E. Furscott, PT* 1928 – 1930
Edith Munro, PT* 1930 – 1932
Margaret S. Campbell Winters, PT* 1932 – 1934
Sarah A. Colby, PT* 1934 – 1936
Constance K. Greene, PT* 1936 – 1938
Helen L. Kaiser, PT* 1938 – 1940
Catherine. Worthingham, PT, PhD, FAPTA* 1940 – 1944
Jessie L. Stevenson West, PT* 1944 – 1946
Susan G. Roen, PT* 1946 – 1948
Lois Ransom, PT* 1948 – 1949
Marguerite I. Irvine, PT* 1949 – 1950
Mary Clyde Singleton, PT, PhD* 1950 – 1952
Harriet S. Lee, PT* 1952 – 1954
Mary E. Nesbitt St. Coeur, PT* 1954 – 1956
Eleanor Jane Carlin, PT, DSc, FAPTA* 1956 – 1958
Agnes P. Snyder, PT* 1958 – 1961
Mary Elizabeth Kolb, PT* 1961 – 1967
Eugene Michels, PT, FAPTA* 1967 – 1973
Charles M. Magistro, PT, FAPTA 1973 – 1976
Robert C. Bartlett, PT, FAPTA 1976 – 1979
Don W. Wortley, PT* 1979 – 1982
Robert W. Richardson, PT, MEd, FAPTA 1982 – 1985
Marilyn Moffat, PT, PhD, FAPTA 1991 – 1997
Jan K. Richardson, PT, PhD, OCS 1997 – 2000
Ben F. Massey, Jr, PT, MA 2000 – 2006
R. Scott Ward, PT, PhD 2006 – 2012
Paul A. Rockar 2012 – 2015
*Deceased
AMERICAN BOARD OF PHYSICAL THERAPY SPECIALTIES (RC 16-80)

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND
In June 1980, the House of Delegates (House) adopted Certification of Advanced Clinical Competence (RC 16-80) requiring the American Board of Physical Therapy Specialties (ABPTS) to provide an annual report of its activities to the House.

DISCUSSION
Number of specialists certified or recertified in 2016. To date, ABPTS has certified 20,144 clinical specialists in 8 specialty areas. ABPTS certified 2,073 of these individuals in 2016: 19 specialists in Cardiovascular and Pulmonary, 9 in Clinical Electrophysiology, 197 in Geriatrics, 259 in Neurology, 1,164 in Orthopaedics, 130 in Pediatrics, 238 in Sports, and 57 in Women’s Health.

Application numbers have continued to increase annually. A record number (3,520) of applications were received in 2016 for the 2017 examination cycle. This represents a 5% increase in applications from the previous year. Of the 2017 specialist certification applicants, 17% were graduates of an APTA-accredited residency program. This is up from 16% in 2016. In 2016, averaged across all specialty areas, examinees who completed an APTA-accredited residency program had a 16% higher passing rate than those who did not.

ABPTS granted recertification to 703 clinical specialists in 2016. To date, 5,241 specialists have achieved recertification, which is a 67% recertification rate.

Specialists who were certified or recertified in 2016 were recognized at the Recognition Ceremony for Clinical Specialists at the 2017 Combined Sections Meeting (CSM).

Exam development and administration. The 2017 specialist certification examinations were administered February 27-March 18 at Prometric testing centers. The National Board of Medical Examiners (NBME) provides test development, editorial production, item writer training, test administration, analysis, and scoring for the specialist certification examinations. NBME is currently contracted to provide these services through the 2018 examination cycle.

Fees for the specialist certification examination. The fees for the 2017 examinations will remain at $1,315 for APTA members and $2,385 for nonmembers. Examination fees support activities related to examination development, administration, and scoring, including the contract with NBME. Current initiatives that require funding include the transition from a “recertification” model to a “maintenance of specialist certification” model; the practice analyses for the Cardiovascular and Pulmonary, Clinical Electrophysiologic, Geriatric, and Women’s Health revalidation studies; and increased activities related to item writing and maintenance of the specialty item banks.
New specialty area petition achieving approval from ABPTS and House of Delegates. In February 2016, ABPTS unanimously voted to recommend to the 2016 House of Delegates that Oncology be recognized as a specialty area for certification. Following an affirmative vote during the 2016 House, Oncology became the ninth ABPTS board-certification specialty area. Members of the newly established Oncologic Specialty Council include Nicole Stout, PT, DPT, CLT-LANA; Lucinda Pfalzer, PT, PhD, FAPTA; Amy Litterini, PT, DPT; Charles McGarvey, PT, DPT, FAPTA; Stephen Morris, PT, PhD, (ad hoc member); and Lisa VanHoose, PT, PhD (ad hoc member). It is anticipated that the first Oncology specialist certification examination will be administered in spring 2019.

Item writing productivity, recruitment, and incentives. ABPTS’s Specialization Academy of Content Experts (SACE) and Committee of Content Experts (CCE) were established as a pool of certified specialists and content experts to write items for the specialist certification examinations. ABPTS has 245 volunteer members of SACE to produce items for the 9 designated specialty exams. The 32 CCE members are experienced item writers who edit items and mentor SACE members in their designated specialty areas. Members of SACE and CCE were recognized as a group during the Recognition Ceremony for Clinical Specialists at CSM 2017.

To encourage and support the item-writing process and increased production from SACE members, ABPTS sponsors an item-writer incentives program. ABPTS annually provides incentives to all SACE members who submit 10 items in a calendar year, to the most productive SACE member from each specialty council in a calendar year, and to the most productive SACE member across specialty areas in a calendar year. Kimberly Klug, PT, DSc, was the recipient of the award for most productive item writer in 2016.

Recertification Audit Review Committee. The Recertification Audit Review Committee, a subcommittee of ABPTS, completed its review of recertification applications in May 2016. The committee reviewed a number of randomly selected recertification applications from the previous year to ensure that the specialty councils had followed procedures consistently and thoroughly. The committee reported that specialty councils had followed the specified procedures and had properly recommended these individuals for recertification.

To help expedite and streamline the recertification review process, as well as to introduce to specialists the continuing education opportunities available through APTA’s Learning Center and APTA sections, the ABPTS specialty councils agreed to review and grant preapproval to appropriate continuing education offerings that would meet recertification requirements. APTA’s specialist certification and postprofessional learning staff are working together to coordinate this effort. The Geriatric Specialty Council is the first to complete its review and provide a listing of preapproved courses.

Maintenance of Specialist Certification (MOSC) system launch. Staff from APTA’s specialist certification and information technology areas spent much of 2016 developing the new MOSC tracking and submission system. ABPTS adopted the MOSC process for recertification in 2013. The new system officially launched to over 4,000 ABPTS specialists in October 2016. ABPTS-certified specialists now have the capability of real-time capture of their professional development activities throughout their 10-year certification period. The online submission system also helps specialists progress toward their MOSC milestones. The MOSC process reflects the dynamic health care environment, which requires a commitment to lifelong learning and continuing clinical competence.
Revalidation studies. All specialty councils perform revalidation studies every 10 years. The Neurologic Specialty Council completed its study and released its new Description of Specialty Practice in summer 2016. The Geriatric Specialty Council appointed subject matter experts and initiated its revalidation study in 2017. It is anticipated that its revised Description of Specialty Practice will be available in spring 2019. The Women’s Health Specialty Council began its efforts in 2014, and it is anticipated that its revised Description of Specialty Practice will be available in fall 2017. The Clinical Electrophysiologic Specialty Council and Cardiovascular and Pulmonary Specialty Council began their efforts in 2015 and also anticipate that their revised Descriptions of Specialty Practice will be available later in 2017.

CSM 2017 activities. During her opening remarks at the 2017 Recognition Ceremony for Clinical Specialists, Jean Irion, PT, EdD, ATC (board-certified sports specialist and immediate past chair of ABPTS), shared her insights on the roles and responsibilities of the clinical specialist as a leader in clinic and community settings as well as for the physical therapy profession. Additionally at CSM 2017, ABPTS sponsored the session “Enhancing Professional Development Through Maintenance of Specialist Certification.” This was an opportunity for board-certified specialists to learn more about the details of ABPTS’s transition to the MOSC process, and about the program requirements and expectations. ABPTS also once again sponsored a networking reception to acknowledge the accomplishments of the individuals who achieved recertification in 2016.

Promotion. The following promotional activities were undertaken to increase participation in and awareness of the specialist certification process:

1) APTA posted, and specialists further distributed, press releases and correspondence for media, health-related associations, and components to publicize the 2016 certified specialists and provide suggestions for promoting specialist certification.

2) As mentioned above, ABPTS conducted a session on specialist recertification and the MOSC program at CSM 2017; it also conducted sessions on initial certification during the 2016 National Student Conclave and the California Chapter Student Conclave.

3) Announcements were published in PT in Motion News and in chapter and section newsletters.

4) Exhibits were staffed at APTA’s 2016 National Student Conclave, CSM 2017, and the 2016 California Chapter annual conference.

5) Specialist certification and professional development staff worked with APTA’s marketing staff to finalize a marketing and communications strategy for the specialist certification and maintenance of specialist certification programs.

Amendments to ABPTS policies and procedures. In 2016, based on recommendations from an established ABPTS work group and APTA’s in-house legal counsel, ABPTS adopted modifications to its existing policies and procedures focused on disciplinary procedures. ABPTS adopted this enhanced disciplinary policy to articulate standards of conduct for individuals seeking certification and recertification, and for those holding certification. This revised disciplinary policy also was adopted to establish a fair process for addressing noncompliance.

As a general principle, all individuals certified by ABPTS are expected to adhere to the Code of Ethics for the Physical Therapist, which delineates the ethical obligations of all physical therapists as determined by the House of Delegates.
Appointments to ABPTS and specialty councils. ABPTS distributed a public call for nominations for ABPTS and specialty council vacancies. Since June 2016, 5 individuals were appointed to ABPTS, and 9 were appointed to the specialty councils:

- ABPTS made the following appointments to ABPTS for terms that began on July 1, 2016: Robin Myers, PT, DPT, for a 4-year term from the neurologic specialty area; Robert Sellin, PT, DSc, for a 4-year term from the clinical electrophysiologic specialty area; Don Straube, PT, PhD (board-certified neurologic clinical specialist) for a 2-year term as its test and measurements representative; and Scott Richards, PhD, PA-C, for a 2-year term as its public representative.

- Susan Appling, PT, DPT, PhD (board-certified orthopaedic clinical specialist), is serving a second 1-year term as the nonvoting Board liaison.

- ABPTS made the following appointments to the specialty councils for 4-year terms beginning January 1, 2017: Courtney Williamson Frankel, PT, MS, to the Cardiovascular and Pulmonary Specialty Council; Jeffrey C. Slear, PT, to the Clinical Electrophysiologic Specialty Council; Karma Marie Lapacek, PT, DPT, to the Geriatric Specialty Council; Hallie Zeleznik, PT, DPT, to the Neurologic Specialty Council; Nicole Stout, PT, DPT, to the Oncologic Specialty Council; Lucinda Pfalzer, PT, PhD, FAPTA, to the Oncologic Specialty Council; Amy Litterini, PT, DPT, to the Oncologic Specialty Council; Charles McGarvey, PT, DPT, FAPTA, to the Oncologic Specialty Council; and Judy R. Gelber, PT, DPT, to the Orthopaedic Specialty Council.

On July 1, 2016, Theresa (Tracy) Spitznagle, PT, DPT, MHS (board-certified women’s health clinical specialist), became the chair of ABPTS, and Ronald Barredo, PT, DPT, EdD (board-certified geriatric clinical specialist), became chair-elect.
COLLABORATIVE RELATIONSHIPS WITH PRIMARY CARE PROVIDER ORGANIZATIONS (RC 16-10)

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND
With the adoption of RC 16-10, Collaborative Relationships with Primary Care Provider Organizations, in 2010 the APTA House of Delegates (House) addressed strategic and collaborative relationships with other organizations that represent primary care providers. The House requested annual progress reports on these efforts beginning in 2011.

DISCUSSION
Beginning in 2014, APTA participated in the American Board of Internal Medicine (ABIM) Foundation’s Choosing Wisely© initiative as the first nonphysician organization to develop its list of “Five Things Providers and Patients Should Question.” The purpose of the campaign is to spark conversations between providers and patients to ensure that the right care is delivered at the right time, and to decrease the use of tests and procedures that have little to no benefit or are either excessively expensive or potentially harmful. More than 70 primary care and specialty societies have joined the campaign since its inception in 2012. Through the Choosing Wisely initiative, APTA participates in quarterly meetings with representatives of primary care and specialty organizations to collaborate on strategies to improve care and reduce waste in health care. APTA has had the opportunity to present its list of “Five Things Physical Therapists and Patients Should Question” to this group and to describe the methodology used in the list development. Participation in this high-profile initiative has strengthened existing relationships and has led to new opportunities for collaboration.

In 2015, this work continued, both with the ABIM Foundation and with Consumer Reports. APTA’s strategic partnerships and collaborations were also centralized within the Public Affairs Unit of the association. The APTA Board of Directors (Board) has added an objective to the APTA Strategic Plan of expanding mutually beneficial partnerships, and staff are undertaking an audit and review of all partnerships to create more focus and strategic impact in this program, including our relationships with primary care organizations.

In 2015, the House passed The Association’s Role in Advocacy for Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability (HOD P06-16-05-06). This policy includes a focus on developing collaborative, interprofessional, and partnering relationships with health care and community organizations that advocate for prevention, wellness, fitness, health promotion, and management of disease and disability. This policy in part led to efforts to update APTA’s strategic plan to consider a formal process for establishing partnerships.

This year, per the direction of the strategic plan, the Board will review criteria for formally establishing a strategic partnership program. In April, the Board will participate in a generative discussion about implementing this program. The partnership program has identified a framework that includes advocacy, science, and service as well as the scope of influence at local, national, and international
levels. The partnership framework will also look at positioning our components to help build on
relationships and partnerships that have been established over the years, including those with primary
care organizations.

In 2016, APTA engaged National Journal’s Network Sciences Initiative to conduct analysis and research
to identify health care groups for collaboration and partnership that can help increase APTA’s
effectiveness on advocacy and public policy initiatives. APTA now has critical information on groups
and organizations that are potential partners with which to engage on specific issues ranging from
quality programs to public health initiatives. For example, in the area of primary care and quality, the
work with National Journal revealed organizations engaged in implementation of the Merit-based
Incentive Payment System (MIPS) and the development of Alternative Payment Models
(APMS). Among these organizations are key leaders in physician and nursing organizations to whom
APTA should prioritize its outreach to advance our policy agenda and to begin to build sustainable
relationships. APTA already has embarked on this work through outreach to primary care organizations
and specialty societies on APM development. APTA will also use this information to position itself for
collaborations that are issue specific, and to begin building relationships that we potentially can
leverage beyond those targeted issues to become part of our partnership structure and priorities.

In 2016, APTA also continued its collaboration with primary care providers through work with entities
such as the US Bone and Joint Initiative, the National Physical Activity Plan Alliance, and the
Osteoarthritis Action Alliance. As part of APTA’s #ChoosePT public relations campaign, APTA also in
2016 ran a print ad in the September/October issue of *Family Practice Management* magazine, the
American Academy of Family Physicians’ peer-reviewed practice-management journal, with a
readership of 734,000.

APTA also is investigating opportunities in 2017 to collaborate on research initiatives with
organizations representing groups of physicians.
CONSUMER INFORMATION AVAILABLE ON THE APTA WEBSITE (RC 30-05)

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND
In 2005, APTA’s House of Delegates (House) adopted RC 30-05 to “convert the present consumer pages of the APTA web site into an interactive consumer/patient/client education portal that provides consumers with information about what physical therapy can offer them in managing their own health, and that assists the consumer/patient/client in making decisions about benefit packages, choosing the best providers, and managing out-of-pocket costs and medical savings accounts.”

The motion further charged that the consumer site “shall be recognized as the definitive source for consumer guidance in the treatment, management, and prevention of conditions that threaten or produce functional limitations,” and that it will be “a critical and strategic link on the web sites of all not-for-profit organizations and associations representing constituencies concerned with functional abilities,” and that it shall be “accessible through the utilization of major search engines.”

At the time of the House charge, APTA had 1 full-time staff member responsible for content management and site architecture of its websites (including APTA.org, which was in need of a redesign), and it had no full-time staff dedicated to the development of consumer resources, nor an established website for consumers. Since that time, additional staff and financial resources have been directed toward the site each year as strategic priorities determine and budget allows. Today, MoveForwardPT.com is supported by 1 part-time staff position that collaborates with numerous additional staff, an APTA member editorial board, and other member volunteers on content and site development and related campaigns.

APTA’s first step, in 2006, was to partner with Healthwise, a company that provides searchable health care databases for consumers at sites such as WebMD. The partnership was intended to provide APTA’s consumer site with vast, immediate, quality content while also leading to improvement of Healthwise’s physical therapy content. However, in 2008 this partnership was terminated because Healthwise’s existing content provided scant specific detail about treatment by a physical therapist, and the company was slow to accept suggested improvements to address these areas.

Meanwhile, in 2008 the development of APTA’s “Move Forward” branding campaign was under way, including initial consumer research, and the creation of a new consumer website was included in APTA’s communication plan as a complementary initiative. Recognizing that APTA’s online content management platform for APTA.org at the time was inadequate to meet the intent of RC 30-05, in 2009 the development of an online portal for consumers (MoveForwardPT.com) was included in a request-for-proposal process to identify a vendor that could develop both that site and the clinician portal, PTNow.org, thus creating cost and resource efficiencies.
Enforme Interactive was hired to work on both portals, and in June 2011, after many months of research and development, the Enforme-hosted version of MoveForwardPT.com was launched, replacing an interim “Move Forward”-themed site that was designed to support the initial months of the branding campaign. This more robust version of MoveForwardPT.com was designed based on an extensive data-gathering phase that included stakeholder interviews, consumer focus groups, and demos for members, and the uniquely generated content was developed by APTA members working to support the MoveForwardPT.com and PTNow.org projects, as well as professional freelance writers. Also that year, 1 existing full-time senior specialist position was identified to oversee the long-term, continual content development of the site.

In late 2012, an editorial board of 6 APTA members was formed after a national call to further MoveForwardPT.com content development as a regular work process. In March 2014, a redesigned, mobile-friendly (“responsive”) version of MoveForwardPT.com was launched, simplifying the look-and-feel and improving access to content that had become more diverse and detailed.

In 2016, MoveForwardPT.com became the hub of APTA’s largest consumer awareness campaign ever, #ChoosePT, which is designed to educate the public about the dangers of opioids and the benefits of physical therapist treatment as a safe alternative for long-term management of most pain conditions, consistent with Centers for Disease Control and Prevention (CDC) guidelines released in March 2016. The ongoing #ChoosePT campaign is a collaborative effort that extends beyond the website.

Additional content development and management of MoveForwardPT.com continues with support from staff and member support, including the editorial board.

**DISCUSSION**

The depth of content at MoveForwardPT.com, and traffic to the site, continues to expand each year.

The centerpiece of MoveForwardPT.com is its collection of more than 145 Symptoms & Conditions guides, which provide comprehensive information written according to web best practices (eighth grade reading level) with specific information about physical therapist treatment. Guides can be accessed via the Symptoms & Conditions heading in the main navigation of the site or via the Interactive Body feature (consumer focus groups indicated a desire to search by an alphabetical conditions list and a body-based interface). Existing guides are reviewed for accuracy on a rotating basis every few years, and new guides will be developed in 2017.

Other popular areas of the site include:

- The Find a PT database where consumers can locate a physical therapist in their area
- Basic information on the benefits of physical therapy and how to choose a physical therapist and prepare for a visit
- The Did You Know section, which uses social media-friendly graphics to promote stories highlighting the benefits of physical therapy and fitness
- The twice-monthly online radio show and podcast, “Move Forward Radio,” which is hosted via BlogTalkRadio and also available to download via iTunes
- The video library showcasing the expertise of physical therapists across multiple settings and patient populations
- A collection of patient stories
• Various comprehensive health centers, health and prevention tips pages (including listicles), insurance information, advocacy information, general information about who physical therapists and physical therapist assistants are and what they do, and information for health care professionals.

Traffic to MoveForwardPT.com has set record highs annually in all measurable areas. In 2016, the site welcomed nearly 3 million unique visitors (2,997,547), which was a significant increase over 2015 (1,636,894 unique visitors) and 2014 (827,483 unique visitors). Visitor sessions also increased in 2016 (3,634,549) over 2015 (1,982,233) and 2014 (996,534). The vast majority of that traffic (81% of all sessions in 2016) is the result of referrals from search engines such as Google and Bing. Meanwhile, social media referrals increased 92% in 2016 (from 73,147 sessions in 2015 to 140,541 sessions in 2016) as MoveForwardPT-branded accounts continue to generate activity on Facebook, Twitter, and Pinterest, which have more than 50,000 combined followers.

APTA continues to explore opportunities to partner with other not-for-profit organizations and associations in the health care arena. Although many organizations and websites are unwilling to create permanent links to external sources, APTA generated links from the websites and/or social media accounts of groups such as the Arthritis Foundation, American Chronic Pain Association, Mayo Clinic Physical Medicine and Rehabilitation, National Multiple Sclerosis Foundation, the National Parkinson Foundation, the Plan Against Pain campaign, and the World Down Syndrome Society. In 2013, MoveForwardPT.com also benefitted from APTA’s collaboration with HuffPost50, a Huffington Post blog, through a series of articles tied to the “Fittest Cities” initiative. In 2015, MoveForwardPT.com published content on the “Community-Based Physical Activity Programs for Arthritis” that was developed in partnership with the CDC.

In 2017, APTA will continue the above efforts, including the #ChoosePT campaign. APTA will also develop a 5-year consumer communications plan based on research conducted in 2016 to benchmark current consumer attitudes about physical therapy against 2007 research conducted during initial brand development. Future efforts will include ongoing engagement with components and other collaboration strategies designed to increase the reach of MoveForwardPT.com.

SUMMARY

The MoveForwardPT.com project is a significant contributor to APTA’s efforts to educate consumers about the benefits of physical therapy, and it is arguably the definitive source of online information about treatment by a physical therapist. The site is core to other initiatives, such as media outreach, promotion of the physical therapist’s role in prevention and wellness, consumer advocacy, and consumer education about integrity in practice. Conference calls with staff responsible for the American Academy of Orthopaedic Surgeons’ OrthoInfo website (www.orthoinfo.org), which has been cited as a model, reinforce that APTA is following a similar content development workflow and producing content at a similar rate, and suggest APTA is an association leader in social media efforts designed to support its consumer information site. APTA staff plans to continue with and expand on the above projects to support the site’s continuing evolution.
GOALS AND OBJECTIVES: DEVELOPMENT AND PRESENTATION
TO THE HOUSE OF DELEGATES (RC 6-04)

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

In August 2014, the Board of Directors (Board) undertook a strategic planning process to shift the focus of the work of the organization from Vision 2020 to the new Vision Statement for the Physical Therapy Profession (HOD P06-13-18-22), adopted by the House of Delegates (House) in 2013:

Transforming society by optimizing movement to improve the human experience.

As part of its annual process, the Board adopted its strategic plan for 2017 in November 2016 along with its budget and work plans. The strategic plan is organized into 3 broad areas that define the area of impact—the association, profession, and society—with measurable objectives and sub-objectives as outlined below:

TRANSFORM SOCIETY

Barriers to movement will be reduced at population, community, workplace, home, and individual levels.

1. Reform payment policy to reflect the essential role of physical therapists in movement, health, and quality of life.
   • Identify alternative payment models for rehabilitation services by January 1, 2019.
   • Identify and recommend patient assessment instruments and outcome measures by January 1, 2018.
   • Include recommended patient assessment instruments and outcome measures in alternative payment models by January 1, 2019.

2. Establish mutually beneficial partnerships to enhance society’s understanding of physical therapists’ movement expertise and to remove barriers to movement.
   • Review current relationships to determine feasibility of formalizing partnership contracts with such entities by January 1, 2019.

3. Physical therapists will develop and implement community-based measures of mobility.
   • Establish a national measure of community-based participation and activity for use by APTA and components, with a report to the Board of Directors by July 1, 2017.

4. Improve society’s recognition and understanding of physical therapy and physical therapists.
   • Begin implementation of a 5-year communications plan by January 1, 2018, that includes sustained public relations campaigns built on results of consumer research.
5. Leverage technology to advance physical therapists’ role in enhancing movement.
   • Achieve payment for physical therapist services delivered via telehealth by Medicare and other
     major payers by January 1, 2019.
   • Identify opportunities for collaboration and develop a formal relationship with the American
     Telehealth Association by January 1, 2018.

TRANSFORM THE PROFESSION

Physical therapist practice will deliver value by utilizing evidence, best practice, and outcomes.

1. Further develop and implement strategies to address unwarranted variations in clinical practice, so
   that physical therapists demonstrate consistency in practice based on outcomes, evidence, and
   cultural competence.
   • By January 1, 2018, develop and disseminate materials for faculty and members to teach
     concepts associated with clinical practice guidelines (CPGs) and how to implement them into
     practice.
   • By January 1, 2019, complete and actively disseminate to physical therapists, physical therapist
     assistants, and other stakeholders 7 new CPGs developed by APTA and sections.
   • By July 1, 2017, develop strategies to decrease the CPG development and publication time from
     the current 4 years to 2 years, and present findings to the Board of Directors on the feasibility
     of implementing these strategies in 2018.
   • Throughout 2017, disseminate to members strategies for best-practice implementation, quality
     improvement, and innovation to enhance practice consistency, outcomes, and value in physical
     therapist practice.
   • By January 1, 2018, enlist and engage components to promote the concepts of cultural
     competence and health disparities as standard parts of practice.

2. Integrate the movement system as a concept into practice, education, and research.
   • By July 1, 2017, publish and disseminate the 2016 Movement System Summit proceedings.
   • Upon Board approval in spring 2017 of the proposed plan from the Summit, develop steps
     toward implementation of the plan to integrate the movement system concept into practice,
     education, and research through 2025.
   • Begin development and vetting of a diagnostic framework, labels, and/or classification system
     that reflect and contribute to the physical therapist’s ability to properly and effectively manage
     disorders of the movement system, to be completed in 2020.

3. Engage with the Education Leadership Partnership Steering Committee to reduce unwarranted
   variations in student qualifications, readiness, and performance across the continuum of physical
   therapist professional education.
   • For a report with recommendations to the Board of Directors by April 1, 2017, investigate the
     feasibility of developing an “entrance” examination for physical therapist professional
     education program applicants.
   • By July 1, 2017, use Board-approved recommendations from the 2016 Clinical Education Task
     Force’s final report to address unwarranted variation in the delivery of clinical education,
     student preparedness, and student performance.
4. Provide academic and clinical faculty with quality professional development opportunities, and PT/PTA programs with updated resources and student assessment tools.
   • By January 1, 2018, achieve ABPTRFE reaccreditation of ELI program.
   • Revise the Clinical Performance Instruments (PT and PTA CPIs).
   • Explore the need to revise the PT and PTA Normative Models (last updates were 2004 and 2007 respectively).
   • Explore the development of a CAS for PTA education programs.
   • Facilitate PTCAS transition to CAS 3.X application platform in the 2017-2018 admissions cycle.

5. Provide education program accreditation practices that afford the necessary rigor and quality control, while offering an application and review process that is efficient and useful.
   • Revise ABPTRFE Evaluative Criteria and streamline the accreditation processes and procedures.
   • CAPTE will conduct an external audit of its accreditation processes for PT and PTA programs.
   • Have CAPTE and ABPTRFE explore the feasibility of using a single database vendor.

6. Identify roles and promote physical therapist participation in primary care delivery models.
   • By April 1, 2017, complete an analysis of the qualifications and education needed to better define the scope of practice and role of physical therapists across the primary care continuum of health care delivery.
   • For a report and recommendations to the Board of Directors by January 1, 2018, develop a plan toward achieving any necessary advanced practice, education, and research competencies required to enhance/integrate physical therapist roles within primary care teams.

7. Investigate emerging trends in health care to identify bioscience initiatives that may have positive impacts on physical therapist management of patients and clients.
   • Submit a report with recommendations to the Board of Directors by June 1, 2017.

TRANSFORM THE ASSOCIATION
APTA will be a relevant organization that is entrepreneurial, employing disciplined agility to achieve its priorities.

1. Develop and refine data sources to drive business intelligence in the areas of public affairs, professional affairs, finance, business affairs, and member affairs.
   • By January 1, 2019, complete a review of all Board, House, and staff policies as well as organizational bylaws to (1) propose areas/processes that can be streamlined and (2) be prepared for potential House of Delegates motions and bylaw revisions for the 2020 House.
   • By January 1, 2021, expand the association’s library catalog of documents to include all Board reports, House documents, APTA publications, and corporate records (eg, policy letters, reports, and press releases).

2. Identify the sources and users of physical therapy information in an effort to make APTA the definitive source of such information.
   • By January 1, 2018, complete pilot implementation of the Knowledge Management System, with anticipated full implementation by January 1, 2020.
   • By January 1, 2018, increase by 2% the overall registrations of postprofessional education opportunities that offer CEUs (eg, Learning Center, Combined Sections Meeting, National
3. Achieve a greater market share of membership.
   - By June 30, 2017, investigate and identify trends in membership data around membership segments such as PTAs, part-time PTs, and early-career members.
   - Investigate, identify, and propose possible new membership models so that new model(s) could be implemented by January 1, 2019, with further bylaw revisions, if necessary, prepared for the 2020 House of Delegates.

4. Demonstrate leadership in establishing and adopting best practices in association management.
   - By July 1, 2017, proceed with the appropriate next steps regarding APTA’s real estate, per the decisions and direction of the Board.
   - By January 1, 2019, increase staff’s participation in APTA University by 50%.
   - By January 1, 2018, increase components’ use of APTA resources and increase points of engagement with components.

In 2017 APTA will begin to solicit member and potential member feedback on the next update of the strategic plan (to be in effect 2019-2021), which will accompany the association’s vision statement and a potential new mission statement. This strategic plan will engage various stakeholders and lead the association into its centennial year—and its new century of impact on individuals and communities, and advancing the physical therapy profession.

HISTORY
The APTA House of Delegates created a process for annual review and approval of association goals in 1988, when it adopted, via RC 24-88, Association Priorities (HOD 06-88-12-20) (amended in 1995 by RC 18-95 to read Association Goals [HOD 06-95-23-13], and later retitled “Goals: Procedure for Adoption”). This process directed the Board to annually review APTA’s goals and present them to the House for adoption. From 1990 through 2004 the Board presented Goals That Represent the Priorities of the Association to the House for adoption every year, whether or not any changes to the goals were being recommended.

In 1994, via RC 50-94, the House adopted Provision of Funding Priorities Information to the House of Delegates (HOD 06-94-40-61), which required the Board to annually review and prioritize the stated objectives of the association and report to the delegates prior to each House. During the 2003 House of Delegates, Goals: Procedure for Adoption was amended and retitled via RC 3-03 to Goals and Objectives: Development and Presentation to the House of Delegates (HOD 06-03-08-03). This substitution combined the intent of Goals: Procedures for Adoption) and Provision of Funding Priorities Information to the House of Delegates. As a result, the House rescinded Provision of Funding Priorities Information to the House of Delegates via RC 4-03.

In 2004, adoption of RC 6-04 amended the policy Goals and Objectives: Development and Presentation to the House of Delegates, removing the requirement for association goals to be submitted annually to the House for approval, while maintaining the obligation to present an annual report of prioritized objectives to the House for information purposes only. This amendment was based on the idea that because APTA’s goals are more permanent in nature and describe outcomes based on long-term efforts, they should not be expected to undergo significant changes each year. Instead, the delegates
determined that it would be more appropriate for the House to take action on goals only when presented with a Board or component proposal to modify them. The House also noted that goals are different from objectives, which describe activities that can be achieved in a shorter time frame.

After the adoption of the APTA Vision Sentence for Physical Therapy 2020 and APTA Vision Statement for Physical Therapy 2020 (HOD P06-00-24-35) (Vision 2020) in June 2000, the Board used Vision 2020 as a guide to revise the goals and accompanying objectives for 2002. The 2002 goals and objectives, as adopted by the 2001 House, were the first to be developed based on the association’s efforts to fulfill Vision 2020. The agreed-upon areas were (in alphabetical order) autonomous practice, direct access, doctor of physical therapy, evidence-based practice, practitioner of choice, and professionalism. House review and adoption of the association goals continued to lay the foundation for attainment of APTA’s Vision 2020. Through adoption of goals, both the House and Board were able to focus on the many issues facing the physical therapy profession and on implementation of initiatives to achieve Vision 2020.

In December 2007, in response to the House charge Strategic Plan to Achieve Vision 2020 (RC 20-06), the association launched the Strategic Thinking and Planning (STP) initiative. The STP initiative comprised 3 components: development of a comprehensive strategic plan, a review of APTA’s governance system, and Board of Directors and staff development. These 3 components shared a common goal: to make APTA a more relevant, effective, and efficient organization that is indispensable to its members.

The Board adopted a new APTA strategic plan in July 2008 to prepare the association to meet the challenges and opportunities of the future through a strategic framework that focused on a 3- to 5-year planning horizon. This strategic plan informed decision making, helped to achieve the goals of Vision 2020, and allowed APTA to better provide representation, services, and products to its members. Progress toward achievement of the strategic outcomes and objectives within the plan was measured throughout the planning horizon and reported on regularly. In 2009, the first year the plan was implemented, the Board reviewed its progress 3 times in conjunction with the March, June, and November Board meetings. The first annual formal evaluation of the plan was conducted on March 11, 2010, and a summary of the 2009 progress on the plan was reported to the 2010 House. The Board formally reviewed progress on the 2010-2011 plan twice (November 2010 and March 2011) and reported on progress to the 2011 House.

In March 2011, the Board discussed the prioritization of APTA’s strategic plan, specifically the strategic outcomes and objectives. Based on the decisions of the Board, the Senior Staff Team identified the top strategic priorities that would drive decisions in the 2012 budget and plan. The Board adopted a slightly modified version of the plan with revised metrics and strategies in June 2011, and began implementation in July 2011 to be extended until December 2012.

In 2011, the House adopted a motion to revise Vision 2020, resulting in a new vision that was adopted by the House in June 2013.

**Vision Statement for the Physical Therapy Profession** (HOD P06-13-18-22)

Transforming society by optimizing movement to improve the human experience.
In 2013 the Board undertook a strategic planning process in an effort to bridge the remaining unmet strategic outcomes and objectives from Vision 2020 to the new Vision Statement for the Profession. Component leaders selected representatives to join the Board in the initial planning session to chart the course, and from that meeting the Board created a new Strategic Plan in 2014. The shift toward a more societal focus created the need to identify new, more outward-facing outcomes that would lead to incremental progress toward a bold and transformative vision. Guiding Principles to Achieve the Vision (HOD P06-13-19-23), along with the need to bridge the previous relevant, unmet outcomes, drove the 3 broad areas of focus for the new strategic plan: Transform Society, Transform the Profession, and Transform the Association. Board work groups were subsequently assigned to monitor progress and provide guidance and direction in each area.

The strategic plan adopted in 2014 guided the 2015 budgeting process, tying resources directly to objectives and sub-objectives outlined in the plan. Staff created tactics, metrics, timelines, and key performance indicators along with a budget that could be monitored to assess progress toward the strategic objectives. This process and data, with refinements each year, have been used annually by the Board for assessment, review, and revision as needed in adopting the 2015–2017 strategic plans and annual budgets.
HOUSE OFFICERS REPORT

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND:
Annually the House officers consider actions taken by and feedback from the prior APTA House of Delegates (House) and consider opportunities to refine the efficiency and effectiveness of the House and elections process. Highlights of the activities over the past year are identified below.

Communication and Education
The House officers and Governance department staff have continued to identify ways to facilitate communication with delegates:

- The House Community has continued to evolve and delegates have utilized it to provide input on motion concepts, as well as on language for motions published in Packet I. In 2016 APTA Communities moved to a new version of the platform that is more mobile friendly, and easier to use and access on smartphones and tablets.
- Following the 2016 House, tools to assist delegates in communicating House actions to members were developed and distributed. The tools included a post-House packet containing motion language (subject to change pending approval of the minutes), which was made available on June 24, 2016, and a summary of House actions in the form of a PowerPoint presentation.
- A comprehensive plan for delegate education, involving several recorded modules on varying topics, has been developed, and production is underway. In the fall of 2015, the House officers launched 2 modules: Delegate Overview and Reference Committee Demystified. In early 2016, another module, Motions are in the Eyes of the Beholder: Motion Makers, was released. In May 2016, the module What to Expect Onsite was shared.
- In an effort to help pace preparatory work of the House, and highlight important information for regional caucus chief delegates, communication between the House officers and the Regional Caucus leads was enhanced through monthly outreach by Stuart Platt, vice speaker.
- A parliamentary procedure educational session was held for delegates of the 2016 House. APTA Parliamentarian Nancy Sylvester led the session. Positive feedback was received and the session will be repeated for the 2017 House. Related reference materials will be created and posted to the House community.
- The livestream of the 2016 House of Delegates was viewed by 317 members. The session has been maintained on the website and delegates report using it to educate students and members on the House proceedings. The 2017 House will also be live-streamed.
- The House officers hosted 2 Virtual Town Hall meetings for delegates in October and December 2016. In October, the Board of Directors shared its plans for taking action on motions adopted at the 2016 House.
- During the 2017 Chief, Section, and Assembly Delegates Philosophical Discussion, held during the Combined Sections Meeting in San Antonio, Texas, attendees received updated information important in preparation for the 2017 House including an overview of all motion concepts to date presented by motion makers.
Onsite House Processes

The House officers and Governance department staff members have continued to identify ways to facilitate effectiveness and efficiency of onsite House processes:

- Background papers were made available a la carte as well as consolidated with Packet I. The crowd went wild!
- Replacement packets for motions were made available in several formats, including the traditional stand-alone packets of replacement and substitute motions as well as consolidated documents that included the motions from Packet I, replacements and substitutes proposed via Packet II and Packet III, and the background papers.

2016 Motions Affecting House Processes

RC 14-16 charged APTA to review all current Board documents for the purpose of identifying those that relate to the profession, and present them to the House for adoption or rescindment by the 2019 House. The work is in process.

Candidacy and Election Cycle Process Review

Based on the bylaws of the APTA, the House officers are responsible for the conduct of APTA candidacy and election activities. Multiple sessions for candidates and campaign managers were held to provide information regarding candidacy and election processes, and information on the specific roles and responsibilities of each office. As has been done annually, the House officers reviewed the processes throughout the cycle and considered operational improvements. Adjustments made this year included:

- Revision of the former ‘Candidate Manual’, now titled ‘Candidates for National Office Manual’, to focus solely on the candidacy phase
- Clarification that APTA bylaws do not require a candidate to be present at the House of Delegates candidate or election activities
- Clarification that physical presence of individuals nominated from the floor is not required by APTA bylaws
- Discontinuation of provision for write-in candidates during elections

Nominating Committee

A report of the Nominating Committee detailing the committee activities and accomplishments is provided to the House in a separate report.

Reference Committee

A summary highlighting the work of the RC is provided to the House in a separate report

Elections Committee

Maureen Kavalar, PT, continued to serve as chair of the Elections Committee from July 1, 2012–June 30, 2016. Gerri Grzybek, PT, is serving as committee vice-chair from 2016-2018. The chair and vice chair are assisted by additional Elections Committee members as needed.

Closing

In closing, the House officers thank the delegates for their collaborative efforts in identifying issues and crafting motion language that came before the House. In addition, the House officers recognize the contributions of the APTA Governance department staff. Accomplishing the feat of holding a successful House requires an inordinate amount of work and time, organization, and attention to detail. The
House officers are indebted to the staff in this department. Their assistance enables us to perform the jobs that you, the delegates, have elected us to do. We extend our sincerest appreciation to these colleagues.

Respectfully submitted,

Susan Griffin, PT, DPT, speaker of the House
Stuart Platt, PT, MSPT, vice speaker of the House
Roger Herr, PT, MPA, secretary
NOMINATING COMMITTEE REPORT

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

The Nominating Committee (NC) is the only elected committee of the House of Delegates (House). The Bylaws of the American Physical Therapy Association (Bylaws) mandate the NC to: (1) prepare a slate of candidates and (2) foster activities that maintain and promote a pool of nominees. To meet those charges the NC, in collaboration with staff and House Officer representation, established strategies to fulfill the Bylaws’ mandates as follows:

BYLAWS MANDATE #1: PREPARE A SLATE OF CANDIDATES.

- **Prepare the slate:** Staff of the APTA Governance department provided the NC with regular updates on the status of recommended individuals for 2017 open national office positions, including eligibility and whether they consented to serve. Prior to the November 2016 NC meeting, weekly updates were provided on the status of individual recommendations for the offices of: Treasurer (32 individuals recommended; 4 consented to serve); Speaker (12 individuals recommended; 2 consented to serve); Director (64 individuals recommended; 12 consented to serve); Nominating Committee (27 individuals recommended; 11 consented to serve).

- **Implement a Strategic/Work Plan for NC Activities:** The strategic plan outlines goals and objectives that align with the APTA Bylaws. Implementation of the NC Strategic Plan included the NC’s collaboration with the APTA Leadership Development Committee (LDC), interactions with component nominating committee chairs, and enhancements to NC processes. The Strategic Plan appears on the NC’s website. The Strategic Plan and other resources were made available to component nominating committees through individual requests and at an annual meeting, where component NC members and APTA NC members met to connect, collaborate, and share ideas. The NC is currently reviewing and analyzing the strategic plan to determine goals and activities for the next 3 years.

- **Improve NC Processes:** The NC consistently reviews its processes, considers positions that occur within the next election cycle and also future cycles that may be 2-to-10 years away. Over the last 3 years, the NC has restructured its liaison appointment process and redesigned its database of identified members for potential future leadership at the national level (potentials). The NC has made significant strides in implementing a succession-planning model that identifies potential candidates for specific offices several years before the position is to be filled. The NC has reevaluated and enhanced its processes for analyzing potential candidates’ leadership aspirations and readiness, including the addition of a potential candidate form and more formal interview process prior to slating. Additionally, the NC held its third annual onsite orientation at APTA headquarters. This orientation allowed the NC more time to focus on roles, responsibilities, and discussion of strategic priorities.
BYLAWS MANDATE #2: FOSTER ACTIVITIES THAT MAINTAIN AND PROMOTE A POOL OF NOMINEES.

- **Increase knowledge about the nominating process:** NC members were assigned as liaisons to members of the APTA Board of Directors and to each component. NC liaisons made contact with Board members and component nominating committee members through both formal and informal methods. During these connection times, NC members were available to provide information about the nomination process, leadership resources, and current and future national positions.

- **Identify potential leaders:** The NC updated the database of potential candidates, based on recommendations from the membership, and assigned NC liaisons to these individuals. The NC also had a presence at CSM, the House of Delegates, Education Leadership Conference, Celebration of Diversity, State Policy and Payment Forum, and various other caucus, chapter, and section meetings to assist with identification of and connection with potential candidates.

- **Promote the growth of potential leaders:** The NC has a collaborative relationship with the LDC. Each year a current member of the NC holds 1 position on the LDC. Linda Eargle served in this role in 2016-2017. Holly Clynch will be serving in this role in 2017-2018.

The NC appreciates the superb Governance department staff assistance and House Officer collaboration through Susan R. Griffin, Stuart Platt and Roger Herr.

This has been an exceptional year for the committee and we thank you for the opportunity to serve.

**2016–2017 APTA Nominating Committee**

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<thead>
<tr>
<th>Name</th>
<th>Term</th>
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<tr>
<td>Secili H. DeStefano, PT, DPT</td>
<td>2014 - 2017</td>
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<td>Holly Clynch, PT, DPT</td>
<td>2016 - 2019</td>
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<td>Linda K. Eargle, PT, DPT</td>
<td>2014 - 2017</td>
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<td>Scott Euype, PT, DPT</td>
<td>2015 - 2018</td>
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<tr>
<td>Chris Petrosino, PT, PhD</td>
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PHYSICIAN/PHYSICAL THERAPIST PRACTICE RELATIONSHIPS (RC 64-81)

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND

In 1981, the House of Delegates (House) adopted Physician/Physical Therapist Practice Arrangements (RC 64-81), which charged the APTA Board of Directors (Board) to report annually on actions taken during the year in response to Employment Arrangements (RC 59-81):

WHEREAS, APTA is committed to meet the physical therapy needs of the people and advocates a system of delivery that results in the most economical and highest quality of patient care;

WHEREAS, When physicians can profit as a result of referring patients for physical therapy, conflicts have arisen in the delivery of physical therapy, which influence both the cost and quality of these services and which also interfere with the consumer’s choice of a physical therapist;

WHEREAS, It may not be in the best interest of the consumer for the physical therapist to practice directly or indirectly under arrangement with a referring physician or group of physicians who, as a result of referring patients to the physical therapist, derive personal income as a direct or indirect result of the referral;

WHEREAS, Spokesmen in medicine have openly voiced concerns about physicians deriving income from health care except those fees earned from their own services;

WHEREAS, APTA’s House of Delegates has provided direction to assist chapters in amending physical therapy practice acts to preclude physical therapists from having, or entering into arrangements with health care practitioners when such arrangements in any manner result in an unearned income for the referring practitioner;

WHEREAS, The Judicial Committee of APTA recognizes the ethical problems posed in such situations but also recognizes that federal antitrust provisions prevent a professional association from outrightly prohibiting any type of employment relationship;

RESOLVED, That the Board of Directors initiate a program that will educate physical therapists about problems that arise in referral-for-profit situations.

RESOLVED, That dialogue be opened with appropriate organizations, including the American Hospital Association and the American Medical Association and its specialty boards, about the possible unethical practice of physicians owning physical therapy practices.

RESOLVED, That the chapters be encouraged to seek legislative alternatives to resolve the problems inherent in such arrangements as set forth above (and that the Board of Directors report annually to the
ISSUE OVERVIEW AND ASSOCIATION ACTIVITIES

Educating physical therapists and colleagues in other health professions about the inherent problems with referral-for-profit arrangements has been among APTA’s highest priorities for the past 40 years. The association has sought many policy initiatives to enact statutory safeguards at both the federal and state levels, and has seen some progress in the elimination of referral for profit in physical therapy. APTA has reported annually on this specific policy issue to the House of Delegates since 1981.

APTA HOUSE OF DELEGATES (2003–2015)

In 2003, the House adopted Opposition to Physician Ownership of Physical Therapy Services (HOD P06-03-27-25) and Strategies to Achieve Legal Prohibition of Physician Ownership of Physical Therapy Services (RC 31-03) in efforts to seek federal or state legislation or regulation to prohibit physician ownership of physical therapy services (POPTS). In response, the APTA Board appointed a task force that year to develop and help implement a strategic plan to prohibit POPTS. In 2007, that task force became a standing committee of the Board, the Referral for Profit Committee. In 2011, as part of its efforts to realign the appointed group structure, the Board disbanded this committee and moved the policy issue under the jurisdiction of the Public Policy and Advocacy Committee (PPAC).

APTA PUBLIC POLICY PRIORITIES (2011–2018)

The issue of referral for profit and POPTS remains a public policy priority for APTA, as evidenced by its inclusion in the association’s public policy priorities list for at least the past 6 years. The 2017–2018 Public Policy Priorities, adopted by the APTA Board of Directors in October 2016, identifies POPTS under the challenge of barriers to care.

PPAC will continue to work with the Board and staff to develop strategies to combat referral for profit and POPTS on many fronts, including state and federal legislation and regulation, member and student education, and public relations.

FOUNDATION FOR PHYSICAL THERAPY (2012–CURRENT)

In 2012, the Foundation for Physical Therapy awarded a grant to study self-referral to Jean Mitchell, PhD, of Georgetown University. Mitchell presented at CSM 2014 in Las Vegas on this topic and issued a report in July 2015. This study looked at non-Medicare patients in Texas. It compared episodes of care for low back pain (LBP) between self-referring and non-self-referring providers. Mitchell found that self-referring episodes had services that were typically less “hands on” and passive, while non-self-referring episodes contained care that was more likely to have active involvement and patient participation. The study also quantified savings and found that for the overall episode, as well as just the physical therapy portion of the episode, costs were higher for self-referring episodes of care.

Another study from Mitchell titled “Use of Physical Therapy Following Total Knee Replacement Surgery: Implications of Orthopedic Surgeons’ Ownership of Physical Therapy” was released in February 2016. It found that patients who undergo total knee replacements and are referred to physician-owned physical therapist services average about twice as many visits as patients who receive physical therapy from an independent provider. Despite the higher number of visits, the self-referred patients receive less "intensive" physical therapy, with far fewer individualized therapeutic exercises than their non-self-referred counterparts.
In 2011, APTA became a founding partner of the Alliance for Integrity in Medicare (AIM), with the American College of Radiology (ACR), the American Society of Therapeutic Radiation Oncology (ASTRO), the College of American Pathologists (CAP), and the American Clinical Laboratory Association (ACLA). The coalition’s aim is to build support for legislation to eliminate the in-office ancillary services (IOAS) exception. AIM has been involved in efforts with MedPAC and the General Accountability Office (GAO) (as outlined below) to build support for policy to address the IOAS exception with integrated medical systems and patient groups. AIM also has launched a website (www.aimcoalition.com) that contains information and advocacy resources on self-referral in health care.

In December 2014, the coalition was instrumental in gaining support from AARP Inc for congressional action to eliminate the IOAS exception to physical therapy, anatomical pathology, radiation oncology, and advanced imaging services. AARP’s letter of support states: “AARP agrees that restrictions on physician self-referral and provider-kickback schemes must be strengthened. Closing the [IOAS] exception for certain services will save taxpayers and Medicare beneficiaries money and reduce unnecessary care.”

In the 114th Congress, AIM led the effort to update legislation that would remove AIM-represented services from the exception. The coalition urged the Senate Finance Committee to look at elimination of IOAS as a cost-saving measure to the Medicare program and has submitted comments regarding physician-owned distributorships. Additionally, in July 2016 APTA, as well as AIM, submitted statements to the record to a Senate Finance Committee hearing on overall improvements to the Stark laws. In April 2016, AIM applauded Rep Jackie Speier (D-CA) for her introduction of the Promoting Integrity in Medicare Act of 2016, the updated legislation that would remove physical therapy and other services from the IOAS exception.

APTA expects challenges to its efforts moving forward, based on historic opposition to APTA’s position by the new Secretary of Health and Human Services. Nonetheless, APTA and AIM will work with Rep Speier and continue dialogue with the Senate Finance Committee to seek opportunities and legislative vehicles to make this policy change.

US CONGRESS (1989–CURRENT)

In 1989, the US Congress included a provision in the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) that barred self-referrals for clinical laboratory services under the Medicare program, effective January 1, 1992. This provision was known as the "Stark Law." Congress extended its efforts in self-referral and referral for profit in health care with the passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). The law expanded the restriction to a range of additional health services, including physical therapy, and applied it to both Medicare and Medicaid. This provision of OBRA 1993, known as "Stark II," also contained clarifications and modifications to the exceptions in the original law. The legislation clearly identified physical therapy as a designated health service in which referral for profit or self-referral situations would not be legal within Medicare and Medicaid. Regulatory exceptions to the law since it was passed have permitted physicians under certain conditions to refer to physical therapy practices in which they have a financial relationship. One of the primary exceptions to Stark II is the IOAS exception.
In October 2009 and January 2010, MedPAC included on its agenda the issue of the IOAS exception under the Stark laws. MedPAC looked at 4 designated health services, including physical therapy, which are included under the IOAS exception. At the October 2009 meeting, APTA provided public comments and followed up with written comments recommending that physical therapy be removed as a designated health service under the IOAS exception. APTA also provided other policy recommendations such as clarification of the centralized building requirement and the ability of physical therapists to reassign their billing to a physician in these situations. APTA contended that the evidence is overwhelming that POPTS arrangements lead to the overutilization of physical therapy and excessive Medicare payments, and they do not provide offsetting patient care or convenience benefits. APTA’s legal counsel, Hogan and Hartson (now Hogan-Lovell), provided a brief outlining the case that physical therapy does not meet the intent of the IOAS exception. APTA continues to work with MedPAC on possible policy recommendations to reform the IOAS exception as it relates to physical therapy services.

In June 2010, MedPAC included a chapter in a report to Congress that outlined issues with the IOAS exception with a specific policy option to eliminate physical therapy as a service that qualifies under the exception. This chapter again identified 5 services under the Medicare program for which Congress should consider eliminating or modifying the IOAS exception. The 5 services are physical therapy, anatomical pathology, advanced radiologic services, radiation oncology, and clinical laboratory services.

GENERAL ACCOUNTABILITY OFFICE (2011–2014)

In 2011, the General Accountability Office (GAO) explored the potential to study referral-for-profit situations and their impact in health care and, most important, on federal programs and expenditures. The action was at the request of Sen Charles Grassley (R-IA), ranking member of the Senate Judiciary Committee; Rep Henry Waxman (D-CA), ranking member of the House Energy and Commerce Committee; and Rep Sander Levin (D-MI), ranking member of the House Ways and Means Committee. In addition to meetings over the course of 2011 and 2012 that AIM had with GAO on this area of policy and its impact, GAO completed reports on 4 services—anatomical pathology, radiation oncology, advance imaging, and physical therapy.

In June 2014, GAO issued its report on physical therapy (14-270), Medicare Physical Therapy: Self-Referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary. The report concluded that the total number of physical therapy services provided to Medicare beneficiaries increased nearly 30% from 2004 through 2010. Over this period, the number of self-referred physical therapy services was generally flat, while the number of non-self-referred services increased. In addition, expenditures increased over this time for both self-referred and non-self-referred services, but this increase was larger for services that were non-self-referred.

APTA issued its response on June 2, 2014, and reinforced its strong position supporting elimination of the IOAS exception for physical therapy under Medicare, arguing that referral-for-profit situations create incentives for overutilization and potential abuse, and that the GAO report was inconclusive and further research is warranted. Specifically, APTA commented on the numerous limitations in the report’s methodology, which GAO itself acknowledges. Most important, the report’s research data lack relevant factors such as the severity of a patient’s condition, impairments, and comorbidities. The
research also fails to capture the quality of care provided. Data on the frequency of visits and total expenditures are irrelevant without knowing patient severity and outcomes.

**PRESIDENT OBAMA—OFFICE OF MANAGEMENT AND BUDGET (2013–2016)**

The president’s 2017 budget, issued on February 9, 2016, contained language recommending the removal of the IOAS exception to the Stark laws for physical therapy, anatomic pathology, advanced diagnostic imaging, and radiation oncology services, for an estimated $5 billion in savings under the Medicare program. This is the fourth consecutive year that the president’s budget has included language recommending the elimination of the IOAS exception.

**CONGRESSIONAL BUDGET OFFICE (2012–2016)**

In 2012, APTA worked with AIM on numerous requests to the Congressional Budget Office (CBO) to score potential savings by eliminating physical therapy and other services from the IOAS exception, while mitigating concerns from opposing organizations. In response, in 2013 CBO estimated that $1.2 billion could be saved by eliminating the 4 services listed above from the IOAS exception.

From 2013 to 2016, CBO, typically stricter than OMB, analyzed language in the president’s budget that recommended the removal of the IOAS exception for therapy, anatomic pathology, advanced diagnostic imaging, and radiation oncology services. In 2013, CBO estimated the savings from this change to be $1.8 billion over 10 years. In 2014, CBO revised its estimate to $3.4 billion, and in 2015 it estimated $3.5 billion. In 2016, CBO estimated that removing these services from the IOAS exception would save $3.3 billion dollars over 10 years.

**OTHER FEDERAL HEALTH POLICY EFFORTS / ACCOUNTABLE CARE ACT (2010–2015)**

To advance policies and programs outlined in the Patient Protection and Affordable Care Act (ACA, PL-111-148 / PL 111-152), there has been interest in repealing or modifying certain provisions of the Stark laws or federal anti-kickback laws to accommodate the shared saving programs associated with accountable care organizations (ACOs), the sharing of health information technology, and other programs to facilitate care coordination or integrated models of care delivery. APTA provided extensive comments on the final regulations outlining the Medicare Shared Saving Program that would establish ACOs. The Centers for Medicare and Medicaid Services (CMS), along with the Office of the Inspector General (OIG), issued an interim final rule on waivers of the Stark II, federal anti-kickback, and gainsharing civil monetary penalties laws for the Medicare Shared Savings Program. In addition, the Department of Justice and Federal Trade Commission issued an enforcement statement that applies a “rule of reason” analysis for antitrust review of potential ACOs and established requirements for the percentage of a primary service area that an ACO cannot exceed in order to receive “safety zone” protections against the antitrust laws. In APTA’s comments to these rules, the association lobbied for the elimination of the IOAS exception under the Medicare Shared Savings Program as well as strict prohibitions against the proliferation of physician and hospital dominance and undue beneficiary inducements in the formation of ACOs.

Furthermore, ACA included language that required disclosure of financial relationships in which physicians are involved. The primary service identified for the disclosure requirement was advanced radiologic services. APTA has sought, through comments to the 2011 Medicare Physician Fee Schedule rule and outreach to CMS, to take advantage of the legislative language that also included “other services as designated by the Secretary of the Department of Health and Human Services.” This effort as yet has been unsuccessful. APTA
also is concerned that disclosure is difficult to enforce and would not adequately address the policy issues associated with referral for profit in physical therapy.

ACA language also imposed a ban on construction of new physician-owned specialty hospitals or the expansion of existing physician-owned specialty hospitals that meet the “wholly owned” exemption to the federal Stark laws. This was implemented on January 1, 2011, but has faced pressure in Congress from those who seek to weaken or repeal this ban. As recently as the Middle Class Tax Relief and Job Creation Act of 2012, efforts were made in the House of Representatives to allow additional physician-owned hospitals to be grandfathered into legal operation. This provision was removed from the final legislation. In addition, following ACA, Physician Hospitals of America and Texas Spine & Joint Hospital filed suit against the Department of Health and Human Services and Secretary Kathleen Sebelius. In March 2011, the US District Court for the Eastern District of Texas ruled that Section 6001 of ACA was constitutional. In August 2012, the appeal was vacated by the US Court of Appeals for the Fifth Circuit.

Finally, from 2007 to 2009, CMS requested comments on its proposed rules on the Medicare physician fee schedule regarding the IOAS exception. Despite hundreds of physical therapists commenting on the proposed rule in support of policies to eliminate physical therapy as an IOAS exception, CMS did not promulgate policy changes specific to the issue. APTA will continue to pursue regulatory options with CMS officials, although CMS did not include relevant language in the 2010 or 2011 proposed or final rules on the Medicare physician fee schedules. APTA is encouraging CMS to continue to consider promulgating rules and policy changes to the IOAS exception in future rules on the Medicare physician fee schedule.

STATE LEGISLATIVE & LEGAL INITIATIVES (2006–CURRENT)
APTA chapters continue to work on a variety of anti-POPTS legislative initiatives. Given the history of fierce opposition to such efforts from physicians, chapters are taking the time to fully prepare for this tough advocacy battle by organizing their grassroots, improving their legislative relations, and raising the needed funds prior to attempting anti-POPTS efforts. APTA is assisting chapters with these efforts. Currently 3 states have some form of anti-POPTS law on their books: Colorado, Delaware, and Missouri. Unfortunately, such state laws are increasingly becoming targets for repeal from physician groups, as was the case in the recent court decision repealing the South Carolina anti-POPTS law.

Missouri Anti-POPTS Repeal Legislation
In Missouri, House Bill 157 and Senate Bill 317 were introduced in early 2017. The legislation would amend the Missouri medical practice licensure law that prohibits physician-ownership of physical therapy services to allow physicians to refer to an entity in which they have an ownership or investment interest, provided they are within the limitation of physician referrals as provided in 42 U.S.C. Section 1395nn (federal Stark law).

South Carolina Prohibition on POPTS Struck Down, Partly on Procedural Issues
In September 2016 the South Carolina State Supreme Court issued a ruling effectively ending the state’s ban on POPTS, but the 3-2 ruling didn’t declare the practice act provision unconstitutional. Instead, 1 of the 3 justices in the majority struck down the board’s interpretation solely due to procedural errors.
The state's physical therapy licensing board and APTA's South Carolina Chapter (SCAPTA) supported the prohibition against POPTS, as did APTA, but physician and orthopedic surgeon groups have been fighting it for a decade. In light of the court’s ruling, as a practical matter physical therapists now will be able to work for a physician-owned practice.

APTA provided significant legal, financial, and staff resources both to SCAPTA and individuals who intervened in the case on behalf of the state licensing board, and joined SCAPTA in fending off attempts to repeal the law in the state legislature.

APTA will continue to both defend policies that are consistent with the association’s position on referral for profit and enact policies to support a prohibition on referral for profit in physical therapy services.

As part of a strategy to educate policymakers, information about referral for profit in physical therapy will continue to be included as part of APTA’s activities with the National Conference of State Legislatures annual meeting. This meeting attracts hundreds of state legislators and their staffs from across the country.

**SUMMARY**

APTA continues its efforts at the state and federal levels to combat self-referral and referral for profit in an environment of increasing opposition to these efforts. These efforts are integrated into our public policy priorities and initiatives.
PUBLIC RELATIONS CAMPAIGN (RC 41-01)

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND
The 2001 House of Delegates (House) adopted RC 41-01 Public Relations Campaign to develop and implement a nationwide public relations (PR) campaign to focus primarily on the physical therapist as the practitioner of choice for conditions that affect movement, function, health, and wellness. The motion, which directs APTA to submit an annual summary of activities to the House, charged APTA to conduct a campaign that may include the following actions:

- A more aggressive nationwide multimedia effort;
- The development of a component public relations package for multimedia use; and
- The development of a public relations package for members to market their profession and practice settings.

DISCUSSION
In 2016, APTA PR and media relations staff continued its work to promote the Move Forward brand promise that physical therapists help you restore and improve motion to achieve long-term quality of life. The core messages of the brand were emphasized to consumers, other health care professionals, and members of the physical therapy profession:

- Physical therapists significantly improve mobility to perform daily activities.
- Physical therapists provide an alternative to painful and expensive surgery, in many cases.
- Physical therapists manage or eliminate pain without medication and its side effects, in many cases.

PR efforts also focused on educating external audiences about the transformative power of physical therapy and physical therapy as a safe alternative to prescription opioids for pain management, with the goal of driving traffic to APTA’s consumer website, www.MoveForwardPT.com, to learn more about physical therapy and to find an APTA member physical therapist. The consumer website remains the hub of the physical therapist brand, providing an interactive experience for consumers who are seeking more information about what physical therapy can do for them.

#CHOOSEPT CONSUMER AWARENESS CAMPAIGN
In the last quarter of 2015, APTA was invited to participate in the White House’s opioid working group, addressing the epidemic of opioid abuse and addiction. At that time, APTA began planning its #ChoosePT campaign, a national effort to raise public awareness of the risks of opioids and to educate consumers about the benefits of physical therapy as a safe, nondrug option for pain management. The campaign received a boost in March 2016 when the Centers for Disease Control and Prevention issued guidelines for prescribing opioids for chronic pain, urging providers to reduce the use of opioids in favor of safe alternatives such as physical therapy. This meshed perfectly with APTA’s planned initiative. In June 2016, during the NEXT Conference & Exposition, APTA launched #ChoosePT, the association’s first sustained consumer campaign.
APTA defined 4 goals for the #ChoosePT campaign:

1. Create a campaign that is sustainable over a longer period;
2. Participate in national health care conversation;
3. Increase MoveForwardPT.com traffic; and
4. Improve component collaboration.

To achieve these goals, APTA employed a variety of strategies and tactics, including earned media, public service announcements, national digital and print advertising, outdoor billboards, and component relations.

#CHOOSEPT OUTCOMES

- **Earned Media:** APTA placed a story in the Associated Press on the day the campaign launched that was picked up by 26 media outlets in 17 states and Washington, DC. APTA succeeded in placing an additional 13 stories in regional news outlets, physical therapy trade publications, and blogs, among other media, totaling 39 placements and 47,157,715 impressions.

- **Public Service Announcements:** In 3 months, the #ChoosePT television and radio PSA aired in 30 states to an audience of nearly 83 million Americans. The print PSA ran 1,044 times across the country to an audience of 152,266,453. The video PSA amassed more than 230,000 additional views online and via social media.

- **Digital Advertising:** The results for this campaign were impressive, bringing in a higher number of ad impressions than our goal and click-through rates, exceeding both our goals and industry standards for success. The success of this campaign helped to drive the number of visitors to www.MoveForwardPT.com to a record annual high, topping out at 3 million unique users for 2016. That is nearly double the number of unique users in 2015 (1.6 million). From June to December, APTA ran mobile and web ads, including a direct ad buy on WebMD, producing 25,531 landing page conversions. The YouTube ad using the video PSA performed very well amassing 56,234 views. APTA also ran digital ads in Morning Consult, a digital publication read by nearly 200,000 government and industry leaders in energy, finance, health, and tech. The ads generated a total of 420,169 impressions.

- **Print Advertising:** APTA ran 2 full-page print ads in Major League Baseball’s American League and National League Championship Series commemorative programs and the World Series program. They reached a combined readership of well over 2 million people. To reach providers, APTA ran a print ad in the September/October issue of Family Practice Management magazine, the American Academy of Family Physicians’ peer-reviewed practice-management journal, with a readership of 734,000. To reach lawmakers, APTA ran an ad in the July/August issue of State Legislators magazine, a publication of the National Conference of State Legislatures, reaching nearly 26,000 subscribers.

- **Outdoor Billboards:** APTA ran a month-long series of 4 outdoor billboards in Nashville, Tennessee, an epicenter of opioid abuse and overdose deaths, in conjunction with APTA’s NEXT Conference & Exposition, the Bonnaroo Music + Arts Festival, and the CMT Music Festival. Estimated weekly impressions for those 4 billboards ranged from 218,000 to nearly 330,000.

- **Component Relations:** From June 2016 through December 2016 PR staff collaborated with and provided guidance to 21 components on their participation in the #ChoosePT campaign.

**OTHER PUBLIC RELATIONS/MEDIA ACTIVITIES**

- Staff exhibited and promoted the #ChoosePT campaign and MoveForwardPT.com at CSM, NEXT, and NSC in 2016.
In 2016, APTA arranged 104 media interviews and was mentioned in more than 267 consumer and trade print and web-based stories. Some of those publications were Everydayhealth.com, PTPinCast, USA Today, The Washington Post, Arthritis Today, Woman’s Day, Associations Now, Prevention, WebPT, 50+ Advocate, RAC Monitor, The Wall Street Journal, and Lower Extremity Review, to name a few.

Staff wrote and distributed 15 press releases. Staff also sent 3 letters to the editor: 1 to The New York Times in response to a story on medicare coverage for patients who are no longer improving, 1 to Spine regarding its general use of the term “physical therapy,” and 1 to The Washington Post in response to a story on physicians and their opioid prescribing habits.

APTA continued to focus on transformational patient stories to give the patient’s perspective on how her or his physical therapist transformed his or her life. APTA added 11 patient stories to the www.MoveForwardPT.com consumer site, bringing the total number of transformational stories in our library to 35.

In 2007, APTA conducted primary qualitative and quantitative research among consumers (including physical therapy users and nonusers) and APTA members (including association leaders, thought leaders, and randomly selected members) to assess public perceptions about physical therapy and identify opportunities to improve public awareness. The result was the “Move Forward” branding campaign, which is grounded at MoveForwardPT.com. In 2016, APTA conducted follow-up research to identify changes and consistencies in public perception, assess the relevance of APTA’s public awareness messaging, and record member input. The results of the new research overwhelmingly confirm the general themes and messages of APTA’s existing Move Forward campaign and underline the fact that consumers have positive perceptions of physical therapists (PTs). Those results will inform APTA’s 5-year consumer communications plan.

APTA issued 4 Component Community Awareness Grants for a total of $15,000. Recipients were Iowa, Kentucky, Nevada, and South Dakota. The grants support these chapters’ efforts to promote APTA’s national #ChoosePT consumer education campaign.

PR staff provided counsel and message support to other APTA staff and volunteer leaders on various communications opportunities and challenges. These included preparing APTA’s CEO for media interviews, and vetting interview opportunities to ensure message continuity and to position APTA for success.

**SUMMARY**

The goal of PR efforts is to position the physical therapist as the practitioner of choice for conditions that affect movement, function, health, and wellness. Promoting the message of the transformative power of physical therapy and the key messages of the Move Forward brand, staff seeks to present the profession and APTA members in the best possible light and educate APTA’s target audiences about who physical therapists are, what and how they treat individuals, and how to find a physical therapist.

APTA recently developed strategic communication plans to guide annual and multiyear communications efforts. These efforts include strategies for enhanced component engagement, and review of additional consumer campaign tactics and options for website redesign.

Continuing a trend, APTA saw some impressive successes last year, with member engagement and several high-profile national media placements. APTA looks forward to building on this success in 2017.
REFERENCE COMMITTEE REPORT

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

At the close of the 2016 House, the Reference Committee (RC) bid Lynn Rivers, PT, PhD, a warm farewell as her 3-year term (July 1, 2013–June 30, 2016) came to a conclusion. Subsequently, Karen Paschal, PT, DPT, MS, FAPTA, and Gabe Yankowitz, PT, DPT, were appointed to serve 3-year terms.

REFERENCE COMMITTEE LIAISONS
Shortly following the 2016 House of Delegates (House), RC liaison assignments to regional caucuses (including individual components), sections, PTA Caucus, Student Assembly, and Board of Directors were made. RC members reached out to the respective chief delegates in July to offer consultation and assistance in the development of potential motions. Caucus assignments were as follows:

- Carol Likens, Board of Directors
- Michael A Pagliarulo, Western
- Karen Paschal, Northeast
- Barney Poole, Midwest
- Gabriel Yankowitz, Southern

TOWN HALLS/VIRTUAL MEETINGS
In addition to its scheduled monthly committee meetings, the RC attended 2 virtual town halls (VTH) in October and December 2016 led by Susan Griffin, speaker of the House. Each VTH hosted over 100 participants. In April and May 2017, the Reference Committee will facilitate 2 virtual town halls that focus on motion discussion.

The RC also scheduled 4 opportunities for virtual appointments in December 2016, and January, May, and June 2017. The focus of the December and January appointments was discussion of motion concepts prior to the March 20 main motion/bylaw amendments deadline. The appointments in May and June provide guidance to motion makers wishing to revise their motions and to other delegations wishing to offer amendments to motion language.

CSM 2017
The Reference Committee met and participated in activities held during the 2017 Combined Sections Meeting in San Antonio, TX, that included 30-minute appointments with delegates to discuss motions and concepts for the 2017 House, attendance at the Chief, Section, and Assembly Delegates Philosophical Discussion, and participation in regional caucus meetings.

PREPARATION OF PACKET I PREVIEW AND PACKET I
During the 2017 motion development cycle the RC reviewed 26 concepts. Of these, 14 developed into motions submitted for consideration by the 2017 House; 7 were withdrawn; and 5 are motion concepts, potentially for the 2018 House. During its March 29-30, 2017, meeting at APTA headquarters the RC reviewed these 14 motions and their accompanying Motion Development Forms (MDFs),
consulting motion makers as necessary. The MDFs played an important role in determining whether
the Main Motion Criteria as described in APTA Standing Rule 17 had been satisfied. The motions were
each assigned an “RC” number based on an order that would provide for efficient and expeditious
management of the business of the 2017 House. *Packet I Preview*, which included motion language
final as of the close of the RC meeting, was posted on April 3, 2017. *Packet I*, which includes final
motion language, will be posted on April 19, 2017. In accordance with Standing Rule 18, the RC made
recommendations to the Board of Directors as to which motions required background papers to assist
delegates with their deliberations and decisions. The background papers will be posted on May 10,
2017.

**ACTIVITIES TO IMPROVE THE MOTION DEVELOPMENT PROCESS**

Over the years, RC members have become more proactive in reaching out to their component liaisons
(chief delegates) in early fall to offer assistance with the motion development process. Additionally,
based on the increasing workload and expectations on RC members, including the work with each
regional caucus and the complexity of motions, the House officers increased the size of the RC from 4
members to 5. This change has allowed RC members the ability to focus more time on individual
motions and help motion makers navigate the process.

**CLOSING**

The Reference Committee thanks the delegates for bringing forward issues of concern that evolve into
motions and move us closer to our vision. RC liaisons are available to delegates throughout the year to
discuss concepts that may ultimately become motions or may be better considered by the Board of
Directors.

Members of the RC are very grateful to Governance department staff for their continued leadership
and support in helping the RC to carry out its responsibilities efficiently during the 2017 motion cycle.
The RC is also grateful to the House officers, Susan Griffin (member, ex officio), Stuart Platt, and Roger
Herr for their continued input and expertise, and parliamentarian Nancy Sylvester, for her advice and
counsel.

**Reference Committee Members**

- Carol Counts Likens, PT, PhD, MBA (TN) - Chair  
  July 1, 2014–June 30, 2017
- Michael A. Pagliarulo, PT, MA, EdD (OR)  
  July 1, 2014–June 30, 2017
- Karen Paschal, PT, DPT, MS, FAPTA (NE)  
  July 1, 2016–June 30, 2019
- Barney Poole, PT, DPT, FAPTA (GA)  
  July 1, 2015–June 30, 2018
- Gabriel Yankowitz, PT, DPT, OCS (NY)  
  July 1, 2016–June 30, 2019
- Susan Griffin, PT, DPT, RP Speaker of the House, Ex-Officio Member  
  July 1, 2014–June 30, 2017

**Consultants to the Reference Committee**

- Stuart Platt, PT, MSPT, Vice Speaker of the House  
  July 1, 2016–June 30, 2019
- Roger Herr, PT, MPA, Secretary  
  July 1, 2016–June 30, 2019

**Parliamentarian**

- Nancy Sylvester, PRP, CPP-T

Respectfully Submitted,

Carol Counts Likens, PT, PhD, MBA
Reference Committee Chair
SECRETARY’S REPORT

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

NOTES FROM THE SECRETARY
Among many responsibilities, the secretary ensures that members have access to information regarding Board of Directors (Board) and House of Delegates (House) actions.

BOARD OF DIRECTORS
In 2016, the Board met face-to-face in February, April, June, July, August, and November, and via conference call in January, March, May, August, September, and October. Any interim decisions made by unanimous consent were ratified and recorded within the minutes of the next meeting. The Executive Committee met as needed throughout the year. Minutes from each Board meeting are published on the APTA website, at the Board of Directors webpage.

To facilitate the work of the Board, the secretary has worked with the Board and Governance department staff to continue to improve the efficiency of Board functions. The Board continues to make operational changes and will continue to evolve as new ideas are implemented that will facilitate business and allow the Board to focus at a high level of decision-making.

HOUSE OF DELEGATES
Traditionally the secretary, along with Governance staff, have determined the eligibility of members to serve as delegates to the House. In 2015 and 2016, components were responsible for ensuring that membership for each delegate is current as required by the bylaws. The secretary also reviewed requests from members about the possibility of dues waivers, as described in the bylaws.

ACTIONS RELATED TO ASSOCIATION POSITIONS, STANDARDS, GUIDELINES, POLICIES, PROCEDURES
The following list reflects actions taken in 2016. Full text of these documents may be found on the APTA website and are easily accessible by using the search option.

ADOPTED
Board of Directors
- Code of Conduct, Conflict of Interest, and Disclosure Policy (BOD Y11-16-02-02)
- Criteria for Physical Therapy Editor-in-Chief Emeritus (BOD Y03-16-05-12)
- Delegate Discount to NEXT (BOD Y02-16-01-01)
- Guidelines: Purpose and Structure of the Council of Health Systems Physical Therapy (CHSPT) (BOD G06-16-02-04)
- Guidelines: Purpose of the Frontiers in Rehabilitation Science and Technology Council (BOD G02-16-03-04)

House of Delegates
- Endorsement of National Efforts Addressing The Opioid Health Crisis (HOD P06-16-14-14)
AMENDED

Board of Directors

- The Board of Directors as a Delegation to the House of Delegates (BOD Y01-16-02-03)
- Catherine Worthingham Fellows of the APTA (BOD Y08-16-03-07)
- Disciplinary Action Procedural Document (BOD R03-16-02-02)
- Definition of the Term Scope of Practice and Clarification of Association Role (BOD P11-16-08-19)

House of Delegates

- The Association’s Role in Advocacy for Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability (HOD P06-16-05-06)
- Physical Therapists’ Role in Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability (HOD P06-16-06-05)
- Consumer Protection Through Licensure of Physical Therapists and Physical Therapist Assistants (HOD P06-16-08-07)
- Clinical Specialization in Physical Therapy (HOD P06-16-10-11)
- Bylaws. Article IV. Membership. Section 1. Categories and Qualifications of Members, A. Physical Therapist, (2)
- Bylaws. Article XIV Amendments, A.

RESCINDED

Board of Directors

- Conflict of Interest Policy (BOD Y06-08-01-02)
- Guidelines: Physical Therapy Claims Review (BOD G08-03-03-07) [Rescinded BOD 03-16-03-08]
- Guidelines: Physical Therapist Pay for Performance Programs (BOD G11-05-06-09) [Rescinded BOD 03-16-03-08]
- Physical Therapy Model Benefit Plan Design (BOD P12-11-01-01) [Rescinded BOD 03-16-03-08]
- Plan of Action Regarding Payor Reimbursement for Physical Therapy Services Delivered without Referral (BOD 11-03-17-55) [Rescinded BOD 03-16-03-08]
- Strategic Plan for Reimbursement (BOD 08-03-02-05) [Rescinded BOD 03-16-03-08]
- Reforming Payment for Outpatient Physical Therapy Services (BOD P03-11-04-09) [Rescinded BOD 11-16-10-24]

House of Delegates

- House Session and Annual Conference Scheduling (HOD Y06-94-28-43) [Rescinded 06-16-05-01]
STATE ADVOCACY GRANTS TO CHAPTERS (BOD Y11-14-02-02)

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND

The American Physical Therapy Association (APTA) is committed to helping its chapters address proposed state legislative or legal issues related to such areas as the physical therapist (PT) scope of practice, patient access, and state legislation related to payment for physical therapist services. APTA Board of Directors (Board) policy State Advocacy Grants to Chapters (BOD Y11-14-02-02) requires the Board to submit an annual report to the House of Delegates that summarizes all requests for grant funding, amounts granted, rationale for denials, and outcomes of activities funded during the previous year. The policy for this grant has 5 criteria based upon the association’s purpose and priorities; the grant criteria also outline acceptable uses of any funds received.

DISCUSSION

In 2016 APTA allocated 2 grants under the provisions of State Advocacy Grants to Chapters (BOD Y11-14-02-02):

- $5,000 legislative grant to the Florida Chapter toward its successful effort to remove restrictions tied to its direct access law and provide title protection for the DPT.

- $50,000 to the North Carolina Chapter to assist with a federal anti-trust lawsuit filed against the North Carolina State Board of Acupuncture over its actions to prohibit PTs from performing dry needling.

In 2016, APTA received a $5,000 grant request from the California Chapter to assist with the chapter’s efforts on the issue of animal rehabilitation. The APTA Public Policy and Advocacy Committee reviewed and considered the chapter’s grant application in the context of the association’s strategic plan and public policy priorities. Within this context, APTA was unable to award a grant to the California Chapter.

SUMMARY

APTA continues to consider chapter requests for grant assistance to address issues that impact the physical therapy profession.
EXECUTIVE SUMMARY

In 2014, the House of Delegates approved 2 motions specific to investigating the future of physical therapist education: RC 12-14: Promoting Excellence in Physical Therapist Professional Education, and RC 13-14: Best Practice for Physical Therapist Clinical Education. In response to RC 12-14, The APTA Board of Directors (Board) established the Excellence in Physical Therapist Education Task Force (EETF) that presented 8 recommendations to the Board in 2015. At its November 2015 meeting, the Board approved the recommendations forwarded by the EETF, which included establishment of the Education Leadership Partnership as the vehicle to address those recommendations. Similarly, in response to RC 13-14 the Board created the Best Practice for Physical Therapist Clinical Education Task Force (BPCETF). The work of the BPCETF began in January 2016 and concluded in January 2017.

The Board’s charge to the BPCETF was to consider strategies and provide a recommendation(s) to the Board of Directors to identify best practice for physical therapist clinical education, from professional level through postprofessional clinical training, and propose potential courses of action for a doctoring profession to move toward practice that best meets the evolving needs of society. The Board identified 4 specific points for the BPCETF to review for the report due to the 2017 House of Delegates.

The BPCETF identified 3 principle challenges as it engaged in its work: (1) A comparison of current clinical education models suggested that inadequate clinical education and postgraduate professional development experiences contribute to unwarranted variation in physical therapist practice; (2) The overall capacity for clinical education placements is limited, leading to competition among physical therapist academic programs; and, (3) Economic factors affecting academic institutions, students, and facilities providing clinical education experiences significantly impact clinical education.

Six assumptions guided the work of the BPCETF: (1) There are complex factors involved in clinical education and no simple solutions to address the issues of unwarranted variability, capacity, and quality in current models; (2) Recommendations being made are interrelated; (3) Implementation of these recommendations will require engagement of multiple stakeholders; (4) Other professions are facing similar challenges in clinical education; (5) There is no evidence supporting a single superior physical therapist clinical education model; and, (6) Economic factors must be a primary consideration in future physical therapist clinical education, and recommendations should not result in increased student debt.

After engaging in a year-long review process, including 2 face-to-face meetings and over 20 conference calls, the BPCETF submitted 5 content recommendations and 1 dissemination recommendation to the Board:
1. That formal preparation for practice includes physical therapist professional education, followed by a clinical internship and mandatory postprofessional residency, and is accomplished through a process of staged licensure and specialty certification;

2. That a structured physical therapist clinical education curriculum be developed and implemented;

3. That a framework for formal partnerships between academic programs and clinical sites that includes infrastructure and capacity building, and defines responsibility and accountability for each (eg, economic models, standardization, sustainable models), be developed;

4. That clinical education be incorporated into the recommendations approved by the Board and forwarded to the Education Leadership Partnership regarding education data management systems;

5. That the physical therapy profession’s prioritized education research agenda include a line of inquiry specific to clinical education; and,

6. That the BPCETF report submitted for the January 2017 Board meeting be made available to the Education Leadership Partnership and other stakeholders within the physical therapist education community.

The BPCETF report was submitted for consideration to the January 2017 Board meeting. After reviewing the scope of the BPCETF’s work and recommendations, the Board adopted a revised version of recommendation 6: That APTA design a plan for dissemination of the BPCETF report for receiving widespread stakeholder input prior to consideration by the Board for adoption at its November 2017 meeting. The rationale for this recommendation was based on an appreciation for the need to allow all stakeholders to engage in a review of the BPCETF’s recommendations, and to let the collective community bring its thoughts and suggestions forward. The Board recommended that the Education Leadership Partnership be charged with leading this stakeholder review and action process, similar to how the recommendations of the EETF were addressed in 2015. The complete BPCETF report to the Board is appended. Clarifications and updates have been added to the BPCETF’s report in response to Boards’ discussions and questions that emerged during the review process.
BACKGROUND

The 2014 House of Delegates adopted RC 13-14 Best Practice for Physical Therapist Clinical Education:

That the American Physical Therapy Association, in collaboration with relevant stakeholders, identify best practice for physical therapist clinical education, from professional level through postgraduate clinical training, and propose potential courses of action for a doctoring profession to move toward practice that best meets the evolving needs of society with a report to the 2017 House of Delegates.

This effort shall include, but not be limited to, the examination of:

• Current models of physical therapist clinical education from professional level through postgraduate clinical training;
• Mandatory postgraduate clinical training;
• Stages of licensure;
• Findings from related studies and conferences; and
• Models and studies of clinical education in other health care professions.

(House of Delegates, 2014, pp. 232-244)

CHARGE

The Best Practice in Clinical Education Task Force (BPCETF) will consider strategies and provide a recommendation(s) to the Board of Directors to identify best practice for physical therapist clinical education, from professional level through postprofessional clinical training, and propose potential courses of action for a doctoring profession to move toward practice that best meets the evolving needs of society.

The Board of Directors’ determined charge for the BPCETF is as follows. The task force will be disbanded as appropriate by the Board of Directors when the charge has been met.

• Investigate current models of physical therapist clinical education from professional level through postprofessional clinical training, including findings from related studies and conferences in physical therapy and other health professions.
• Define the scope of current and anticipated future needs in clinical education with particular investigation into how to best prepare physical therapists for practice in an evolving health care environment.
• Investigate options for future clinical education models, including but not limited to relationships between academic institutions and clinical education sites, mandatory postprofessional clinical training, and staged licensure.
• Describe the feasibility of future clinical education models, including pros and cons.
• Provide options to the Board of Directors with recommendations for action and a report to the 2017 House of Delegates.

All APTA appointed groups will conduct their work with the Association Organizational Values in mind and in the context of (1) APTA's mission, vision, and strategic plan; and (2) the potential for their work
to have implications related to physical therapist assistants, women, diversity, and risk management.

(Board of Directors, November 2014, pp. 13-14)

SCOPE OF THE PROBLEM

The 2014 House of Delegates’ call to identify “best practice in physical therapist clinical education” in order to produce practitioners capable of meeting the ever-evolving societal health care needs is not a new call to action. Rapid proliferation of new physical therapist education programs and expanding class sizes leading to intense competition for clinical sites; burdensome evaluations required of clinical educators, students, and academic faculty; increased variability in academic and clinical education; and lack of absolute standards of clinical performance are among the challenges that have been repeatedly noted over the past 50+ years. (Worthingham, 1965; Hislop, 1975; Moore & Perry, 1976).

Compounding these issues are economic factors including the increased debt load of graduates, and changes in reimbursement for physical therapist services. While the entry-level physical therapist degree has evolved over time to the clinical doctorate (DPT), the basic model of clinical education remains relatively unchanged from the early days of physical therapist education.

In her 1965 McMillan Lecture, Catherine Worthingham described physical therapy as a profession able to acknowledge “present and obvious inadequacies” when compared with professions that were already established. Many of her thoughts, ideas, and suggestions delivered in that speech continue to ring true for us as a profession today. Worthingham stated, “Physical therapists, both teachers and practitioners, have need for further education, whether in continuous residence, short courses, or by means not yet foreseen or devised” (Worthingham, 1965, p. 939). Worthingham recognized the challenge of establishing a partnership between academic and clinical sites/clinical educators in part attributed to the variability in educational pathways through which one could enter the profession. Ten years after Worthingham’s McMillan lecture, Helen Hislop revisited a continued list of professional challenges and provided multiple solutions, stating that “… we must set up absolute standards of clinical performance rather than remain lost in morass of relativity” (Hislop, 1975, p. 1077). Hislop was careful to promote the burgeoning need for clinical specialization amidst the challenge of “capacity of any practitioner to encompass the entire field” of physical therapy knowledge and practice. Furthermore, she recognized that advances in medical science are enormously impactful and drive modifications in our practice, as they continue to do today.

Since 1975, multiple professional work groups and task forces have been formed with subsequent consensus conferences or summits to specifically address issues facing physical therapist student clinical education. A partial list of these activities includes:

- 1998: “Clinical Education: Dare to Innovate” (APTA, 1998)
- 2004: “Clinical Education in a Doctoring Profession” (APTA, 2004)
- 2014: “Clinical Education Summit” (ACAPT, 2014)

Despite an extensive list of recommendations, innovations, and potential solutions that resulted from these collective works, physical therapist student clinical education training has changed little over the past several decades. The status quo persists because by some measures the current models have been effective, in that the educational community continues to produce graduates who successfully become licensed. Additionally, significant changes to academic and clinical education models will require a degree of consensus and cooperation among multiple stakeholders with competing priorities and varied perspectives, that could or might result in uncharted disruptions to practice and education.

However, the BPCETF believes the time has come for the profession to acknowledge that DPT program graduates cannot be fully prepared at the conclusion of entry-level education to manage the care of clients and patients of all diagnoses and conditions across the lifespan. The current licensure process, the National Physical Therapy Examination (NPTE), provides a level of competency evaluation, and promotes patient and client safety, by assessing a basic level of knowledge and problem-solving abilities. The current licensure process is limited by assessing competency at a single point in time, and the NPTE does not assess important clinical skills. While opportunities for postprofessional education exist, there is no cultural expectation or requirement driving this phase of learning. Outcomes associated with postprofessional education clinical residency and fellowship programs include improvements in physical therapist clinical reasoning abilities, and patient and client outcomes (Rodeghero et al, 2015; Robertson & Tichenor, 2015). Professional sentiment has long existed that entry-level graduates are novices and require additional support, education, or training to achieve the desired level of physical therapist competence (Black et al, 2010; DiFabio et al, 1999; Furze et al, 2016; Tichenor, 2000; Kulig, 2014). This type of educational structure and professional development ladder has been present in allopathic medical education for decades, representing an understanding that medical school preparation is designed to be the beginning, not the end, of professional training. Even the initial phase of a medical residency includes acquisition of additional general knowledge and skill development before the resident is considered prepared for advancing to higher levels of training and specialization (AAMC, 2016).

In the 2012 APTA McMillan Lecture, Alan M. Jette (2012) described 3 major societal storms: lack of access to health care, the age wave, and costs of health care. Jette proposed that to meet societal needs, “physical therapists must possess and use critical systems skills” including “... universal standardized measurement and data collection, widespread quality and improvement and implementation techniques, interprofessional coordination and care management, diffusion of practice innovations and standardized practice models, and health policy leadership for widespread change” (Jette, 2012). Physical therapist education must continue to evolve as physical therapists increasingly position themselves to function as points-of-entry in the complex and evolving health care system focused on outcomes, value, and efficiency. Physical therapist professional education programs should build capacity to increase emphasis related to didactic content and clinical practice experiences in chronic care management, interprofessional collaboration, primary care practice, and population health and wellness.

Regarding physical therapist clinical education, we must ask ourselves whether we have met the challenges described by Catherine Worthingham, Helen Hislop, and other past leaders, or whether we are indeed no further along than we were 50 years ago. Based on recent opinions and events, and feedback from multiple stakeholders, it is the opinion of this task force that current clinical
education models are unsustainable, suboptimal, and not designed to produce practitioners required by the health care system of the future, nor will they help the profession achieve our vision.

The BPCETF took a global approach when forming its recommendations, not wanting to be prescriptive but to provide a framework for future consideration. The task force recognizes that the details of any formative plan for the future of clinical education will come from the collective involvement of multiple stakeholders, and that the transition process could take decades.

The BPCETF reviewed the 2015 Excellence in Physical Therapist Education Task Force report and recommendations (APTA, 2015). All 8 of the principle challenges in pursuing excellence in education identified in that report were relevant to clinical education, with 2 specifically including clinical education:

- There are widespread concerns that students are not optimally prepared for clinical education, practice, and the evolving health care environment
- There is unwarranted variation in student qualifications, readiness, and performance across the professional education continuum that impacts academic and clinical faculty’s ability to plan and implement a quality educational experience that will optimize patient outcomes

The recommendations adopted by the APTA Board of Directors (Board) also included 2 that are most directly relevant to clinical education:

- That essential resources to initiate and sustain physical therapist education programs that include, but are not limited to, faculty, clinical sites, finances and facilities, be determined
- That the adoption of a system of standardized performance-based assessments that measure student outcomes and establish benchmarks be developed and promoted

Standardized assessment for physical therapist students entering their terminal clinical experience was identified as a priority in the second recommendation.

Although not specific to clinical education, the Board also approved in November 2015 the development and implementation of a steering committee comprising core member groups—the American Council of Academic Physical Therapy, APTA, and the Education Section—to oversee the implementation of efforts designed to move physical therapist education forward. That steering committee’s efforts led to the development of the Education Leadership Partnership (ELP), which was formally ratified in a Memorandum of Understanding in October 2016. The ELP is intended to be a global, decision-making group that brings all stakeholders together to speak with 1 voice toward enhancement of the common cause of promoting excellence in physical therapist education.

MEETING HISTORY

The BPCETF met 24 times, including 22 web conferences and 2 onsite meetings (APTA headquarters in Alexandria, Virginia, on March 13-14 and November 6-7, 2016) between January 8, 2016, and January 4, 2017. Multiple stakeholders were engaged during the year-long process of the task force’s work. While these stakeholders do not serve as a substitute for the larger physical therapy community, receiving diverse views and options helped shape the recommendations that evolved.

Stakeholders Engaged
- American Board of Physical Therapist Residency and Fellowship Education (ABPTRFE): staff and external consultant
FINDINGS OF THE BEST PRACTICES IN CLINICAL EDUCATION TASK FORCE

Based on its work, the BPCETF identified the following principle challenges facing clinical education:

- A comparison of current clinical education models suggested that inadequate clinical education and postgraduate professional development contributes to unwarranted variation in physical therapist practice. There is significant variability in the quality of physical therapist clinical education in structure, process, and outcomes (Jette et al, 2014). Much of the quality is
dependent on the clinical instructor, who may or may not be an effective teacher and may lack a strong connection to the academic program.

- The overall capacity for clinical education placements is limited, leading to competition among physical therapist academic programs. This capacity problem is exacerbated by the proliferation of new physical therapist education programs and increasing class sizes. Overall capacity is also affected by other demands on clinical sites, including longer clinical experiences, establishment of residency and fellowship programs, observation and volunteer hours for prospective students, physical therapist assistant clinical education programs, and nonphysical therapy internships.

- Economic factors significantly impact clinical education. Recent trends of clinical sites requiring payment for student placements intensifies the debate over the typical current model of financing clinical education. Typically, clinical sites are not paid for their contributions to physical therapist student education, while the student continues to pay tuition to the academic program for clinical education courses (Jette et al, 2014). The static payment for provision of services that does not keep pace with increased costs has resulted in an increased financial burden on clinical sites. This is compounded by the demands for increased practitioner clinical productivity, and the inability to receive reimbursement for work performed by nonlicensed students under supervision. Payer policies are likely to become even more restrictive in the future.

As the BPCETF progressed through its charge, the following guiding assumptions supported the development of recommendations.

- There are complex factors involved in clinical education and no simple solutions to address the issues of unwarranted variability, capacity, and quality in current models.

- Recommendations are interrelated.

- Implementation of these recommendations will require engagement of multiple stakeholders.

- Other professions are facing similar challenges in clinical education.

- There is no evidence supporting a single superior physical therapist clinical education model.

- Economic factors must be a primary consideration in future physical therapist clinical education, and recommendations should not result in increased student debt.

**RECOMMENDATION 1:**

That formal preparation for practice includes physical therapist professional education, followed by a clinical internship and mandatory postprofessional residency, and is accomplished through a process of staged licensure and specialty certification (Note: The model in Figure 1 is provided to serve as an example only, as it includes the criteria identified in the recommendation. The task force recognizes that any standard process model adopted by the profession will emerge during dialog among all stakeholders).

SS: The physical therapy profession continues to evolve and now includes: all graduates earning the DPT degree, all licensure jurisdictions having some form of direct access and practitioners assuming varying degrees of primary care responsibilities highlighted by long-established models in the uniformed services divisions of the United States military and Public Health Service. Additionally, postprofessional residency and fellowship programs continue to grow at an exponential rate. Considering these examples of growth and the escalation of higher education costs, corresponding
In today's health care environment, the expectation that a new graduate is prepared to practice in any setting, providing care to all age groups, is unrealistic (IOM, 2011; Rapport et al, 2014). There is evidence that new graduates, while possessing the knowledge and skills to ensure patient and client safety and provide care for less-complex patients and clients, may benefit from having exposure to additional clinical skill-development opportunities in order to best meet the needs of society in the fast-evolving health care arena (Curtis & Martin, 1993). Yet, many practice settings do not provide the additional mentorship and postgraduate education for new graduates to further develop the necessary clinical skills. The BPCETF also believes it is time to move away from the concept of graduating a “generalist” practitioner, a concept that appears to have evolved without formal adoption or direction. The term “generalist” in the context of physical therapy does not appear to be defined by the Commission on Accreditation in Physical Therapy Education (CAPTE), the Normative Model of Physical Therapist Education (APTA, 2004), or any other seminal APTA documents.

This suggestion does not discount the necessity that a core knowledge base and set of clinical skills should be required of all graduates. This foundational level of competence, as determined by the initial (restricted) licensure examination (See Figure 1), would represent a practitioner best described as a “basic-ist”: a practitioner capable of independently managing less-complex patients and clients and capable of recognizing when a patient or client referral to another practitioner is indicated.
Removing the expectation that a new graduate can, as a “generalist,” treat patients and clients of all ages, with any condition, and in every setting, would allow new graduates to begin clinical practice under the expectation that they would continue their formal educational experience and begin a path toward specialization. The concept of graduating a DPT with core knowledge and skills, followed by an intense, structured clinical internship and finally specializing in an area of practice through an accredited clinical residency program, aligns with other doctoring professions (eg, medicine, optometry, pharmacy, podiatry, psychology) (Rapport et al, 2014). The educational pathway portrayed in Figure 1 consists of 3 required phases: (1) professional education, (2) postgraduate clinical internship, and (3) a mandatory clinical residency.

While timeframes marked by ranges are presented for each phase, the BPCETF hopes the numerous benefits of reduced variability will lead the educational community to reach consensus and adopt universally accepted timeframes. One goal should be a reduction in the total amount of time required to attain the DPT degree, shifting a significant portion of the clinical training to the postgraduate phase. This shift would require that programs graduate practitioners who have a well-defined core set of knowledge and skills, and are beginning to identify potential desired areas of clinical specialization. Upon completion of the postgraduate clinical internship, where core practice skills are refined the physical therapist will enter an accredited clinical residency program.

The professional education curriculum will include a didactic phase combined with integrated clinical education experiences, allowing students to acquire the core set of foundational knowledge and skills to prepare them for the stage of restricted licensure. A structured curriculum will be developed for the integrated clinical education experiences (see Recommendation 2). A written examination, analogous to the current National Physical Therapist Examination administered by the Federation of State Boards of Physical Therapy (FSBPT), would assess student readiness and provide a validation of progression of clinical skills and clinical reasoning, required for the progression to the pathway’s second phase, postgraduate clinical internship.

Other health care professions (eg, medicine and dentistry) use staged licensure to ensure the progression of knowledge during several developmental time points throughout the educational process and to assess a provider’s “ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in promotion of health and management of disease” (USMLE, 2017). Upon successful completion of the written examination and graduation, the physical therapist graduate would enter a mandatory postgraduate clinical internship. A structured curriculum (See Recommendation 2) would provide a core set of benchmarks, milestones, competencies, or core entrustable professional activities (Ten Cate, 2013; AAMC, 2012) that the graduate would need to achieve before being eligible to proceed to the next pathway phase, mandatory clinical residency. Once the clinical internship is successfully completed, the physical therapist would begin clinical residency training.

It is essential to establish clinical residencies as the final required phase of the formal physical therapist professional education pathway; the final step prior to entry into unrestricted licensure (second stage of licensure) clinical practice. The second stage of licensure would consist of an examination consistent with the American Board of Physical Therapy Specialties clinical specialist certification examination. The clinical residency model and curriculum would evolve to build upon physical therapist professional education and postgraduate clinical internships phases. The required postprofessional clinical
The residency phase of education would promote the following:

- Development of physical therapists who demonstrate high levels of professionalism, clinical skills, knowledge for specialty practice, communication, clinical reasoning, evidence-based practice, and systems-based practice; (Furze et al, 2016)
- Development of physical therapists who are adequately trained to manage complex patients and clients within general and specialty practice settings;
- Development of physical therapists who are able to successfully function in leadership roles within the health care system;
- Promotion of physical therapy as a valued service within health care by consumers, payers, and regulators;
- Establishment of physical therapists as a portal to the health care system for individuals with movement impairments; and
- Improvement of patient and client outcomes and value within the health care system.

There would remain an important role for a general practice physical therapist. Physical therapists working in large medical centers, acute care settings, rural hospitals, or home health care provide services that are highly specialized, requiring extensive knowledge and skill. Therefore, the physical therapy profession should expand specialty options and define the general care specialist as akin to the “specialty” of family practice or family medicine in physician medicine, and create a Description of Specialty Practice (DSP) to support this residency option.

The development and universal adoption of the formal physical therapist professional education pathway with staged licensure would lead to more structured didactic and clinical education curricula, more standardized and structured levels of student preparedness, reduce the students’ overall cost of professional education, and produce a practitioner better prepared to meet the demands of the ever-evolving health care system. Upon successful completion of the first stage of licensure the graduate could begin billing for services, thereby reducing the financial stress on clinical education sites. Adjustments in pay levels based on stages of licensure might help facilities budget more appropriately for novice clinicians, residents, and, finally, the more-advanced clinicians practicing with an unrestricted license. The ability for employers of interns and residents to be reimbursed for clinical services provided by these restricted-license practitioners would help to support this economic model (FSBPT, 2011).

Finally, the BPCETF believes this model of physical therapist professional education will also establish a firm foundation for graduates who wish to pursue postprofessional masters and doctoral degrees, and
postprofessional fellowship opportunities. Discussion of these learning opportunities was outside the
scope of the task force’s work but should be considered, in context, by stakeholders as a universal
adoption of a new model of professional education is developed and implemented.

RECOMMENDATION 2:

That a structured physical therapist clinical education curriculum that includes, but is not limited to,
the following elements be developed and implemented:

- Determination of a minimum and maximum amount of full-time clinical education that can be
  integrated into the didactic phase (prelicensure) of physical therapist professional education.
  Once determined, this standard shall be universally adopted;
- Define the role and structure for clinical education experiences within the didactic phase of
  physical therapist professional education programs;
- Define essential clinical education settings, experiences, and exposure to patient and client
  populations that shall be required for all physical therapist students in the didactic phase of
  physical therapist professional education programs Define minimal student competencies
  required for engaging in integrated full-time clinical education experiences during professional
  education and postgraduate clinical internship phases, including knowledge, skills, and
  behaviors;
- Define the roles of simulation and learning technologies as part of clinical education in the
  phase of professional education;
- Define essential competencies for transition into entry-level (restricted license) practice,
  including knowledge, skills, and behaviors;
- Enhance existing residency and certification processes to complement the total of the
  professional education and postgraduate clinical internship phases;
- Develop and implement standardized tools for measurement of expected student
  competencies at all phases of physical therapist education to ensure that student and graduate
  competencies are consistent with expected student outcomes; and
- Identify opportunities for standardization of clinical rotation schedules, onboarding
  requirements, or other factors that may influence program and site capacities and efficiencies.

SS: Graduates from physical therapist professional education programs, beginning with the first day of
their employment, are expected to be skilled, productive, and contributing members of an
interprofessional health care team. The health care environment has rapidly evolved to one in which
physical therapists will encounter higher productivity demands, greater acuity and chronicity of
patients and clients in all settings, limited time and resources, and payment tied to patient and client
outcomes. These conditions leave little to no time for a new graduate to “ramp up” their knowledge,
skills, and behaviors, especially without significant mentorship and support. As referenced in the
support statement for Recommendation 1, the current models of clinical education, combined with the
lack of required postgraduate education experiences, do not support the needs of the evolving physical
therapy profession.

The BPCETF Recommendation 2 is consistent with Recommendation 2 from the Excellence in Physical
Therapist Education Task Force (2015), “That essential, rigorous, and progressively higher levels of
outcome competencies [knowledge, skills, and attitudes] for physical therapist graduates that are
responsive and adaptive to current and future practice be identified and adopted, and with its
Recommendation 5, “That the adoption of a system of standardized performance-based assessments
that measure student outcomes and establish benchmarks be developed and promoted”. As Jette and colleagues (2014) stated, “Although the problem is complex, to successfully manage clinical education, improve outcomes, and reduce costs, some degree of profession-wide consensus must be reached about best practices related to structure, processes, and outcomes.”

Based on information gathered by BPCETF members during their work—including interviews with several stakeholders and group deliberations, and individual and collective experiences of task force members, it has become clear that there is a need for a structured approach to physical therapist clinical education to reduce unwarranted variation in education that leads to unwarranted variation in clinical practice (Jette et al, 2014).

**RECOMMENDATION 3:**
That a framework for formal partnerships between academic programs and clinical sites be developed that includes infrastructure and capacity building, and defines responsibility and accountability for each (ie, economic models, standardization, sustainable models, etc.). Infrastructure and capacity must be developed across all stages of clinical education, to include:

- Models of clinical supervision (eg, trainee to instructor ratios, academic faculty as preceptors);
- Mandatory clinical instructor training, certification, and recertification;
- Effective communication among all stakeholders across all phases of clinical training;
- Student readiness to enter each stage of clinical education; and
- A comprehensive evaluation plan for clinical education.

SS: In a 2002 *PTJ* editorial, Jules Rothstein (2002, p. 127) offered the following challenge to the physical therapy profession: “Without a proper ongoing partnership between faculties in schools and people in practice, clinical education will never prepare our new graduates to the level necessary, to the level described by our Association’s vision statement, and to the level that justifies the professional doctorate.”

Despite continuing professional discussions about this concept, little has changed in Rothstein’s observation over the past 15 years (Applebaum et al, 2014). Thus, this recommendation is based on sentiments and a vision expressed by leaders in the physical therapy profession for decades.

Formal partnerships between academic programs and clinical sites should be expanded to include defined accountabilities for all parties. These partnerships should include opportunities for innovative relationships and care delivery models. During the physical therapist professional education, clinical instruction of students in integrated clinical experiences should be overseen by academic institutions that have close, formal relationships with clinical faculty who serve as clinical instructors. The clinical instructors must be vested in the program’s curriculum and held accountable to the academic program in some way.

A culture of excellence in clinical education requires all stakeholders to have a shared responsibility for setting and upholding standards during every phase of clinical education. The challenges of limited capacity in number and variety of settings, and the variability in the quality of clinical instruction, while not unique to the physical therapy profession, has been a consistent concern among physical therapy leaders for decades (AAMC, 2014). It is impossible to judge whether the current pool of licensed
physical therapists is adequate to provide quality clinical education within the current model of clinical education or in the model of clinical education being proposed by the BPCETF. Academic programs face challenges placing students in settings that meet accreditation requirements. The lack of clinical placements is a common reason for CAPTE to deny candidacy status.

Two significant challenges to the current models of physical therapist clinical education are (1) a lack of standards that foster excellence in clinical education, and (2) inadequate capacity to provide quality clinical training from the earliest clinical exposure through post-licensure residency and fellowship experiences. Consistency in clinical education is hampered by varied communication strategies among academic programs and clinical sites regarding students’ competency level prior to them entering clinical education and the myriad outcome expectations of all stakeholders. Improving quality in clinical education depends on addressing structure, process, and outcomes of clinical education (Jette et al, 2014). A concerted effort to achieve an adequate supply of excellent clinical training sites that are configured to meet trainee needs at every stage of their professional development is vital to the future of the physical therapy profession.

Joint development of standards for excellence in clinical education by all stakeholders, with mechanisms to evaluate compliance is necessary to address the quality and capacity challenges facing physical therapist education. CAPTE provides minimum standards for physical therapist education programs, and the standards specific to clinical education have become more defined over that past 10 years. Academic programs are held accountable to CAPTE through the accreditation process. Clinical training sites currently have no direct accountability to CAPTE, and accountability to the academic programs is limited to what is included in written agreements between each academic program and clinical site. The ability of academic programs to hold sites accountable is limited to not sending students to the site for training; an approach that does nothing to motivate training sites to improve their clinical training programs. Likewise, the only recourse of clinical sites that are dissatisfied with the preparation of students, communication with the academic program faculty, or other aspects of clinical education is not to accept students. Including a clinical education accountability model, similar to that found in current residency and fellowship standards, into formal professional education standards would promote consistent quality, to the benefit of the student and ultimately to the profession.

Quality clinical instruction and clinical mentoring are at the heart of clinical education. Clinical instructors must demonstrate a commitment to advancing clinical practice, including developing skills relevant to the role of a clinical preceptor. Education for clinical instructors is available but not mandatory. Mandatory education, to include certification and recertification, will advance clinical educators’ skills and will decrease unwarranted variation, improve efficiency, and assist with students’ skill development. Physical therapists choose to become clinical instructors for a variety of reasons, including a desire to give back to the profession, to stimulate their own learning, or for the enjoyment in the role of teaching. Disincentives to serving as a clinical instructor include difficulty meeting productivity requirements, the paperwork burden, and a perceived lack of support or inadequate resources to address students with challenging problems in the clinic. Creation of standards, and incentives to meet those standards, will build capacity and encourage higher levels of participation by physical therapists in clinical education.

RECOMMENDATION 4:
That clinical education be incorporated into the recommendations approved by the Board of Directors that were forwarded to the Education Leadership Partnership regarding education data management
systems, and include but not be limited to the following elements:

- A unique “professional (secure, or protected) lifetime” identifier is assigned to individuals at the time application or acceptance.
- A national clinical education matching program is used for assigning students to clinical education sites.
- Outcomes of care provided by physical therapist students/interns/residents are included in patient/clinical outcome registries.
- Data entry and data management systems are interoperable with other data systems relevant to physical therapist education (eg, CAPTE, FSBPT, ABPTRFE, CPI, CSIF).
- Data is accessible to researchers, academic programs, regulatory bodies, program evaluators, clinical training sites, and interested parties.

SS: The critical need to understand the existing state of all aspects of physical therapist clinical and residency education is hampered by the paucity of relevant research (Jette, 2014). Although data related to physical therapist clinical and residency education is available from various sources (eg, CPI/CSIF, PTCAS, NPTE, ABPTRFE, Physical Therapy Outcomes Registry), these data sets are not connected through a common interoperable framework. Subsequently, the available data is fragmented and does not use common elements, making it difficult to evaluate and compare current models of, and outcomes associated with, pre-licensure and post-licensure education. A unique identifier would connect data among various databases.

Besides creating a common database framework, other strategies are needed to facilitate the generation of relevant research. Identifying data elements for the management system that could be aggregated securely should be a high priority. The ROMEO (Research on Medical Education Outcomes) Registry is 1 example of a health professions education data registry that should be reviewed. The establishment of a unique “professional lifetime” identifier for each DPT program applicant would enable longitudinal mapping of student educational and postgraduate career paths and outcomes. The longitudinal data would be invaluable for educational program and workforce evaluation.

A national data management system would potentially allow for matching trainees to clinical education sites and residency programs. A great deal of variability exists among academic programs with regard to the number of clinical sites with which they have formal written agreements to provide clinical education. For many academic programs, many of these sites rarely or no longer provide clinical education experiences for their students (http://www.apta.org/CSIF/). A national data management system could include required compliance information (eg, immunizations, criminal background checks, HIPAA), which would facilitate “onboarding” at each clinical education site.

**RECOMMENDATION 5:**

That the physical therapy profession’s prioritized education research agenda include a line of inquiry specific to clinical education.

SS: Recent calls for changing physical therapist education to meet the ever-evolving health care delivery climate have been frustrated by the limited research and scientific data necessary to make informed decisions. The profession of physical therapy has long called for an increase in education-related research to identify best practices and improve on them (Education Section APTA, 2013, APTA
Excellence in Education Task Force Report, 2015; Gwyer et al., 2015; Jensen et al., 2013; Jensen et al., 2016). However, these calls have frequently been unanswered due to the dearth of research funding and infrastructure, or to the lack of researchers with the requisite skill set. The need to promote interest in education research, and to invest in the development of educational researchers has also been identified (Jensen et al., 2016). In October 2016, the newly established ELP created a subgroup to develop a prioritized educational research agenda and strategy focused on funding, prioritization, and faculty development programming. Building on the education research-related work completed and the recommendations included in those resources, there is a need to ensure the inclusion of clinical education-related topics in any national research agenda. Answers to research questions relative to clinical education costs, best models, culture, environments, outcomes, standardization, variability, and other variables have been cited as a critical need. Future research should address student learning in multiple clinical environments and scenarios, whether they are integrated clinical experiences, terminal internship experiences, residencies, or fellowships as elements of an ongoing learning process. Developing new data repositories and enhancing access to, and quality of, existing data sets (eg, CPI, CSIF, PTCAS, NPTE, Physical Therapy Outcomes Registry) will be essential to aiding education researchers in their work.

**RECOMMENDATION 6:**
That the Best Practice in Clinical Education Task Force (BPCETF) report submitted for the APTA Board of Directors January 2017 meeting be made available to the Education Leadership Partnership (ELP) and other stakeholders within the physical therapist education community.

SS: Making this report available to the ELP and other stakeholders within the physical therapist education community (eg, FSBPT) will facilitate transparency, trust, and collaboration. The intent is to share the contents of this report, regardless of what recommendations are adopted. Sharing the information with the ELP will help the represented organizations begin to understand the discussions and ideas considered by the BPCETF, and to identify areas of collaboration and different strategies to achieve the common goal of excellence in clinical education. If other recommendations are adopted, successful implementation will only occur with full participation and collaboration among all relevant parties.

**JANUARY 31, 2017 BOARD OF DIRECTORS ACTION:**

V-1 PASSED (Saladin)

That APTA design a plan for the dissemination of the Best Practice in Clinical Education Task Force report for receiving widespread stakeholder input prior to consideration by the APTA Board of Directors for adoption at the November 2017 Board of Directors meeting.

SS: Making this report available to the ELP and other stakeholders within the physical therapist education community (eg, FSBPT) will facilitate transparency, trust, and collaboration. The intent is to share the contents of this report, regardless of what recommendations are adopted. Sharing the information with the ELP will help the represented organizations begin to understand the discussions and ideas considered by the BPCETF, and to identify areas of collaboration and different strategies to achieve the common goal of excellence in clinical education. If
other recommendations are adopted, successful implementation will only occur with full participation and collaboration among all relevant parties.

REFERENCES


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**APPENDIX A**

<table>
<thead>
<tr>
<th>Model</th>
<th>Total Length of DPT Program</th>
<th>Approx. Length of CE in DPT Program</th>
<th>Max Length of Each CE</th>
<th># of Exp</th>
<th>Types of Exposure Standardized</th>
<th>Standard CE Start/End Times</th>
<th>Ratio of Preceptor to Student</th>
<th>Flexibility</th>
<th>Length of Course</th>
<th>Final Exam</th>
<th>Final Exam</th>
<th>Final Exam</th>
<th>Final Exam</th>
<th>Flexibility</th>
<th>Length of Course</th>
<th>Final Exam</th>
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<th>Final Exam</th>
<th>Final Exam</th>
<th>Final Exam</th>
<th>Flexibility</th>
<th>Length of Course</th>
</tr>
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<tbody>
<tr>
<td>Option 1</td>
<td>2 to 2.5 yrs (764 to 130 wks)</td>
<td>16 to 24 wks</td>
<td>8 wks each</td>
<td>2 to 4</td>
<td>Yes, includes unstructured observation</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>24 wks to 1 year</td>
<td>CS Exam</td>
<td>current criteria</td>
<td>4 to 4.5 yrs</td>
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<tr>
<td>Option 2</td>
<td>3 to 3.5 yrs (1164 to 150 wks)</td>
<td>16 to 24 wks</td>
<td>8 wks each</td>
<td>2 to 4</td>
<td>Yes, includes unstructured observation</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>24 wks to 1 year</td>
<td>CS Exam</td>
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<td>3 to 3.5 yrs</td>
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<td>Option 3</td>
<td>4 to 4.5 yrs (1568 to 210 wks)</td>
<td>16 to 24 wks</td>
<td>8 wks each</td>
<td>2 to 4</td>
<td>Yes, includes unstructured observation</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>24 wks to 1 year</td>
<td>CS Exam</td>
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<td>3 to 3.5 yrs</td>
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<td>16 to 24 wks</td>
<td>8 wks each</td>
<td>2 to 4</td>
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<td>Y</td>
<td>Y</td>
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<td>current criteria</td>
<td>3 to 3.5 yrs</td>
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<th>Approx. Length of CE in DPT Program</th>
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<th># of Exp</th>
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<th>Ratio of Preceptor to Student</th>
<th>Flexibility</th>
<th>Length of Course</th>
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<th>Final Exam</th>
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<th>Flexibility</th>
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EXPLORE THE ROLES OF PHYSICAL THERAPISTS IN PRIMARY CARE TEAMS (RC 19-15)

FINAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND: In 2015, the House of Delegates (House) adopted RC 19-15 Explore the Roles of Physical Therapists in Primary Care Teams:

That the American Physical Therapy Association investigate and identify:
• The roles of physical therapists in primary care teams;
• Those services of physical therapists that may qualify as components of primary care delivery; and,
• The current and future opportunities for physical therapists to integrate these roles and services into practice, education, and research.

In 2016 a preliminary report was submitted to the House stating that relevant stakeholders would be recruited to initiate a report on the feasibility of advancing physical therapists in primary care practice models. The report would include an assessment and analysis of the practice, education, and research competencies required to support these expanded roles, and the sequential required steps toward achieving these competencies. Upon completion of the report, APTA’s leadership would determine the required resources and the impact on current priorities if it is determined to pursue an agenda and plan for physical therapists to have primary care roles, provide primary care services, and participate on primary care teams.

DISCUSSION
In June 2016 a staff selected work group was established, made up of US and international (Canadian and Bahamas) physical therapists with experience in primary care health delivery models. The group’s collective clinical experiences represent a variety of practice settings including the military outpatient model and public sector settings such as emergency room, outpatient ambulatory, home health, and inpatient acute care hospital departments. The group’s varied clinical expertise included the areas of pediatrics, health and wellness, orthopedics, and neurology.

The work group compiled information related to practice, education, and research from literature referencing primary care and physical therapist practice, and APTA documents including the Guide to Physical Therapist Practice 3.0 (Guide) and House of Delegates positions. Regarding RC-19-15 charge, the following information is provided.

Historically, primary care has been thought of in the context of physician practice. With the increase in demand for primary care services, nurse practitioners and physician assistants have assumed many of the physician’s roles and responsibilities and as such have been deemed primary care providers by CMS. In the U.S., physical therapists in the military and Kaiser Permanente Northern California have long-assumed roles in the primary care arena. Their roles and responsibilities include providing first-contact care, ordering imaging, and prescribing medications. Despite this history, numerous questions exist related to primary care and physical therapist practice, education and research, leading to the
passage of RC19-15 at the 2015 House. In response, the staff work group investigated and researched the following:

- A definition of primary care as it relates to physical therapist practice
- An environmental scan of roles and services provided by physical therapists (PT) currently practicing in primary care teams
- Review of physical therapist educational curricular content
- Conduct a gap analysis to identify current vs. future opportunities for PT integration in primary care teams

RESPONSES TO THE RC 19-15 CHARGES

Definition

- The definition of primary care identified by the National Academies of Sciences, Engineering, and Medicine (formerly known as Institute of Medicine) states that primary care is the “provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” This definition is currently found in the Guide to Physical Therapist Practice, is the most widely recognized among stakeholders in the primary care arena, and was identified as adequately defining the various aspects of care delivered by physical therapists.

Delivery Models

- Outside of the U.S. military and Kaiser Permanente Northern California examples, few documented health care delivery models exist in the United States that include physical therapists in the delivery of primary care services typically provided by physicians.

Environmental Scan of Roles and Services Currently Provided by Physical Therapists

US primary care settings:
- Hospital, private practice, and military-based settings
- Industrial or workplace settings
- Telephone and video consultation

US primary care roles:
- Working on primary care teams as described in the Guide for acute musculoskeletal and neuromuscular conditions and certain chronic conditions, providing services in primary, secondary, and tertiary care capacities
- Prescribing specified medication (military settings)
- Ordering diagnostic imaging studies (military and some public sector settings)
- Serving as a first-contact provider for musculoskeletal and neuromuscular conditions

International primary care settings and roles:
- Hospital-based and now emerging in homecare
- Working on primary care teams, providing physical therapist services in primary, secondary, and tertiary capacities
- Prescribing specified medication
- Ordering diagnostic imaging studies
e. Performing electrodiagnostic testing (e.g., electromyograms)

f. Serving as a first-contact provider for musculoskeletal and neuromuscular conditions

**Perceived Gaps**

**Education:**

- There has been no wide-spread adoption of primary care curricular content tracks in entry-level physical therapist education programs, nor is there a Description of Specialty Practice for physical therapists in primary care. Due to the lack of these curricular tracks or post-professional training in preparation for practicing in primary care settings, individual organizations such as the military and Kaiser models have developed internal mandatory advanced training modules. This is consistent with the international physical therapy community. Post-professional (advanced) training is required, especially related to prescribing medications, ordering imaging, and carrying out invasive electrodiagnostic procedures.

**Regulation**

- Physical therapists possess a unique knowledge base and skill set, allowing for provision of valuable services for patients and clients across the lifespan. However, to date there are no practice acts that designate or list physical therapists as primary care providers in support or prohibition. Direct access exists in all 50 US states but is not regulated consistently from state to state and in most cases requires not only coordination with other patient providers but oversight by a primary care physician or nurse practitioner following the initial evaluation or 30 days of treatment. Work in this area needs to include regulatory language delineating physical therapists’ ability to order and interpret specific imaging, lab tests and prescribe medications.

- A primary care practitioner is traditionally considered to be a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or a nurse practitioner, clinical nurse specialist, or physician assistant from the payment perspective of the Centers for Medicare and Medicaid Services (CMS). Therefore, in most cases, physical therapists are financially excluded from operating as primary care clinicians despite the relevance to the personal health care needs of patients.

- To maximize the benefit of physical therapists assuming roles in primary care settings, state practice acts, payer policies, public policies and regulations, and professional and post-professional education would need to continue to evolve.

**POTENTIAL OPPORTUNITIES FOR FUTURE CONSIDERATION**

- Highlight innovative integration of physical therapists in primary care settings, possibly through an Innovation Summit 3.0;

- Consider creation of a primary care educational manual for academic programs similar to the manipulation and diagnostic imaging manuals;

- Consider partnerships in Interprofessional Education (IPE) for teaching primary care in a team environment;

- Possible establishment of primary care as an ABPTS Board Certified clinical specialty;

- Potential development of post-professional residencies in primary care as a specialty area;

- Support state chapter legislative activities, related to the removal of practice act restrictions and limitations;

- Continue to pursue partnerships with other primary care stakeholders, associations and organizations;
• Consider opportunities to model and predict value and appropriate payment for physical therapists assuming roles in primary care settings;
• Advocacy for physical therapists to be added to the list of practitioners eligible for loan reimbursement and scholarship programs related to primary care roles and the provision of care in underserved populations; and
• Advocacy for physical therapist eligibility for funding opportunities related to primary care research.

SUMMARY
A report providing a summary of background information and opportunities will be submitted to the APTA Board of Directors for review and consideration at its April 25, 2017, meeting.
OVERVIEW OF THE MOVEMENT SYSTEM SUMMIT

ANNUAL REPORT TO THE 2017 HOUSE OF DELEGATES

BACKGROUND

APTA’s Vision Statement for the Physical Therapy Profession is supported by Guiding Principles to Achieve the Vision, which demonstrate how the profession and society will look when the vision is achieved. One of the guiding principles is “identity,” which includes “that the physical therapy profession define and promote the movement system as the foundation for optimizing movement to improve the health of society.”

- In 2013, a Movement System Board Work Group (BWG) was charged by the APTA Board of Directors (Board) to define the term “movement system” and develop the framework for a short- and long-term plan for promoting and integrating the concept of the movement system into physical therapist practice, education, and research.
- The 2015, House of Delegates (House) report outlined the work of the BWG and included the Board-approved definition of the movement system.
- In 2015, the House adopted Management of the Movement System (HOD P06-15-25-24), which states: APTA endorses the development of diagnostic labels and/or classification systems that reflect and contribute to the physical therapists’ ability to properly and effectively manage disorders of the movement system.
- In November 2015, the Board voted to establish the Movement System Task Force and charged this group to:
  - From RC 16-15, develop diagnostic labels and/or classification systems
  - Using the plan developed by the BWG as a catalyst, develop and refine a comprehensive and flexible final short-term (1-3 year) and long-term (4-8 year) plan for the integration of the movement system in practice, education, research, and advocacy
  - Determine the long-term measures and outcomes resulting from implementation of this plan and how this plan will transform society, the profession, and the association
  - Identify critical benchmarks that serve as points along a continuum in which initiatives would either continue as planned or would require revision based on changes in health care, higher education, society, and the profession
  - Following Board approval of the plan, champion the short-term plan over the next 3 years with recommendations from the Movement System Task Force in coordination with association staff
  - Enlist the support and assistance of expert consultants, as needed, throughout the planning and championing phases to advance the plan, including members from the BWG, components, and other health professions
  - Provide annual reports to the Board on the status of the work of the task force, and ensure that newly elected Board members are apprised of the ongoing work of this group
  - Track presentations (platforms, posters, conference presentations nationally and component-based) and publications that result from the implementation of the plan to assess overall impact and penetration within the profession
Assess how physical therapists are using the movement system diagnosis within their
practice, within education curriculum, and in conducting research to determine if and how
this is changing a paradigm within the profession regarding movement system diagnosis.

- During the budget process for 2016, the Board determined that to refine an action plan for the
integration of the movement system into practice, education, and research, a Movement System
Summit could help inform the process and provide critical stakeholder feedback.

- The Movement System Task Force revised the initial definition of the movement system based on
stakeholder feedback. The Board approved the new definition in October 2016. The revised
definition is: The "movement system" represents the collection of systems (cardiovascular,
pulmonary, endocrine, integumentary, nervous, and musculoskeletal) that interact to move the
body or its component parts.

DISCUSSION

The Movement System Task Force planned the Movement System Summit agenda, which included
discussions of the history of the movement system, how the movement system integrates with the
Guide to Physical Therapist Practice, the essential components of a movement system analysis, the
criteria for movement system diagnostic labels, with the goal of developing a plan to integrate the
movement system into practice, education, and research.

The summit took place December 8–10, 2016, in Alexandria, Virginia. The Overview of the Movement
System Summit is in Appendix A.

SUMMARY

The Overview of the Movement System Summit summarizes the discussions, which were rich and
provided much information. The Board will review the recommendations of the task force that were
informed by the Summit at the April Board meeting.
In 2013, the American Physical Therapy Association (APTA) adopted an inspiring new vision, “Transforming society by optimizing movement to improve the human experience.” A guiding principle of the new vision is “identity,” which articulates that the physical therapy profession will define and promote the movement system as the foundation for optimizing movement to improve the health of society. Over the last year, APTA’s Movement System Task Force has led efforts to define the “movement system” and to make recommendations to the APTA Board of Directors for integrating the concept into practice, education, and research.

Related to these efforts, APTA held a Movement System Summit (Summit) December 8–10, 2016, in Alexandria, Virginia. APTA brought together a diverse group of 100 physical therapist thought leaders to provide input into the Movement System Task Force’s recommendations.

Summit participants were nominated by APTA sections, caucuses, and the Student Assembly. The event also included early-career members, journal editors, and representatives of the Foundation for Physical Therapy, the Federation of State Boards of Physical Therapy, the Commission on Accreditation in Physical Therapy Education, and the APTA Board of Directors. Prior to the Summit, participants were given background information, pre-readings, and questions to help prepare for the meeting. The expectation was for participants to be actively engaged throughout the Summit and to be willing to serve as ambassadors for the movement system following the Summit.

The Summit format consisted of plenary sessions and active roundtable discussions for the following topic areas:

- The history of the movement system and its relationship to the APTA Vision. The question for consideration was:
  - If all physical therapists were movement system experts, and the public, our colleagues, and all other stakeholders recognized us that way, what positive changes would we see in the profession of physical therapy?

- The relationship of the movement system language to the current language of the International Classification of Functioning, Guide to Physical Therapist Practice 3.0, (Patient/Client Management Model), and APTA policies and positions. The questions for consideration were:
  - What is your understanding of the movement system?
  - How do you see the Patient/Client Management Model interfacing with the movement system?

- Providing recommendations on the essential components of movement analysis that should be included in the patient and client examination for assessment of movement performance.
  - The participants were asked to identify the activities that are essential to a movement system examination, and what they observe and measure when patients perform an activity. The generated list will be further discussed and refined.

- Providing recommendations for the criteria for movement system diagnostic labels.
  - In 2015, the House of Delegates adopted the position: Management of the Movement System. It stated that “APTA endorses the development of diagnostic labels and/or
classification systems that reflect and contribute to the physical therapists’ ability to properly and effectively manage disorders of the movement system.” Summit participants were given 3 criteria proposed from the Diagnosis Dialogue group to consider, refine, and then bring to a consensus. The agreed-upon criteria will be presented to the Board of Directors for consideration.

- The development of recommendations for a plan to integrate the movement system concept into physical therapist practice, education, and research.
  - The participants provided valuable input on the task force’s proposed recommendations to the Board.

Plenary session videos are now posted on the APTA website at: www.apta.org/MovementSystem/Summit, and the sessions will be available in the APTA Learning Center for CEU credit.

The breadth of Summit participants’ experiences and backgrounds, and their level of engagement, helped to create an environment for valuable dialogue and discussion. The next step is for the Board to officially review the Movement System Task Force’s and Summit’s work and recommendations.