### 2016 PACKET I

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<td>to Change the Bylaw Deadline to Coincide with the Main Motion Deadline</td>
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MEMORANDUM

April 1, 2016

From: Susan R. Griffin, PT, DPT, MS, GCS, RP, speaker, House of Delegates
       Marie Stravlo, manager, National Governance and Leadership – House of Delegates

RE: 2016 House of Delegates Packet I, Background Papers, and Reports to the House (formerly House Handbook)

Packet I, which contains all proposed main motions received by the March 7 deadline, is attached, along with subsequent appendices (Appendices A–E) that contain information about additional materials, planning, and resources. Business of the House of Delegates (House) is conducted through the introduction of main motions. Therefore, in order to be thoroughly prepared to represent your component, delegates must make the time to read and educate themselves about each motion and stay current with all information found on the House of Delegates HUB. Questions, concerns, or opinions about a motion should be directed to the maker of the motion. When information is desired from the Board of Directors (Board) or staff, this request should be posted to the appropriate discussion thread under ‘Motion Discussions’ on the House of Delegates Community to allow all delegates to benefit from the reply. Delegates contemplating amendments to motions should communicate with the motion maker, and the Reference Committee liaison listed on the motion. In addition, all delegates are encouraged to participate in the Virtual Town Halls on Thursday, April 7 and Thursday, May 12.

Within Packet I, delegates will find the Rules of the House of Delegates and the General Order of Business, both adopted by the House as the first and second orders of business, and Implications for Motion Language, developed by the Reference Committee to identify the implication of certain terms when used within House motions. Newly added to Packet I is a document that explains Special Committees of the House.

The Detailed Agenda, a subset of the General Order of Business, is adopted immediately prior to the start of new business, and delineates the proposed order of motions to come before the House of Delegates. Motions are placed into categories adopted by the Reference Committee to guide the order. However, ultimately, the order of motions is determined at the discretion of the speaker, in consultation with the House officers and the Reference Committee chair, in order to facilitate the business of the House in the way deemed most logical and efficient.

Much more information will be provided to you over the next 2 months. Please allot time weekly (at a minimum!) to devote solely to reading motions, background information, reports, and delegate comments, and to reflect on how this information relates to the transformation of the association, profession, and society. This will ensure that you are prepared to fully engage in the serious and weighty responsibilities of a delegate.

Downloading Packet I is accomplished by accessing the documents from the House community. From the APTA homepage, at the top of the page in the teal horizontal tool bar, select “APTA Communities.” Click on “Communities” and select “House of Delegates.” Under “File Library” select “Motions, House Reports, and Background Papers.”

As you read through Packet I, you will notice 1 motion with conforming amendments (RC 8-16) with each amendment named as a separate part (Part A and Part B.) The concept of conforming amendments was introduced in Robert’s Rules of Order Newly Revised, 11th edition. When several changes are required to achieve one end, these separate changes are considered conforming amendments, and are adopted by a single motion.

The House officers wish to thank the delegates for their preparation thus far and for their timely submission of motions. We are confident that the House can complete all the business to come before it this year if we work together, efficiently and openly. Early and frequent networking with delegates and motion makers will greatly improve our ability to resolve conflict and reach mutual understanding for the good of the association and the profession. Do not hesitate to contact us if you have questions, concerns, or suggestions for expediting the business of the House. We look forward to seeing you soon!
PREPARATION AND PLANNING FOR THE HOUSE

- The Reports to the House of Delegates (previously known as the **House of Delegates Handbook**) contains annual and special reports to the House. All reports except the House Officers, Reference Committee, Secretary, and Nominating Committee reports, have been written in response to charges from the House. Be sure to read these thoroughly. Questions related to these reports should be posted under ‘**House Report Discussions**’ on the House of Delegates Community. Delegates may also ask questions or share comments during the House on Monday, June 6 when reports are taken up. The Reports to the House of Delegates will be posted to the House Community on **Friday, April 8**.

- **Background Papers**, which are written by APTA staff, are an invaluable resource to delegates in helping to understand background of motions published in **Packet I**. Background papers will be made available to delegates by **Friday, May 6**.

- **Reference Committee Onsite Appointments** will be held **Sunday, June 5**, and **Tuesday, June 7**. For specific information regarding booking an appointment, please refer to the **House Community**.

- **Reference Committee Virtual Appointments** will be held on **Thursday, April 21** and **Wednesday May 12**. The Reference Committee will be available from 12:00 pm–2:00 pm, ET, for 15 minute appointments. Please refer to the **House Community** for more information.

- The Reference Committee and House officers will lead **2 Virtual Town Halls**: **Thursday, April 7, 8:00–9:30 pm, ET**, and **Thursday, May 12, 8:00–9:30 pm, ET**. The purpose of the spring town halls is to discuss motions, the implications should the motion be adopted, and ask informational questions. To present a motion please contact **Dawn Paulson** with any motion you would like to discuss. Please note that, based on conversations taking place on the House Discussion board, the Reference Committee and House officers may add specific motions to the agenda as well. For connection information, please visit the **House Community** – no RSVP or registration is needed to participate.

- **Pre-House Motions Discussion Groups** will be held on **Sunday June 5, 6:00 pm – 7:45 pm, ET**. The agenda will be posted to the **House Community**.
The House of Delegates Community (House community) is the most important resource available to delegates. The House Community is your source for all of the important materials necessary to prepare for the House.

The House Community may be accessed from the APTA homepage (www.apta.org) by logging on and, at the very top of the page in the teal horizontal tool bar, selecting “APTA Communities.” Once on the main community page, select “House of Delegates” under “My Communities.”

The House Community is organized into 2 sections:

1. **Forum** – the sole purpose of these forums is to facilitate motion discussion prior to arrival onsite. All delegates should subscribe for alerts to each one of the discussion boards listed on the House Community. Discussion boards are organized as follows:
   - **House of Delegate Updates** – This forum is used to alert delegates about any upcoming deadline, events, or the posting of new material to the file library.
   - **Discussions with the House Officers** – This forum allows delegates to initiate discussions with the House officers. It also facilitates the discussions that the House officers would like to have with the delegates.
   - **Motion Discussion** – This forum is used by all delegates to provide opinion or to ask questions related to the motions that have been released in Packet I. Although the forum is open to all delegates, only chief, section, and assembly delegates may post the official opinion of a delegation, and should identify themselves within a post when providing official opinion.
   - **House Report** – This forum is used by all delegates to provide opinion or to ask questions related to the reports to the House of Delegates.
   - **Archived Discussions** – This is an archive of discussions from the prior year.

2. **File Library** – contains materials in document formats (i.e. PDF, Word, PowerPoint, etc.). Folders are organized as follows:
   - **Motions, House Reports, and Background Papers**
   - **House Resources**
   - **Nominations, Candidacy, and Elections**
   - **Archive**
To assist with delegate preparation for the House, a downloadable file that contains materials each delegate is responsible for having in his/her possession during House proceedings will be made available by Friday, May 27, 2016. The file will contain the following materials:

Positions, Bylaws, and Core Documents
- APTA Bylaws
- APTA Standing Rules
- Association Positions, Standards, Guidelines, Policies, and Procedures Link
- Code of Ethics for the Physical Therapist
- Guide for Professional Conduct
- Guide for Conduct of the Physical Therapist Assistant
- Standards of Ethical Conduct for the Physical Therapist Assistant
- Vision Statement for the Physical Therapy Profession and Guiding Principles to Achieve the Vision

House Reference Materials
- House of Delegates Schedule
- Seating Chart and Microphone List
- House of Delegates Dates and Deadlines
- Chapter delegate apportionment
- Packet I
- Background Papers
- Reports to the House (Formerly House Handbook)
- Motions Discussion Group Agendas
- Reference Committee Roster and Liaison List

Elections Materials
- Nominating Committee Roster and Liaison List
- Slate of Candidates
- Candidate Statements and Bios
- Candidate Interview Schedule

To access and download the Downloadable File, access the House Community and in the House Resources File Library, select HOD Download File.

The Downloadable File is composed of self-extracting Zip files, which compress large documents for fast and easy downloading and enable the user to then “expand” the file in its native format – MS Word. Self-extracting zip files do not require the user to have a special computer program necessary for “unzipping.”
GUIDELINES TO CREATE A SPECIAL COMMITTEE OF THE APTA HOUSE OF DELEGATES

Introduction: APTA bylaws provide that ‘the House may create and appoint such special committees as it deems necessary’. A special committee may be created through a main motion to the House of Delegates (House), or by referring a pending motion to a special committee. In either case, items 1 and 2 below shall be included when creating a special committee.

1. **Charge to the committee:** The motion must clearly delineate the purpose of the committee and the desired outcome. A special committee may be charged to simply investigate an idea, or to investigate and bring recommendations to a future House. If not specifically charged to bring recommendations back, the committee may choose to do that on its own. The charge must include a date by which the House expects to have a report or recommendation returned to it.

2. **Committee composition:** The motion to create the committee may list specific individuals to serve on the committee. According to Roberts Rules of Order, newly revised, the first person listed will serve as the chair. Rather than a list of individuals, the motion may simply delineate the number and types or categories of individuals to serve, in which case the House officers would follow these guidelines and select the individuals. A final alternative is that the motion may simply state that the House officers will select committee members, and leave that selection entirely to the House officers’ discretion.

3. **Resource allocation:** The House cannot direct that the APTA Board of Directors allocate a specific amount of resources, including dollars and staffing, to a special committee of the House. If a special committee is created, the House officers will work with the Board to determine resource allocation.

4. **Committee management:** The House officers will oversee activities of a special committee between meetings of the House.
### APPENDIX E

**BASIC CHARACTERISTICS OF MOTIONS ©**
*The Guerrilla’s Guide to Robert’s Rules*
Nancy Sylvester, MA, PRP, CPP  www.nancysylvester.com

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<tr>
<td>1   Fix the Time to Which to Adjourn</td>
<td>Sets the time for a continued meeting</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>2   Adjourn</td>
<td>Closes the meeting</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>3   Recess</td>
<td>Establishes a brief break</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>4   Raise a Question of Privilege</td>
<td>Asks an urgent question regarding rights</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Ruled by chair</td>
</tr>
<tr>
<td>5   Call for Orders of the Day</td>
<td>Requires that the meeting follow the agenda</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>One member</td>
</tr>
<tr>
<td>6   Lay on the Table</td>
<td>Puts the motion aside for later consideration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>7   Previous Question</td>
<td>Ends debate and moves directly to the vote</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Two-thirds</td>
</tr>
<tr>
<td>8   Limit or Extend Limits of Debate</td>
<td>Changes the debate limits</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Two-thirds</td>
</tr>
<tr>
<td>9   Postpone to a Certain Time</td>
<td>Puts off the motion to a specific time</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>10  Commit or Refer</td>
<td>Refers the motion to a committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>11  Amend an amendment (Secondary Amendment)</td>
<td>Proposes a change to an amendment</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>12  Amend a motion or resolution (Primary Amendment)</td>
<td>Proposes a change to a main motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>13  Postpone Indefinitely</td>
<td>Kills the motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>14  MAIN MOTION</td>
<td>Brings business before the assembly</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
</tr>
</tbody>
</table>

1 Is debatable if the motion is made while no question is pending
2 Unless no question is pending
3 Majority, unless it makes the question a special order
4 If the motion it is being applied to is debatable

*Note: Motions above are in the Order of Precedence of Motions. Based on Robert’s Rules of Order Newly Revised, 11th Edition*
## BASIC CHARACTERISTICS OF MOTIONS ©
Nancy Sylvester, MA, PRP, CPP-T  www.nancysylvester.com

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<tr>
<td>Point of Order</td>
<td>Requests that the rules be followed</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Ruled by chair</td>
</tr>
<tr>
<td>Appeal from the Decision of the Chair</td>
<td>Challenges a ruling of the chair</td>
<td>Yes</td>
<td>Yes</td>
<td>Depends⁴</td>
<td>No</td>
<td>Majority⁵</td>
</tr>
<tr>
<td>Suspend the Rules</td>
<td>Allows the group to violate the rules (not bylaws)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Two-thirds</td>
</tr>
<tr>
<td>Objection to Consideration</td>
<td>Keeps the motion from being considered</td>
<td>Yes⁶</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Two-thirds⁷</td>
</tr>
<tr>
<td>Division of the Question</td>
<td>Separates consideration of the motion</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Majority</td>
</tr>
<tr>
<td>Division of the Assembly</td>
<td>Requires a standing vote</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>One member</td>
</tr>
<tr>
<td>Parliamentary Inquiry or Request for Information</td>
<td>Allows a member to ask a question about the business at hand</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Responded to by chair</td>
</tr>
<tr>
<td>Withdraw a Motion</td>
<td>Removes a motion from consideration</td>
<td>Yes</td>
<td>Depends⁸</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
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<td>(after stated by the chair)</td>
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<td>Take from the Table</td>
<td>Resumes consideration of a motion that was laid on the table</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>Reconsider</td>
<td>Considers a motion again</td>
<td>Yes⁹</td>
<td>Yes</td>
<td>Depends¹⁰</td>
<td>No</td>
<td>Majority</td>
</tr>
<tr>
<td>Rescind or Amend Something</td>
<td>Repels a previously adopted motion or amends it after it has been adopted</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Depends¹¹</td>
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<tr>
<td>Previously Adopted</td>
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</table>

⁵ Majority in negative required to reverse chair’s decision
⁶ Yes, until debate has begun or a subsidiary motion other than Lay on the Table has been stated by the chair
⁷ Two-thirds against consideration sustains objection
⁸ Yes, if motion is made by the person requesting permission; no, if made by another member
⁹ When another member has been assigned the floor, but not after he or she has begun to speak
¹⁰ Only if the motion to be reconsidered is debatable
¹¹ Requires a) a majority with notice, b) two-thirds, OR c) majority of entire membership
RULES OF THE HOUSE OF DELEGATES

The following rules govern the conduct of business at the House of Delegates. Only Section III – Rules of the House of Delegates – Adopted for the Session: May be Suspended, are adopted by the House of Delegates.

I. RULES OF THE HOUSE OF DELEGATES REQUIRED BY APTA BYLAWS - MAY NOT BE SUSPENDED

Rules of the House as outlined within the Bylaws of the American Physical Therapy Association:

- ARTICLE IV. MEMBERSHIP, Section 2: Rights and Privileges of Members
- ARTICLE VIII. HOUSE OF DELEGATES
- ARTICLE IX. BOARD OF DIRECTORS, Section 2: Qualifications
- ARTICLE X. COMMITTEES AND COUNCILS, Section 2: Committees of the House of Delegates
- ARTICLE XIV. AMENDMENTS

II. RULES OF THE HOUSE OF DELEGATES - REQUIRED BY RELEVANT APTA STANDING RULES - MAY BE SUSPENDED

Rules of the House as outlined with the Standing Rules of the American Physical Therapy Association:

13. ELECTIONS: TELLER’S REPORTS

A. The teller’s report to the House of Delegates shall include for each position to be filled:
   (1) The number eligible to vote.
   (2) The number of votes cast.
   (3) The number of votes necessary for election (for officers).
   (4) The number of votes cast for each eligible candidate.
   (5) The number of illegal votes, and the reason therefore.

14. VACANCIES -- OFFICERS AND DIRECTORS

A. If a vacancy occurs within the first year of a 3-year term, the Nominating Committee shall select a candidate(s) for election at the next annual session of the House of Delegates; the elected person shall serve for the remaining 2 years of the term.
B. If a vacancy occurs after the first year of a 3-year term, the vacancy shall be filled by appointment by the Board of Directors.
C. Notwithstanding Standing Rule 14(B), if a vacancy occurs on the Board of Directors as a result of an election, a second election shall be required. The Nominating Committee shall prepare the slate for the second election and additional nominations from the floor shall be in order.

All candidates who were slated for any position on the Board of Directors and were not elected in the first election will be slated in the second election unless they have indicated otherwise. Candidates who were not elected for the Nominating Committee shall not be automatically slated but may be nominated from the floor.

15. REFERENCE COMMITTEE

A. The committee shall receive and correlate motions and resolutions to be presented to the House of Delegates and shall identify motions which fall outside the object or functions of the Association. The committee shall provide advice and counsel regarding form, wording, and method of presentation of matters to be presented to the House.
B. All main motions and resolutions, except for procedural motions presented for action by the House of Delegates, shall be referred to the Reference Committee unless this rule is suspended in any particular case by a majority vote of the House of Delegates.
C. The committee will review main motions that are submitted by the established deadline and in the manner prescribed in the standing rule titled Main Motion Criteria.
D. Appointed members of the committee shall be seated in the House of Delegates and shall reply to inquiries directed to the committee by the Speaker of the House.

E. On a regular basis the committee will review the Association bylaws and standing rules and, as it deems appropriate, propose to the Board of Directors that it bring amendments to the House of Delegates for consideration.

16. DEADLINE FOR MAIN MOTIONS

All main motions to be considered by the House of Delegates shall be submitted in writing to APTA headquarters by a date set by the Speaker of the House of Delegates, which shall be at least 2 months and no more than 3 months prior to the date of the House of Delegates meeting. Any main motion which has not been so submitted shall require a majority vote, without debate, to be considered by the House.

17. MAIN MOTION CRITERIA

All main motions submitted by the established deadline shall meet the following criteria.

It is the responsibility of the maker of the motion to:

(1) Provide a statement of the intended outcome of the motion.
(2) Demonstrate that the motion’s subject is national in scope or importance.
(3) Provide pertinent background information, in collaboration with the APTA Board of Directors or staff including (a) a description of previous House, Board, or staff activity relating to the subject and (b) an identification of the stakeholders affected by the motion.
(4) When possible, demonstrate that the motion concept has been disseminated to delegates of other delegations prior to the deadline for submission of main motions.
(5) Provide a description of the potential fiscal impact of adopting and implementing the motion.

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

20. CONSENT CALENDAR

A. The officers of the House of Delegates shall prepare a list of recommended motions that are routine, standard, non-controversial, or self-explanatory and where general approval is anticipated, for placement on a consent calendar.

B. The preliminary consent calendar will be distributed 3 weeks prior to the start of the first meeting of the House of Delegates.

C. Prior to the first meeting of the House of Delegates motions may be removed from the consent calendar by the officers of the House of Delegates or at the request of 5 chief delegates.

D. The revised consent calendar will be prepared by the officers of the House of Delegates for presentation to chief, section, and assembly delegates prior to the first meeting of the House of Delegates.

E. Following the opening of the House of Delegates motions may be removed from the consent calendar by an affirmative vote of one-third of the voting body of the House of Delegates.

F. If a motion is removed from the consent calendar, it shall be placed appropriately in the order of business previously assigned by the Speaker of the House and the chair of the Reference Committee.
G. The consent calendar shall be presented for adoption in a single motion.

III. RULES OF THE HOUSE OF DELEGATES – ADOPTED FOR THE SESSION - MAY BE SUSPENDED.

Italicized items refer to parliamentary process, and require a 2/3 vote to suspend. All others are logistical and procedural, and require a majority vote to suspend.

1. Only members of the American Physical Therapy Association, Association headquarters staff, component executive personnel, and nonmember guests approved by an officer of the House of Delegates may attend meetings of the House of Delegates. If the House of Delegates votes to go into executive session, the speaker, in consultation with the president and chief executive officer, may invite the following non-APTA members to remain in the House proper during the session: the parliamentarian, the House recorder, APTA staff, component executive personnel, and others.

2. An official delegate badge is required for admission of delegates to the meetings of the House. Admission cards, signed by an officer of the House, are required for the admission of nonmember guests to the House.

3. Delegates shall keep badges in evidence when attending the meetings of the House of Delegates.

4. All registered delegates (chapter, section, PTA Caucus delegates, and assembly delegates) and members of the Board of Directors, consultants to the House, and Nominating Committee shall be seated in designated areas within the House proper. PTA Caucus representatives, designated APTA staff, and Component Executives shall be seated in a designated area of the gallery.

5. All members of APTA may have the floor to speak, but registered delegates will be recognized first.

6. No delegate or member shall be entitled to the floor until recognized by the speaker of the House.

7. Individuals recognized to speak shall provide their name, delegate affiliation if appropriate (e.g., name of chapter, section or assembly), and speak with the aid of a microphone.

8. Members of APTA headquarters staff and members of APTA appointed groups may be recognized for the purpose of giving information and participating in discussions.

9. The vice speaker shall be the official timekeeper at all meetings.

10. When speaking to a motion, each speaker shall be limited to 3 minutes. The vice speaker will indicate when 30 seconds remain in the allotted time.

11. A speaker may not speak twice to the same motion until everyone wishing to speak has done so.

12. A delegate may not rise to debate and close by moving the previous question.

13. A motion may not be seconded by a delegate from the same delegation as the delegate making the motion.

14. The delegate who moves the motion may not speak in opposition to the motion.

15. Motions to amend must be in writing. Electronic submission is preferred. If a handwritten amendments is submitted, six copies must be forwarded to the Reference Committee, and then to the dais, prior to the motion being heard.

16. The motion to suspend the requirement that all main motions and resolutions be referred to the Reference Committee must identify the subject of the motion to be presented.

17. Any motion to amend something previously adopted is a main motion and falls under the standing rule of submitting main motions by the deadline date set by the speaker of the House. In addition, the vote required for such motions is a majority if notice is given. If notice is not given, a two-thirds vote or a vote of a majority of the entire voting membership of the House is required.

18. Replacement or substitute motions for motions contained in Packet I will be published in a subsequent packet. These motions must be reviewed by the Reference Committee no later than Sunday, June 15 for Packet II and Tuesday, June 7 for Packet III.

19. Motions may be withdrawn by the motion maker after notice has been given via Packet I only if there is no objection by the delegates.

20. When voting during elections by use of an electronic keypad, a mechanism for indicating a “write-in” candidate will be provided.
21. If the number of anonymous write-in candidates is sufficient to preclude the election of a candidate or candidates, the floor will be opened for nominations and the election will proceed with the addition of those nominees to the ballot.

22. When a nomination comes from the floor of the House, the candidate will be provided the opportunity to present a statement in support of their candidacy that is no more than 5 minutes in length.

23. There must be an affirmative vote of one-fifth (1/5) of the voting body of the House of Delegates to order a roll call vote, except when ordered by the speaker of the House.

24. Electronic keypads may be used for counted votes at the discretion of the speaker of the House.

25. The secretary, in consultation with the speaker, shall: 1) Edit all House motions for grammar and punctuation; 2) Edit related items (positions, policies, guidelines) when newly adopted motions require editorial changes in previously adopted motions; and 3) Provide documentation of editorial changes to any delegate upon request.

26. No tape or other recordings may be made of the proceedings of the House of Delegates other than those made by the individuals approved by House officers.

27. Exhibitors are not to distribute promotional items in the House of Delegates, other than those approved by the House officers.

28. Delegates who are recognized to speak should consider those individuals who are hearing impaired and position themselves at the microphone so that their mouth and lips are not obscured from view.

29. Delegates who require a reasonable accommodation for a qualified disability should make their request known to the speaker of the House.

30. Service animals are permitted in the House proper and gallery.
MONDAY, JUNE 6

Call to Order

Opening Ceremonies

1. Pledge of Allegiance
2. Introductions
3. In Memoriam

Adoption of the Rules of House of Delegates

Adoption of General Order of Business

(Adoption of Detailed Agenda deferred until Tuesday morning)

Report from the Nominating Committee

Introduction of Candidates

Appointments

1. Committee to Approve the Minutes
2. Elections Chair and Vice-Chair

Elections for National Office

Recognition of Catherine Worthingham Fellows

APTA President Address to the House of Delegates

Chief Executive Officer Address to the House of Delegates

Reports

1. President
2. House Officers
3. Secretary’s Report
4. Treasurer
5. Nominating Committee
6. Reference Committee
7. Reports from Board of Directors to House of Delegates

Recognition of New Delegates

Introduction of Student House Ushers

Report of Elections

Adjournment
**TUESDAY, JUNE 7**

Adoption of Detailed Agenda (Packet I)

New Business (Packet I)

Adjournment

**WEDNESDAY, JUNE 8**

Continuation of New Business

Special Orders: 2:00 pm–3:00 pm
- Installation of New Nominating Committee Members
- Installation of New Officers and Directors
- Recognition of Retiring Nominating Committee Members
- Recognition of Retiring Members of the Board of Directors

Adjournment
RC 1-16  Rescind: House Session and Annual Conference Scheduling (HOD Y06-94-28-43)
RC 2-16  Amend: The Association’s Role in Advocacy for Prevention, Wellness, Fitness, Health Promotion and Management of Disease and Disability (HOD P06-15-22-14)
RC 3-16  Amend: Physical Therapists’ Role in Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability (HOD P06-15-23-15)
RC 4-16  Amend: Consumer Protection Through Licensure of Physical Therapists and Physical Therapist Assistants (HOD P06-14-08-18)
RC 5-16  Charge: Educational Campaign Regarding Designations
RC 6-16  Charge: Recognition of Board Certification by American Board of Physical Therapy Specialties
RC 7-16  Adopt: Definition of Professional Scope of Practice
RC 8-16  Adopt: Oncologic Physical Therapy as an Area of Specialization
RC 9-16  Charge: Analysis of American Board of Physical Therapy Residency and Fellowship Education Structure, Function, and Accreditation Process
RC 10-16 Charge: Accurate Representation of Physical Therapist Practice and Research
RC 11-16 Charge: Investigation and Plan to Address Student Debt in Physical Therapy
RC 12-16 Charge: Plan for Achieving Practice Authority and Payment for Ordering and Performing Imaging Studies
RC 13-16 Election to Honorary Membership in the American Physical Therapy Association: Richard L. Lieber, PHD
RC 14-16 Adopt: Consideration of Board-Adopted Policy for the Profession
RC 15-16 Charge: Create and Maintain a Virtual Physical Therapy Museum
RC 16-16 Amend: Bylaws of the American Physical Therapy Association to Change the Definition of a Post-Professional Student
RC 17-16 Amend: Bylaws of the American Physical Therapy Association to Change the Bylaw Deadline to Coincide with the Main Motion Deadline

For the logic behind the ordering of the motions, please see Appendix A.
The Reference Committee has adopted the following categories as a guide for ordering the business of the House.

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

- Categories 1-6 consist of motions that can only be handled by the House of Delegates.
- Category 7 provides information about activities the House of Delegates would like to debate and potentially direct the Board of Directors to accomplish.
- In non-bylaws years, bylaw amendments will be ordered at the end of the agenda with the exception of bylaw amendments to Article XI: Finance, Section 3, Dues.
- Motions included on the consent calendar shall also include identification of the appropriate category in the event the motion is removed from the consent calendar.
**IMPLICATIONS FOR MOTION LANGUAGE**

The following lists, developed by the Reference Committee, identify the implication of certain language that may be used in motions to be considered by the House. The first list applies to motions that are designed to request specific action of the Board. Motions in this category, once passed, will be addressed by the Board of Directors to determine appropriate next steps, over the course of subsequent Board meetings following the House of Delegates.

The second list applies to motions to create standards, positions, and guidelines. Motions in these categories will be included in the Association’s Policy Booklet to be used as guidance for future behavior on the part of members and staff of the APTA.

This standardized language helps to clarify the implication or direction of a motion adopted by the House. Delegates should refer to this standardized list to ensure that the words selected are consistent with the intent of the action or any outcome expected.

**APPROPRIATE TO USE**

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

<table>
<thead>
<tr>
<th>Word</th>
<th>Definition</th>
<th>Association Interpretation</th>
<th>Fiscal Implication (monetary and human resources)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate</td>
<td>To speak in favor of; recommend</td>
<td>Emphasize, raise awareness of. Not as strong as pursue, promote</td>
<td>Minimal to moderate</td>
</tr>
<tr>
<td>Develop</td>
<td>To bring into being; make active</td>
<td>requires an end product</td>
<td>Usually significant</td>
</tr>
<tr>
<td>Encourage</td>
<td>To foster; to stimulate</td>
<td>Non-financial; to foster member action</td>
<td>None</td>
</tr>
<tr>
<td>Endorse</td>
<td>To give approval</td>
<td>General approval with minimal financial commitment</td>
<td>Minimal</td>
</tr>
<tr>
<td>Explore</td>
<td>To look at something in a careful way to learn more about it; research</td>
<td>The end product is information, rather than a recommendation</td>
<td>Minimal to significant</td>
</tr>
<tr>
<td>Evaluate</td>
<td>To determine or fix the value of; to examine carefully or appraise</td>
<td>Requires an end product</td>
<td>Minimal to significant</td>
</tr>
<tr>
<td>Identify</td>
<td>To find out the original nature or obligation</td>
<td>Requires an end product</td>
<td>Moderate to significant</td>
</tr>
<tr>
<td>Implement</td>
<td>To put into effect</td>
<td>Put into effect; make happen</td>
<td>Usually significant</td>
</tr>
<tr>
<td>Promote</td>
<td>To raise to a more important or reasonable rank; to contribute to the</td>
<td>Raise to a more important rank; Emphasize; Raise awareness; not as strong as “pursue”;</td>
<td>Minimal to moderate</td>
</tr>
<tr>
<td>Provide</td>
<td>To furnish; supply; to make available</td>
<td>requires an end product</td>
<td>Minimal to significant</td>
</tr>
<tr>
<td>Pursue</td>
<td>To strive to obtain or accomplish</td>
<td>Goal directed activity with an identified end product</td>
<td>Moderate to significant</td>
</tr>
</tbody>
</table>
B. MOTIONS THAT ARE DESIGNED TO CREATE STANDARDS, POSITIONS, AND GUIDELINES

There are no direct or immediate fiscal implications for any of these actions.

<table>
<thead>
<tr>
<th>Word</th>
<th>Definition</th>
<th>Association Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be/Is/Are</td>
<td>Used to describe the qualities or condition of a person or thing</td>
<td>Describes expected behavior</td>
</tr>
<tr>
<td>Oppose</td>
<td>To disagree with</td>
<td>Affirmative statement of disagreement</td>
</tr>
<tr>
<td>Shall</td>
<td>Used to express duty or obligation</td>
<td>Obligates action and is preferred over “should” and stronger than “may”</td>
</tr>
<tr>
<td>Support</td>
<td>To agree with</td>
<td>Affirmative statement of agreement</td>
</tr>
</tbody>
</table>

Other verbs may be used as appropriate to describe the expected behavior of the targeted groups. However, the verbs listed above for use with charges should not be used in standards, positions, and guidelines.

<table>
<thead>
<tr>
<th>Word</th>
<th>Definition</th>
<th>Rationale for not using the term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge</td>
<td>Unnecessary, since certain types of motions are charges</td>
<td></td>
</tr>
<tr>
<td>Consider</td>
<td>To think about seriously</td>
<td>Inappropriate for use in motions, as it does not provide clear direction</td>
</tr>
<tr>
<td>May</td>
<td>To be allowed or permitted</td>
<td>Inappropriate for use in motions, as it does not provide clear direction</td>
</tr>
<tr>
<td>Ought</td>
<td>Probability or likelihood; duty or obligation</td>
<td>Inappropriate for use in motions; use “shall”</td>
</tr>
<tr>
<td>Recommend</td>
<td>To counsel or advise (that something be done)</td>
<td>Only a suggestion; does not require action</td>
</tr>
<tr>
<td>Should</td>
<td>Used to express expectation</td>
<td>Implies expectation but no action</td>
</tr>
<tr>
<td>Will</td>
<td>To decree; to resolve with a forceful will</td>
<td>Implies expectation, not action; use “shall”</td>
</tr>
</tbody>
</table>
Required for Adoption: Majority Vote
Category: 4

Motion Contact: Robert H. Rowe, PT, DPT, DMT, MHS, FAAOMPT
APTA Board of Directors
Phone: 985/774-8909 E-mail: robertrowe@apta.org

RC Contact: Michael A. Pagliarulo, PT, MA, EdD
Phone: 503/516-9592 E-mail: pags@ithaca.edu

PROPOSED BY: BOARD OF DIRECTORS

COSPONSORED BY:

RC 1-16 RESCIND: HOUSE SESSION AND ANNUAL CONFERENCE SCHEDULING (HOD Y06-94-28-43)

That House Session and Annual Conference Scheduling (HOD Y06-94-28-43) be rescinded.

SS: This House of Delegates policy consists of two parts, one relating to scheduling and the other relating to fees. It should be rescinded because both parts are outdated and are no longer necessary.

In regards to the scheduling issue, in recent years the House session often has ended on a Wednesday, with conference programming beginning the next day. There has not been overlap of a portion of two or more days for at least fifteen years. Thus, the second sentence of the House policy has not been applicable any year in this century. In addition, current House policy is out of compliance with Bylaws of the American Physical Therapy Association, which grants authority to the Board to schedule these events.

Likewise, the part of the House policy calling for prorated fees based upon overlap of the House of Delegates and conference programming has not been applicable this century. APTA’s practice in recent years has been to give registered delegates a 50% discount if they register for annual conference. The purpose of giving this discount has been to recognize the delegates’ service to the association and to give them an incentive to partake of the conference programming. The Board of Directors recently adopted a motion calling for the continuation of the 50% discount for registered delegates. See Delegate Discount to NEXT (BOD Y02-16-01-01).

Rescinding this policy would retain the Board’s authority derived from the bylaws to determine the time and place of the annual session of the association (House of Delegates) and would continue the practice of reduced conference fees for delegates for legitimate reasons.

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:

HOUSE SESSION AND ANNUAL CONFERENCE SCHEDULING (HOD Y06-94-28-43)

RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:

BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE VII, MEETINGS, SECTION 1, ANNUAL SESSION
BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE VII, MEETINGS, SECTION 4, ANNUAL CONFERENCE
DELEGATE DISCOUNT TO NEXT (BOD Y02-16-01-01)
Required for Adoption: Majority Vote Category: 4

Motion Contact: Chris Hinze, PT, DPT, delegate
Michigan Chapter
Phone: 231/633-4566 E-mail: cjhinze@gmail.com

RC Contact: Carol Counts Likens, PT, PhD, MBA
Phone: 901/270-8135 E-mail: clikens@uthsc.edu

PROPOSED BY: MICHIGAN CHAPTER

COSPONSORED BY: ARIZONA, MISSOURI, OHIO, TEXAS, VIRGINIA CHAPTERS; ONCOLOGY, PEDIATRICS SECTIONS

RC 2-16 AMEND: THE ASSOCIATION’S ROLE IN ADVOCACY FOR PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT OF DISEASE AND DISABILITY (HOD P06-15-22-14)

That The Association’s Role in Advocacy for Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability (HOD P06-15-22-14) be amended:

The American Physical Therapy Association (APTA) advocates for prevention, wellness, fitness, health promotion, and management of disease and disability.

Advocacy includes but is not limited to scientific, educational, regulatory, and legislative activities that promote regular physical activity and exercise to enhance health and prevent disease. It includes 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.

Priorities for association advocacy include, but are not limited to:

- Appropriate physical activity and exercise goals and objectives put forth by government and other nationally recognized agencies and organizations
- Appropriate efforts that enhance community design to promote physical activity and active forms of transportation for individuals and populations of all ages and abilities
- Consumer recognition of the value of the physical therapist to provide services for prevention, wellness, fitness, and health promotion, and for management of disease and disability for all populations and conditions
- Physical education, physical conditioning, and wellness instruction at all levels of education, from preschool through higher education
- Physical therapists making healthy personal lifestyle choices that include meeting national guidelines for participation in physical activity and exercise and engaging in active forms of transportation

SS: As identified by the APTA House of Delegates in 2013, our society is in need of transformation. One-third of adults and one-fifth of children in the United States are obese.\(^1\) Nearly half of all Americans are living with one or more chronic diseases.\(^2\) Non-communicable diseases, such as heart disease, stroke, and cancer are among the leading causes of death in our country. Despite strong evidence that regular physical activity reduces risk for obesity and all-cause mortality, the majority of individuals in the U.S. do not meet the 2008 Physical Activity Guidelines.\(^3\) The factors for a lack of adherence to physical activity recommendations are many, but according to the CDC, “a lack of parks, sidewalks, bicycle trails, or safe and pleasant walking paths convenient to homes or offices” has been identified as a barrier to physical activity participation.\(^4\) Conversely, enhancements to the built environment, such as installation of infrastructure that supports safe walking or biking has shown to enhance participation in physical activity.\(^5,6\)
The Vision Statement for the Physical Therapy profession reads: “Transforming society by optimizing movement to improve the human experience.” To achieve this Vision, the built environment that supports society must also be optimized to facilitate opportunities for movement. Communities that are intentionally designed and maintained to support movement, such as walking, bicycling or wheelchair rolling, provide members of society opportunities for physical activity.5,6

The 2016 APTA Strategic Plan has identified three key areas of transformation that will be addressed in order to achieve this Vision. The first of these is “Transform Society: Barriers to movement will be reduced at the population, community, workplace, home, and individual levels.” A lack of safe and welcoming sidewalks, absence of safe areas to bike such as bike lanes or bike paths, unsafe driver behavior, traffic, and large distances between destinations are just a few examples of barriers to movement that exist as part of the built environment of a community.7 This amendment provides an opportunity for the association to put the strategic plan into action by working to reduce barriers to movement through advocacy efforts that enhance community design to promote physical activity.

One opportunity for APTA to advocate in this area is through collaboration with organizations or initiatives that aim to promote opportunities for active transportation or physical activity through community design. Currently, APTA is an organizational partner in the National Physical Activity Plan Alliance, a not-for-profit organization that is committed to ensuring the success of the National Physical Activity Plan (NPAP). The NPAP contains a section that describes strategies and tactics designed to influence transportation, land use and community design. Physical therapy representation in this initiative is important but it is only the first step. APTA should continue to collaborate on initiatives that support walkable and bikeable community design. Furthermore, APTA can aid the efforts of physical therapists, physical therapist assistants, and students by providing tools and resources to assist them in advocating for community design that promotes physical activity and active transportation where they live and work.

In 2015, The U.S. Surgeon General issued a call to action, encouraging all Americans to Step It Up! by incorporating more walking into our daily lives and to design communities that support safe and easy walking routes for people of all abilities. This Call to Action includes 5 goals, with goal 2 stating: “Design Communities that Make It Safe and Easy to Walk for People of All Ages and Abilities.” The call to action also states that “Improving the walkability of communities can benefit people of all abilities, including those who run, bike, skate, or use wheelchairs.”8

It is time for the physical therapy profession to Step It Up! Societal transformation is a massive effort that will involve more than transforming the individuals and populations that make up society but also the environment that supports society. Advocating for community design that supports physical activity and active transportation will help to ensure that more Americans will have access to safe and welcoming places to be physically active.

REFERENCES:

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
THE ASSOCIATION’S ROLE IN ADVOCACY FOR PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION AND
MANAGEMENT OF DISEASE AND DISABILITY (HOD P06-15-22-14)

RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
PHYSICAL THERAPISTS’ ROLE IN PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT
OF DISEASE AND DISABILITY (HOD P06-15-23-15)
PROPOSED BY: MICHIGAN CHAPTER

COSPONSORED BY: ARIZONA, MISSOURI, OHIO, TEXAS, VIRGINIA CHAPTERS; CARDIOVASCULAR AND PULMONARY, HEALTH POLICY AND ADMINISTRATION, ONCOLOGY, PEDIATRICS SECTIONS

RC 3-16 AMEND: PHYSICAL THERAPISTS’ ROLE IN PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT OF DISEASE AND DISABILITY (HOD P06-15-23-15)

That Physical Therapists’ Role in Prevention, Wellness, Fitness, Health Promotion, and Management of Disease and Disability (HOD P06-15-23-15) be amended:

Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals and populations. This means that although physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals and populations improve overall health and prevent the need for avoidable health care services. Physical therapists’ roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession’s vision of transforming society by optimizing movement to improve the human experience.

Physical therapists, like most health professionals, are educated to provide services in the health services delivery environment. Physical therapists also are uniquely educated and trained to adapt health care recommendations to the community environment where individuals live, work, learn, and play. This knowledge and ability enables physical therapists to adapt medical recommendations to specific environments, to meaningfully interpret health recommendations, to help individuals modify their health behaviors, and to ensure clinical and community services are integrated, available, and mutually reinforcing.

For their role in prevention, wellness, fitness, and health promotion, physical therapists:

1. Integrate decision-making skills across all dimensions and contextual factors of the International Classification of Function (ICF)
2. Incorporate medical and health history into a plan of care that includes data related to body functions and structures, activities and participation, and relevant personal and environmental factors
3. Integrate scientific principles of movement, function, and exercise progression to promote physical activity and improve health outcomes for individuals and populations
4. Incorporate concepts of prevention, wellness, fitness, and health promotion with every patient or client as appropriate
5. Integrate and interpret the elements of medical, biopsychosocial, and health promotion models that allow them to monitor health status over time
6. As part of a community-based integrated team that is focused on healthy lifestyles, design and develop integrated clinical and community screening programs to prevent and manage disease and disability, and refer as appropriate as part of that team
7. Apply the best available evidence in selecting and prescribing exercise for individuals, and planning physical activity and injury prevention programs for individuals and communities
8. Use skills in behavior change to promote healthy lifestyles in individuals and communities
9. As part of a community-based integrated team, adapt tasks and the environment to promote healthy
behaviors and improved health outcomes for individuals and populations of all ages, including those
with complex health and functional needs
10. Adopt healthy lifestyle choices for themselves that include meeting national guidelines for
participation in physical activity and exercise and engaging in active forms of transportation

For their role in management of disease and disability, physical therapists:
1. Recognize the risk factors for, and the course of, chronic diseases and the potential impact on quality
of life and on activities and participation
2. Establish and facilitate collaborative, interprofessional, patient- and client-centric relationships that
empower individuals and populations in self-management across the lifespan and through the health
continuum, with an emphasis on movement and function
3. Apply best available evidence in selecting, prescribing, and using intervention and measurement
strategies to establish exercise prescription for individuals to help them prevent primary, secondary,
and tertiary conditions or optimize functional mobility
4. Apply best available evidence in planning programs to educate populations to help them prevent
primary, secondary, and tertiary conditions or restore functional mobility
5. Provide nonsurgical and nonpharmacological services as a hallmark of physical therapist practice
6. Predict and interpret health outcomes and functional needs where people live, work, learn, and play

For their role as a dynamic link between health and health services delivery, physical therapists:
1. Apply their expertise in exercise and physical activity to adapt health recommendations for individuals
and populations, from clinical settings to the home and community
2. Function as a member of an interprofessional team of health providers, wellness and fitness
providers, community health workers, public health providers, and other diverse professionals to help
individuals and populations reduce their disease risk and improve their health and quality of life
3. Communicate and collaborate with relevant health professionals to help individuals and populations
receive appropriate health services

For their role as advocates for prevention, wellness, fitness, health promotion, and management of disease
and disability, physical therapists:
1. Support scientific, educational, legislative, and other policy initiatives that promote regular physical
activity and exercise to enhance health and prevent disease
2. Advocate for physical education, physical conditioning, and wellness instruction at all levels of
education, from preschool through higher education
3. Advocate for community design that promotes opportunities for physical activity and active forms of
transportation for individuals and populations of all ages and abilities

SS: “APTA’s bold new vision statement, transforming society by optimizing movement to improve the human
experience, places new responsibility on physical therapists and the profession to assume a leadership role to
improve the health of our population. Physical inactivity is a significant risk factor for many chronic diseases and
conditions and is an even greater problem for those with limited mobility. Physical therapists are uniquely
qualified to have a significant impact on health and quality of life by serving as a dynamic link between the clinic
and the community.”

One opportunity for physical therapists to serve as a dynamic link between the clinic and the community is to
serve as advocates for design to the built environment that supports physical activity where they live and work.
The Centers for Disease Control and Prevention has identified “a lack of parks, sidewalks, bicycle trails, or safe
and pleasant walking paths convenient to homes or offices” as a barrier to participation in physical activity.
Conversely, enhancements to the built environment, such as installation of infrastructure that supports safe
walking or biking has shown to enhance participation in physical activity. Physical Therapists are uniquely
qualified to leverage their expertise in human movement across the lifespan to advocate for safe places to be physically active. This can be accomplished by directly participating in the community planning process and by serving as health role models by engaging in active forms of transportation.

Captured in the intent of this motion are three of the Vision’s guiding principles: Collaboration, Access/Equity and Advocacy. Physical therapists can work to transform society by collaborating with organizations and individuals in their communities to enhance the built environment to promote physical activity. Furthermore, they can work to reduce health disparities by advocating for safe and welcoming places for physical activity and active transportation for individuals and populations of all ages and abilities.

As experts in physical activity prescription and human movement across the lifespan, physical therapists can be an invaluable resource to national and local efforts aimed at enhancing the environmental factors that influence physical activity participation. Input from health professionals can help to advance projects that enhance community design that supports physical activity. Katrina Hedberg, State Epidemiologist and State Health Officer at the Oregon Public Health Division states:

“People in other aspects of community planning are very happy to have people from the health arena at the table. They’re thinking that it’s not just them who are out there arguing for a bicycle lane—there are actually people who think that it’s important from a health perspective. It gives them added ammunition to advocate for a healthier community...Stepping out of our realm, which tends to be disease-focused and individual risk factor-focused, we actually have something to offer the broader community. And people do listen to us. They like having us at the table.”

In 2015, The U.S. Surgeon General issued a call to action, encouraging all Americans to Step It Up! by incorporating more walking into our daily lives and to design communities that support safe and easy walking routes for people of all abilities. This call to action includes 5 goals, with goal 2 stating: “Design Communities that Make It Safe and Easy to Walk for People of All Ages and Abilities.” The call to action also states that “Improving the walkability of communities can benefit people of all abilities, including those who run, bike, skate, or use wheelchairs.”

It is time for physical therapists to Step It Up! Societal transformation is a massive effort that will involve more than transforming the individuals and populations that make up society but also the built environment that supports society. Advocating for community design that promotes physical activity and active transportation will help to ensure that more Americans will have access to places to be physically active.

REFERENCES:

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
PHYSICAL THERAPISTS’ ROLE IN PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT OF DISEASE AND DISABILITY (HOD P06-15-23-15)
RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
THE ASSOCIATION’S ROLE IN ADVOCACY FOR PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION AND MANAGEMENT OF DISEASE AND DISABILITY (HOD P06-15-22-14)
Required for Adoption: Majority Vote

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**PROPOSED BY: ARIZONA CHAPTER**

**COSPONSORED BY:**

**RC 4-16 AMEND: CONSUMER PROTECTION THROUGH LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS (HOD P06-14-08-18)**

That Consumer Protection through Licensure of Physical Therapists and Physical Therapist Assistants (HOD P06-14-08-18), Principle II. State Regulatory Designations for the Physical Therapy Profession, Section A. Designation “PT,” “PTA,” “SPT,” and “SPTA,” be amended by substitution:

**PRINCIPLE II. STATE REGULATORY DESIGNATIONS FOR THE PHYSICAL THERAPY PROFESSION**

A. Designation “PT,” “PTA,” “SPT,” and “SPTA”

APTA supports the use of “PT” as the regulatory designation of a physical therapist. Other letter designations such as “RPT,” “LPT,” or academic and professional degrees should not be substituted for the regulatory designation of “PT.” “PTA” is the preferred regulatory designation of a physical therapist assistant.

APTA supports the recognition of the regulatory designation of a physical therapist or a physical therapist assistant as taking precedence over other credentials or letter designations. To promote consistent communication within and external to the profession of the presentation of credentials and letter designations, the association shall recognize the following preferred order:

1. PT/PTA (the regulatory designation)
2. Highest earned physical therapy-related degree
3. Other earned academic degree(s)
4. American Board of Physical Therapy Specialties certification credentials in alphabetical order
5. Other credentials external to APTA
6. Other certification or professional honors (e.g., FAPTA)

All other designations, such as American Board of Physical Therapy Specialties certifications, credentials external to APTA, and other certifications or professional honors, should not use acronyms or abbreviations but should, if used, be written out. In the case of stationary, business cards, signage, advertising, or signature lines, such descriptions should be placed below the line containing the name and letter designations specified in 1 through 3 above. The option shall exist for either writing out Catherine Worthingham Fellow of the American Physical Therapy Association or abbreviating it as FAPTA.

The following examples will serve as style guides:

Tamica Dallas, PT, DPT
Board-Certified Cardiovascular and Pulmonary Clinical Specialist
James Kuta, PT, DPT, PhD
Catherine Worthingham Fellow of the American Physical Therapy Association

Danyelle Newkirk, PT, DPT
Certified Hand Therapist

Seth Coney, PT, DSc
Board-Certified Orthopaedic Clinical Specialist
Fellow of the American Academy of Orthopaedic Manual Physical Therapists

Denna Dilullo, PT, ATC/L, MS
Board-Certified Sports Clinical Specialist
Certified Strength and Conditioning Specialist

APTA supports the designations “SPT” and “SPTA” for physical therapist students and physical therapist assistant students, respectively, up to the time of graduation. Following graduation and prior to licensure or certification, graduates should be designated in accordance with state law. If state law does not stipulate a specific designation, graduates should be designated in a way that clearly identifies that they are not licensed physical therapists or licensed or certified physical therapist assistants.

Proviso: When the intent of RC 9-14 is achieved in any state and a uniform designation of “DPT” is approved by legislative change of a practice act and/or by a licensing authority for all licensed physical therapists in that state, APTA supports the use of the regulatory designation of “DPT.” Such designation denotes the successful completion of professional education and entry-level examination, thus meeting the dual requirements for licensure that assures entry-level competence to practice physical therapy. In this instance, #1 and #2 in the preferred order of letter designations (above) are subsumed in the single designation “DPT” for physical therapists.

Proviso: The American Physical Therapy Association shall incorporate this preferred nomenclature into all relevant documents, publications, and communications as appropriate, and in a manner that is efficient.

SS: From Victor Hugo’s Notre-Dame de Paris, Book 1: Chapter III

Then arrived, two by two, with a gravity which made a contrast in the midst of the frisky ecclesiastical escort of Charles de Bourbon, the eight and forty ambassadors of Maximilian of Austria.... A deep silence settled over the assembly, accompanied by stifled laughter at the preposterous names and all the bourgeoise designations which each of these personages transmitted with imperturbable gravity to the usher, who then tossed names and titles pell-mell and mutilated to the crowd below.

Designations, degrees, certificates – all have a certain purpose: to convey to society that we are qualified and educated in our chosen profession. In the last 30 years we have seen the trend of multiplying such designations to the point where we’ve gone beyond the mark. The average person is no longer confident but confused about our qualifications. It is not uncommon to see 4, 6, even 9 or 10 separate designations following a physical therapist’s name. A good game of Scrabble could begin with some of these letter pairings. “Stifled laughter,” as Hugo wrote, is sometimes heard even among our own colleagues. Scratching of heads occurs among patients as they try to figure out the meaning of some letter combinations representing designations.

Less is more! The profession should confirm the primacy of our regulatory designation and highest professional or clinical degrees, and make such letters as PT, DPT along with well-established terminal academic degrees as among the limited number of letters commonly used behind our names. The motion proposes clearly spelling out the other specialty certifications, honorary titles, or non-APTA certifications that may be important to include. The motion also suggests that we, as professionals, be more discriminating and not include those
certifications that may not be essential (the “bourgeois” as Hugo said), so that our patients or other professional colleagues will clearly understand and have confidence in our most important qualifications.

It is becoming more common to have CE offerings attach a trademarked certification that is associated with new letters to be added behind one’s name. Such non-accredited or even accredited educational offerings should not use letter designations for the intent of conveying legitimacy on the same level as accredited higher education programs. (See Are You Financing a Sham? Jules M. Rothstein, editorial in Physical Therapy, September 2001.)

Opposition to this motion and a revised position may arise from those whose certifications come from a source that uses a more formal credentialing or approval process of the certificate or certification program, such as using the Institute for Credentialing Excellence (ICE) (see http://www.credentialingexcellence.org). One may assert that such a process equates with standards used in determining board specialty certification. The motion’s intent is not to contest such a claim. The motion’s intent is that, for the benefit of public and other professions alike, all certifications be spelled out and not obscured behind letter designations.

A member of our chapter CE Course Review Committee, who has 38 years of experience as a physical therapist and 6 years of service on this committee compiled a 19-page list with descriptions of 110 lettered acronyms, certificates and professional credentials used by course presenter applicants and of which he was NOT familiar as a reviewer. If he was not familiar with these designations imagine what lack of benefit or added confusion might exist for the public.

In public relations the topic of this motion relates to professional “branding.” Take a name with 6 or 7 separate designations following it and compare with any of the style examples above and ask, “Which ‘brand’ is best presented to the public to strengthen the understanding and appreciation of the qualifications of each one of us, and also of the entire physical therapy profession?” Spelling out board specialty certifications will go so much further in public education and in educating other health professionals about our qualifications rather than just using the letters CCS, ECS, GCS, NCS, etc., etc. This motion encourages replacing such letter designations in favor of writing them out clearly after or below one’s name.

This branding will become even more effective when, presumably by 2025, we only use a single designation, “DPT,” to convey both licensure designation and degree as with MD, DO, DPM, DDS and other doctoring professions.

Other internal documents or guidelines may need to be amended as well to conform if this position is so amended, such as the ABPTS Guidelines on the Use of Specialty Designations. (See http://www.abpts.org/uploadedFiles/ABPTSorg/For_Specialists/Marketing/ABPTSGuidelinesOnUseOfSpecialtyDesignations.pdf#search=%22PTA specialty recognition%22).

Two companion motions propose (a) an internal campaign to encourage compliance in use of and display of professional credentials, and (b) a public relations focus to strengthen awareness by the public and other health care professionals about the growing number of physical therapists who are board certified clinical specialists.

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:

CONSUMER PROTECTION THROUGH LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

(HOD P06-14-08-18)

RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:

NONE

OTHER RELATED DOCUMENTS:

ABPTS GUIDELINES ON THE USE OF SPECIALTY DESIGNATIONS
Required for Adoption: Majority Vote

Category: 7

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PROPOSED BY: ARIZONA CHAPTER

COSPONSORED BY: WASHINGTON CHAPTER

RC 5-16 CHARGE: EDUCATIONAL CAMPAIGN REGARDING DESIGNATIONS

That the American Physical Therapy Association implement a campaign throughout the profession to
encourage compliance with the newly adopted language and style changes in state regulatory and other
designations as adopted in RC 4-16 Amend: Consumer Protection Through Licensure of Physical Therapists
and Physical Therapist Assistants (HOD P06-14-08-18).

SS: (Also see support statement for RC 4-16.)

This separate motion directs the American Physical Therapy Association (APTA) to raise the awareness
throughout its membership of this change in the preferred style of displaying professional credentials, degrees
and other certifications. Consistency in how APTA maintains this standard in its own publications and
communications will be an important first step, and that is accomplished with the Proviso in RC 4-16. This
motion takes it a step further to actively encourage a cultural shift in how we display credentials. A “Style Guide”
might be published and disseminated for achieving a uniform “brand.” Such a guide might include
recommendations for various media to include printed promotional material (i.e. business cards, letterhead,
door signage, referral pads), websites and online descriptions, and for use in medical records.

Here are style examples also used in RC 4-16:

Tamica Dallas, PT, DPT
Board-Certified Cardiovascular and Pulmonary Clinical Specialist

James Kuta, PT, DPT, PhD
Catherine Worthingham Fellow of the American Physical Therapy Association

Danyelle Newkirk, PT, DPT
Certified Hand Therapist

Seth Coney, PT, DSc
Board-Certified Orthopaedic Clinical Specialist
Fellow of the American Academy of Orthopaedic Manual Physical Therapists

Denna Dilullo, PT, ATC/L, MS
Board-Certified Sports Clinical Specialist
Certified Strength and Conditioning Specialist
CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
CONSUMER PROTECTION THROUGH LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS (HOD P06-14-08-18)

RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
ABPTS GUIDELINES ON THE USE OF SPECIALTY DESIGNATIONS
PROPOSED BY: ARIZONA CHAPTER

COSPONSORED BY:

RC 6-16 CHARGE: RECOGNITION OF BOARD CERTIFICATION BY AMERICAN BOARD OF PHYSICAL THERAPY SPECIALTIES

That the American Physical Therapy Association develop and implement strategies that promote the recognition and understanding by consumers, the health care community, and others of the services provided by physical therapists who are certified by the American Board of Physical Therapy Specialties in 1 or more of the specialty areas of practice.

SS: 2016 is the 40\textsuperscript{th} anniversary of the House of Delegates adopting support for the concept of clinical specialties in physical therapy. American Board of Physical Therapy Specialties (ABPTS) currently lists over 18,000 physical therapists as having been certified across eight different clinical specialties since 1985. However, how widely known is this fact by the public or by colleagues in other health care disciplines? For that matter, how attuned is our own profession to the availability of this specialty resource within and between our own colleagues, and to the practice of referral to or consultation with specialty providers within our own profession?

See also the support statement for RC 4-16.

In the House of Delegates position statement, Clinical Specialization in Physical Therapy (HOD P06-06-22-15), it identifies five “purposes of the APTA’s Clinical Specialization Program...” One of these includes:

“Assist consumers, the health care community, and others in identifying certified clinical specialists in each specialty area.”

This motion speaks to the means for achieving this end, primarily because we feel association efforts to date have been inadequate. We can and should do more.

Upon certification, ABPTS provides a packet or list of resources for individual physical therapists so they can “spread the word”? Do we know how effective this has been in general public and professional awareness? The 2015 annual report of ABPTS to the House of Delegates also mentioned that “promotion” included press releases sent to major media and health related associations publicizing the 2014 certified specialists. Do we have any metrics that demonstrate the effectiveness of personal or ABPTS efforts toward promotion and awareness?

Recently, four Arizona physical therapist colleagues in one practice went to lunch with a fairly new podiatric surgeon in their area. The podiatrist asked the question: “Tell me the most common diagnoses that other podiatrists refer to you for your services?” During the follow-up discussion, the therapists shared the fact that 3 of the 4 were board certified specialists, 2 in orthopedics, and 1 in geriatric clinical practice. The podiatrist admitted that he had no prior awareness that such specialties existed or that board certification existed in physical therapy. As makers of this motion, we are unaware of how widely known or unknown this information is within the healthcare community about board specialty certification for physical therapists, but we suspect it is not widely known.
Important questions to consider and that may require APTA research as a preliminary step before developing an overall strategy may include:

1. How informed is the public and other health care disciplines regarding ABPTS board certification in physical therapist specialties?
2. What is the influence of board specialty certification on the public in selecting a physical therapist for their services or for referrals from other providers?
3. What is the frequency of referral from or consultation between board certified physical therapist specialists and physical therapists who are not so certified?

The APTA Strategic Plan for Public Relations and Advertising 2005-2010 is a Board document that appears outdated, particularly as it relates to the new APTA Vision Statement and Guiding Principles to Achieve the Vision. If and when updated, or in other public relations planning, it may be appropriate to consider this motion’s intent within the context of overall public relations about the entire physical therapy profession. This motion particularly relates to the APTA new vision’s Guiding Principles “Identity” and “Collaboration” but touches on several others.

A graphic model of physical therapist decision making related to other providers is now part of the Guide to Physical Therapist Practice version 3.0 (see http://guidetoptpractice.apta.org/content/1/SEC2.body or below for Figure 2.1 from the Guide). The first provider listed in the boxes related to “Refer” and “Consult” is another physical therapist. When this model was constructed the primary reason for these referrals or consultations to another physical therapist related to specialty certification and/or expert care. It is one thing to draw this model up and refer to it as the ideal. It is another to make it happen in day-to-day practice and patient care management. We believe that strategies developed as part of this motion should also take this decision-making model into account from Figure 2.1 in the Guide.
Another question to explore is if referral to, consultation with, and co-managing between a physical therapist and another discipline listed in the boxes in Figure 2.1 of the Guide might be enhanced and facilitated where better awareness of board specialty certification or actual specialty practice exists.

There is no timeframe placed on this motion, as we understand this may take years and careful investigation and planning to determine direction and to implement the desired strategies.

**CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**
NONE

**RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**
CLINICAL SPECIALIZATION IN PHYSICAL THERAPY (HOD P06-06-22-15)
ABPTS ANNUAL REPORT TO THE HOUSE OF DELEGATES (HOD Y06-80-08-24)
APTA STRATEGIC PLAN FOR PUBLIC RELATIONS AND ADVERTISING 2005-2010 (BOD 03-05-11-33)

**OTHER RELATED DOCUMENTS:**
GUIDE TO PHYSICAL THERAPIST PRACTICE 3.0, PRINCIPLES OF PHYSICAL THERAPIST PATIENT AND CLIENT MANAGEMENT, INTRODUCTION
PROPOSED BY: BOARD OF DIRECTORS

COSPONSORED BY:

RC 7-16 ADOPT: DEFINITION OF PROFESSIONAL SCOPE OF PRACTICE

That the following be adopted:

DEFINITION OF PROFESSIONAL SCOPE OF PRACTICE

The professional scope of physical therapist practice, based upon a distinct body of knowledge of the human movement system, is the examination of, evaluation of, diagnosis of, prognosis of, and interventions for individuals, and engagement with communities and populations, to optimize health. This scope is grounded in contemporary education, best available evidence, and ethical conduct. Dynamic in nature, it is responsive to innovation and collaboration, thereby transforming practice, policy, and society.

GUIDING PRINCIPLES:

Professional scope of physical therapist practice:

- is supported by education and evidence
- encompasses jurisdictional and personal scopes of practice
- is broad enough to stimulate or allow for innovation
- encompasses interprofessional collaboration
- is open to innovative or evolving models of care and/or service delivery throughout the lifespan
- is patient- or client-centric
- is not to be a list of activities
- overlaps with some components of other health professions’ scope of practice
- is grounded in the human movement system
- is dynamic and responsive to changes in the literature and societal needs
- shapes the future of practice and policy (eg, professional, legislative, regulatory, health, environmental, administrative)
- is consistent with the International Classification of Functioning, Disability, and Health
- is consistent with the Guide to Physical Therapist Practice definition of “management”
- is consistent with the Code of Ethics for the Physical Therapist and Standards of Practice for Physical Therapy

SS: The development and language being brought to the House of Delegates (House) to define the physical therapist’s professional scope of practice and its Guiding Principles has been a work in progress for over 2-1/2 years. It took 2 task forces, multiple meetings, conference calls and multiple Board of Directors’ meetings to bring to the House a definition that no longer identifies physical therapists based on a list of treatments and services; but rather, a definition that recognizes the House new Vision and professional judgment required in today’s practice. Understanding how this final definition and guiding principles were crafted should assist in the delegates’ discussions and deliberations.
In 2014, the APTA Board of Directors (Board) appointed a Scope of Practice Task Force (TF) to develop recommendations to the Board on the appropriate role and authority of APTA in decisions on scope of practice in physical therapy as well as recommend a consistent process and criteria to establish current and future physical therapist’s scope of practice. The TF identified and defined 3 components of scope of practice: Jurisdictional, Personal and Professional. The TF also developed a process for APTA to address new and emerging scope of practice issues. The final report of the TF stated that the profession would not be well-served by a definition of professional scope of practice that consisted of a list of activities, which is currently how professional scope of practice is defined. (See BOD G02-14-18-12.) Hence, the Board felt the exploration of the definition of the physical therapist’s professional scope of practice was needed and should ultimately be determined by the House. Accordingly, the initial TF had completed its work and was disbanded. Thereafter, the Board appointed another TF to address the need for a definition of the physical therapist’s professional scope of practice.

Based on the recommendations from the initial TF, the Board charged the Professional Scope of Practice TF to:

1. Review the work and recommendations of the previous Scope of Practice TF;
2. Review international physical therapy associations’ definitions of professional scope of practice;
3. Define the physical therapist’s professional scope of practice as a global statement rather than as a list of activities; and
4. Develop recommendations of the definition of the physical therapist’s professional scope of practice for the Board to consider bringing to the 2016 House.

The Professional Scope of Practice TF (PSOP TF) worked on the definition and guiding principles to reflect current physical therapist’s practice as well as a definition that would allow for advances in research and ongoing innovation in practice. This work was accomplished through 1 face to face meeting and several conference calls as well as email dialogues. In June 2015, the PSOP TF provided the Board a draft definition and draft guiding principles for review and approval. At this point the Board wanted member feedback about the proposed drafts.

As a result, the Board’s approved draft definition and draft guiding principles were provided to APTA members for comment in a survey from 8/25/15 – 9/11/15. To help heighten awareness about the desired member feedback, announcements about the survey and need for member feedback were sent to Component Leaders as an alert requesting their assistance to facilitate members to take the survey. Fifty-two (52) responses were received; 30 of the respondents indicated agreement with the definition; 21 did not agree with the definition; 1 abstained. The results and comments were reviewed, discussed and the PSOP TF determined that no changes to the definition were necessary as all comments’ subject areas had been previously debated and vetted within the TF. The TF did modify the guiding principles based on the survey feedback.

In November 2015, the PSOP TF report was presented to the Board. The report included the proposed definition and guiding principles. The Board deliberated, discussed and amended the language of the definition to reflect some of the comments received from the survey. Thereafter, the Board approved the physical therapist’s professional scope of practice definition as amended and the Guiding Principles. After approval, this definition and guiding principles were posted to the House Hub for Motion Discussions and is being brought forward by the Board for the House consideration.

It is imperative to understand that each of the words were carefully chosen by the PSOP TF and Board. The PSOP TF built on the Vision that includes “the movement system as the foundation for optimizing movement to improve the health of society”; and that the “movement system is the core of physical therapist practice, education and research.” It was equally important to include the components of patient or client management as outlined in the Guide to Physical Therapist Practice and emphasize the fact that diagnosis is a critical component in physical therapist practice. It was also imperative to include that physical therapists not only provide care for individuals, but are also involved with communities and in optimizing the health of populations in order to transform society. Because the physical therapist’s scope evolves and changes as well as the physical therapist’s education based on current evidence, it was critical to emphasize that the scope is grounded in contemporary education. The TF did not want the definition to paint the profession into a corner as the physical therapist’s profession evolves in the...
future. Consequently, defining the professional scope of practice broadly and all-encompassing eliminates being
defined by treatments or services, which allows for evolution and innovation as the profession continues to
expand and grow.

**CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**
NONE

**RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**
GUIDELINES: PHYSICAL THERAPIST SCOPE OF PRACTICE (BOD G02-14-18-12)
Required for Adoption: Majority Vote  
Category: 7

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PROPOSED BY: BOARD OF DIRECTORS

COSPONSORED BY: ARIZONA, GEORGIA, KANSAS, LOUISIANA, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, NEBRASKA, NEW HAMPSHIRE, OREGON, VERMONT, WASHINGTON, WISCONSIN CHAPTERS; AQUATIC, CARDIOVASCULAR AND PULMONARY, CLINICAL ELECTROPHYSIOLOGY AND WOUND MANAGEMENT, GERIATRIC, HAND REHABILITATION, HEALTH POLICY ADMINISTRATION, ONCOLOGY, ORTHOPAEDIC, PEDIATRIC SECTIONS

RC 8-16 ADOPT: ONCOLOGIC PHYSICAL THERAPY AS AN AREA OF SPECIALIZATION

(Note: This is a motion with 2 conforming amendments - Parts A and B.)

That oncologic physical therapy be approved as an area of specialization, and that it be added as an approved specialty area to Clinical Specialization in Physical Therapy (HOD 06-06-22-15).

PART A

That oncologic physical therapy be approved as an area of specialization through the American Board of Physical Therapy Specialties.

PART B

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

That Clinical Specialization in Physical Therapy (HOD P06-06-22-15) be amended by adding the new specialty area of oncologic physical therapy, so that it would read:

* * * *

Criteria for establishment of a new specialty area are established by the American Board of Physical Therapy Specialties and guide the development of all new specialty areas. The APTA House of Delegates approves all new specialty areas. The approved specialty areas are:

Cardiovascular and Pulmonary Physical Therapy 1981
Clinical Electrophysiologic Physical Therapy 1982
Geriatric Physical Therapy 1989
Neurologic Physical Therapy 1982
Orthopaedic Physical Therapy 1981
Pediatric Physical Therapy 1981
Sports Physical Therapy 1981
Women’s Health Physical Therapy 2006
Oncologic Physical Therapy 2016

* * *
SS: Per Clinical Specialization in Physical Therapy (HOD 06-06-22-15), the APTA House of Delegates approves all new specialty areas. The petition submitted by the Section on Oncology meets all the criteria and requirements for recognition as a specialized area of physical therapy practice as stated in the Policies and Procedures of the American Board of Physical Therapy Specialties. Therefore, the American Board of Physical Therapy Specialties (ABPTS) recommends that oncology be established as a specialty area for certification.

The ABPTS granted preliminary approval in December 2015 to the petition submitted by the Section on Oncology for recognition as a specialty area for certification. The ABPTS then issued a call for comment in support or opposition to the petition to provide an opportunity for physical therapists to communicate their opinion about the petition to the ABPTS. The responses received were in support of the petition. Additionally, an open hearing was held at the 2016 Combined Sections Meeting to allow oral or written testimony either in support of or in opposition to the petition. The testimony was overwhelmingly in favor of the petition and recognition of oncology as a specialty area. Following the open hearing, the ABPTS evaluated information gathered in response to the call for comment and the public hearing and voted unanimously to recommend approval of oncology as a specialty area for certification.

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
CLINICAL SPECIALIZATION IN PHYSICAL THERAPY (HOD P06-06-22-15)

RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
NONE
Required for Adoption: Majority Vote

Category: 7

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PROPOSED BY: GEORGIA AND COLORADO CHAPTERS

COSPONSORED BY:

RC 9-16 CHARGE: ANALYSIS OF AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP
EDUCATION STRUCTURE, FUNCTION, AND ACCREDITATION PROCESS

That the American Physical Therapy Association conduct an analysis of the structure, function, and accreditation process of the American Board of Physical Therapy Residency and Fellowship Education, to determine whether the current structure, function, and process used are supporting or impeding the growth and development of quality residency and fellowship programs, and develop a plan to support the growth and development of new and existing residency and fellowship programs for advanced clinical training.

SS: The American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE) was created by the American Physical Therapy Association (APTA) Board of Directors (Board) to facilitate the credentialing process of residency and fellowship education for advanced clinical training. In 2013, a decision was made to shift from credentialing to accreditation, as this seemed more appropriate to the mission of the ABPTRFE. In 2013, all programs were notified that they were to utilize the accredited designation versus the credentialed designation.

Since that time, the overall residency/fellowship accreditation process has evolved into a burdensome process that has significantly impacted the growth and development of new and existing programs. Accreditation of post-professional programs should support and encourage ongoing development of physical therapist practice as postprofessional education helps advance physical therapist practice. In seeking broad review from those who would be most affected by the current accreditation process, a survey was conducted in January 2016, which included orthopedic residency program directors, and OMPT and spine fellowship program directors. This survey included assessment of most of the evaluative criteria required of programs, ABPTRFE processes, site reviewers, and APTA staff customer service to members. This survey was developed and distributed by the Orthopaedic Section and the Georgia Chapter. An individual who conducts survey research and not involved with residency/fellowship programs analyzed the data to prevent bias. Unfortunately, the data are only representative of Orthopaedic residency programs and Orthopaedic Manual Physical Therapy (OMPT) and Spine fellowship programs.

The survey results showed areas where ABPTRFE is doing well and areas that need immediate attention to support the growth and development of new programs, and maintenance of accreditation of existing programs. The survey response was 54% (53/91) of orthopaedic residency program directors, 85% (22/26) OMPT fellowship directors, and 100% (2/2) spine fellowship directors. The accreditation process and requirements were reported as overly burdensome among 65% of the program directors. There were 25% of programs that will not be seeking re-accreditation and 33% of programs not considering the addition of new programs. There are also 30% of program directors considering other avenues for accreditation of their programs. The current accreditation process was viewed as a hindrance and detrimental to innovation. The training for residents and fellows was viewed to be mutually exclusive by 90% of program directors and the accreditation evaluative criteria should reflect this. An overwhelming majority of respondents (60%) would like the Orthopaedic Section to investigate the feasibility of developing an accreditation process for orthopaedic residency programs.
There has been a significant reduction in program development in the past two years. Currently there are four acute care, three faculty development, 4 geriatric, 14 neurologic, 15 orthopaedic, 5 pediatric, 14 sports, 1 cardiovascular pulmonary, and 3 woman’s health programs seeking accreditation in development or candidacy status. Most of these programs will accommodate 1-2 residents. The addition of these programs to all existing programs will roughly accommodate .04% of new DPT graduates seeking postprofessional clinical training.

There is one neonatology fellowship program in candidacy status, and six OMPT, one performing arts, two spine, and one division 1 sports fellowship programs in development. The lack of fellowship program development is a major concern for advancing physical therapist practice. Also, in October 2013, a memorandum of understanding agreement was enacted between American Academy of Orthopaedic Manual Physical Therapists (AAOMPT), APTA and ABPTRFE which shifted the guidelines for educational standards from AAOMPT to the International Federation of Orthopaedic Physical Therapists (IFOMPT) standards. This shift in process has removed lines of communication from the FOMPT program directors for OMPT development in the USA.

We have implemented burdensome requirements and increased confusion for advanced clinical training programs. Further, every physical therapist involved in post-graduate residency/fellowship training is already licensed to practice, and is practicing under rigid state board authority demanding ethical and professional practice. These facts are overlooked in regards to the oversight necessary to ensure accuracy in reporting for residency/fellowship training. Undermining a basic level of trust of the process in which these individuals are involved.

To achieve our vision we must transform the association especially in efforts for advanced clinical training that ultimately affect physical therapist practice. We have arrived at a tipping point in the future of residency and fellowship training. We must take this opportunity to evaluate and implement necessary changes so that all physical therapists have an opportunity to seek out residency and/or fellowship training programs.

**CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**

NONE

**RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**

GUIDELINES: AMERICAN BOARD OF PHYSICAL THERAPY RESIDENCY AND FELLOWSHIP EDUCATION (BOD G09-15-02-04)
PROPOSED BY: MASSACHUSETTS CHAPTER

COSPONSORED BY: ONCOLOGY SECTION

RC 10-16 CHARGE: ACCURATE REPRESENTATION OF PHYSICAL THERAPIST PRACTICE AND RESEARCH

That the American Physical Therapy Association pursue strategies to ensure research publications, clinical practice guidelines, and payment or other practice policies accurately reflect the available evidence and do not represent physical therapist practice or research as a single or limited set of interventions.

SS: Physical therapy is a profession, not an intervention or a limited set of interventions. It is not uncommon for research studies to state conclusions about the entirety of physical therapist practice based on a limited set of interventions which typically do not represent all of the appropriate interventions nor the meaningful interaction with a physical therapist for the clinical presentation in question. Guidelines are developed based on such unsupported and overly broad conclusions by researchers which then negatively impact physical therapists' ability to provide and/or be paid for patient care covered by such guidelines.

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
NONE

RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
PREFERRED NOMENCLATURE FOR THE PROVISION OF PHYSICAL THERAPY (HOD P06-13-25-20)
PROPOSED BY: OREGON CHAPTER

COSPONSORED BY: GEORGIA, MARYLAND, MISSISSIPPI, MISSOURI, NEW MEXICO, TEXAS CHAPTERS; ONCOLOGY, PEDIATRICS SECTIONS

RC 11-16 CHARGE: INVESTIGATION AND PLAN TO ADDRESS STUDENT DEBT IN PHYSICAL THERAPY

That the American Physical Therapy Association investigate the effect of student loan debt upon the physical therapy profession, and develop and implement a plan with feasible options to address it, by June 2018.

SS: The overarching goals of this motion are to better understand the effect of student debt on the profession, the association, and, ultimately, society, and to take steps to ameliorate that effect.

Many of our new graduates, as well as current and future students, are walking into a world of insurmountable debt as they begin practice as a physical therapist or physical therapist assistant. This may threaten both our profession and our association. When debt levels become unsustainable and the debt-to-income ratio to become a physical therapist becomes excessive, we risk losing young minds to other professions. For those who do become physical therapists, monthly loan payments that equal a mortgage payment will increasingly impel them to forego association membership while they work to make ends meet. Debt also affects the physical therapists’ ability to enroll in post-professional programs, such as residencies and fellowships.

To fulfill the goals of this motion, we first need to determine the nature and scope of the problem. Debt on its own is not necessarily a problem and may even be a wise investment. At this point, however, we do not know whether or not this is the case for members of our profession. The last APTA survey conducted to investigate student loan debt burden occurred in 2007, with no known tangible action taken as a result of the survey, and no follow-up survey completed or planned at this point.

There are many unanswered questions about how student debt affects our profession. What is the impact on the size and characteristics of the applicant pools to education programs, from the physical therapist assistant to post-professional levels? How might this affect our ability to serve diverse populations? Does the increased cost of education favor blended learning curricular designs and, if so, is this a positive factor? Are new graduates seeking initial employment positions based upon financial considerations rather than career enhancement and skills development, as some evidence indicates? How does student debt affect the choice to pursue post-professional PhD education, needed to train physical therapist educators and researchers? We need to know where the physical therapy profession stands compared to the other healthcare professions as we compete to recruit future colleagues, and we would be wise to track this trend over time. We must also learn how the debt-to-income burden to become a physical therapist or physical therapist assistant impacts the future workforce and our ability to meet society’s physical therapy needs. Finally, we need to understand how a rising debt-to-income ratio impacts an individual’s decision to maintain membership in our association.

Research conducted to draft this motion suggests that certain actions can be taken now by the APTA. For example, the webpage under Debt Management Resources at the APTA website contained documents that were either dated, duplicative, or with links that were no longer active (see http://www.apta.org/DebtManagement/). Subsequently, these have been fixed thanks to the work of APTA staff. It would not require extensive resources in time or funds to continue to update this webpage with
currently available resources to help students and new graduates with student debt as well as with updates on related legislation and policies to more clearly guide students in loan management. This motion also requests that the APTA use the information learned in the investigation stage to provide recommendations for additional action to mitigate threats facing our profession and association related to student loan debt. This type of work involves many internal and external stakeholders, and a plan that considers many relevant factors will be needed to deliver meaningful end results. A landscape analysis could be conducted to identify the individuals, groups, and other entities with the ability to influence the student loan debt equation, and a well-crafted strategy and action plan will engage each of these stakeholders in the solution. A situation this complex requires the leadership and guidance of the APTA. APTA is the one organization positioned to foster involvement of a wide variety of influential stakeholders to assist in orchestrating a plan for the greater good of the physical therapy profession.

Although student loan debt can seem like an overwhelming issue, the good news is that the APTA can expand upon strategies used by other professional associations, optimizing them for the physical therapy profession, in four main areas: 1) education, 2) loan refinancing, 3) scholarship, and 4) advocacy. A few examples with possible actions follow:

**Education**: The American Association of Medical Colleges (AAMC) established a partnership with SALT, a program of the non-profit organization American Student Assistance to help the members of the academic medicine community across the United States and Canada strengthen their financial literacy and money management skills. Under a three-year agreement announced in January 2015, the AAMC will provide SALT’s financial education resources to medical students and residents represented by its member medical schools and teaching hospitals, as well as to the faculty and staff who advise medical students.

Possible action: ACAPT or another similar organization could provide financial literacy and money management skills to prospective and current physical therapy students and new professionals to aid in decision making around student loan debt.

**Loan refinancing**: The American Dental Association (ADA) partnered with DRB to allow dental students to receive preferred student loan refinancing rates. For the best qualified borrowers, DRB’s rates for refinancing existing federal and private undergraduate and graduate school loans currently starts at 1.90 percent APR for variable loans; 3.50 percent APR fixed. In addition, through the endorsement, qualifying ADA members receive an additional 0.25 percent rate reduction as a membership benefit. Many times, endorsed vendors will compensate the endorsing organization. However, the compensation resulting from the DRB endorsement will be given to the ADA members in the form of the additional 0.25 percent discount in the loan rate. DRB is the preferred provider of student loan refinancing for the ADA.

Possible action: APTA could partner with a lending organization to offer an attractive new member benefit to new professionals with student loan debt who maintain membership in our organization.

**Scholarship**: The American Chiropractic Association (ACA) offers the American Chiropractic Foundation Endowment Fund to “ensure that chiropractic education is made available to many people who cannot afford it, and that high-level research at colleges and universities is not stymied for lack of funds.”

Possible action: The Foundation for Physical Therapy or another similar organization could establish an endowment funded by individuals and groups to support scholarships and loan forgiveness for well-qualified physical therapy students and new professionals. Although this is not within the current mission of the Foundation, initial communication with the Foundation on this indicates it is willing to consider this.

**Advocacy**: The American Medical Student Association (AMSA) has developed strategic alliances with multiple organizations, including the National Association of Graduate- Professional Students (NAGPS), the National Student Nursing Association (NSNA), the American Student Dental Association (ASDA), and the American
Association of Medical Colleges (AAMC), to collectively monitor and take action on student loan debt issues impacting their members. Their current area of focus is on the Higher Education Act Reauthorization.

Possible action: Our Student Assembly and other new professional and student-focused special interest groups could increase their power to impact state and national student loan debt legislation by intentionally aligning with an increased breadth of allies to significantly increase the number of individuals and voices working in ways that will benefit physical therapy.

The motion makers believe that the best solutions will emerge from a workgroup or task force charged with creating a comprehensive plan, and we anticipate a combination of simple and complex recommendations will emerge in that process. Solutions may range from simple efforts within our direct control, such as better coordination within the association to promote the efforts already underway such as the scholarship opportunities and debt management resources, to more complex efforts such as collaboration with external groups like lenders and policymakers to improve the financial outlook for many of our members. We believe that finding shared interests among stakeholders will reveal innovative ways for us to begin and ultimately accomplish the goal of this motion. The actions listed above, already undertaken by other professional associations, demonstrate that it is possible for APTA to work with others to accomplish tangible change.

The timeline proposed in this motion is intended to provide adequate time for APTA leaders to prioritize and budget necessary resources to thoroughly investigate the situation, begin to enact a plan to address the debt burden, and establish measures of success for this effort. Measures that may demonstrate success for this motion include, but are not limited to, a debt-to-income ratio for the average physical therapist that stabilizes or improves over time, availability of lower interest loan refinancing, a debt-to-income ratio for the profession as a whole that is comparable to or more attractive than that of other doctoring professions, a rise in membership retention levels for new graduates, and a better outlook for quality of life reported by new professionals.

The time for action is now. Each year that passes increases the number of individuals in our profession affected by student loan debt. The House of Delegates elevated our profession to the level of doctor to optimize our expertise and our utility to society. It is now time for us to make that plan sustainable by protecting the future of our profession.

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
NONE

RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
NONE
PROPOSED BY: ORTHOPAEDIC SECTION

COSPONSORED BY: ARIZONA CHAPTER

RC 12-16 CHARGE: PLAN FOR ACHIEVING PRACTICE AUTHORITY AND PAYMENT FOR ORDERING AND PERFORMING IMAGING STUDIES

That the American Physical Therapy Association develop and implement a plan to achieve practice authority for ordering and performing imaging studies across practice settings. The plan will include but not be limited to:

- obtaining payment for physical therapists performing imaging
- identifying and pursuing CPT code and relative value changes to reflect imaging procedures performed or ordered by physical therapists
- strategies to engage with outside organizations that influence physical therapists’ ability to order, perform, and receive payment for imaging procedures such as professional societies, and government agencies, all major payers, and policy organizations

SS: Currently performing imaging in physical therapy practice pertains to ultrasound imaging. A search did not find physical therapists performing other types of imaging. The motion allows for physical therapists to perform other types of imaging in the future if education, practice, and research supports such activity.

The ability of Physical Therapists (PTs) to refer for diagnostic imaging has been in existence for decades. An obvious example is the U.S. military, where, since 1972, PTs practice as direct access providers with imaging privileges. This model is not solely within the military; as other government agencies have adopted this model. PTs in the Public Health Service, Indian Health Service, the Veterans Administration Health System, and the Bureau of Prisons now have imaging privileges. Additionally, in the civilian sector PTs have imaging privileges in some hospitals, and outpatient clinics.

House of Delegates policy articulates the physical therapist’s role in imaging. The policy Diagnosis by Physical Therapists HOD P06-12-10-09 contains the following relevant language. When indicated, physical therapists order appropriate tests, including but not limited to imaging and other studies, that are performed and interpreted by other health professionals. Physical therapists may also perform or interpret selected imaging or other studies.

The Federation of State Boards of Physical Therapy published a resource paper in 2010 on Rehabilitative Ultrasound Imaging which concludes in part, “...there is a historical basis, available education and training as well as an educational foundation in the CAPTE criteria, and supportive scientific evidence for including rehabilitative ultrasound imaging in the scope of practice of physical therapist, ... [T]he appropriate machine settings and the ability to differentiate structures and comprehend the images obtained during rehabilitative ultrasound imaging, at this time, are not entry level skills and should require additional training.” The terminology of “rehabilitative ultrasound imaging” has been used to describe ultrasound imaging used by physical therapists. This terminology is not recommended at this time.
In 2009, the American Academy of Orthopaedic Manual Physical Therapists adopted the position statement, “It is the position of the AAOMPT that ultrasound imaging is within the scope of physical therapist practice.”

Recently PT use of imaging and recognition of imaging in physical therapy practice has been challenged in Wisconsin. An amendment to the statutes relating to the use of diagnostic x-ray equipment by radiography examining board licensees and permit holders included a list of practitioners from whom they could take orders. PTs were excluded from that list. This amendment superseded a previously received legal opinion from the WI state department of regulation and licensure to the WPTA, that had allowed PTs to directly refer patients to radiology departments for x-ray imaging. The American Registry of Diagnostic Medical Sonography (ARDMS) offers two qualifications for musculoskeletal (MSK) ultrasound, one for physicians, and one for sonographers. Initially PTs were qualified to sit for the physician credential. Recently the ARDMS reclassified PTs as sonographers for the MSK sonography credential. Successful advocacy by the Orthopaedic Section and its Imaging Special Interest Group resulted in the ARDMS maintaining PTs in the full MSK physician ultrasound credential.¹

The use of imaging by PTs has grown considerably over the years and will be more important in the future. To optimize efficiency of patient management particularly in first contact settings the ability to order/perform imaging is important. If PTs do not order/perform imaging in first contact settings then they must refer to another practitioner, often solely to order the study. This incurs added costs, delays definitive management, and is suboptimal.² An inability to order imaging reduces the value of PTs as first contact providers. Advances in technology have seen ultrasound imaging move from the radiology department to the point-of-care where it is used by many medical specialties including PTs with great results.

No data exists quantifying payment for performing and/or interpreting imaging by PTs. Anecdotal information suggests payment is spotty and some payment may occur without the payer realizing the provider is a PT. Many payers including Medicare preclude PTs from being paid for performing and/or interpreting ultrasound imaging. APTA recently formed a work group on imaging which has now been transitioned to the Imaging Special Interest Group (ISIG) Orthopaedic Section. The ISIG is developing a white paper that will outline the practice and payment landscape for imaging in PT practice. Imaging is not the sole domain of orthopaedic practice. Imaging is within all specialty areas of practice. Addressing practice and payment for imaging requires a profession-wide approach. Given recent threats to PTs utilizing imaging, being recognized as qualified; and the growing use of imaging in PT practice with advances in research, technology, and innovative service delivery models, it is prudent for the APTA to adopt and implement a plan on imaging in physical therapy practice and payment.

References:
1. Musculoskeletal (MSK Sonography) Prerequisite. American Registry for Diagnostic Medical Sonography [http://www.ardms.org/Prerequisite%20Charts/RMSK%20Prerequisites%202015.pdf](http://www.ardms.org/Prerequisite%20Charts/RMSK%20Prerequisites%202015.pdf)

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE: NONE

RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
DIAGNOSIS BY PHYSICAL THERAPISTS (HOD P06-12-10-09)
DELIVERY OF VALUE-BASED PHYSICAL THERAPIST SERVICES (HOD P06-15-17-09)
PHYSICAL THERAPY IN THE EMERGENCY CARE ENVIRONMENT (HOD P06-08-18-12)
REFORMING PAYMENT FOR OUTPATIENT PHYSICAL THERAPY SERVICES (BOD P03-11-04-09)
PUBLIC POLICY EFFORTS TO IMPROVE CONSUMER ACCESS TO PHYSICAL THERAPISTS (HOD P06-13-24-17)
AUTONOMOUS PHYSICAL THERAPIST PRACTICE: DEFINITIONS AND PRIVILEGES (BOD P03-03-12-28)
DELIVERY OF VALUE-BASED PHYSICAL THERAPIST SERVICES (HOD P06-15-17-09)
PROPOSED BY: BOARD OF DIRECTORS

COSPONSORED BY: MASSACHUSETTS CHAPTER

RC 13-16: ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION:
RICHARD L. LIEBER, PHD

Whereas, Richard L. Lieber, PhD, has made significant contributions to the science and practice of physical therapy;

Whereas, Richard L. Lieber, PhD, is a distinguished scientist who is recognized nationally and internationally for his ground-breaking research in the areas of muscle physiology and mechanics;

Whereas, Richard L. Lieber, PhD, has fundamentally shaped the practice of physical therapy through his research related to skeletal muscle architecture, injury, and repair;

Whereas, Richard L. Lieber, PhD, has authored 217 primary manuscripts, 40 peer-reviewed reviews, 30 book chapters, and 3 editions of his classic textbook on muscle physiology, *Skeletal Muscle Structure, Function, and Plasticity*;

Whereas, Richard L. Lieber, PhD, has a 30-year history of collaborating with physical therapists, and has provided direct mentorship of many of our profession’s top scientists; and,

Whereas, Richard L. Lieber, PhD, has a deep understanding and appreciation of clinical questions related to rehabilitation and has been a friend to the profession of physical therapy throughout his career;

Resolved, That Richard L. Lieber, PhD, be elected as an Honorary Member of the American Physical Therapy Association.

SS: Richard L. Lieber, PhD, is a distinguished scholar who is recognized nationally and internationally for his important research and teaching contributions in biomechanics, muscle physiology, orthopaedic science, and physical therapy. He has contributed to the profession through regular presentations at California and national physical therapy meetings and has a 30-year history of collaborating with physical therapists. He has made several major contributions to physical therapy and rehabilitation science, including the characterization of muscle architecture, laser diffraction technique, discovery of mechanisms of muscle injury, and the characterization of muscle remodeling. He is a prolific author, including authoring 217 primary manuscripts, 40 peer-reviewed reviews, 30 book chapters, and 3 editions of his textbook, *Skeletal Muscle Structure, Function, and Plasticity*. He was awarded a 7-year Senior Research Career Scientist grant from the Department of Veterans Affairs and he successfully administered 2 Center grants from the National Institutes of Health, which have directly impacted the trajectory of rehabilitation basic science. He serves as a reviewer and is on several Editorial Boards, including *Journal of Biomechanics*, *Journal of Orthopaedic Research* and the *Brazilian Journal of Physical Therapy*. Finally, he has recently become Chief Scientific Officer and Senior Vice President at the Rehabilitation Institute of Chicago, and remains active in APTA events.
PROPOSED BY: ARIZONA CHAPTER

COSPONSORED BY:

RC 14-16 ADOPT: CONSIDERATION OF BOARD-ADOPTED POLICY FOR THE PROFESSION

That the following be adopted:

CONSIDERATION OF BOARD-ADOPTED POLICY FOR THE PROFESSION

Consistent with authority specified in the Bylaws of the American Physical Therapy Association for both the House of Delegates (House) and Board of Directors (Board), when the Board adopts a policy that relates to the profession, the Board shall present the document to the House for consideration at the immediately following session of the House. If adopted by the House, it shall become a document of the House.

Proviso: After adoption of this motion, the House officers, in consultation with the Board, shall review all current Board documents, now found at http://www.apta.org/policies/, separating those that are operational and that concern Board, staff, or association operation. All remaining documents that relate to the profession shall be rescinded or presented, with or without amendments, to the House for action no later than 2019. If adopted by the House, they shall become documents of the House.

SS: The intent of this motion is to bring certain policies adopted by the Board of Directors (Board) within the direct realm of authority of the House of Delegates (House). This applies to both future policies adopted by the Board between sessions of the House (body of motion), as well as those previously adopted and residing in the APTA policy booklet (Proviso). The proviso provides a mechanism and timeframe to review and cleanup policies previously adopted by the Board that will include consideration by the House. This motion is largely a housekeeping exercise, but one in which the policy making role of the House and the Board is revisited and clarified going forward.

Certain interpretations apply to this motion and proviso. The use of the term “policy” is in accordance with the authority vested in the bylaws. In addition, the policies for consideration are limited to those that relate to the profession.

The American Physical Therapy Association (APTA) policy creating authority in general resides in the following areas of the Bylaws of the American Physical Therapy Association (bylaws).

Note: Triple asterisks (* * *) indicate language that has not been included in order to make the document more concise.

For the House of Delegates:

ARTICLE VIII. HOUSE OF DELEGATES, Section 1: General Powers
The House of Delegates has authority to determine directives and policies of the Association, to elect the Board of Directors and Nominating Committee; and to:
D. Modify or reverse a decision of the Board of Directors.

For the Board of Directors:

**ARTICLE IX. BOARD OF DIRECTORS, Section 5: Duties**

*B*

B. Between sessions of the House of Delegates, the Board of Directors shall determine the Association's policy, taking into account directives and policies previously passed by the House of Delegates.

This bylaw authority for the Board might be interpreted in different ways. First, for example, could be a conservative interpretation that Board’s authority to “determine” does not mean to create but rather to clarify policy based on previously adopted House positions or actions. A moderate interpretation might be that the Board does indeed have policy-creating authority as long as it is fully consistent with those “policies previously passed by the House of Delegates.” A third and more liberal interpretation may be that the Board is free to develop policy, even new policy, after it has taken into account existing policies.

The Board has occasionally taken the moderate or liberal interpretation. A case in point is the 2014 modification of Guidelines: Physical Therapist Scope of Practice (BOD G02-14-18-12). Herein the Board amended their Guidelines to include “dry needling” as an established intervention within the scope of physical therapist practice. There had been no prior action by the House on this subject but it was important and timely to have this inclusion.

This motion does not challenge the policy-creating role of the Board. It clarifies it by providing a process for what it means to “determine the Association’s policy” and also strengthens the role through the sanctioning imprimatur of the House. Nothing in this motion precludes the Board from taking timely action on any item between sessions of the House.

This motion and proviso will also solve an impediment that the House has had when developing or considering any newly proposed position. In such consideration, it is necessary to consult all policy documents relative to a proposed action, including Board documents. The House traditionally has not directly amended or addressed a Board position. However, it can supersede such a position if an existing Board position is in conflict with a newly adopted House position.

The APTA policy booklet of 686 pages contains approximately 363 unique documents, 156 (43%) of which are labeled as House documents or originating with the House of Delegates, and 207 (57%) labeled as Board documents or originating with the Board of Directors. Of the 207 BOD documents, 87% of these are procedural or relate to the operation of the Board, staff, or APTA as an organization. The remaining 13% of BOD documents (about 27), however, may relate to the entire profession and so the House has an inherent or vested interest in these documents. These documents are the principle focus of the proviso.

The proviso also directs a separation of current Board documents that are operational in nature and relate to Board, staff, or APTA operating issues. These, according to the proviso, will be separated from the APTA Policy Booklet and might likely best be referred to as an “Operations Manual” or some similar appropriate title. The BOD has, and will continue to have, the operating and fiduciary responsibility over the APTA as an organization. The House, through bylaws, grants such authority to the Board. The fact that these operational policies and procedures now exist co-mingled with other professional positions in the APTA Policy Booklet has added to the confusion that this motion is addressing. The House should never micromanage the operations of the Board and APTA. But, it does have a preeminent role in broader professional policy, something that this position will affirm.

So to be clear, here is what will happen if this motion with the proviso is adopted in the 2016 House of Delegates:
1. After the 2016 House, any new policy or position that the Board adopts between sessions of the House that relates to the entire profession becomes, with full authority, the policy or position of the APTA, just as it now occurs. Such documents will be further presented to the House at the next annual session, and, if adopted, will become a document of the House. Of note, since 2012 only 2 new positions have been adopted by the Board, while 2 previously adopted positions were amended by the Board.

2. After the 2016 House, the House officers in consultation with the Board will begin a review process of all existing documents in the APTA policy booklet. Those that are procedural and relate to Board, staff, or APTA operation will be separated from those that relate to the profession and placed in a separate Operations Manual (as suggested above). Over the ensuing 3 years, House officers and the Board will then further have the opportunity to update, amend, consolidate, or delete what have been Board documents related to the profession. Those policies/positions remain in force during this 3-year process just as they are now. At any time during this 3-year process, the Board shall submit the remaining policies to the 2017, 2018, or 2019 House.

Standing Rule 20 relates to the consent calendar of the House, and the first paragraph states “officers of the House of Delegates shall prepare a list of recommended motions that are routine, standard, non-controversial, or self-explanatory and where general approval is anticipated, for placement on the consent calendar.” Some of the affected policies and positions may meet this standard to be placed on the consent calendar and, the makers of the motion will urge, should fit the requirement of “where general approval is anticipated” since they have already been adopted Board policies and in operation for several years. Whether on the consent calendar or not, the House in 2017, 2018, and 2019 will have the opportunity to consider and adopt such motions to create documents of the House.

Here is an example of a Board adopted “position” that might easily transition from a Board document to House document in the next 3 years under the intent of the proviso:

APTA’S PURPOSE AND PRINCIPLES FOR GLOBAL ENGAGEMENT BOD P11-11-02-02

APTA’s Purpose for Global Engagement
As a responsible global citizen and a member of the World Confederation for Physical Therapy (WCPT), the American Physical Therapy Association (APTA) aspires to engage in opportunities and accept the responsibility presented by the current global environment to improve the health and quality of life of individuals in society. Focusing on global issues adds relevance, depth, and breadth to the profession’s and APTA’s goals and enhances the association’s ability to thrive in the 21st Century.

APTA’s Principles for Global Engagement
Consistent with APTA’s purpose and organizational values, engagement opportunities will be approached with respect and sensitivity and APTA’s engagement will:
• be characterized by collaborative partnerships that are reciprocally beneficial
• empower and help to build capacity of all partners
• facilitate the highest standards of education, practice, and research for the profession

3. After the 2019 House, there will be no division of House and Board policies that relate to the profession. Board policies and procedures that are purely operational will reside separately. Delegations considering main motions may consider all policies in the APTA policy booklet as relevant and amendable.

CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:
NONE
RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:

1. BYLAWS, ARTICLE VIII. HOUSE OF DELEGATES, SECTION 1: GENERAL POWERS
2. BYLAWS, ARTICLE IX. BOARD OF DIRECTORS, SECTION 5: DUTIES, B
3. STANDING RULES OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, 20. CONSENT CALENDAR
Required for Adoption: Majority Vote  Category: 8

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PROPOSED BY: MASSACHUSETTS CHAPTER

COSPONSORED BY:

RC 15-16 CHARGE: CREATE AND MAINTAIN A VIRTUAL PHYSICAL THERAPY MUSEUM

That the American Physical Therapy Association (APTA) create a virtual physical therapy museum that will include the origin and continuing evolution of the profession of physical therapy and the APTA, including but not limited to:

- historical and contemporary global physical therapy
- historical and contemporary physical therapy in the United States
- history of APTA
- all components of APTA and other entities such as Commission on Accreditation in Physical Therapy Education and Physical Therapist Assistant Caucus
- lectures such as the Mary McMillan, John H.P. Maley, and Pauline Cerasoli lectures
- archives such as videos and testimonies of key figures in the physical therapy profession

Steps to be taken shall include:

- incorporation of the virtual physical therapy museum as 1 aspect of the existing APTA integrated communication plan;
- assessment of APTA’s current IT infrastructure capacity in consultation with external contractors as needed for all architectural, engineering, and programming aspects to support the launch and future needs of the physical therapy museum; and
- development of a capital campaign to support the creation and continued maintenance of the physical therapy museum.

This physical therapy museum will be launched at a time to correspond with the centennial celebrations of APTA in 2021. Beyond the launch, the museum will be maintained to remain current and will host temporary exhibits.

SS: Many physical therapy students and practicing physical therapists and physical therapist assistants do not have sufficient knowledge regarding the histories of our physical therapy profession and our APTA. There are many individuals and groups who have authored papers, chapters, books, and presentations regarding the profession of physical therapy and the APTA. These resources, however excellent, are fragmented with regards to access, quality, and purpose. The purpose of this museum is to take current technologies and create a site where students, clinicians, consumers, and other stakeholders could systematically tour the museum’s creative exhibits. This museum is intended to be mostly funded by members or by external companies sponsoring museum wings or exhibits.

The following steps should be considered:

- Assign a project manager to create the museum and to develop strategies for maintaining is currency and contemporary purpose post launch.
• Prepare an RFP and contract a qualified company to develop all the architectural, engineering, and programming aspects of the museum
• Develop capital campaign strategies to obtain funding for the project through pledges and sponsorship by members, external friends, and stakeholders and implement those strategies in a timely manner
• Dedicate sufficient staff, to include a museum curator, to maintain and constantly improve the museum once it has been launched

The targeted museum audience/visitors are physical therapy students, physical therapists and physical therapist assistants, other healthcare professionals, organizations, and the public. The following are potential outcomes associated with visiting the virtual physical therapy museum:
• Visitors would have access to all recent and current information regarding all entities of the APTA.
• Visitors would have access to oral and written histories of the profession of PT and the APTA.
• Visitors would experience a coordinated understanding of global physical therapy.
• Visitors to the museum’s collection would better understand of the depth and breadth of the physical therapy profession and APTA.
• APTA members and non-members would better recognize the value of being a member.
• Historical information will be acquired before it is lost forever.

The following section of the support statement is a rough draft of a conceptual layout of the proposed physical therapy museum. It is a 4-story museum, which houses both permanent and temporary exhibits. It is intended to be a living museum that will provide permanent historical perspectives but be maintained to include contemporary aspects of physical therapy. There will be a central directory with information stations. There will be a virtual library and reading room with different levels of access for members, non-members, and public.

As you look over the floor plan, try to envision the historical and present-day content and technology that could be included in these spaces. The museum would not have to look like this 4-story building, but we need some architectural concept to get us started! Each room, hall, and exhibit will include appropriate links to pertinent information. Again, this is a very rough draft, intended for viewers to start thinking like museum visitors and to think of what the museum should include. The architectural conception is attached.

**CURRENT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**

NONE

**RELATED POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**

PLAN FOR THE PRESERVATION OF ASSOCIATION HISTORY (BOD 03-01-22-73)
Required for Adoption: 2/3 Vote to Consider, 2/3 Vote to Adopt  
Category: 1

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PROPOSED BY: FLORIDA CHAPTER

COSPONSORED BY: ALABAMA, ARIZONA, COLORADO, CONNECTICUT, DELAWARE, DISTRICT OF COLUMBIA,  
GEORGIA, IDAHO, KANSAS, KENTUCKY, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, NEBRASKA, NEW  
JERSEY, NEW MEXICO, NORTH DAKOTA, OHIO, OREGON, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE,  
TEXAS, UTAH, VERMONT, VIRGINIA, WASHINGTON, WEST VIRGINIA, WISCONSIN CHAPTERS;  
CARDIOVASCULAR AND PULMONARY, CLINICAL ELECTROPHYSIOLOGY AND WOUND MANAGEMENT,  
EDUCATION, FEDERAL, GERIATRICS, HAND REHABILITATION, HEALTH POLICY AND ADMINISTRATION,  
ONCOLOGY, ORTHOPAEDIC, PEDIATRIC, PRIVATE PRACTICE, RESEARCH, WOMEN'S HEALTH SECTIONS

RC 16-16 AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION TO CHANGE THE DEFINITION  
OF A POST-PROFESSIONAL STUDENT

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

That Bylaws of the American Physical Therapy Association, Article IV. Membership, Section 1. Categories and  
Qualifications of Members, A. Physical Therapist, (2) be amended as follows:

ARTICLE IV. MEMBERSHIP  
Section 1. Categories and Qualifications of Members  
A. Physical Therapist  
*  
*  
*  
(2) Physical Therapist – Post-Professional Student: Be a Physical Therapist member who is enrolled in a post-  
professional masters or doctoral program, or APTA credentialed post-professional residency or fellowship  
program, or a post-doctoral research fellowship, and meets the Membership Qualifications Prescribed by the  
Board of Directors.

SS: After completing a doctoral degree, some physical therapists continue intensive training in research by  
completing post-doctoral fellowships. Post-doctoral fellowships are not American Physical Therapy Association  
(APTA) American Board of Physical Therapy Residency & Fellowship Education (ABPTRFE) accredited post-  
professional programs, but rather funded through institutional or extramural funding sources, including National  
Institutes of Health and the Foundation for Physical Therapy. For example, one of the primary missions of the  
Foundation for Physical Therapy’s Center of Excellence, CoHSTAR, is to train physical therapists to become  
health services researchers. A primary mechanism for doing this is through full-time, post-doctoral fellowships.  
APTA should further support the post-doctoral fellows, and others, in pursuit of post-doctoral fellowships, just  
as they do those who pursue APTA ABPTRFE accredited residencies and fellowships.

Physical therapists who complete post-doctoral fellowships are strongly encouraged and often required to  
complete post-doctoral fellowship training to more readily compete for tenure-track positions in physical  
thérapist programs, particularly at top research-intensive universities, and especially those with very high research  
activity (Carnegie Classifications-IPEDS system). The post-doctoral research fellowship are necessary to transform
the profession to assist in delivering value through the utilization of evidence, best practice and outcomes. For example, at the University of Florida, 8 of the 18 faculty in the Department of Physical Therapy with a physical therapy degree, completed post-doctoral fellowships in research. At Washington University in St. Louis, all PhD-trained physical therapists hired over the past 10 years have completed postdoctoral research fellowships prior to becoming faculty. Many PhD graduates roll directly into post-doctoral fellowships and have already been on significantly reduced incomes for several years. The post-doctoral fellowship positions are typically not commensurate with the salaries of full-time physical therapists in clinical practice; but rather with individuals in APTA-accredited residencies and fellowships. For example, a person entering an National Institute of Health (NIH) funded research fellowship in 2015 starting with an NIH salary of not more than $42,840-$48,192, depending upon incoming qualifications.3

Determining the exact number of members the proposed change would affect, is difficult to ascertain, as the data is not currently collected from membership or pooled specifically with the PT classification in the NIH database. However, we do have confidence that the number, overall, is likely to be small. We believe that supporting the post-doctoral research fellows in this manner supports the transformation of the profession, especially with respect to the Vision Guiding Principles of Collaboration, Value, Innovation, and Advocacy. Many of the post-doctoral research fellows are conducting research in inter-professional, collaborative laboratories. The post-doctoral fellows would not only be promoted within our own profession, yet also encouraged and valued to share their innovative research at APTA conferences and events. This will assist in advocacy for the profession and the patients that we serve, who benefit from physical therapy services and the results of the nationally funded research outcomes. We also believe that the opportunities for translating research into practice would be enhanced by having the post-doctoral research fellows’ outcomes highlighted through APTA. As we continue to move the profession forward, the proposed addition of the post-doctoral research fellow as a member qualified for post-professional student membership would further promote progression of the profession to further address the paucity of qualified faculty for physical therapist programs.

Reference Definitions

Definition - a postdoc — also known as a postdoctoral fellow (PDF), or research fellow — is an individual who has received a doctoral degree (or equivalent) and is engaged in a temporary and defined period of mentored advanced training to enhance the professional skills and research independence needed to pursue his or her chosen career path.* A post doc must meet the following:

- Be temporary
- Involve substantially full-time research or scholarship
- Be viewed as preparatory for a full-time career
- Not be part of a clinical training program
- Be working under the supervision of a senior scholar or a department in a university or similar institution, and
- Allow and encourage the appointee to publish the results of his or her research or scholarship

*As defined by the National Institutes of Health (NIH) and the National Science Foundation (NSF), January 29, 2007.

Please Note – post doc research fellows are full time position in fellowships that often cannot obtain other forms of meaningful employment, PRN or part-time clinical, due to RESTRICTIONS on outside activities (other than research duties) from an institution or funding agency such as NIH. Hence the lack of ability to obtain reasonable income, compared to their qualified PT counterparts, is diminished. Hence this is very important for the post-doc research fellow to have the opportunity for reduced membership fees. POST Doctoral research fellows are NOT students and their fellowships are NOT credentialed or accredited by the APTA. APTA does NOT credential postdoctoral research fellowships. Post doc research fellows are trainees, essentially, conducting research as a part of a temporary academic appointment, after the completion of their doctoral studies (typically a PhD) that is subject to annual income restrictions.
What is an APTA ABPTRFE Residency?

Residency programs are post professional programs that occur after the graduate physical therapist has obtained their license to practice. Residency programs in physical therapy may be clinical programs that advance a physical therapist's knowledge and skills in patient/client management, or nonclinical focusing on advancing a physical therapist's career outside of their clinical duties. Currently, only clinical-based residency programs are credentialed through ABPTRFE. A residency candidate must be licensed as a physical therapist in the state where the program is located. Clinical training will occur prior to entry into the program. Neither 'clinical residency' nor 'clinical fellowship' is synonymous with the terms 'clinical internship.' The residency program must be completed with a minimum of 1,500 hours and in no fewer than 9 months and no more than 36 months. http://www.abptrfe.org/ResidencyPrograms/About/

What is an APTA ABPTRFE Fellowship?

A fellowship program must be completed within a minimum of 1,000 hours and in no fewer than six (6) months and no more than 36 months. Fellowship programs in physical therapy may be clinical programs that advance a physical therapists knowledge and skills in patient/client management within an area of subspecialty, or nonclinical focusing on advancing a physical therapist's career outside of their clinical duties. http://www.abptrfe.org/FellowshipPrograms/About/

What is the Difference between an APTA ABPTRFE Residency vs. Fellowship?

A clinical residency program is designed to substantially advance a physical therapist's expertise in examination, evaluation, diagnosis, prognosis, intervention, and management of patients in a defined area of clinical practice (specialty). This focus may also include non-clinical aspects of physical therapy including community service, patient education, research, and supervision of other health care providers (professional and technical). Often, the clinical residency experience prepares an individual to become a board-certified clinical specialist through the American Board of Physical Therapy Specialties (ABPTS). Applicants to a residency program are typically new graduates from their entry-level physical therapy degree.

A fellowship program is designed to provide greater depth within a subspecialty area (beyond specialty) than that which is covered in a residency program. Therefore new graduates are not eligible for admission to a fellowship program. Applicants of a clinical fellowship program must possess one or more of the following qualifications: 1) specialist certification, 2) completion of a residency in a specialty area, or 3) demonstrable clinical skills within a particular specialty area.

References:

CURRENT BYLAW:
BYLAW OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE IV. MEMBERSHIP, SECTION 1:
CATEGORIES AND QUALIFICATIONS OF MEMBERS, A. PHYSICAL THERAPIST
PROPOSED BY: BOARD OF DIRECTORS

COSPONSORED BY:

RC 17-16 AMEND: BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION TO CHANGE THE BYLAW DEADLINE TO COINCIDE WITH THE MAIN MOTION DEADLINE

That Bylaws of the American Physical Therapy Association, Article XIV. Amendments, A., be amended by striking out the words, “4 months but no more than 5” and inserting the words “2 months but no more than 3” so that it would read:

ARTICLE XIV. AMENDMENTS

A. Any proposed amendment has been submitted in writing to the Association’s headquarters by a date set by the Speaker of the House of Delegates, which shall be at least 2 months but no more than 3 months before the session of the House of Delegates.

SS: For many years, amendments to the bylaws were published within Physical Therapy in order to meet the mandate that bylaw amendments be distributed to all members. The 4 months lead-time was necessary in order to meet publication deadlines. Bylaw amendments are now shared with members electronically via PT in Motion News and therefore timeframes and deadlines are more flexible. Making this change will provide more time for motion makers to perfect their bylaw amendment language and will streamline the process by aligning the deadlines for bylaw amendments with all other main motions to the House as per Standing Rule 16, Deadline for Main Motions.

CURRENT BYLAW:

BYLAWS OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, ARTICLE XIV. AMENDMENTS, A.