



Motions to the 2026 APTA House of Delegates

May 8, 2026

Table of Contents

RC 01-26 ADOPT: APTA POSITION ON UNFAIR PAYER CLAIM DENIALS	6
RC 02-26 ADOPT: APTA POSITION ON UNFAIR AND DECEPTIVE PRACTICES BY PAYERS AND INTERMEDIARIES	9
RC 03-26 ADOPT: UNIFIED ADVOCACY AND COLLABORATION TO ADVANCE PAYMENT POLICY	12
RC 04-26 RECOMMEND: ADVOCATING FOR FEDERAL RECOGNITION OF THE FULL LICENSED SCOPE OF PRACTICE OF DOCTORS OF PHYSICAL THERAPY	17
RC 05-26 ADOPT: POSITION ON PHYSICAL THERAPY WORKFORCE SUSTAINABILITY AND RETENTION AND RESCIND: WORKFORCE PLANNING	20
RC 06-26 AMEND: STANDING RULES OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, 9. MAIN MOTION CRITERIA	27
RC 07-26 AMEND: STANDING RULES OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, 10. NUMBER OF MAIN MOTIONS PER HOUSE OF DELEGATES SESSION	31
RC 08-26 RECOMMEND: EVALUATE A COLLABORATION WITH THE AMERICAN HEART ASSOCIATION MILLION HEARTS CAMPAIGN.....	35
RC 09-26 RECOMMEND: WEBSITE AUTHORSHIP	39
RC 10-26 RECOMMEND: MOTIONS NOT HEARD IN THE HOUSE OF DELEGATES	41
RC 11-26 RECOMMEND: ADVOCACY FOR THE USE OF THE DOCTOR OF PHYSICAL THERAPY TITLE AND THE DPT CREDENTIAL	43
RC 12-26 RECOMMEND: PAYMENT RESOURCES FOR THE SCOPE OF PHYSICAL THERAPIST SERVICES	45
RC 13-26 AMEND: GUIDING PRINCIPLES TO ACHIEVE THE VISION	48
RC 14-26 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: KEVIN FORD, PhD, FACSM	55
RC 15-26 RECOMMEND: GUIDANCE FOR APPROPRIATE UTILIZATION AND PROTECTION OF THE PHYSICAL THERAPIST ASSISTANT ROLE.....	58
RC 16-26 RECOMMEND: IMPROVING TRANSPARENCY OF FINANCIAL RESOURCES FOR PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT STUDENTS.....	62
RC 17-26 AMEND: THE ROLE OF AIDES IN A PHYSICAL THERAPY SERVICE.....	67
RC 18-26 AMEND: INTERVENTIONS PERFORMED EXCLUSIVELY BY PHYSICAL THERAPISTS.	71

RC 19-26 AMEND PHYSICAL THERAPISTS' ROLE IN PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT OF DISEASE AND DISABILITY and RESCIND HEALTH PRIORITIES FOR POPULATIONS AND INDIVIDUALS.....	74
RC 20-26 RECOMMEND: ADVANCING DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES PRESCRIPTIVE AUTHORITY	83
RC 21-26 RECOMMEND: EVALUATION OF EDUCATIONAL AND REGULATORY FRAMEWORKS FOR PHYSICAL THERAPIST MEDICATION PRESCRIPTIVE AUTHORITY	86
RC 22-26 RECOMMEND: CREATION OF EDUCATIONAL RESOURCES FOR THE PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT REGARDING PSYLOCYBIN THERAPY	89
RC 23-26 AMEND: DIAGNOSIS BY PHYSICAL THERAPISTS	93
RC 24-26 AMEND: CARDIOPULMONARY RESUSCITATION.....	97
RC 25-26 RESCIND: OPPOSITION TO PHYSICIAN OWNERSHIP OF PHYSICAL THERAPIST SERVICES AND SELF-REFERRAL BY PHYSICIANS	102
RC 26-26 AMEND: OPPOSITION TO PHYSICIAN OWNERSHIP OF PHYSICAL THERAPIST SERVICES AND SELF-REFERRAL BY PHYSICIANS	107
RC 27-26 RECOMMEND: EVALUATE REVISIONS TO THE GUIDE TO PHYSICAL THERAPIST PRACTICE 4.0 AS RELATED TO ENVIRONMENTAL FACTORS.....	110
RC 28-26 RECOMMEND: ADVOCATING FOR EVIDENCE-INFORMED ENHANCEMENTS TO THE NATIONAL PHYSICAL THERAPY EXAMINATION	114
RC 29-26 AMEND: EDUCATIONAL DEGREE QUALIFICATIONS AND NOMENCLATURE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS.....	117
RC 30-26 ADOPT: CLASSIFICATION OF THE DOCTOR OF PHYSICAL THERAPY DEGREE AS A PROFESSIONAL DEGREE	124
RC 31-26 AMEND: PREFERRED NOMENCLATURE FOR THE PROVISION OF PHYSICAL THERAPIST SERVICES	128
RC 32-26 RECOMMEND: DEMOGRAPHIC REPRESENTATION OF THE PROFESSION ON THE APTA BOARD OF DIRECTORS AND HOUSE OF DELEGATES	136

TO: House of Delegates
FROM: Bill McGehee, PT, PhD, Speaker of the House
DATE: May 8, 2026
SUBJECT: Motions to the 2026 House of Delegates

Welcome!

The House Officers wish to thank delegates for their preparation thus far and for their timely submission of motions. Collaboration is key for the House to function at its highest capacity and make impactful decisions that will continue to move the profession forward. Key areas that play an important role in the quality and efficacy of our collaboration include communication, coordination, transparency, accountability, and trust. Embracing these key elements of collaboration will greatly improve our ability to resolve conflict and reach mutual understanding to make decisions that are in the best interests of the profession and the members we represent.

This is the moment we've been waiting for: this document contains the 32 motions to the 2026 House of Delegates.

Organization of Motions

Motions have been provided RC numbers organized first by Strategic Pillar, and then alphabetically Z to A by the primary motion maker's component. This is in reverse of last year's organization and aims to balance us from year to year; ensuring that voices are heard as equitably as possible.

Motion Language

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

Motion language has been edited and formatted to be consistent with standards for documents published by APTA. The same has not been done to support statements. These statements are the sole purview of the motion maker and have been presented as submitted with very little formatting.

The [Use of Language in Association Policies, Positions, and House of Delegates Recommendations](#) (BOD Y11-25-04-01) policy document lists words that are appropriate for policies, positions, and recommendations, and the definitions of those words. The goal is to provide consistency in use of these terms and clarity of intent. Review this document as you read the motions, and particularly if you are contemplating amendments.

Detailed Agenda, Consent Calendar, and Cosponsoring Motions

The Detailed Agenda will be published June 18 once the Chief Delegates Council and the House Officers develop the ranked order.

RCs 01-26 to 04-26 will remain at the top of the agenda as these motions have been identified as propelling the Advancing Our Payment strategic pillar forward. As advancing payment was designated as APTA's top priority via a House position last year, it is fitting that these motions warrant our top priority.

The Consent Calendar is a group of motions that will be adopted as a package by general consent of the House.

The Consent Calendar will be published June 18, following the polling of Chief Delegates. According to APTA Standing Rules, prior to the meeting of the House a motion may be removed from the consent calendar by the House Officers or at the request of 5 chief delegates. These requests must be in writing to governancehouse@apta.org and should include all 5 delegations submitting the request if possible.

Following the opening of the House meeting, 1/3 of the assembly, voting in the affirmative, is required to remove an item from consent and placed back into the detailed agenda.

Chief Delegates will use a cosponsor signup available through July 13 to indicate co-sponsorship of a specific motion.

House Officers suggest Chief Delegates begin conferring with their delegations about the detailed agenda order and which motions should be placed on the consent calendar as soon as possible. Some guiding questions for your conversations are outlined below:

1. Will this motion help APTA accomplish its desired outcomes in the [Strategic Framework for 2030](#)? How does it directly impact our ability to achieve a strategic pillar and/or objective within the framework?
2. Is this motion needed immediately? Does the concept need to be addressed this year?

Motion Questions and Inquiries

As delegates are aware motion discussion and collaboration have already begun on the [2026 House Motions community](#). This community was created specifically for delegates to

discuss, ask questions, and collaborate with one another to develop the motions to finally be here, at your fingertips. We encourage these continuing conversations all the way up until the motion is heard in the House July 12 and/or 13.

All motion questions and inquiries must be posted to the discussion threads on the 2026 House Motions Community and should be directed to the motion maker. Delegates should use this medium, and not social media, so that all delegates are aware of the information being shared. To keep conversation organized, no new discussion threads should be created on the 2026 House Motions Community, and threads will be closed if a motion is withdrawn or merged with another.

Motion makers that convene a discussion group regarding their motion(s) should communicate outcomes on the 2026 House Motion Community in the corresponding motion discussion threads.

Proposing Amendments

All proposed amendments to motions, including replacement language from motion makers, must be submitted using the [Amendment Submission Form](#).

Pre-House amendments to motion language are due June 12, 5:00 pm ET and will be shared on the House Community June 26. Delegates are under no obligation to move these amendments in July but submitting them in advance allows more time for your colleagues to be prepared for the discussion.

Do not hesitate to contact us with questions, concerns, or suggestions for expediting the business of the House.

Thank you for all that you do for our association.

I wish you and yours good health.

Motion to 2026 House of Delegates

Main Motion:

RC 01-26 ADOPT: APTA POSITION ON UNFAIR PAYER CLAIM DENIALS

1 **Proposed by:** Maine

2 **Primary Motion Contact:** Gwen Simons, PT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 **That the following be adopted:**

8

9 APTA POSITION ON UNFAIR PAYER CLAIM DENIALS

10

11 APTA opposes nonpayment of claims or recoupment of monies already paid, including but not
12 limited to the following reasons:

- 13 • Arbitrary and capricious denials that force providers and/or patients to file appeals to get
14 paid.
- 15 • Payer determination, without specificity, that documentation did not support the claim.
- 16 • Payer policies that require excessive and unnecessary documentation requirements beyond
17 Medicare documentation requirements.
- 18 • Payer policies that require the provider to justify the medical necessity of individual
19 interventions for every occurrence when medical necessity justification has been previously
20 provided in the plan of care or treatment records.
- 21 • Use of algorithms, software programs, and/or online platform systems to arbitrarily deny
22 visits (including prior authorization of visits) based solely on the number of visits provided
23 without an analysis of each patient's individual presentation and circumstances that affect
24 medical necessity.

25

26

27 **Support Statement**

28

29 **What is this motion seeking to achieve?**

30 This position statement is intended to call out unfair claim denial practices by payers that are
31 arbitrary and capricious or based on a pretext that documentation is inadequate. Any payer conduct
32 that denies PT claims, whether it is pre-service or post-service, and whether it is through the

33 application of arbitrary expectations about the number of visits required for a certain diagnosis
34 without taking into consideration the patient’s individual medical problems and impairments is
35 inappropriate. We are increasingly seeing commercial carriers deny claims and recoup payment
36 for claims already paid after an audit for “inadequate” documentation. Frequently these
37 determinations are not supported with specifics and seem to be designed to shift the burden back
38 on the provider or patient to file appeals. We are also seeing payors enact policies that require
39 excessive documentation, like start and stop time for each exercise or CPT intervention instead of the
40 start and stop time for the visit and the total time for each CPT code billed as required by CMS.
41 Payor payment policies that require extraordinary and excessive documentation beyond Medicare
42 requirements are not necessary to support the skill, medical necessity and correct coding of the
43 service provided. Excessive documentation requirements merely add unnecessary administrative
44 burdens and serve as an excuse to deny claims for covered benefits. The medical necessity of
45 planned interventions should only have to be explained in the Plan of Care, Progress Notes/Re-
46 evaluations, and in subsequent visits when new interventions are initiated or the Plan of Care
47 changes – not each and every visit. We need APTA to aggressively oppose these payor policies
48 and unfair claims handling practices through the work that APTA’s payment and policy staff routinely
49 do and not assume that, broadly speaking, physical therapists’ documentation is indeed inadequate.
50 State Chapters also need this position statement when seeking legislative or regulatory solutions to
51 various payment problems. We do not anticipate this RC having a fiscal impact on APTA’s budget or
52 requiring any new initiatives by staff.

53
54 **How does this motion contribute to achieving the Vision?**

55 The Motion seeks to ensure that PTs are appropriately paid and remain a viable option for rehab
56 services.

57
58 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

59 As above, the Motion seeks to ensure PTs are not unnecessarily burdened by excessive
60 documentation requirements that serve no meaningful purpose.

61
62 **How is this motion’s subject national in scope and importance?**

63 We have seen national payers establish policies that require excessive documentation far beyond
64 Medicare standards (see example in the support statement), therefore this issue affects PTs in all
65 settings on a national level. It is time to stand up to payers who are implementing policies merely
66 to have an excuse to deny claims instead of assuming PTs really are failing to meet adequate
67 professional documentation standards.

68
69 **What previous or current initiatives and positions of the Association address this topic?**

70 We know of no APTA policies that addresses this issue.

71

72 **What interested parties will be impacted by this motion?**

73 This issue affects all providers in private practice and hospital systems. The Motion may be an
74 example for other professional associations if they do not already have a position on this issue.

75

76 **Additional background information**

77 We do not intend for this position statement to affect the business practices of ethical provider
78 networks that contract collectively and knowingly with payers to provide reasonable (not coercive,
79 harmful) discounts in consideration for the steering of referrals to network providers.

80

81 **References:**

82 No references are really necessary, but Maine PTs passed a law in 2021 that prohibits the use of
83 excessive documentation requirements in facility wide pre-payment reviews. References: An Act
84 To Regulate Insurance Carrier Practice or Facility-wide Prepayment Review, Public Law 272, 2021;
85 24-A MRSA §4303, sub-§24.

86

87 **Last Updated:** 5/8/2026

88 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 02-26 ADOPT: APTA POSITION ON UNFAIR AND DECEPTIVE PRACTICES BY PAYERS AND INTERMEDIARIES

1 **Proposed by:** Maine

2 **Primary Motion Contact:** Gwen Simons, PT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 **That the following be adopted:**

8

9 APTA POSITION ON UNFAIR AND DECEPTIVE PRACTICES BY PAYERS AND INTERMEDIARIES

10

11 APTA opposes unfair or deceptive acts or practices by payers and third-party intermediary entities:
12 aka provider networks, preferred provider organizations, "Silent PPOs," repricers, bill review entities,
13 discount brokers, and any other term that describes an entity that is not a payer; third-party
14 administrators to a payer, or a payer's exclusive network (hereinafter "Intermediary" or
15 "Intermediaries") whose primary purpose is to discount providers' claims. Deceptive acts or practices
16 include but are not limited to:

17

- 18 • Intermediaries using false and misleading promises of consideration to solicit providers into
19 network (discount) agreements, such as promising "steerage" (volume referrals) or prompt
20 payment of claims.
- 21 • Intermediaries selling access to the network (discount) agreement to payers who are not
22 explicitly identified in the network agreement at the time the provider entered into the
23 agreement.
- 24 • Intermediaries failing to inform network providers through a properly executed notice or
25 contract amendment when proposing to give network access to a new affiliate, customer,
26 beneficiary, or assignee.
- 27 • Using a bait-and-switch technique where the intermediary originally solicits an out-of-
28 network provider to accept a "Single Case Discount," then subsequently substitutes a
29 misleading agreement that broadly expands the scope of payers who can claim the discount.
- 30 • Intermediaries failing to remove (or ensure removal of) a provider's information, Tax
31 Identification Number, and other identifying information from all databases that the

32 Intermediary has sold its network provider list to when that provider terminates their network
33 agreement.

- 34 • Intermediaries and payers claiming indirect access to a provider’s network (discount)
35 agreements merely because the provider’s name or business name is in a database.
- 36 • Intermediaries and payers refusing to provide a copy of the network agreement(s) being used
37 to reprice claims upon the provider challenging the existence or validity of a contract being
38 used to take a discount.
- 39 • Intermediaries and payers requiring providers to participate in all networks or none in their
40 network agreements even when the payers are unrelated, resulting in anticompetitive price
41 fixing of providers’ reimbursements.

42
43
44

Support Statement

45 46 **What is this motion seeking to achieve?**

47 Intermediary networks have grown over the last thirty (30) years, taking earned profits away from
48 physical therapy practices through deceptive trade practices. These intermediaries solicit PTs into
49 “networks” by promising access to Payor networks, volume referrals and prompt payment that the
50 intermediary frequently does not control. Providers frequently enter into an agreement thinking it is
51 only for one or a limited number of payors only to later discover the agreement could be accessed
52 by essentially any and all payors due to “silent PPO” contract language. These deceptive business
53 practices must stop. They have caused substantial financial harm to thousands of practices
54 nationwide and even caused some practices to go out of business. This position statement
55 explicitly states that these deceptive business practices are unacceptable. It provides examples of
56 deceptive business practices to educate our members on what to look for when reviewing network
57 agreements and negotiating with Intermediaries. This position statement will also help state
58 Chapters in legislative and regulatory advocacy efforts to fight against unfair and deceptive trade
59 and contracting practices – especially in workers’ compensation and out of network claims. We do
60 not expect this Position Statement to have a fiscal impact or require APTA staff to implement any
61 significant new initiatives. It primarily serves the purpose of calling public attention to this problem
62 and explicitly stating deceptive trade practices are wrong.

63 64 **How does this motion contribute to achieving the Vision?**

65 The Motion seeks to ensure that PTs are appropriately paid and remain a viable option for rehab
66 services.

67 68 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

69 As above, the Motion seeks to ensure PTs are appropriately paid and informs members about the
70 deceptive trade practices they should be on the lookout for.

71 72 **How is this motion’s subject national in scope and importance?**

73 The business practices this Motion draws attention to are widely by the bad actors in every state.
74 Some of the bad actors are making millions of dollars from these deceptive trade practices – money
75 that should be going to the providers who treat the patients.

76

77 **What previous or current initiatives and positions of the Association address this topic?**

78 We are bringing this motion forward because we know of nothing that addresses this issue.

79

80 **What interested parties will be impacted by this motion?**

81 This issue affects all providers in private practice and hospital systems. The Motion may be an
82 example for other professional associations if they do not already have a position on this issue.

83

84 **Additional background information**

85 We do not intend for this position statement to affect the business practices of ethical provider
86 networks that contract collectively and knowingly with payers to provide reasonable (not coercive,
87 harmful) discounts in consideration for the steering of referrals to network providers.

88

89 **References:**

90

91 **Last Updated:** 5/8/2026

92 **Contact:** governancehouse@apta.org

93

Motion to 2026 House of Delegates

Main Motion:

RC 03-26 ADOPT: UNIFIED ADVOCACY AND COLLABORATION TO ADVANCE PAYMENT POLICY

1 **Proposed by:** Iowa , Private Practice
2 **Primary Motion Contact:** Colleen Louw, PT
3 [Discussion Thread](#)

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

6
7 **That the following be adopted:**

8
9 UNIFIED ADVOCACY AND COLLABORATION TO ADVANCE PAYMENT POLICY

10
11 APTA supports unified advocacy that leverages the collective expertise and efforts of organizations
12 working to advance sustainable and fair payment policies for physical therapist services. APTA
13 believes that mutually beneficial partnerships with organizations and alliances aligned with APTA
14 values strengthen these efforts and explores them where possible.

15
16
17 **Support Statement**

18
19 **What is this motion seeking to achieve?**

20 APTA will open the door to collaboration with like-minded organizations that share the same values
21 to advance physical therapy payment.

22
23 **How does this motion contribute to achieving the Vision?**

24 This motion advances the vision of “transforming society by optimizing movement to improve the
25 human experience” by strengthening the systems that make high-quality physical therapy care
26 possible. By supporting unified advocacy and fostering partnerships with organizations that share
27 aligned values, this motion: Expands access to care – Advocacy for sustainable and fair payment
28 policies helps ensure patients can receive physical therapy services without unnecessary financial or
29 systemic barriers. Strengthens the profession’s impact – Unified efforts amplify the voice of
30 physical therapy, leading to policy changes that support broader reach and influence in healthcare.
31 Enables high-quality, outcomes-driven care – Fair reimbursement supports evidence-based practice,

32 innovation, and care models focused on optimizing movement and improving lives. Promotes
33 long-term sustainability – Collaboration across aligned organizations builds a more stable and
34 effective payment environment, allowing the profession to grow and better serve society.
35 Ultimately, this motion empowers the profession to deliver on its full potential - enhancing
36 movement, improving health outcomes, and elevating the human experience at both individual and
37 societal levels.

38

39 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

40 This motion directly supports APTA’s Strategic Framework for 2030 by advancing all three strategic
41 priorities—advancing our payment, empowering our members, and evolving our practice—through
42 unified advocacy and strategic partnerships. Advancing our payment: The motion most directly
43 aligns by promoting coordinated advocacy efforts and collaboration with like-minded organizations
44 to achieve sustainable and fair payment policies. Leveraging collective expertise strengthens APTA’s
45 ability to influence policy and drive meaningful payment reform. Empowering our members: By
46 leading unified advocacy efforts, APTA amplifies the voice of its members and provides them with
47 stronger representation. Partnerships expand resources, knowledge-sharing, and opportunities for
48 engagement. . Evolving our practice: Sustainable payment models support innovation in care
49 delivery, adoption of evidence-based practices, and expanded roles for physical therapists.
50 Collaboration with aligned organizations also help the profession adapt and thrive in a changing
51 health care environment.

52

53 **How is this motion’s subject national in scope and importance?**

54 This motion is national in scope because payment policies impacting physical therapy are largely set
55 at the federal level and affect providers and patients across all states. Unified advocacy strengthens
56 APTA’s ability to drive consistent, nationwide improvements in access, sustainability, and care quality.

57

58 **What previous or current initiatives and positions of the Association address this topic?**

59 There are several listed in our references but also APTA is hosting the first-ever Advocacy Summit in
60 2026, which will invite several other entities/groups to collaborate on strategies on payment
61 advocacy. <https://www.apta.org/advocacy/payment-advocacy-summit>

62

63 **What interested parties will be impacted by this motion?**

64 Physical therapists and physical therapist assistants: Benefit from stronger advocacy for fair,
65 sustainable payment, supporting practice viability and professional growth. Patients and
66 communities: Gain improved access to physical therapy services and better health outcomes
67 through more sustainable care delivery. APTA members and components: Experience enhanced
68 representation, resources, and opportunities to engage in unified advocacy efforts. Partner
69 organizations and alliances: Gain opportunities for collaboration, shared expertise, and increased
70 collective influence on payment policy. Payers (e.g., Medicare and commercial insurers): Engage
71 with a more coordinated and influential stakeholder group advocating for value-based, sustainable
72 payment models. Health care systems and employers: Benefit from more stable reimbursement

73 structures that support integration of physical therapy services and efficient care delivery.
74 Policymakers and regulators: Receive more cohesive, evidence-informed input to guide decisions on
75 payment policy and health care reform.

76
77 **Additional background information**

78 For decades, and notably over the past five years, APTA has had innumerable advocacy successes in
79 defining, revising, and advancing payment and health policies that positively impact physical
80 therapists and physical therapy practice.¹⁻¹⁰ This motion furthers the advocacy agenda for the
81 profession by pursuing a unified approach with multiple entities outside of the association for more
82 effective and efficient advocacy efforts in the future.

83
84 The creation of APTA's *Strategic Framework for 2030* APTA¹¹ is an important step to advance physical
85 therapy payment¹ though these efforts may not always be fully recognized across the profession,
86 sometimes resulting in a skewed perception among both members and non-members. At the same
87 time, other organizations are also working independently to strengthen payment advancement and
88 support the future of physical therapy practice. APTA seeks to open the door to collaboration with
89 these like-minded groups, creating an inclusive and unified approach grounded in shared goals.
90 While strategies may differ, aligning efforts on common ground will strengthen advocacy, amplify
91 impact, and help advance sustainable, equitable payment policies for physical therapy services.

92
93 In 2022, the American Physical Therapy Association, Academy of Orthopaedic Physical Therapy and
94 APTA Private Practice founded the State Payer Advocacy Resource Consortium (SPARC) to
95 collaborate on legislative and advocacy strategies.⁹ Building on decades of advocacy by the
96 association and its members, this collaborative think tank worked alongside current staff and
97 volunteers to support an unprecedented number of state-level successes in recent years.

98
99 In 2025, APTA collaborated with our traditional rehabilitation allies to push for reforms in Medicare
100 policies.¹⁰ The "[Policy Principles of Outpatient Therapy Reform Under the Medicare Physician Fee
101 Schedule](#)" is a road map developed by APTA, APTA Private Practice, the American Speech-Language-
102 Hearing Association, and the American Occupational Therapy Association which recommends five
103 specific changes applicable to outpatient therapy for the continued sustainability of Medicare in
104 rehabilitation therapy. The recommendations include everything from abolishing the Multiple
105 Procedure Payment Reduction (MPPR) policy⁴ to allowing therapists to privately contract or "opt out"
106 of Medicare to reforms that would allow physical therapists to more fully participate in alternative
107 payment systems, along with changes that would significantly reduce red tape for therapy providers.

108
109 With APTA's stated action plans to convene *The First-ever APTA Payment Advocacy Summit*¹ in 2026,
110 this proposed position overtly articulates that intended audiences and participants are sought other
111 than internal partners collaborators to external stakeholders who represent physical therapists and
112 physical therapy interests in the United States. This valuable strategy is intended to further shared
113 goals to benefit our patients, members, and the profession.

114
115 This motion supports the three pillars of the strategic framework by

- 116 • Increasing chances of success in advocacy for changing payment policies to create more
117 economic opportunities and success for members, i.e. Payment Advancement;
- 118 • Improving practice conditions for members across all settings and stages of their careers, i.e.
119 Empowers Members
- 120 • Supporting viability and innovation of various practice models and services through
121 improved reimbursement. i.e. Evolving Our Practice.

122
123 References:

- 124 1. Payer Advocacy by the Numbers: APTA Members and Staff Driving Progress. February 4,
125 2026. [https://www.apta.org/article/2026/02/04/payer-advocacy-by-the-numbers-apta-](https://www.apta.org/article/2026/02/04/payer-advocacy-by-the-numbers-apta-members-and-staff-driving-progress)
126 [members-and-staff-driving-progress](https://www.apta.org/article/2026/02/04/payer-advocacy-by-the-numbers-apta-members-and-staff-driving-progress)
- 127 2. APTA State Chapters Record 48 Wins in 2025, Work Continues in 2026. February 10, 2026.
128 [https://www.apta.org/article/2026/02/10/apta-state-chapters-record-48-wins-in-2025-work-](https://www.apta.org/article/2026/02/10/apta-state-chapters-record-48-wins-in-2025-work-continues-in-2026)
129 [continues-in-2026](https://www.apta.org/article/2026/02/10/apta-state-chapters-record-48-wins-in-2025-work-continues-in-2026)
- 130 3. #FixMedicareNow. 2025. [https://www.apta.org/advocacy/issues/medicare-physician-fee-](https://www.apta.org/advocacy/issues/medicare-physician-fee-schedule)
131 [schedule](https://www.apta.org/advocacy/issues/medicare-physician-fee-schedule)
- 132 4. Multiple Procedure Payment Reduction Policy. [apta-positionpaper-mppr-final.pdf](#)
- 133 5. [https://www.apta.org/contentassets/20fd564984b446949c89517f546e4fb3/apta-](https://www.apta.org/contentassets/20fd564984b446949c89517f546e4fb3/apta-positionpaper-medicarefeeschedule-1.pdf)
134 [positionpaper-medicarefeeschedule-1.pdf](https://www.apta.org/contentassets/20fd564984b446949c89517f546e4fb3/apta-positionpaper-medicarefeeschedule-1.pdf)
- 135 6. Letter of Congressional Leadership October 11, 2024.
136 [https://www.apta.org/siteassets/pdfs/advocacy/10.11.2024---final---medicare-physician-fee-](https://www.apta.org/siteassets/pdfs/advocacy/10.11.2024---final---medicare-physician-fee-schedule-proposed-cuts-letter-to-house-leadership.pdf)
137 [schedule-proposed-cuts-letter-to-house-leadership.pdf](https://www.apta.org/siteassets/pdfs/advocacy/10.11.2024---final---medicare-physician-fee-schedule-proposed-cuts-letter-to-house-leadership.pdf)
- 138 7. Letter to Senate Leadership. February 23, 2024.
139 [https://fixmedicarenow.org/sites/default/files/2024-](https://fixmedicarenow.org/sites/default/files/2024-02/Boozman%2C%20Welch%20Lead%20Letter%20Calling%20for%20Legislative%20Solution%20to%20Protect%20Access%20to%20Medicare%20Services%20February%202024.pdf)
140 [02/Boozman%2C%20Welch%20Lead%20Letter%20Calling%20for%20Legislative%20Solution](https://fixmedicarenow.org/sites/default/files/2024-02/Boozman%2C%20Welch%20Lead%20Letter%20Calling%20for%20Legislative%20Solution%20to%20Protect%20Access%20to%20Medicare%20Services%20February%202024.pdf)
141 [%20to%20Protect%20Access%20to%20Medicare%20Services February%202024.pdf](https://fixmedicarenow.org/sites/default/files/2024-02/Boozman%2C%20Welch%20Lead%20Letter%20Calling%20for%20Legislative%20Solution%20to%20Protect%20Access%20to%20Medicare%20Services%20February%202024.pdf)
- 142 8. Position Paper: Medicare Payment Reform. 2025. [https://www.apta.org/advocacy/position-](https://www.apta.org/advocacy/position-papers/position-paper--medicare-payment-reform)
143 [papers/position-paper--medicare-payment-reform](https://www.apta.org/advocacy/position-papers/position-paper--medicare-payment-reform)
- 144 9. APTA-Supported Medicare Payment Reform Legislation. 2025.
145 <https://www.apta.org/advocacy/issues/apta-legislative-update-bill-status>
- 146 10. State Payer Advocacy Resource Consortium (SPARC). 2022. <https://sparc.apta.org/>
- 147 11. Policy Principles for Outpatient Therapy Reform under the Medicare Physician Fee Schedule.
148 2025.
149 https://www.apta.org/contentassets/01533035f7a84ffc80007c9d077e0ab1/policy_principles_t
150 [herapy_reform_mpfs_march2024.pdf](https://www.apta.org/contentassets/01533035f7a84ffc80007c9d077e0ab1/policy_principles_t).
- 151 12. Built by Our Community, Designed for Our Future: Inside APTA's Strategic Framework for
152 2030. February 1, 2026. [https://www.apta.org/apta-magazine/archive/2026/02/01/built-](https://www.apta.org/apta-magazine/archive/2026/02/01/built-by-our-community-designed-for-our-future)
153 [by-our-community-designed-for-our-future](https://www.apta.org/apta-magazine/archive/2026/02/01/built-by-our-community-designed-for-our-future).
- 154 13. <https://sparc.apta.org/>
- 155 14. Care Delayed is Care Denied: [https://www.apta.org/siteassets/pdfs/advocacy/apta-priorauth-](https://www.apta.org/siteassets/pdfs/advocacy/apta-priorauth-coalition-principles.pdf)
156 [coalition-principles.pdf](https://www.apta.org/siteassets/pdfs/advocacy/apta-priorauth-coalition-principles.pdf)

157

158

159 **Last Updated:** 5/8/2026

160 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 04-26 RECOMMEND: ADVOCATING FOR FEDERAL RECOGNITION OF THE FULL LICENSED SCOPE OF PRACTICE OF DOCTORS OF PHYSICAL THERAPY

1 **Proposed by:** Hawaii

2 **Primary Motion Contact:** Douglas White, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That APTA shall advocate for federal statutory and regulatory reforms to ensure doctors of physical
8 therapy are recognized and authorized to practice to the full extent of their licensed scope of
9 practice and to receive payment for all services.

10

11

12 **Support Statement**

13

14 **What is this motion seeking to achieve?**

15 The ability to practice and get paid for all services controlled or influenced by federal law

16

17 **How does this motion contribute to achieving the Vision?**

18 If we can't practice and get paid for all our services we can't meet the needs of society.

19

20 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

21 Advances payment and practice innovation

22

23 **How is this motion's subject national in scope and importance?**

24 Federal law and regulation applies to all DPTs.

25

26 **What previous or current initiatives and positions of the Association address this topic?**

27 APTA has ongoing piecemeal initiatives to address this issue which despite decades of action have
28 yielded little. Payment is APTA's top priority.

29

30 **What interested parties will be impacted by this motion?**

31 Congress, CMS, DOL, all DPTs who provide services to federally insured individuals and those
32 individuals. Millions of people!

33

34 **Additional background information**

35 Why does this matter? The identity of the profession is intricately aligned with the rights and
36 privileges afforded the profession. DPTs are considered by many who are in positions of controlling
37 access and payment for our services as “ancillary” and “allied health” (“allied” meaning subservient to
38 MDs) Currently most of the other established doctoring professions are recognized under these
39 statutes and regulations¹, See: <https://www.law.cornell.edu/uscode/text/42/1395x#r> These disciplines
40 mostly enjoy a broader scope of practice and payment for services than afforded to DPTs.

41 Obtaining recognition under federal law and regulation as a doctoring profession has been debated
42 for many years and has largely resulted in inaction or a lack of effective advocacy. (Maybe a few
43 crumbs thrown our way at most.) Hawaii fully realizes obtaining such recognition will require a
44 significant resources expenditure. Whatever it takes is necessary to achieve our vision. Optometry
45 more recently has achieved this status why can’t we as well? It is doable and mandatory if we are to
46 grow and change with the evolution of health and wellness to meet the needs of society.
47 Individual carve outs for specific services such as was adopted decades ago for EMG/NCV testing has
48 resulted in tiny increments to practice. We cannot continue to fight for incremental expansions of
49 our practice each one takes decades to achieve. We need a strategy which recognizes and pays for
50 the full scope of our services today, tomorrow, and ten years from now whatever our scope of
51 practice may be in the future.

52 Obtaining full federal recognition of doctors of physical therapy licensed scope of practice will have
53 a cascading benefit to state practice acts and related laws and regulations, and payer polices.
54 The terminology doctor of physical therapy instead of physical therapists is intentional to be
55 consistent with federal law.

56

57 ¹ a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the
58 State in which he performs such function or action (including a physician within the meaning of
59 section 1301(a)(7) of this title), (2) a doctor of dental surgery or of dental medicine who is legally
60 authorized to practice dentistry by the State in which he performs such function and who is acting
61 within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine
62 for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1395f(a),
63 1395k(a)(2)(F)(ii), and 1395n of this title but only with respect to functions which he is legally
64 authorized to perform as such by the State in which he performs them, (4) a doctor of optometry,
65 but only for purposes of subsection (p)(1) and with respect to the provision of items or services
66 described in subsection (s) which he is legally authorized to perform as a doctor of optometry by
67 the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or
68 in a State which does not license chiropractors as such, is legally authorized to perform the services
69 of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform
70 minimum standards promulgated by the Secretary, but only for the purpose of subsections (s)(1)

71 and (s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to
72 correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which
73 such treatment is provided. For the purposes of section 1395y(a)(4) of this title and subject to the
74 limitations and conditions provided in the previous sentence, such term includes a doctor of one of
75 the arts, specified in such previous sentence, legally authorized to practice such art in the country in
76 which the inpatient hospital services (referred to in such section 1395y(a)(4) of this title) are
77 furnished.

78

79 **References:**

80

81 **Last Updated:** 5/8/2026

82 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 05-26 ADOPT: POSITION ON PHYSICAL THERAPY WORKFORCE SUSTAINABILITY AND RETENTION AND RESCIND: WORKFORCE PLANNING

1 **Proposed by:** Texas and Cardiovascular and Pulmonary

2 **Primary Motion Contact:** Rupal Patel, PT, PhD

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 *This is a motion with two conforming amendments: Parts A–B.*

8

9

Part A

10

11 **That the following be adopted:**

12

POSITION ON PHYSICAL THERAPY WORKFORCE SUSTAINABILITY AND RETENTION

14

15 The American Physical Therapy Association believes that workforce sustainability is essential to
16 ensuring societal access to physical therapist services across communities and care settings. Physical
17 therapists and physical therapist assistants deserve work environments that support professional
18 fulfillment, well-being, and sustainable careers throughout their professional lifespan. Evidence-
19 informed understanding of separation patterns, contributing factors, and effective interventions is
20 necessary to guide APTA activities, policy advocacy, and resource development. Workforce retention
21 is a shared responsibility requiring collaboration among APTA, employers, educators, policymakers,
22 and clinicians.

23

24

25

Part B

26

27 **That Workforce Planning (HOD P06-20-41-33) be rescinded.**

28

29 WORKFORCE PLANNING

30

31 ~~The American Physical Therapy Association supports and participates in workforce planning efforts~~
32 ~~with other stakeholders to meet the needs of the profession and society. The primary goal of~~
33 ~~workforce planning is optimizing access to physical therapist services to meet the needs of patients~~
34 ~~and clients through an appropriate specialty and practice mix and geographic distribution of physical~~
35 ~~therapists and physical therapist assistants. Effective workforce planning efforts include measures of~~
36 ~~supply, demand, and need.~~

37

- 38 ~~• Supply assessment includes accurate and contemporary descriptions of the inflows and~~
39 ~~outflows of the workforce, with analyses over time of the trends in these numbers.~~
- 40 ~~• Demand assessment includes payment and insurance mechanisms, practice environment~~
41 ~~changes, and the number and roles of other relevant health professionals providing services.~~
- 42 ~~• Need assessment includes various factors of the health services system, such as projected~~
43 ~~demographics and other characteristics of patients and clients that can predict need, whether~~
44 ~~or not payment and access are available.~~

45

46

47 **Support Statement**

48

49 **What is this motion seeking to achieve?**

50 The physical therapy profession faces a growing workforce sustainability crisis. Current data reveals
51 alarming trends:

52 Nearly half of practicing physical therapists report capacity shortfalls in meeting local demand, with
53 new patients waiting an average of 15 days for services.

54 Research indicates approximately 70% of therapists are considering leaving their current position or
55 the profession entirely.

56 Almost half of U.S. physical therapists report experiencing burnout

57 PT and PTA incomes have not kept pace with inflation since 2016, despite increasing productivity
58 demands.

59 Multiple studies identify 53 risk factors for separation, with 49 being avoidable through workplace
60 and policy interventions.

61 Despite this evidence, APTA lacks systematic separation tracking. The current workforce analysis
62 model acknowledges: "Unfortunately, there is not enough data available on the separation of
63 physical therapist assistants to make reliable projections on the future supply of PTAs," and uses
64 estimated separation rates for PTs rather than measured data.

65 Quantifiable metrics: "APTA will establish baseline separation rates within 18 months and track year-
66 over-year improvement"

67 Benchmark comparisons: Reference separation rates in similar healthcare professions for context

68 Success indicators: Specific percentage reduction targets for preventable separation

69

70 **Expected Outcomes**

71

72 Short-term (1-2 years):

73 Establish retention as a profession-wide priority through creation of a “data dictionary” of workforce
74 related variables at the national level partnering with related organizations.

75 Board integration of retention considerations into existing strategic initiatives

76 Enhanced member value through APTA attention to career sustainability and development of an
77 “exit” interview/survey when members leave the organization.

78 Medium-term (2-5 years):

79 Development of retention resources and best practices for employers

80 Inclusion of separation metrics (required element) in annual workforce data collection that could be
81 part of the annual membership renewal process.

82 Strengthened advocacy messaging linking payment reform to workforce sustainability

83 Long-term (5+ years):

84 Measurable reduction in separation rates

85 Improved career longevity across the profession by developing a tracking mechanism from
86 application (PTCAS) to perpetual (ie., licensing jurisdictions, FSBPT, Healthcare Regulatory Research
87 Institute)

88 Enhanced public access to physical therapist services through workforce stability

89

90 **How does this motion contribute to achieving the Vision?**

91 This motion directly advances that vision by ensuring the physical therapy profession has the
92 workforce capacity to fulfill its societal promise. A sustainable, experienced workforce is the
93 foundation upon which transformation occurs. Specifically, this policy supports the vision through
94 alignment with its guiding principles:

95 Access/Equity: Communities cannot experience equitable access to movement optimization when
96 workforce separation creates service gaps. Research shows that nearly half of physical therapists
97 report capacity shortfalls, with patients waiting an average of 15 days for services. This policy
98 addresses the root causes of these access barriers.

99 Quality: Experienced clinicians are essential to delivering high-quality care. When approximately 70%
100 of therapists consider leaving their positions, society loses the accumulated clinical expertise
101 necessary for optimal outcomes. Retention strategies preserve institutional knowledge and clinical
102 excellence.

103 Value: Workforce instability undermines the value proposition of physical therapy to society. High
104 separation rates increase recruitment and training costs, reduce continuity of care, and limit the
105 profession’s capacity to demonstrate population health impact.

106 Innovation: Sustained workforce engagement enables the profession to innovate in practice models,
107 technology adoption, and service delivery. Clinicians who plan long-term careers invest in
108 professional development and drive transformation forward.

109 In summary, APTA cannot transform society by optimizing movement if the workforce needed to
110 provide those services is leaving the profession prematurely. This policy makes workforce
111 sustainability a strategic imperative, not an afterthought, in achieving the vision.

112

113 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

114 This comprehensive policy provides specific operational guidance for advancing all three strategic
115 priorities:

116 Advancing Our Payment:

117 Creates data infrastructure to quantify economic impact of inadequate payment on workforce
118 sustainability

119 Mandates advocacy connecting payment reform to retention (Action Item 3)

120 Establishes employer accountability for sustainable compensation (Position Item 2)

121 Links administrative burden reduction to retention outcomes (Position Item 4)

122 Empowering Our Members:

123 Mandates development of member resources for career sustainability (Action Item 2)

124 Requires tracking retention across career stages to ensure value delivery "when and how members
125 need it"

126 Explicitly addresses belonging through diversity-aware retention strategies (Position Item 6)

127 Creates professional development emphasis supporting lifelong engagement (Position Item 5)

128 Evolving Our Practice:

129 Enables practice model innovation by ensuring workforce stability

130 Supports technology adoption through retention of experienced clinicians who can champion
131 change

132 Provides data to guide development of sustainable new practice models (Action Item 1)

133 Creates feedback loop between workforce sustainability and practice transformation (Action Item 5)

134

135 **How is this motion's subject national in scope and importance?**

136 This policy is national in scope and importance because it requires national coordination of:

137 Standardized Metrics: Only APTA can establish profession-wide definitions and measurement
138 approaches enabling cross-state, cross-setting comparison

139 Federal Policy Advocacy: Student debt, Medicare reimbursement, and regulatory burden require
140 national advocacy infrastructure

141 Evidence Synthesis: Aggregating data from 50 states and multiple practice settings requires national-
142 level analysis capacity

143 Resource Development: Creating evidence-based resources achieves economies of scale at national
144 level vs. 51 separate state efforts

145 Professional Standards: APTA is the authoritative voice for professional expectations around
146 workforce sustainability

147 Research Coordination: National policy enables coordinated research agenda and funding strategies

148

149 **What previous or current initiatives and positions of the Association address this topic?**

150 [Workforce Planning](#) (HOD P06-20-41-33): we are proposing to rescind this position and replace it
151 with this motion/policy

152

153 **What interested parties will be impacted by this motion?**

154

155 Internal:

156 APTA Board of Directors: Strategic integration of retention data and resource allocation

157 APTA Components and Chapters: Collaboration on data collection and state-level advocacy

158 PT and PTA Members: Career longevity resources and improved workplace advocacy

159 PT and PTA Student Members: Preparation for sustainable careers

160 PT and PTA Education Programs: Curriculum guidance and career preparation

161 Foundation for Physical Therapy Research: Research collaboration on retention interventions

162 External:

163 Employers and Healthcare Organizations: Evidence-based retention strategies and benchmarking
164 tools

165 Patients and Communities: Improved access, continuity of care, and quality (addressing 49% burnout
166 rate)

167 Payers: Cost-effectiveness through workforce stability and data-driven reimbursement discussions

168 Policymakers: Data-driven advocacy for payment reform and administrative burden reduction

169 Other Healthcare Professions: Model for workforce sustainability approaches

170 Employer Groups and Wellness Programs: Sustainable PT workforce for direct-to-employer services

171

172 **Additional background information**

173 Potential Association Actions

174 To operationalize this policy, APTA shall:

175 Enhance Data Collection:

176 Establish standardized definitions and metrics for tracking PT and PTA separation from clinical
177 practice, including disaggregated demographic data;

178 Incorporate separation and retention indicators into annual Physical Therapy Profile reports;

179 Track longitudinal career and work schedule patterns to identify critical separation points and
180 protective factors.

181 Commitment to disaggregated demographic analysis to identify equity gaps Partnership with
182 existing data collection mechanisms (FSBPT, etc.)

183 Clear definitions of "separation" vs. "career change" vs. "retirement"

184 Develop Evidence-Based Resources:

185 Create and disseminate best practice guidelines for employers on evidence-based retention
186 strategies;

187 Develop benchmarking tools enabling practice settings to assess their retention risk factors;

188 Produce resources for individual clinicians on career sustainability strategies;

189 Provide guidance for educators on preparing students for career longevity.

190 Strengthen Advocacy:

191 Utilize separation data to strengthen advocacy arguments for payment reform, administrative
192 burden reduction, and student debt relief;

193 Advocate for policy changes addressing root causes of preventable separation;

- 194 Collaborate with employer organizations to promote sustainable workforce practices;
- 195 Creating employer recognition programs for retention excellence
- 196 Development of case studies demonstrating ROI of retention strategies
- 197 Collaboration with large healthcare system partners as pilot sites
- 198 Support state chapters in state-level retention advocacy.
- 199 Support Research:
- 200 Identify research priorities related to workforce retention and career longevity;
- 201 Encourage and facilitate research on effective retention interventions and return-to-practice
- 202 pathways;
- 203 Partner with academic institutions and the Foundation for Physical Therapy Research to advance the
- 204 evidence base.
- 205 Monitor and Report:
- 206 Regularly assess progress toward workforce sustainability goals;
- 207 Report annually to the House of Delegates on workforce retention trends and APTA initiatives;
- 208 Adjust strategies based on emerging data and evidence.
- 209 6. PTA Specific Considerations:
- 210 Acknowledging unique retention challenges for PTAs
- 211 Committing to PTA-specific data collection (currently noted as a gap)
- 212 Including PTA representation in advisory/implementation groups
- 213

214 **References:**

- 215 1. Handlery K, McQueeney S, Handlery R, Regan EW, Fritz SL. Factors contributing to physical
- 216 therapist separation: a qualitative study. *J Phys Ther Educ.* 2024;53(1):e1-e12.
- 217 2. Mak S, Thomas A, Razack S, Root K, Hunt M. Unraveling separation and retention: a
- 218 qualitative study with rehabilitation professionals. *Work.* 2024;77(4):1227-1241.
- 219 3. Bhardwaj A, Gibson JAG, Dunlop S, et al. Prevalence of burnout among physiotherapists: a
- 220 systematic review and meta-analysis. *Physiotherapy.* 2024;124:35-42.
- 221 4. Campo M, Shiyko M, Lichtman SW, Rohde C. Risk factors associated with physical therapist
- 222 burnout: a systematic review. *Physiotherapy.* 2022;116:9-19.
- 223 5. Kooienga S, Carryer J. Globalization and advancing mental health nursing knowledge and
- 224 practice. *J Psychiatr Ment Health Nurs.* 2015;22(9):742-752.
- 225 6. Bowens AN, Amamoo MA, Blake DD, Clark B. Assessment of professional quality of life in the
- 226 Alabama physical therapy workforce. *Phys Ther.* 2021;101(5):pzab089.
- 227 7. Roth L, Le Saux C, Gilles I, et al. Strategies that impact the workforce retention of
- 228 physiotherapists and other allied health professionals: a scoping review. *Physiother Theory*
- 229 *Pract.* 2025;41(3):663-683.
- 230 8. Haynes SL, Lee MHL, Yeager JL. Current and projected future supply and demand for physical
- 231 therapists from 2022 to 2037: a new approach using microsimulation. *Phys Ther.*
- 232 2025;105(1):pzae143.
- 233 9. American Physical Therapy Association. Vision Statement for the Physical Therapy Profession.
- 234 HOD P06-13-18-22. <https://www.apta.org/apta-and-you/leadership-and->

governance/policies/vision-statement-for-the-physical-therapy-profession. Accessed February 1, 2026.

10. American Physical Therapy Association. Guiding Principles to Achieve the Vision. HOD P06-19-46-54. <https://www.apta.org/siteassets/pdfs/policies/guiding-principles-to-achieve-vision.pdf>. Accessed February 1, 2026.

Last Updated: 5/8/2026

Contact: governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 06-26 AMEND: STANDING RULES OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, 9. MAIN MOTION CRITERIA

1 **Proposed by:** Ohio
2 **Primary Motion Contact:** Anthony DiFilippo, PT, DPT, MEd
3 [Discussion Thread](#)

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

6
7 **That Standing Rules of the American Physical Therapy Association, Rule 9. Main Motion Criteria,**
8 **be amended by substitution:**

9
10 9. Main Motion Criteria

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

- 13 (1) Provide a statement of the intended outcome of the motion.
- 14 (2) Demonstrate that the motion meets the purposes of the association.
- 15 (3) Demonstrate that the motion’s subject is national in scope or importance.
- 16 (4) Provide pertinent background information, in collaboration with the Board or
17 staff, as necessary, including (a) a description of previous House, Board, or staff
18 activity relating to the subject and (b) an identification of the stakeholders affected by
19 the motion.
- 20 (5) When possible, demonstrate that the motion concept has been disseminated to
21 delegates of other delegations prior to the deadline for submission of main motions.
- 22 (6) Provide a description of the potential resources needed to adopt and implement
23 the motion.

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

30
31

32 **Support Statement**

33

34 **What is this motion seeking to achieve?**

35 If adopted by the House, this motion will enhance the efficiency and effectiveness of delegate
36 preparations for thoughtful debates thereby enhancing the decision-making process within the
37 American Physical Therapy Association House of Delegates. It will ensure that only motions that
38 meet the established criteria are considered, allowing delegates to focus their preparation and
39 deliberations.

40

41 **How does this motion contribute to achieving the Vision?**

42 This motion advances the APTA Vision by ensuring that only fully vetted motions—those meeting
43 the criteria established by the Reference Committee—are considered during House proceedings.
44 Delegates are thus able to dedicate their attention to motions that are impactful, time sensitive, and
45 most likely to drive meaningful progress within the profession. In fostering a focused and rigorous
46 deliberative environment, this motion enhances delegate engagement, strengthens decision-making,
47 and supports the advancement of physical therapy in alignment with the American Physical Therapy
48 Association’s Vision.

49

50 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

51 This motion supports APTA priorities as reflected in the 2026 Strategic Framework by promoting
52 operational excellence, member engagement, and the advancement of physical therapy practice. By
53 hearing only vetted motions that meet established guidelines set forth by the Reference Committee,
54 the House can be more focused and engage in thoughtful deliberation and evidence-based
55 decision-making, which is essential to fostering innovation and professional growth. Furthermore,
56 prioritizing thoroughly vetted motions reduces administrative burden and allows delegates to
57 dedicate their efforts toward initiatives that directly contribute to APTA’s mission of transforming
58 society through physical therapy. In doing so, the motion advances strategic priorities of leadership
59 development, advocacy, and the dissemination of best practices within the profession.

60

61 **How is this motion’s subject national in scope and importance?**

62 This motion is nationally significant as it affects decision-makers representing physical therapy
63 professionals across the United States. By hearing only motions meeting established criteria, the
64 proposal improves efficiency and reduces the House’s workload. It ensures all regions and specialties
65 are considered in evidence-based advancements, supports nationwide consistency and excellence,
66 and helps the American Physical Therapy Association effectively address challenges for practitioners,
67 patients, and communities. Ultimately, this motion enhances the profession’s ability to adapt to
68 healthcare needs and uphold high practice standards nationwide.

69

70 **What previous or current initiatives and positions of the Association address this topic?**

71 Across reporting cycles from 2021 through 2025, APTA has demonstrated consistent commitment to
72 modernizing governance structures, strengthening member engagement, and advancing impactful

73 professional initiatives. In 2021 the House of Delegates adopted RC 13-21 Charge: Review of Year-
74 Round Governance, which read: “That the American Physical Therapy Association, to ensure
75 efficient, optimal, and equitable delegate engagement in the House of Delegates, evaluate the
76 expectations of the House governance cycle and the resulting obligations of members, components,
77 and APTA staff and resources to assess the purposes, outcomes, and sustainability of the House
78 governance cycle. A report with a description of the evaluation and recommendations, including a
79 calendar, will be made available to delegates at least two weeks before the 2022 main motion
80 deadline.” As noted in the Report to the 2024 House of Delegates, In January 2023, the Board of
81 Directors began an initiative to rethink the House of Delegates' roles and operations to better
82 support the physical therapy profession by 2030. The House Officers outlined this vision and value
83 proposition in a Case Statement, positioning the House as a guiding force for these changes: “By
84 2030, the APTA House of Delegates will be inclusive and welcoming of broad viewpoints. The House
85 will identify and deliberate strategic priorities that result in impactful and relevant action, focused on
86 the profession’s future.’ By changing the rule to allow only those motions that the Reference
87 Committee determines meet the criteria, this motion prioritizes proposals that are time sensitive and
88 impactful to our profession. The 2025 Report to the House demonstrates full integration of the year
89 round governance structure. The House also engaged in generative discussions addressing major
90 professional priorities such as payment and workforce challenges. Topics were selected through
91 structured delegate input, strengthening alignment with broader professional needs. Furthermore,
92 the motion concept phase was expanded to support early collaboration, improve clarity, and
93 enhance the quality of motions submitted to the House. This motion will continue to strengthen
94 proactive engagement helping build consensus, identify potential concerns early, and ensure that all
95 voices are heard before formal debate begins, and contribute to a more informed and productive
96 session of the House.

97
98 **What interested parties will be impacted by this motion?**

99 Internal stakeholders impacted by this motion include APTA members, delegates and chief
100 delegates, reference committee members, leadership, and staff, as they will need to adapt to any
101 changes in association policies, procedures, or operations resulting from the motion.

102
103 **Additional background information**

104 Beyond the aforementioned points, it is essential to recognize that this motion and its accompanying
105 support statement demonstrate the Association's dedication to continuous advancement and
106 responsiveness.

107 The purpose of this amendment is to streamline the process for main motion deliberation for the
108 delegates, minimizing unnecessary stress and expenditure of time and effort for all parties involved.
109 Importantly, the revised language is not intended to prevent new ideas from being considered by
110 the House; rather, it ensures that motions are reviewed efficiently while maintaining an open
111 pathway for thoughtful proposals to move forward. The established criteria for bringing a motion
112 forward will not change, nor will the evaluation process that the Reference Committee uses for
113 evaluating motions.

114 This amendment would ensure that all future motions meet the established minimum criteria. By
115 focusing their efforts on motions that meet established criteria, delegates can avoid unnecessary
116 preparation for items that may not merit full consideration, thereby reducing stress and allowing for
117 a more efficient and focused decision-making environment.
118 Encouraging early collaboration and communication among delegates—particularly through the
119 community page—will significantly improve the quality of deliberations. Sharing insights, addressing
120 questions, and exchanging pertinent information before the House session enables delegates to
121 understand the motions and their potential impacts more deeply. This proactive approach fosters
122 consensus, surfaces concerns early, and ensures inclusive participation.

123
124 **References:**

125

126 **Last Updated:** 5/8/2026

127 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 07-26 AMEND: STANDING RULES OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, 10. NUMBER OF MAIN MOTIONS PER HOUSE OF DELEGATES SESSION

1 **Proposed by:** Ohio
2 **Primary Motion Contact:** Anthony DiFilippo, PT, DPT, MEd
3 [Discussion Thread](#)

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

6
7 *Ellipses (...) indicate language that is not being amended and therefore has not been included to make*
8 *the document more concise.*

9
10 That Standing Rules Of The American Physical Therapy Association be amended by inserting a
11 new rule 10 and renumbering the remaining rules so that it would read:

12
13 **9. Main Motion Criteria**

14

15
16 10. Number of Main Motions per Session of the House

- 17 A. The House will consider no more than 25 main motions per session, in addition to the
18 consent calendar.
19 B. The House Officers shall prioritize and rank the motions, in consultation with the Chief
20 Delegates Council, to determine the 25 motions to be considered by the House.
21 C. The prioritization process shall be based on criteria including, but not limited to, national
22 impact, alignment with the association’s strategic framework, and relevance to the profession.
23 D. Motions not selected will not be considered during the current House session but may be
24 resubmitted in accordance with established procedures for future House sessions.

25
26 ~~10-11.~~ **Bylaws and House Documents Committee**

27

28
29
30 **Support Statement**

31

32 **What is this motion seeking to achieve?**

33 If adopted by the House, this motion will ensure motions deemed most essential to the future of the
34 PT profession will be brought forth to the house floor. The motion will enhance the efficiency and
35 effectiveness of delegate preparations for thoughtful deliberations. It will ensure that only
36 thoroughly vetted and qualified motions are considered, allowing delegates to focus their
37 preparation and deliberations on main motions which merit the time and energy investment of those
38 serving to advance physical therapy practice. By limiting the volume of main motions being
39 considered, the House of Delegates will be focusing on those issues which are legitimately impactful
40 to the profession and our membership while motions with limited scope and impact will not be
41 brought forth.

42
43 **How does this motion contribute to achieving the Vision?**

44 This motion contributes to the APTA vision by fostering an environment where delegates can
45 concentrate on motions that impact our patients, our profession, our association, and our society.
46 Motions with the greatest potential impact to the future of our profession will be prioritized.

47
48 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

49 This motion supports APTA priorities as reflected in the 2026 Strategic Framework by promoting
50 operational excellence, member engagement, and the advancement of physical therapy practice. By
51 streamlining the review and decision-making process, the motion ensures that proposals receiving
52 consideration are aligned with the association's standards and strategic goals. This focused approach
53 encourages thoughtful deliberation and evidence-based decision-making, which are essential to
54 fostering innovation and professional growth. Furthermore, prioritizing thoroughly vetted motions
55 reduces administrative burden and allows delegates to dedicate their efforts to initiatives that
56 directly contribute to APTA's mission of transforming society through physical therapy. In doing so,
57 the motion advances key strategic priorities such as leadership development, advocacy, and the
58 dissemination of best practices within the profession.

59
60 **How is this motion's subject national in scope and importance?**

61 This motion's subject is national in scope and importance because it impacts the decision-making
62 processes of delegates representing physical therapy professionals across the United States. By
63 establishing a more efficient and effective method for reviewing and prioritizing motions, the
64 proposal ensures that all regions and specialties within the profession benefit from thoughtful,
65 evidence-based advancements. The streamlined approach supports consistency and excellence
66 nationwide, enabling the American Physical Therapy Association to address challenges and
67 opportunities affecting practitioners, patients, and communities throughout the country. Ultimately,
68 this motion strengthens the profession's ability to respond to evolving healthcare needs and
69 promotes the highest standards of practice on a national level.

70
71 **What previous or current initiatives and positions of the Association address this topic?**

72 This Motion to amend does not directly impact initiatives or positions but will streamline future
73 initiative and position motions to ensure thorough review and thoughtful vetting prior to final
74 decision-point discussions.

75
76 **What interested parties will be impacted by this motion?**

77 Internal stakeholders impacted by this motion include APTA members, leadership, and staff, as they
78 will need to adapt to any changes in association policies, procedures, or operations resulting from
79 the motion. These groups may experience shifts in responsibilities, engagement in new initiatives, or
80 adjustments to current practices to align with the amended motion. Optimally delegates will be
81 able to focus on motions that will have a greater impact on external stakeholders.

82
83 **Additional background information**

84 The goal of this motion to amend the current policy represents a commitment of the Association to
85 improve the delegate experience by streamlining the motion process. This in turn will manage the
86 workload and will encourage collaboration across the community to improve the substance of
87 deliberations.

88 The purpose of this amendment is to streamline the process for main motion deliberation for the
89 delegates, minimizing unnecessary expenditure of time and effort for all parties involved.

90 Importantly, the revised language is not intended to prevent new ideas from being considered by
91 the House; rather, it ensures that motions are reviewed efficiently while maintaining an open
92 pathway for thoughtful proposals to move forward.

93 The amendment aims for the most pertinent, high-impact issues to be brought forth and debated in
94 full on the house floor. The structure enables delegates to adequately prepare for vetted motions in
95 advance, ensuring informed discussion and thoughtful deliberation. By focusing their efforts on a
96 focused number of motions, delegates can avoid unnecessary preparation for items that will not be
97 considered, thereby reducing stress and allowing for a more efficient and focused decision-making
98 environment.

99 It is envisioned that chief delegates, with input from their delegation, will rank all motions in terms of
100 national importance and alignment with APTA vision and strategic plan (ranking 1-xx). The chief
101 delegates will rank individually, and mean values will be used to order motions. At the time the
102 house commences, items on the consent calendar will be removed from the rank order; the
103 remaining top 25 motions will be brought forth. In the event that a motion is removed from the
104 consent calendar following the commencement of the house, it will go back to its previous ranking.
105 No more than the top 25 motions will be brought forth on the house floor.

106 This strategy will incentivize motions that are candidate for the consent calendar to be discussed and
107 refined prior to the HOD. By sharing perspectives, clarifying questions, and exchanging relevant
108 information in advance, delegates can enter the session with a deeper understanding of the motions
109 and their implications. This proactive engagement helps build consensus, identify potential concerns
110 early, and ensure that all voices are heard before formal debate begins. Allowing the chief delegates
111 to determine the 25 motions to be considered ultimately contributes to more informed and
112 productive results during the House session.

113

114 **References:**

115 American Physical Therapy Association. (2025). APTA Bylaws and Policy Manual.

116

117 **Last Updated:** 5/8/2026

118 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 08-26 RECOMMEND: EVALUATE A COLLABORATION WITH THE AMERICAN HEART ASSOCIATION MILLION HEARTS CAMPAIGN

1 **Proposed by:** Minnesota
2 **Primary Motion Contact:** Nathan Hellyer PT, PhD
3 [Discussion Thread](#)

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

6
7 That the American Physical Therapy Association evaluate a collaboration with the American Heart
8 Association Million Hearts campaign to advance cardiovascular health promotion, disease
9 prevention, and interprofessional collaboration within the physical therapy profession.

10
11
12 **Support Statement**

13
14 **What is this motion seeking to achieve?**

15 If adopted, this motion would direct the APTA to evaluate a formal collaboration with the American
16 Heart Association's Million Hearts® campaign, positioning physical therapists as essential
17 contributors to national cardiovascular disease prevention efforts. This coalition would elevate the
18 profession's visibility in public health initiatives, strengthen interprofessional relationships with
19 cardiology and primary care clinicians, and create opportunities for physical therapists to
20 demonstrate their expertise in exercise prescription and movement-based interventions at the
21 population health level. Ultimately, it would advance the profession's role in preventing disease—not
22 just treating its consequences—and reinforce the value of movement optimization in improving
23 health outcomes across the lifespan. Cardiovascular disease remains the leading cause of death in
24 the United States. Physical therapists possess unique and vital expertise in prescribing exercise and
25 movement interventions, tailored to individual capacity and risk. A collaboration with Million
26 Hearts® would create essential pathways to integrate this expertise into large-scale prevention
27 efforts, proactively reaching populations before they experience cardiac events, rather than solely
28 afterward. The American Heart Association's (AHA) Million Hearts® campaign specifically targets the
29 prevention of heart attacks and strokes by addressing modifiable risk factors such as physical
30 inactivity, hypertension, and obesity. The Million Hearts® Collaboration to Prevent Heart Disease
31 and Stroke (MHC), established in 2015, unites national, state, and local partners to implement Million

32 Hearts® strategies. MHC organizations disseminate evidence-based cardiovascular disease
33 prevention resources, promote consistent cardiovascular health messaging, and facilitate the sharing
34 of best practices. While esteemed organizations like the AMA, YMCA of the USA, the Association of
35 Public Health Nurses, and the Preventive Cardiovascular Nurses Association are active collaborators,
36 the APTA is notably absent from this crucial initiative. This motion for the 2026 House of Delegates
37 seeks to have the APTA Board of Directors explore a collaborative membership with the AHA Million
38 Hearts® campaign. This motion fully aligns with the APTA's vision and mission to transform society
39 and build community to improve health. Achieving such societal transformation necessitates working
40 beyond traditional professional silos. Aligning with the American Heart Association—a highly visible
41 and trusted organization—will significantly amplify physical therapy's voice in national health
42 conversations and powerfully demonstrate our profession's commitment to collaborative,
43 population-level impact.

44
45 **How does this motion contribute to achieving the Vision?**

46 a. Expanding Physical Therapy's Role

47 The Million Hearts® campaign focuses on preventing heart attacks and strokes through addressing
48 modifiable risk factors like physical inactivity, hypertension, and obesity. By partnering with this
49 initiative, physical therapists position themselves as essential contributors to cardiovascular health—
50 not just rehabilitation specialists, but proactive agents in disease prevention. This expands the
51 profession's influence on society's understanding and use of movement as medicine.

52 b. Optimizing Movement as a Public Health Intervention

53 Cardiovascular disease remains the leading cause of death in the United States. Physical therapists
54 possess unique expertise in prescribing exercise and movement interventions tailored to individual
55 capacity and risk. A coalition with Million Hearts® creates pathways to integrate this expertise into
56 large-scale prevention efforts, reaching populations before they experience cardiac events rather
57 than only afterward.

58 c. Improving the Human Experience Through Prevention

59 The vision speaks to improving the human experience, encompassing quality of life, not just the
60 treatment of dysfunction. Preventing a heart attack or stroke means preserving someone's ability to
61 move, work, care for family, and participate in their community. This coalition positions physical
62 therapists as partners in helping people maintain their fullest lives rather than recovering from
63 preventable losses.

64 d. Transforming Society Through Interprofessional Collaboration

65 Achieving societal transformation requires working beyond professional silos. Aligning with the
66 American Heart Association—a highly visible, trusted organization—amplifies physical therapy's
67 voice in national health conversations and demonstrates the profession's commitment to
68 collaborative, population-level impact.

69
70 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

71 a. Advancing Our Payment

72 A collaboration with the Million Hearts® campaign would strengthen the case for physical therapists
73 as essential providers in value-based care models that prioritize prevention and outcomes over
74 volume. Cardiovascular disease prevention programs increasingly attract reimbursement through
75 Medicare's chronic care management codes, cardiac rehabilitation programs, and emerging value-
76 based payment arrangements. By formally aligning with a CMS co-led initiative, the profession gains
77 credibility and visibility with the very payers shaping future reimbursement policy, creating
78 opportunities to expand covered services and to demonstrate physical therapy's role in reducing
79 costly downstream events such as heart attacks and strokes.

80 b. Empowering Our Members

81 This collaboration would open doors for professional development, specialized training, and practice
82 resources related to cardiovascular health promotion. Members across career stages and settings—
83 from new graduates seeking differentiation to experienced clinicians expanding their scope—would
84 benefit from APTA-developed toolkits, continuing education, and evidence-based protocols
85 emerging from the partnership. It provides a tangible, high-profile initiative that members can
86 engage with locally while feeling connected to a broader national effort.

87 c. Evolving Our Practice

88 The motion directly supports practice transformation by encouraging physical therapists to move
89 beyond traditional episode-based care toward proactive, population-health models. Partnering with
90 Million Hearts® accelerates adoption of prevention-focused services, positions physical therapists
91 within interprofessional care teams addressing chronic disease, and demonstrates the profession's
92 capacity to contribute to public health priorities—expanding how society views and utilizes physical
93 therapy.

94
95 **How is this motion's subject national in scope and importance?**

96 Cardiovascular disease is the leading cause of death in the United States, claiming approximately
97 695,000 lives annually and affecting every community regardless of geography, demographics, or
98 socioeconomic status. The Million Hearts® campaign is a national initiative co-led by the Centers for
99 Disease Control and Prevention and the Centers for Medicare & Medicaid Services, with a goal of
100 preventing one million heart attacks and strokes over five years. Physical therapists practice in all 50
101 states and across diverse settings—from rural health clinics to urban hospital systems—making the
102 profession uniquely positioned to contribute to this nationwide effort. A collaboration between APTA
103 and Million Hearts® would establish a unified, national framework for physical therapist
104 engagement in cardiovascular prevention, ensuring consistent messaging, shared resources, and
105 coordinated advocacy efforts that transcend state and regional boundaries. This motion addresses a
106 health crisis affecting every corner of the nation and leverages the physical therapy profession's full
107 geographic reach to make a meaningful impact.

108
109 **What previous or current initiatives and positions of the Association address this topic?**

110 [Commitment to Interprofessional Education and Practice](#) (HOD P07-24-09-16)

111 [Endorsements](#) (BOD Y11-22-05-25)

112 [Health And Social Issues](#) (HOD P06-19-46-21)

113 [Physical Therapists' Role In Prevention, Wellness, Fitness, Health Promotion, And Management Of](#)
114 [Disease And Disability](#) (HOD P06-19-27-12)
115 [Health Priorities For Populations And Individuals](#) (HOD P06-19-41-15)
116

117 **What interested parties will be impacted by this motion?**

118 The APTA will need to collaborate with the American Heart Association (AHA) and the Million
119 Hearts® Collaboration (MHC). The MHC was established in 2015 to bring together national, state,
120 and local partners to implement Million Hearts® strategies.
121

122 **Additional background information**

123 <https://www.heart.org/en/professional/million-hearts/about-million-hearts>
124

125 **References:**

- 126 1. American Heart Association. (2024). Heart disease and stroke statistics—2024 update: A
127 report from the American Heart Association. *Circulation*, 149(8), e347–e913.
128 <https://www.ahajournals.org/doi/10.1161/CIR.0000000000001209>
- 129 2. American Physical Therapy Association. (2024). APTA strategic plan and framework.
130 [https://www.apta.org/apta-and-you/leadership-and-governance/vision-mission-and-](https://www.apta.org/apta-and-you/leadership-and-governance/vision-mission-and-strategic-plan/strategic-framework)
131 [strategic-plan/strategic-framework](https://www.apta.org/apta-and-you/leadership-and-governance/vision-mission-and-strategic-plan/strategic-framework)
132

133 **Last Updated:** 5/8/2026

134 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 09-26 RECOMMEND: WEBSITE AUTHORSHIP

1 **Proposed by:** Maine

2 **Primary Motion Contact:** Heather Eastty, PT, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That information on the American Physical Therapy Association website, including but not limited to
8 guidance on practice, legal, regulatory, licensure, and ethical matters, shall include documentation of
9 or links to references and the names of the authors. APTA encourages its components to follow
10 similar guidelines for information on their websites.

11

12

13 **Support Statement**

14

15 **What is this motion seeking to achieve?**

16 The website of the American Physical Therapy Association includes guidance on practice, legal,
17 regulatory, licensure, and ethical matters (hereinafter referred to as “articles”). These articles about
18 career development and advancement, patient care, payment, and advocacy serve as a valuable
19 resource to members during their decision-making related to each of these issues. All clinical
20 summaries and clinical practice guidelines, many of the test and measures reviews, and some articles
21 in the areas of intervention, payment, and advocacy include authorship. This is evidence that the
22 APTA does value the role of documenting who authored the publication. This motion would require
23 that authorship is documented for all articles. This would be ideally completed in a by-line, at the
24 beginning or end of each article. Additionally, resources utilized in many of the articles and resources
25 are well-documented in online resources. This motion would expand this typical practice to a
26 requirement for all articles and ask that these resources include a permalink, when possible, to allow
27 for the greatest access to resources by members.

28

29 **How does this motion contribute to achieving the Vision?**

30 By maintaining the quality of practice, ensuring that all information published by the professional
31 organization is accurate, properly references, and authors are accountable.

32

33 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

34 By indicating the source of all communication on the website, members are better able to follow up
35 on payment-related issues. The website features numerous articles that address payment-related
36 problems, many of which include interpretations of complex laws or regulatory matters. By allowing
37 follow-up with authors and associated resources, members can clarify confusing or conflicting
38 information.

39
40 **How is this motion's subject national in scope and importance?**

41 Resources on the APTA's website are available to all members regardless of region or practice
42 setting.

43
44 **What previous or current initiatives and positions of the Association address this topic?**

45 Unable to locate any that address this issue.

46
47 **What interested parties will be impacted by this motion?**

48 The Board will have to utilize time resources to ensure authorship on all articles posted on the
49 website.

50
51 **Additional background information:**

52
53 **References:**

54 Examples of articles without authorship:

55 [https://www.apta.org/your-practice/payment/coding-billing/coding-interpretations-group-therapy-](https://www.apta.org/your-practice/payment/coding-billing/coding-interpretations-group-therapy-patient-scenarios)
56 [patient-scenarios](https://www.apta.org/your-practice/payment/coding-billing/coding-interpretations-group-therapy-patient-scenarios)

57 <https://www.apta.org/your-practice/payment/coding-billing/commercial-insurance/tpa-umur>

58 <https://www.apta.org/your-practice/payment/medicaid/medicaid-enrollment-requirements>

59
60 **Last Updated:** 5/8/2026

61 **Contact:** governancehouse@apta.org

62

Motion to 2026 House of Delegates

Main Motion:

RC 10-26 RECOMMEND: MOTIONS NOT HEARD IN THE HOUSE OF DELEGATES

1 **Proposed by:** Hawaii

2 **Primary Motion Contact:** Douglas White, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 Any main motion placed on the agenda of the House of Delegates that is not considered prior to
8 adjournment due to time constraints shall be referred to the Board of Directors for review.

9

10

11 **Support Statement**

12

13 **What is this motion seeking to achieve?**

14 A considerable amount of time, money, opportunity costs, and human resources are expended for
15 each motion ordered on the House of Delegates agenda. Collectively APTA, its components, and
16 delegates pay in excess of \$2 million each year for the HOD. Due only to time constraints, in some
17 years, some motions are not heard.

18

19 The BOD has stated they have no intention of acting on any motions not heard regardless of the
20 merits of the motion. This arbitrary position is a disservice to APTA members, the profession, and a
21 huge waste of resources. There are motions, which with time permitting, would easily be adopted by
22 HOD. Some of these motions have the potential for significant positive impact on the profession.
23 Some reordering of the agenda could be avoided if the BOD committed to addressing some
24 motions. Some motions are reintroduced the following year incurring additional costs. Some
25 motion-makers give up and are dissatisfied with APTA and the process.

26

27 It would be a low resource initiative for the BOD to consider those motions which have merit, a huge
28 cost savings for all involved, and a huge boost to membership belonging. The BOD would have
29 full discretion to decide what motions if any to act on, but responsible leadership requires
30 consideration at a minimum.

31

32 **How does this motion contribute to achieving the Vision?**

33 Motions not heard solely due to time constraints have the potential to impact the Vision.

34

35 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

36 In 2025 there were multiple motions implicating payment policy that were not heard due to time. If
37 these motions had been heard or at least considered by the BOD payment could have been
38 improved.

39

40 **How is this motion's subject national in scope and importance?**

41 Applies to HOD motions which is the national policy body of APTA.

42

43 **What previous or current initiatives and positions of the Association address this topic?**

44 APTA does not have a position on motions not heard in the HOD.

45

46 **What interested parties will be impacted by this motion?**

47 HOD, BOD, potentially others. The HOD will be assured the BOD will look at the merits of any motion
48 not heard and take action as appropriate. This will allow for better use of HOD time by reducing
49 reordering and ensure motions that have merit are acted on by either the HOD or the BOD

50

51 **Additional background information**

52 The following are the number of motions not considered over the last 10 years: 2016 – 0 2017 – 0
53 2018 – 0 2019 – 0 2020 – 6 2021 – 1 2022 – 3 2023 – 2 2024 – 2 2025 13

54

55 **References:**

56

57 **Last Updated:** 5/8/2026

58 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 11-26 RECOMMEND: ADVOCACY FOR THE USE OF THE DOCTOR OF PHYSICAL THERAPY TITLE AND THE DPT CREDENTIAL

1 **Proposed by:** Hawaii

2 **Primary Motion Contact:** Douglas White, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That the American Physical Therapy Association advocate for and promote the consistent use of the
8 “Doctor of Physical Therapy” title and credential in all contexts.

9

10

11 **Support Statement**

12

13 **What is this motion seeking to achieve?**

14 Require APTA to come into compliance with House policy. Gain recognition of the DPT as the
15 regulatory and professional title and credential.

16

17 **How does this motion contribute to achieving the Vision?**

18 Identity: Gain recognition that physical therapists are doctorly trained. Elevate the stature of the
19 profession.

20

21 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

22 Sustainable profession: increase visibility of physical therapists training and qualification. Quality of
23 Care: demonstrate the high level of education and qualifications of physical therapists.

24

25 **How is this motion’s subject national in scope and importance?**

26 Almost one half of states and probably more than one half of DPTs can use the DPT as a regulatory
27 credential but it is widely unknown. APTA has not taken the necessary steps to encourage adoption
28 of the DPT as the regulatory credential. This applies to every state practice act.

29

30 **What previous or current initiatives and positions of the Association address this topic?**

31 Implementation of [Consumer Protection Through Licensure Of Physical Therapists And Physical](#)
32 [Therapist Assistants](#) (HOD P06-19-51-57)

33
34 **What interested parties will be impacted by this motion?**

35 All physical therapists. All state licensure boards. APTA. DPTs where permitted will use the credential
36 and drop the PT. Licensure boards will use the initiative as a resource. APTA will come into
37 compliance with House policy.

38
39 **Additional background information:**

40 [Consumer Protection Through Licensure Of Physical Therapists And Physical Therapist Assistants](#)
41 (HOD P06-19-51-57)

42
43 The referenced position originates from a position adopted in 2014. Since then, APTA has not
44 actively worked to further the intent of the position. Additionally, APTA's internal policy on
45 credentials is not aligned with the HOD policy. Currently 20 states permit the use of the DPT as the
46 regulatory credential and another 4 have language with some caveats.

47
48 Many physical therapists in the 20 states are unaware of the proper use of the DPT. APTA
49 publications does not align with House policy.

50
51 All physical therapist education programs have been at the DPT level for decades. For all intents the
52 profession is comprised of Doctors of Physical Therapy. The use of the PT credential by DPTs is an
53 anachronism.

54
55 **References:**

56
57 **Last Updated:** 5/8/2026

58 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 12-26 RECOMMEND: PAYMENT RESOURCES FOR THE SCOPE OF PHYSICAL THERAPIST SERVICES

1 **Proposed by:** Hawaii

2 **Primary Motion Contact:** Douglas White, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That the American Physical Therapy Association publish on the APTA website educational materials
8 describing the range of procedures and services within physical therapist services, to support
9 practice sustainability, accurate billing, and expanded payer fee schedules.

10

11

12 **Support Statement**

13

14 **What is this motion seeking to achieve?**

15 Physical therapists billing for and getting paid for the full scope of practice. Greater recognition of
16 the full scope of physical therapist practice within and external of the profession.

17

18 **How does this motion contribute to achieving the Vision?**

19 The motion will increase quality by giving physical therapists the resources to provide all needed
20 services. It will provide value by more efficiently providing services by the physical therapist without
21 unnecessary referrals to others. It will foster innovation by providing resources for physical therapists
22 to offer more services. It will benefit the consumer by having increased access to needed services.

23

24 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

25 This motion contributes to every aspect of the strategic plan. Providing a member value, improving
26 payment which will increase sustainability, improving quality of care by physical therapists providing
27 all needed services, increase demand for physical therapists and increase access to all services
28 physical therapists provide.

29

30 **How is this motion's subject national in scope and importance?**

31 CPT codes are used by all outpatient and inpatient physical therapists who bill third party payors.

32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72

What previous or current initiatives and positions of the Association address this topic?

APTA has intermittently addressed this issue. Currently activity seems to be confined to member resources around new or changed codes.

What interested parties will be impacted by this motion?

All PTs and PTAs who provide clinical services which are billable to third parties. All public and private third part payors. All state policy makers involving physical therapy.

Additional background information:

APTA has limited resources for members describing the range of services which are billable. While copyright restrictions limit APTA's ability to publish specific CPT codes APTA can describe the services physical therapists provide in so that members can easily find and use the appropriate CPT code to bill. Moreover, many payers have narrow fee schedules for physical therapist services thus preventing payment for the full scope of services. The educational materials should be crafted to provide resources for members and comonents to use in advocacy for expanded payer fee schedules.

In addition to the 97xxx series of CPT codes there are many other codes which are within the scope of physical therapist practice. There are codes for strapping, vestibular testing, pulmonary procedures, ultrasound imaging (MSK and abdominal/pelvic), EMG/NCV, vestibular, motion analysis, and neurologic procedures to name some.

Many/most physical therapists are unaware they can bill for procedures outside of the 97xxx series of codes and are unaware of the full range of procedures they can bill. This results in physical therapists leaving millions of dollars on the table each year. This perception also results in physical therapists not performing procedures which are medically necessary and within their scope of practice. This situation also leaves external entities with a perception of physical therapist practice as much smaller than reality.

Members have previously advocated for APTA to fulfill the intent of this motion intermittently over many years. Intermittently APTA has published resources addressing some of these codes, but it has been few and far between. Some resources are no longer available.

One aspect of addressing the long-standing payment crisis is to not leave money on the table. Additionally, if payment can be made for services currently not provided then those services should increase in volume thus providing society with needed services.

References:

73 **Last Updated:** 5/8/2026

74 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 13-26 AMEND: GUIDING PRINCIPLES TO ACHIEVE THE VISION

1 **Proposed by:** APTA Board of Directors

2 **Primary Motion Contact:** Kyle Covington, PT, DPT, PhD

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That Guiding Principles To Achieve The Vision (HOD P06-19-46-54) be amended by substitution.

8

9 GUIDING PRINCIPLES TO ACHIEVE THE VISION

10

11 Movement is a key to optimal living and quality of life across the lifespan that enables every
12 person to participate in and contribute to society. Detriments to health, such as those resulting
13 from a lack of movement, emphasize the need for the physical therapy profession to engage with
14 consumers to overcome barriers and reduce preventable health care costs.

15

16 While transforming society by optimizing movement to improve the human experience is APTA's
17 vision for the physical therapy profession, this vision is meant to inspire society to create systems
18 that optimize movement and function across the lifespan. The following Guiding Principles of
19 Identity, Quality, Collaboration, Value, Innovation, Person-Centricity, Access/Equity, and Advocacy
20 demonstrate how the profession and society will look when this vision is achieved.

21

22 The Guiding Principles are described as follows:

23

24 **Identity.** Physical therapists and physical therapist assistants promote the movement system as
25 the foundation for optimizing movement to improve the health of society. The movement system
26 is the integration of body systems that generate and maintain movement at all levels of bodily
27 function and is the core of the domains of physical therapist services, education, and research.
28 Human movement is a complex behavior within a specific context and is influenced by social,
29 environmental, and personal factors. The human movement system is essential to understanding
30 the structure, function, and potential of the human body. Doctors of physical therapy are
31 qualified and responsible to address all aspects of patient and client management to improve an
32 individual's movement system across the lifespan.

33

34 **Quality.** Physical therapists and physical therapist assistants commit to establishing and
35 adopting best practice standards across the domains of practice, education, and research to
36 respond to a dynamic and ever-changing world. As independent practitioners, doctors of
37 physical therapy embrace best practice standards in all aspects of patient and client
38 management; generate, validate, and disseminate evidence, outcomes, and quality indicators;
39 strive to prevent adverse events related to the care of patients and clients; and demonstrate
40 continuing competence. Educators seek to propagate the highest standards of teaching and
41 learning and support collaboration and innovation throughout academia. Researchers
42 collaborate with clinicians to expand evidence and translate it into practice, conduct comparative
43 effectiveness research, standardize outcome measurements, and participate in interprofessional
44 and intraprofessional research teams.

45

46 **Collaboration.** Physical therapists and physical therapist assistants demonstrate the value of
47 collaboration with other professionals, consumers, community organizations, and governing entities
48 to solve the health-related challenges that society faces. Physical therapists and physical therapist
49 assistants collaborate to ensure that services are coordinated, of value, and person-centered,
50 recognizing practice limitations and referring to and participating with other individuals. Education
51 values and fosters intraprofessional and interprofessional approaches to best meet consumer and
52 population needs and embody team values. Research integrates an interprofessional approach to
53 ensure quality evidence that translates to person-centered, interprofessional practice.

54

55 **Value.** Value in health care is the measured improvement in a person's health outcomes for the
56 cost of achieving that improvement.¹ To ensure the best value, quality physical therapist services
57 provided are effective, safe, person-centered, timely, equitable, integrated, and efficient.²
58 Outcomes are both cost-effective and meaningful to patients and clients. Value is demonstrated
59 and achieved in all settings where physical therapist services are delivered. Accountability is a
60 core characteristic of the profession and is essential to demonstrate value.

61

62 **Innovation.** Physical therapists and physical therapist assistants offer innovative and proactive
63 solutions to enhance health services delivery and demonstrate the value of physical therapist
64 services to society. Innovation in clinical practice occurs in many settings and dimensions,
65 including the adoption of technology to enhance diverse health care delivery models for all
66 aspects of patient and client management. Innovation in education enhances interprofessional
67 and intraprofessional learning and quality by anticipating adult learning needs, fostering
68 educational models, and remote delivery methods. In research, innovation accelerates evidence
69 and the application of new knowledge to optimize movement and function through discovery.
70 Translation of evidence through technology expediently puts discoveries into the hands and
71 minds of clinicians and educators.

72

73 **Person-Centricity.** Physical therapists and physical therapist assistants deliver person-centered
74 care that includes patient and client values and goals and embraces cultural competence and
75 cultural humility to ensure best practice in the delivery of physical therapist services.
76

77 **Access/Equity.** Physical therapists and physical therapist assistants improve access to and equity
78 within the health care system, and minimize the impacts of social drivers of health that contribute
79 to health inequities and disparities for patients and clients across the lifespan.
80

81 **Advocacy.** Physical therapists and physical therapist assistants advocate for patients and clients,
82 their families, caregivers, and support systems at the individual and population levels, and for the
83 physical therapy profession, in all settings. Advocacy promotes societal change; adoption of best
84 practice standards and approaches; and systems that are designed to be person-centered,
85 improve access, enhance equity, and reduce disparities.
86

- 87 1. Teisberg, Elizabeth PhD; Wallace, Scott JD, MBA; O'Hara, Sarah MPH. Defining and
88 Implementing Value-Based Health Care: A Strategic Framework. Academic Medicine 95(5):p
89 682-685, May 2020.
- 90 2. <https://www.who.int/health-topics/quality-of-care>
91

92 Movement is a key to optimal living and quality of life for all people that extends beyond health to
93 every person's ability to participate in and contribute to society. The complex needs of society, such
94 as those resulting from a sedentary lifestyle, beckon for the physical therapy profession to engage
95 with consumers to reduce preventable health care costs and overcome barriers to participation in
96 society to ensure the successful existence of society far into the future.
97

98 While this is APTA's vision for the physical therapy profession, it is meant also to inspire others
99 throughout society to, together, create systems that optimize movement and function for all people.
100 The following principles of Identity, Quality, Collaboration, Value, Innovation, Consumer-centricity,
101 Access/Equity, and Advocacy demonstrate how the profession and society will look when this vision
102 is achieved.
103

104 The principles are described as follows:

105 *Identity.* The physical therapy profession promotes the movement system as the foundation for
106 optimizing movement to improve the health of society. The movement system is the integration of
107 body systems that generate and maintain movement at all levels of bodily function. Human
108 movement is a complex behavior within a specific context, and is influenced by social, environmental,
109 and personal factors. Recognition and validation of the movement system is essential to understand
110 the structure, function, and potential of the human body. The physical therapist will be responsible
111 for evaluating and managing an individual's movement system across the lifespan to promote
112 optimal development; diagnose impairments, activity limitations, and participation restrictions; and

113 provide interventions targeted at preventing or ameliorating activity limitations and participation
114 restrictions. The movement system is the core of physical therapist practice, education, and research.
115

116 *Quality.* The physical therapy profession will commit to establishing and adopting best practice
117 standards across the domains of practice, education, and research as the individuals in these
118 domains strive to be flexible, prepared, and responsive in a dynamic and ever-changing world. As
119 independent practitioners, doctors of physical therapy in clinical practice will embrace best practice
120 standards in examination, diagnosis/classification, intervention, and outcome measurement. These
121 physical therapists will generate, validate, and disseminate evidence and quality indicators,
122 espousing payment for outcomes and patient/client satisfaction, striving to prevent adverse events
123 related to patient care, and demonstrating continuing competence. Educators will seek to propagate
124 the highest standards of teaching and learning, supporting collaboration and innovation throughout
125 academia. Researchers will collaborate with clinicians to expand available evidence and translate it
126 into practice, conduct comparative effectiveness research, standardize outcome measurement, and
127 participate in interprofessional research teams.
128

129 *Collaboration.* The physical therapy profession will demonstrate the value of collaboration with other
130 health care providers, consumers, community organizations, and other disciplines to solve the
131 health-related challenges that society faces. In clinical practice, doctors of physical therapy, who
132 collaborate across the continuum of care, will ensure that services are coordinated, of value, and
133 consumer-centered by referring, co-managing, engaging consultants, and directing and supervising
134 care. Education models will value and foster interprofessional approaches to best meet consumer
135 and population needs and instill team values in physical therapists and physical therapist assistants.
136 Interprofessional research approaches will ensure that evidence translates to practice and is
137 consumer-centered.
138

139 *Value.* Value has been defined as “the health outcomes achieved per dollar spent”.¹ To ensure the
140 best value, services that the physical therapy profession will provide will be safe, effective,
141 patient/client-centered, timely, efficient, and equitable.² Outcomes will be both meaningful to
142 patients/clients and cost-effective. Value will be demonstrated and achieved in all settings in which
143 physical therapist services are delivered. Accountability will be a core characteristic of the profession
144 and will be essential to demonstrating value.
145

146 *Innovation.* The physical therapy profession will offer creative and proactive solutions to enhance
147 health services delivery and to increase the value of physical therapy to society. Innovation will occur
148 in many settings and dimensions, including health care delivery models, practice patterns, education,
149 research, and the development of patient/client-centered procedures and devices and new
150 technology applications. In clinical practice, collaboration with developers, engineers, and social
151 entrepreneurs will capitalize on the technological savvy of the consumer and extend the reach of the
152 physical therapist beyond traditional patient/client-therapist settings. Innovation in education will
153 enhance interprofessional learning, address workforce needs, respond to declining higher education

154 funding, and, anticipating the changing way adults learn, foster new educational models and delivery
155 methods. In research, innovation will advance knowledge about the profession, apply new
156 knowledge in such areas as genetics and engineering, and lead to new possibilities related to
157 movement and function. New models of research and enhanced approaches to the translation of
158 evidence will more expediently put these discoveries and other new information into the hands and
159 minds of clinicians and educators.

160
161 *Consumer-centricity.* Patient/client/consumer values and goals will be central to all efforts in which
162 the physical therapy profession will engage. The physical therapy profession embraces cultural
163 competence as a necessary skill to ensure best practice in providing physical therapist services by
164 responding to individual and cultural considerations, needs, and values.

165
166 *Access/Equity.* The physical therapy profession will recognize health inequities and disparities and
167 work to ameliorate them through innovative models of service delivery, advocacy, attention to the
168 influence of the social determinants of health on the consumer, collaboration with community
169 entities to expand the benefit provided by physical therapy, serving as a point of entry to the health
170 care system, and direct outreach to consumers to educate and increase awareness.

171
172 *Advocacy.* The physical therapy profession will advocate for patients/clients/consumers both as
173 individuals and as a population, in practice, education, and research settings to manage and
174 promote change, adopt best practice standards and approaches, and ensure that systems are built to
175 be consumer-centered.

176
177 1. Porter ME, Teisberg EO. Redefining health care: creating value-based competition on results.
178 Boston: Harvard Business School Press, 2006.
179 2. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC:
180 Institute of Medicine of the National Academies, 2001.

181

182

183 **Support Statement**

184

185 **What is this motion seeking to achieve?**

186 If revised, this document will be updated to improve clarity and update language in both relevance
187 and timeliness.

188

189 **How does this motion contribute to achieving the Vision?**

190 The motion is intended to provide clarity to the "how" behind achieving the vision as it is a revision
191 to the Guiding Principles to Achieve the Vision.

192

193 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

194 This motion addresses the APTA Strategic Framework priority: Evolving our Practice.

195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234

How is this motion’s subject national in scope and importance?

Given its scope of influence, the Guiding Principles to Achieve the Vision are national in scope and importance addressing the Identity, Quality, Collaboration, Value, Innovation, Person-centricity, Access/Equity, and Advocacy for the profession.

What previous or current initiatives and positions of the Association address this topic?

[Guiding Principles to Achieve the Vision](#) (HOD P06-19-46-54) [Vision Statement for the Physical Therapy Profession](#) (HOD P06-13-18-22)

What interested parties will be impacted by this motion?

This motion affects all physical therapists, physical therapist assistants and students of physical therapy in that it provides the foundational values and beliefs which shape the behavior, decisions and goals of our organization and profession.

Additional background information:

In 2025 the APTA Academy of Leadership and Innovation forwarded RC 10-25 Amend: Guiding Principles to Achieve the Vision to the House. The House of Delegates voted to refer RC 10-25 to the Board of Directors, reasoning that prior to adopting revised guiding principles, the Vision Statement for the Physical Therapy Profession should be reviewed to determine if changes were needed since its adoption in 2013. In addition, the House felt that more time was necessary to consider how changes to the Guiding Principles could impact the future of the profession. The APTA Board of Directors is submitting this concept to signal its interest in collaborating with other delegations to consider amendments that may be needed. The Vision Statement for the Profession was reviewed by the Board as part of its work developing the Strategic Framework and feels that no changes to the Vision are needed at this time. For additional information, please see the original support statement below that accompanied RC 10-25. Original SS: The Vision Statement for the Physical Therapy Profession was revised in 2013 by the House of Delegates, (HOD P06-13-18-22) [Initial HOD P06-00-24-35] [Position] and it reads: Transforming society by optimizing movement to improve the human experience. At the same time, the House adopted the Guiding Principles to Achieve the Vision HOD P06-19-46-54 [Initial HOD P06-13-19-23] [Position]. These important foundational values or beliefs shape the behavior, decisions and goals of our organization and profession. They are used in several important ways: setting strategic direction, shaping organizational and professional culture, influencing policy and advocacy and building member engagement and public trust. Revisions to the Guiding Principles to Achieve the Vision have been minimal since the initial position was created in 2013. Given the importance of this document, it is time to update the language to ensure that it stays current, inclusive and reflective of evolving societal and professional norms. Revising the Guiding Principles to Achieve the Vision demonstrates the Association’s and House of Delegates’ commitment to society and the evolving landscape of local, national and global health and healthcare. In these revisions, changes such as digital health, innovation, interprofessional

235 and intraprofessional collaboration and an emphasis on evidence-based, person-centered care
236 acknowledge changes since the initial adoption and latest revision of the Guiding Principles.

237

238 **References:**

239

240 **Last Updated:** 5/8/2026

241 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 14-26 ELECTION TO HONORARY MEMBERSHIP IN THE AMERICAN PHYSICAL THERAPY ASSOCIATION: KEVIN FORD, PhD, FACSM

1 Proposed by: APTA Board of Directors

2 **Primary Motion Contact:** Kyle Covington, PT, DPT, PhD

3

4 **Required for Adoption:** 2/3 Vote

5

6 Whereas, Dr. Kevin Ford has made significant contributions to the practice of physical therapy;

7

8 Whereas, Dr. Ford has authored over 200 peer-reviewed articles exploring the prevention and
9 rehabilitation of anterior cruciate ligament injuries;

10

11 Whereas, Dr. Ford has garnered over \$8 million dollars in research funding;

12

13 Whereas, Dr. Ford has earned national recognition including the Orthopaedic Research and
14 Education Foundation Clinical Research Award, the American Academy of Sports Physical Therapy
15 Excellence in Research Award, and the JOSPT George J. Davies – James A. Gould Excellence in Clinical
16 Inquiry Award;

17

18 Whereas, Dr. Ford was a founding faculty member of the High Point University Department
19 of Physical Therapy;

20

21 Whereas, Dr. Ford has fostered American Board of Physical Therapy Residency and Fellowship
22 Education residency placement in more than 20% of his previous three physical therapist cohorts;

23

24 Whereas, Dr. Ford has mentored multiple APTA award winners at the federal and state levels,
25 including the winners of the APTA Societal Impact Award and the APTA Federal Government Affairs
26 Leadership Award;

27

28 Whereas, Dr. Ford has conducted 94 peer-reviewed presentations at APTA Combined
29 Sections Meetings, and;

30

31 Whereas, Dr. Ford has mentored over 500 physical therapist students and 30 physical therapy faculty
32 members;

33

34 Resolved, that Dr. Ford be elected as an Honorary Member of the American Physical Therapy
35 Association.

36

37

38 **Support Statement**

39

40 **Motion Concept:**

41 This motion forwards the nomination for Kevin Ford to the House of Delegates for election as an
42 Honorary Membership in the APTA.

43

44 **What is this motion seeking to achieve?**

45 If elected, Kevin Ford will be an Honorary Member of APTA.

46

47 **How does this motion contribute to achieving the Vision?**

48 Honorary membership supports the Vision by recognizing outstanding service to the Association or
49 notable contributions of individuals who would not otherwise be eligible for membership in the
50 Association.

51

52 **How does this motion support APTA priorities as reflected in the current APTA Strategic Plan?**

53 Honorary membership supports APTA's Strategic Plan by recognizing outstanding service to the
54 Association or notable contributions of individuals who would not otherwise be eligible for
55 membership in the Association.

56

57 **How is this motion's subject national in scope and importance?**

58 Honorary membership in APTA is a national recognition, the purpose of which is stipulated in the
59 Bylaws of the APTA.

60

61 **What federal or state laws and regulations also address this topic?**

62

63 **What previous or current initiatives and positions of the Association address this topic?**

64 The purpose of this honor is stipulated in the Bylaws of the American Physical Therapy Association.
65 Criteria for selection, eligibility, and process are outlined in association policy APTA Honors and
66 Awards (BOD Y02-24-04-06)

67

68 **What interested parties will be impacted by this motion?**

69 Honorary membership recognizes the impact of individuals other than members in any other
70 membership category, who have rendered outstanding service to the Association or have made
71 notable contributions to the health of humanity.

72

73 **Additional background information:**

74 It is with great enthusiasm that APTA North Carolina nominates Kevin Ford, Ph.D., FACSM, for
75 Honorary Membership within APTA. Dr. Kevin Ford has been a steady presence in the development
76 of physical therapy faculty and future physical therapists while serving as founding faculty member
77 of the High Point

78 University Department of Physical Therapy. Moreover, he is one of the most influential researchers in
79 the physical therapy space. Additionally, he is a consistent presenter at physical therapy conferences
80 at the national and state level. It is notable that despite these achievements, Kevin Ford is neither a
81 physical therapist nor a physical therapist assistant. While he isn't "one of us," he certainly deserves
82 to be recognized as "one of us." To that end, I believe an Honorary Membership in the APTA would
83 be a fitting recognition for his contributions to the profession.

84

85 **References:**

86

87 **Last Updated:** 5/8/26

88 **Contact:** governancehouse@apta.org

89

Motion to 2026 House of Delegates

Main Motion:

RC 15-26 RECOMMEND: GUIDANCE FOR APPROPRIATE UTILIZATION AND PROTECTION OF THE PHYSICAL THERAPIST ASSISTANT ROLE

1 **Proposed by:** Arizona, PTA Council

2 **Primary Motion Contact:** Jamie Kuettel, PT, DPT, EdD

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That the American Physical Therapy Association develop and disseminate guidance and resources to
8 improve awareness, appropriate utilization, and protection of the physical therapist assistant role
9 across clinical, regulatory, and employer-facing environments.

10

11

12 **Support Statement**

13

14 **What is this motion seeking to achieve?**

15 For the purposes of this motion, physical therapist assistants (PTAs) include individuals who are
16 licensed or certified according to state law. Unlicensed personnel refer to aides, technicians, or other
17 support staff who do not hold physical therapy licensure or certification. The expected outcome of
18 this motion is improved clarity and consistency regarding the role and utilization of PTAs across
19 clinical practice settings, regulatory environments, and employer structures. Clearer national
20 guidance will help members, employers, and regulators better distinguish the responsibilities of
21 licensed/certified PTAs from those of unlicensed personnel, thereby supporting ethical delegation,
22 effective team-based care, and safe patient management.

23

24 **How does this motion contribute to achieving the Vision?**

25 This motion aligns with the APTA Vision statement in that society benefits from greater access to
26 high-quality physical therapist services. By reinforcing appropriate PT/PTA team utilization, the
27 profession can improve efficiency, expand patient access to care, and support sustainable workforce
28 models while maintaining professional and ethical standards.

29

30 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

31 This motion reflects APTA’s Strategic Framework 2030 by focusing on quality, collaboration, value,
32 innovation, and access. It relies on recommendations from the Physical Therapist Assistant Education
33 Summit Report, which identified the need for greater consistency in understanding and applying the
34 PTA role across education, practice, and regulation. This motion operationalizes those
35 recommendations by asking the Board to coordinate and standardize messaging, guidance, and
36 advocacy tools that reinforce PTAs as licensed/certified providers, not an interchangeable substitute
37 for unlicensed personnel. The Summit findings also underscore that PTAs are educated extenders
38 whose education and licensure/certification are designed to support contemporary physical therapist
39 practice, not to be diluted or replaced by unlicensed personnel. Implementation of this motion may
40 include developing consistent messaging across APTA resources; providing chapters with advocacy
41 tools to address misuse of unlicensed personnel; promoting best-practice PT/PTA utilization models;
42 and offering guidance to members, employers, and regulators regarding appropriate delegation and
43 supervision.
44

45 **How is this motion’s subject national in scope and importance?**

46 This issue is national in scope because the utilization of PTAs and unlicensed personnel varies widely
47 across states, employers, and practice settings. Differences in the interpretation of PTA roles and
48 supervision requirements contribute to confusion among clinicians, employers, and regulators.
49 Reports from clinicians across practice settings indicate that unlicensed personnel are sometimes
50 being used to perform patient-related tasks that require the training and clinical judgment of
51 licensed PTs or licensed/certified PTAs. This variability poses risks to patient safety, increases
52 supervising PTs' liability, and undermines PTAs' professional role. A national policy statement from
53 APTA would provide unified guidance that supports appropriate delegation under licensed PTs,
54 reinforces the PT/PTA team as the standard model for delivery of physical therapist services, and
55 helps prevent the erosion of professional standards driven by cost-cutting or staffing shortages.
56 Such a policy would also support advocacy efforts with regulators, payers, and employers at the
57 federal and state levels by clearly distinguishing the roles of licensed/certified PTAs from those of
58 unlicensed personnel, thereby promoting patient safety and ethical practice nationwide.
59

60 **What previous or current initiatives and positions of the Association address this topic?**

- 61 1. APTA House of Delegates Position: Direction and Supervision of the Physical Therapist
62 Assistant (HOD P08-22-09-11)
- 63 2. APTA House of Delegates Position: The Role of Aides in a Physical Therapy Service (HOD P06-
64 19-12-07)
- 65 3. APTA Guide to Physical Therapist Practice 3.0
- 66 4. APTA Standards of Ethical Conduct for the Physical Therapist Assistant
- 67 5. Federation of State Boards of Physical Therapy (FSBPT) Model Practice Act for Physical
68 Therapy
- 69 6. Physical Therapist Assistant Education Summit Report (2022)

70

71 **What interested parties will be impacted by this motion?**

72 Stakeholders affected by this motion include physical therapists, physical therapist assistants,
73 students, employers, health systems, private practice owners, payers, regulators, and patients.
74 External stakeholders include state licensure boards, legislators, accrediting bodies, and other
75 healthcare organizations. State practice acts and rules govern delegation and supervision
76 requirements, and the Federation of State Boards of Physical Therapy (FSBPT) Model Practice Act
77 provides additional guidance. This motion does not seek to override state law but rather to provide
78 clear, consistent national guidance to support appropriate interpretation and implementation.

79

80 **Additional background information:**

81 The APTA has long maintained that the PTA is the "only individual" who assists the PT in the
82 provision of physical therapist services according to HOD P08-22-09-11. Despite this clear position,
83 research and workforce discussions have highlighted variability in how physical therapy services are
84 delivered, including the extent to which unlicensed personnel are involved in patient-related tasks.
85 This motion reinforces existing APTA policy and clarifies expectations regarding the appropriate
86 utilization of licensed/certified PTAs within the physical therapist service." Licensure is the bedrock
87 of public protection. Unlike unlicensed personnel, PTAs are graduates of CAPTE-accredited programs
88 and are tracked via the FSBPT ELDD database, ensuring accountability and transparency. Substituting
89 licensed/certified PTAs with unlicensed personnel bypasses these safety "pillars," creating an
90 unmanageable liability for the supervising PT and a direct threat to the consumer. By adopting this
91 motion, the House of Delegates moves beyond a passive definition of the PTA and takes an active
92 stance against the commoditization of our services. We are not just protecting a job title; we are
93 protecting the clinical integrity of the profession in a new era of healthcare economics. Across
94 practice settings nationwide, there is increasing variability and confusion regarding the utilization of
95 PTAs and unlicensed personnel in the delivery of physical therapy services. Anecdotally, PTs and
96 PTAs report situations in which unlicensed personnel are being used to perform tasks beyond their
97 training or legal scope, sometimes in place of licensed/certified PTAs, often driven by staffing
98 shortages or cost-containment pressures rather than patient-centered care considerations. Despite
99 PTAs being licensed/certified healthcare professionals with defined scopes of practice and
100 supervision requirements, their role is not consistently understood or valued by employers, payers,
101 or within the profession. This variability creates risk to patient safety, places ethical and legal burdens
102 on supervising PTs, and undermines the professional identity of PTAs. Inconsistent interpretation and
103 enforcement of state and federal regulations, combined with the absence of a clear national policy
104 statement, have contributed to ongoing ambiguity that this motion seeks to address.

105

106 **References:**

- 107 1. American Physical Therapy Association. (n.d.). Guide to physical therapist practice 3.0.
108 <https://guidetoptpractice.apta.org>
109 2. American Physical Therapy Association. (n.d.). Code of Ethics for the Physical Therapy
110 Profession
111 3. <https://www.apta.org>

112 4. American Physical Therapy Association. Direction and supervision of the physical therapist
113 assistant. HOD P08-22-09-11. Amended October 2022. Accessed March 10, 2026.
114 <https://www.apta.org>

115 5. American Physical Therapy Association. The role of aides in a physical therapy service. HOD
116 P06-19-12-07. Last updated September 20, 2019. Accessed March 10, 2026.
117 <https://www.apta.org>

118 6. American Physical Therapy Association. (n.d.). Workforce and practice resources related to
119 PTA utilization. <https://www.apta.org>

120 7. Federation of State Boards of Physical Therapy. (n.d.). Model practice act for physical therapy.
121 <https://www.fsbpt.org>

122 8. Giffin, Kathrine A. PTA, MEd; Levangie, Pamela K. PT, DPT, DSc, FAPTA. The Physical Therapist
123 Assistant Education Summit Report: Prioritized Recommendations for the Future. *Journal of*
124 *Physical Therapy Education* 36(4s1):p 1-13, December 2022. | DOI:
125 10.1097/JTE.0000000000000251

126
127
128 **Last Updated:** 5/8/2026
129 **Contact:** governancehouse@apta.org
130

Motion to 2026 House of Delegates

Main Motion:

RC 16-26 RECOMMEND: IMPROVING TRANSPARENCY OF FINANCIAL RESOURCES FOR PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT STUDENTS

1 **Proposed by:** Arizona, Colorado

2 **Primary Motion Contact:** Jennifer Zoucha, PT, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That the American Physical Therapy Association will regularly update and promote web-based
8 financial resources to improve transparency of physical therapist and physical therapist assistant
9 student debt relative to anticipated entry-level income. These resources will be prominently
10 displayed on the APTA website, easy to locate, and readily accessible to prospective students,
11 members, and nonmembers.

12

13

14 **Support Statement**

15

16 **What is this motion seeking to achieve?**

17 This motion is seeking to improve access and transparency on the APTA's web-based financial
18 resources, currently titled the "Financial Solutions Center", for perspective students and nonmembers
19 so that they have a better understanding of student loan debt related to financial stability. In 2022,
20 CAPTE began requiring Student Financial Fact Sheets for DPT and PTA programs within one "click"
21 from their program webpage to provide the public with current, accurate, and easily available
22 information regarding cost of attendance because of HOD P06-20-40-32 [Position] FINANCIAL
23 TRANSPARENCY OF PHYSICAL THERAPY EDUCATION PROGRAMS. On every Financial Fact Sheet, the
24 APTA's Financial Solutions Center link is listed for APTA student members to visit. This was a
25 significant step in better transparency regarding the cost of education. Additionally, the APTA has
26 currently partnered with third parties to provide web-based resources to increase financial literacy
27 for both members and nonmembers (target audience of nonmembers are PT/PTA program
28 applicants as well as early PT/PTA students). Currently, these APTA resources are non-intuitive to
29 access and are underutilized. This lack of easily accessible financial literacy resources regarding
30 student debt, expected median incomes for new graduates, graduate degree federal loan limits, and
31 current workforce vacancy and growth rates exacerbates the DPT/PTA student debt crises. This

32 motion highlights the existing APTA web-based financial literacy resources and seeks to improve
33 access and transparency to this type of information for both members and nonmembers so they may
34 be better informed on financial literacy principles in preparation for the true cost of a physical
35 therapy education. This language, through the support of the APTA, further encourages academic
36 DPT and PTA programs to publicize and promote these resources at appropriate time points such as
37 orientation or other time points in their respective programs. Additionally, this language encourages
38 all academic programs to prominently display the resource link directly on their webpage that also
39 links to the CAPTE-required financial fact sheet. The authors acknowledge the resource link does
40 exist in the financial fact sheet each program currently provides. However, the link is at the bottom
41 of the page, is not prominent, and states it is for APTA student members.

42
43 **How does this motion contribute to achieving the Vision?**

44 Each year our physical therapy institutions produce thousands of highly qualified graduates to
45 pursue our Vision of “transforming society by optimizing movement to improve the human
46 experience”. However, the cost of a DPT degree continues to climb while the expected base salaries
47 are unable to keep pace. In a recent APTA 2025 Report on Demographics of the Profession, over
48 23% of PT survey respondents are considering leaving the field or reducing their hours. It is vital that
49 we turn our attention to the importance of helping secure the next generation of clinicians to sustain
50 a workforce that meets our national health needs. Having web-based financial resources that are
51 easily accessible to members and nonmembers that provide robust literature on the current state of
52 the profession will help potential PT and PTA students have a clearer financial understanding of the
53 impact of debt and realistic base salary expectations.

54
55 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

56 APTA strategic framework for 2030 focuses on advocating for increased payment and decreased
57 administrative burden for physical therapist services. In 2025 the APTA’s Incomes in the Profession
58 Report noted that physical therapist incomes increased with inflation earlier this century, but they
59 have not kept pace with inflation since 2016. As the cost of graduate education continues to increase
60 and the median newer graduate income remains relatively even (increasing slightly from \$70,000 to
61 \$72,000 from 2017-2020), we must look to improve current and prospective PT students’
62 understanding of these concepts. Having APTA web-based financial resources provide the public
63 with this type of return on investment data will help with financial transparency regarding the true
64 cost of a physical therapy education.

65
66 **How is this motion’s subject national in scope and importance?**

67 Since 2007, graduate and professional students have been able to borrow up to the full cost of
68 attendance. The One Big Beautiful Bill Act (P.L. 119-21) signed into law in July 2025 creates a lifetime
69 cap of \$100,000 in borrowing for graduate students for non-professional students. The Department
70 of Education has not identified physical therapy as a professional degree; therefore, PT students will
71 be able to borrow no more than \$20,500 a year. The bill also terminates Grad PLUS loans, which
72 graduate and professional students have used to pay for education expenses not covered by other

73 financial aid. Ideally, having APTA web-based financial resources be a source for members and
74 nonmembers to access these types of updates regarding student loan changes would be another
75 way to help with financial literacy for prospective students.

76

77 **What previous or current initiatives and positions of the Association address this topic?**

78 There are multiple reports completed by the APTA that the web-based financial resources can help
79 make student members and nonmembers better aware of vacancy rates, growth rates, and the true
80 ratio between physical therapy student debt and expected earnings. In June 2020, the APTA took a
81 comprehensive look at the Impact of Student Debt on the Physical Therapy Profession. The report
82 highlighted that nearly 93% of recent physical therapist graduates are carrying debt, at an average of
83 \$152,882 for all debt except mortgages. For 89% of PTs with education debt, most of that amount
84 (80%) is attributed to loans for their PT education, the average balance being \$116,183. One of the
85 solutions outlined in the report was to improve students' financial literacy. The 2020 APTA report
86 also highlighted the median income of PTs who are within three years out of school. Annual income
87 remained relatively even from APTA's 2017 survey to 2020, increasing slightly from \$70,000 to
88 \$72,000 over the three-year period. APTA's 2025 Physical Therapy Profile: Incomes in the
89 Profession Report found that incomes have not kept pace with inflation. While incomes increased
90 with inflation earlier this century, they have not kept pace with inflation since 2016. In APTA's 2025
91 Report on Demographics of the Profession, survey respondents were asked about their employment
92 intentions over the next 2 years. 7.4% of PTs reported planning for retirement and 16.2% had
93 intentions of reducing their work hours, indicating significant vacancy rates will continue to remain
94 elevated for the profession. On the current Financial Solutions Center, APTA has partnered with
95 third parties (Enrich and Fitbux) to provide web-based resources to increase financial literacy for
96 both members and nonmembers. Per the Board of Directors, Enrich registration numbers do not
97 support the continuation of this paid partnership and without growth in the number of subscribers,
98 APTA will sunset the Enrich program in 2026.

99

100 **What interested parties will be impacted by this motion?**

101 With improved access and publicity of the APTA web-based financial resources, prospective and new
102 students would be better financial consumers regarding the amount of debt they are willing to
103 assume in order to obtain a physical therapy education.

104

105 **Additional background information:**

106 Additional non-APTA generated literature that could be considered worthwhile for prospective
107 students to have access to on the Financial Solutions Center are return on investment articles and
108 importance of financial literacy, with a few examples noted below. In 2018, Shields and Dudley-
109 Javoroski found that physical therapist education is a good investment up to a certain amount of
110 debt. At \$150,000 of debt, the net present value for the DPT is lower than all health professions
111 careers (other than veterinary medicine and chiropractic). Once debt exceeds \$266,000, the
112 economic value of a physical therapist degree "no longer exceeded that of a typical bachelor's
113 degree." They also noted in the last 10 years from publish date, the cost of a DPT education had

114 risen between two and three times more quickly than growth in entry level salaries. In 2023,
115 Shields et al. found that careers with low salary growth and high debt relative to salary (e.g. physical
116 therapy) had career net present value (NPV) at the lowest range of modeled professions. 29% of
117 physical therapy students graduated with more debt than could be supported by entry-level salaries.
118 Physical therapy students from minoritized groups graduated with 10–30% more debt than their
119 non-minoritized peers. In Ambler’s study in 2020 it was suggested that practice setting choice may
120 be affected by physical therapist student debt, and student debt may be a barrier overall to practice
121 and career choices in physical therapy. In Sawyer’s 2024 study, 125 DPT students completed a
122 financial knowledge survey and their student loan literacy scores were below those of other college
123 students. Furthermore, 85% of DPT students either had no awareness of the APTA financial
124 education platform or had not accessed it. In Sawyer’s national study of DPT students (n=364) [in
125 review] from 12 DPT programs across the U.S., the average financial literacy score was 54% of
126 questions correct. Further, 77% of the respondents in this survey were not aware nor have accessed
127 APTA Financial Literacy resources.

128

129 **References:**

- 130 1. Shields, Richard; Dudley-Javoroski, Shauna. “Physiotherapy Education Is a Good Financial
131 Investment, Up to a Certain Level of Student Debt: An Inter-Professional Economic Analysis.”
132 Journal of Physiotherapy, July 2018. <https://www.ncbi.nlm.nih.gov/pubmed/29914805>
- 133 2. Ambler, Steve. “The Debt Burden of Entry-Level Physical Therapists.” Physical Therapy, April
134 2020. [https://academic.oup.com/ptj/advance-article-
135 abstract/doi/10.1093/ptj/pzz179/5651322?redirectedFrom=fulltext](https://academic.oup.com/ptj/advance-article-abstract/doi/10.1093/ptj/pzz179/5651322?redirectedFrom=fulltext).
- 136 3. Physical Therapy Profile: Incomes in the Profession, 2025. A Report From the American
137 Physical Therapy Association. December 2025
138 <https://www.apta.org/siteassets/pdfs/2025/reports/apta-incomes-report-2025.pdf>
- 139 4. Aggregate Program Data 2024 Physical Therapist Education Programs Fact Sheet
140 [https://www.captionline.org/globalassets/capte-docs/aggregate-data/2024-pt-aggregate-
141 program-data-fact-sheet.pdf](https://www.captionline.org/globalassets/capte-docs/aggregate-data/2024-pt-aggregate-program-data-fact-sheet.pdf)
- 142 5. United States Department of Education. [https://www.ed.gov/about/news/press-release/myth-
143 vs-fact-definition-of-professional-degrees](https://www.ed.gov/about/news/press-release/myth-vs-fact-definition-of-professional-degrees)
- 144 6. Impact of Student Debt on the Physical Therapy Profession. A Report From the American
145 Physical Therapy Association June 2020. [https://www.apta.org/apta-and-you/news-
146 publications/reports/2020/impact-of-student-debt-on-the-physical-therapy-profession#](https://www.apta.org/apta-and-you/news-publications/reports/2020/impact-of-student-debt-on-the-physical-therapy-profession#)
- 147 7. Shields et al. Healthcare educational debt in the united states: unequal economic impact
148 within interprofessional team members BMC Medical Education (2023) 23:666
149 <https://doi.org/10.1186/s12909-023-04634-1>
- 150 8. A Physical Therapy Profile: Demographics of the Profession, 2025. A Report From the
151 American Physical Therapy Association. December 2025.
152 <https://www.apta.org/siteassets/pdfs/2025/reports/apta-demographics-report-2025.pdf>

- 153 9. Sawyer, E., Eigsti, H. J., Gorman, I., Reinking, M.F., Palmer, R.J., Struessel, T. A Financial Literacy
154 Pilot Project: Are Matriculating DPT Students Prepared to Manage Their Debt? J Allied Health.
155 2024 Fall; 53(3):196-202.
- 156 10. Sawyer, E., Eigsti, H. J., Gorman, I., Reinking, M.F., Palmer, R.J., Struessel, T. DPT Student
157 Financial Literacy: A Multicenter Cross-Sectional Study of Student Knowledge and
158 Preparation. J of Phys Ther Educ. In Review.

159

160 **Last Updated:** 5/8/2026

161 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 17-26 AMEND: THE ROLE OF AIDES IN A PHYSICAL THERAPY SERVICE

1 **Proposed by:** Arizona, PTA Council

2 **Primary Motion Contact:** Jamie Kuettel, PT, DPT, EdD

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 **That The Role Of Aides In A Physical Therapy Service (HOD P06-19-12-07) be amended by adding**
8 **a sentence to the first paragraph so that it would read:**

9

10 THE ROLE OF AIDES IN PHYSICAL THERAPY SERVICES

11

12 Physical therapy aides are any support personnel who perform designated tasks related to the
13 operation of the physical therapy services. Tasks are activities that do not require the clinical
14 decision-making of the physical therapist or the clinical problem-solving of the physical therapist
15 assistant. Aides may not independently perform, adjust, or progress components of patient and
16 client management.

17

18 Tasks related to patient and client services must be assigned to the physical therapy aide by the
19 physical therapist, or where allowable by law the physical therapist assistant, and may be performed
20 by the aide only under direct personal supervision. Direct personal supervision requires that the
21 physical therapist, or where allowable by law the physical therapist assistant, be physically present
22 and immediately available to supervise tasks that are related to patient and client services. The
23 physical therapist maintains responsibility for patient and client management at all times, including
24 for tasks performed by a physical therapy aide.

25

26 Given this role of the physical therapy aide, the American Physical Therapy Association opposes
27 certification or credentialing of physical therapy aides.

28

29

30 **Support Statement**

31

32 **What is this motion seeking to achieve?**

33 The expected outcome of this motion is improved national clarity, consistency, and awareness
34 regarding the appropriate utilization of licensed or certified physical therapist assistants (PTAs) and
35 the role of support personnel in the delivery of physical therapist services.
36

37 **How does this motion contribute to achieving the Vision?**

38 This motion advances APTA's Vision to transform society by optimizing movement and enhancing
39 the human experience by reinforcing the physical therapist, physical therapist assistant (PT-PTA)
40 team as the standard model for delivering high-quality care and more clearly identifying the
41 appropriate use of support personnel.
42

43 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

44 It supports APTA's Strategic Plan priorities related to access, workforce sustainability, and value-
45 based care by promoting appropriate utilization of licensed/certified providers, improving efficiency
46 without compromising patient safety, and strengthening public trust in the profession.
47

48 **How is this motion's subject national in scope and importance?**

49 This issue is national in scope due to widespread variability in how PTAs and support personnel are
50 utilized across practice settings, employers, and regulatory environments. While state practice acts
51 govern supervision and delegation, stakeholders frequently rely on APTA policy to interpret
52 appropriate roles and responsibilities. Reports from clinicians across the country indicate that
53 support personnel are increasingly being used to perform patient-related tasks that require clinical
54 judgment, sometimes in place of licensed or certified PTAs. This variability creates inconsistency in
55 care delivery, introduces risk to patient safety, and contributes to confusion among clinicians,
56 employers, and regulators. A national, coordinated approach from APTA is necessary to provide clear
57 guidance, promote consistency, and support appropriate implementation of team-based care
58 models across all states.
59

60 **What previous or current initiatives and positions of the Association address this topic?**

61 [THE ROLE OF AIDES IN A PHYSICAL THERAPY SERVICE](#) (HOD P06-19-12-07)
62

63 **What interested parties will be impacted by this motion?**

64 Stakeholders affected by this motion include physical therapists, physical therapist assistants,
65 students, employers, health systems, private practice owners, payers, regulators, and patients.
66 External stakeholders include state licensure boards, legislators, accrediting bodies, and other
67 healthcare organizations. State practice acts and rules govern delegation and supervision
68 requirements, and the Federation of State Boards of Physical Therapy (FSBPT) Model Practice Act
69 provides additional guidance.
70

71 **Additional background information:**

72 Across practice settings, there is increasing evidence and anecdotal reporting that support personnel
73 are being utilized beyond their intended role, at times performing tasks that require the clinical

74 judgment of a licensed physical therapist or the clinical problem solving of a licensed or certified
75 physical therapist assistant. These practices are often driven by workforce shortages, cost-
76 containment strategies, and variability in employer understanding of appropriate delegation. Tasks
77 appropriate for physical therapy aides are intended to be non-clinical, preparatory, or supportive in
78 nature. These may include, but are not limited to, preparation of treatment areas, equipment setup
79 and cleaning, transportation of patients, and other administrative or operational duties. Activities
80 that require clinical decision making or clinical problem solving are not appropriate for delegation to
81 support personnel. Aides may not initiate, perform, adjust, or progress components of patient care
82 or treatment programs.

83 Examples of activities that are not appropriate for delegation include, but are not limited to:

- 84 • Therapeutic exercise prescription, progression, or modification
- 85 • Neuromuscular re-education
- 86 • Gait training
- 87 • Balance or endurance training
- 88 • Manual therapy techniques
- 89 • Application or removal of therapeutic modalities
- 90 • Patient examination, evaluation, or reassessment
- 91 • Clinical interpretation of patient response to intervention
- 92 • Modification of interventions based on patient status

93 Despite PTAs being licensed or certified healthcare providers educated through CAPTE-accredited
94 programs and held accountable through regulatory systems, their role is not consistently understood
95 or appropriately utilized. This has contributed to role erosion, increased liability for supervising
96 physical therapists, and potential risks to patient safety. Additionally, APTA policy related to the
97 role of aides, while foundational, was last updated in 2019 and does not fully reflect current
98 workforce dynamics or explicitly address the inappropriate substitution of unlicensed personnel for
99 licensed providers. This motion provides an opportunity to align existing policy with contemporary
100 practice realities and reinforce the integrity of the PT–PTA team.

101
102 **References:**

- 103 1. American Physical Therapy Association. Direction and Supervision of the Physical Therapist
104 Assistant. HOD P08-22-09-11. Amended October 2022. Available at: <https://www.apta.org>
- 105 2. American Physical Therapy Association. The Role of Aides in a Physical Therapy Service. HOD
106 P06-19-12-07. Last updated September 20, 2019. Available at: <https://www.apta.org>
- 107 3. American Physical Therapy Association. Standards of Ethical Conduct for the Physical
108 Therapist Assistant. Available at: <https://www.apta.org>
- 109 4. American Physical Therapy Association. Code of Ethics for the Physical Therapist. Available at:
110 <https://www.apta.org>
- 111 5. Federation of State Boards of Physical Therapy. Model Practice Act for Physical Therapy.
112 Available at: <https://www.fsbpt.org>

113
114

115 **Last Updated:** 5/8/2026

116 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 18-26 AMEND: INTERVENTIONS PERFORMED EXCLUSIVELY BY PHYSICAL THERAPISTS

1 **Proposed by:** Wisconsin

2 **Primary Motion Contact:** Krissa Reeves, PTA, MEd

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That Interventions Performed Exclusively By Physical Therapists (HOD P06-18-31-36) be amended
8 by adding the word “thrust” before the words spinal and peripheral joint
9 mobilization/manipulation so that it would read:

10

11 INTERVENTIONS PERFORMED EXCLUSIVELY BY PHYSICAL THERAPISTS

12

13 Physical therapists' practice responsibility includes all elements of patient and client management:
14 examination, evaluation, diagnosis, prognosis, intervention, and outcomes. The entirety of evaluation,
15 diagnosis, and prognosis, as well as components of examination, intervention, and outcomes, must
16 be performed by the physical therapist exclusively due to the requirement for immediate and
17 continuous examination, evaluation, or synthesis of information. Physical therapist assistants may be
18 appropriately utilized in components of intervention and in collection of selected
19 examination and outcomes data.

20

21 Selected interventions are performed exclusively by the physical therapist. Such interventions
22 include, but are not limited to, thrust spinal and thrust peripheral joint mobilization/manipulation
23 and dry needling, which are components of manual therapy; and sharp selective debridement, which
24 is a component of wound management.

25

26

27 **Support Statement**

28

29 **What is this motion seeking to achieve?**

30 Joint mobilization/manipulation and whether the PTA possesses the knowledge and clinical decision-
31 making skills necessary to safely, effectively, and appropriately apply the intervention have been

32 debated for many years. But the evolution of our profession has mandated that PTAs become
33 educated and skilled to provide interventions under the direction and supervision of a clinical,
34 doctoral-level Physical Therapist. While the physical therapist assistant's degree level has not been
35 advanced to keep pace with that of the physical therapist, the depth and breadth of the content has
36 had to increase and in a large majority of PTA program (where permitted by state statute) this has
37 meant including non-thrust, spinal and peripheral joint mobilization/manipulations including
38 identification of contraindications and precautions, risk assessment of based on the patients'
39 surrounding tissue structures, continuous assessment of the patient's response during application,
40 immediate adjustment to the application when appropriate, and request for the physical therapist to
41 assist or re-assess if red-flags emerge. By amending the intervention performed exclusively by the
42 physical therapist to exclude non-trust spinal and non-thrust peripheral joint
43 mobilizations/manipulations we are seeking to acknowledge the change clinical practice as already
44 demanded and align the APTA policy with how effective and efficient PT/PTA teams provide patient
45 care.

46
47 **How does this motion contribute to achieving the Vision?**

48 The optimal PT/PTA team provides care to patients that is highly skilled, evidence-based, and both
49 effective and efficient. This team functions on a foundation of trust and mutual respect, and an
50 understanding of each person's knowledge and skill level. It is always the physical therapist's
51 decision what to delegate to a PTA. The current position statement that all spinal and peripheral joint
52 mobilization/manipulation interventions are to be performed exclusively by the physical therapist
53 does not allow for the PT to make that decision, even when the PTA team member has the
54 knowledge and skill set to do so.

55
56 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

57 The optimal PT/PTA team provides care to patients that is highly skilled, evidence-based, and both
58 effective and efficient. This team functions on a foundation of trust and mutual respect, and an
59 understanding of each person's knowledge and skill level. It is always the physical therapist's
60 decision what to delegate to a PTA. The current position statement that all spinal and peripheral joint
61 mobilization/manipulation interventions are to be performed exclusively by the physical therapist
62 does not allow for the PT to make that decision, even when the PTA team member has the
63 knowledge and skill set to do so. Amending the policy on PTAs performing non-thrust spinal and
64 non-thrust peripheral joint mobilizations/manipulations is inline with the strategic framework goal of
65 evolving our practice and empowering our members.

66
67 **How is this motion's subject national in scope and importance?**

68 PTAs who have not been taught joint mobilization/manipulation techniques in school are taking
69 continuing education courses to become proficient in the skill, as clinical practice is driving the need
70 to be able to apply the intervention as part of the plan of care. Clinical practice demands that entry-
71 level PTAs have the foundational knowledge to learn and perform non-thrust joint
72 mobilizations/manipulations, as supported by the FSBPT's Practice Analysis Reports. The final 2022

73 report, which was used to create the 2024 NPTE Content Outlines (<https://www.fsbpt.org/Free-Resources/NPTE-Development/Ensuring-Validity>), identifies the following as CRITICAL PTA Work
74 Activities: Joint Integrity & Range of Motion Perform tests and measures of... ...spinal joint stability
75 (e.g., ligamentous integrity, joint structure) ...peripheral joint stability (e.g., ligamentous integrity,
76 joint structure) ...spinal joint mobility (e.g., glide, end feel) ...peripheral joint mobility (e.g., glide, end
77 feel) ...range of motion (e.g., passive, active, functional) ...flexibility (e.g., muscle length, soft tissue
78 extensibility) Manual Therapy Techniques Perform spinal manual traction Perform peripheral
79 manual traction Perform and/or train patient/client/caregiver in soft tissue mobilization (e.g.,
80 connective tissue massage, therapeutic massage, foam rolling) Perform peripheral joint range of
81 motion Perform peripheral mobilization/manipulation (non-thrust) Perform spinal mobilization
82 (non-thrust) This means that PTAs are being tested on this content on the NPTE, and the current
83 APTA position that only physical therapists have the knowledge, skills, and clinical reasoning to apply
84 non-thrust joint mobilizations/manipulations is not supported by clinical practice. The majority of
85 state practice acts either are silent or explicitly allow for PTAs to perform non-thrust spinal and non-
86 thrust peripheral joint mobilizations/manipulations and the practices that do not typically site APTA's
87 Interventions Performed Exclusively by the Physical Therapist policy as the reason.
88
89

90 **What previous or current initiatives and positions of the Association address this topic?**

91
92 **What interested parties will be impacted by this motion?**

93 PTs, PTAs, patients

94
95 **Additional background information:**

96
97 **References:**

98 <https://www.fsbpt.org/Free-Resources/NPTE-Development/Ensuring-Validity>

99
100 **Last Updated:** 5/8/2026

101 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 19-26 AMEND PHYSICAL THERAPISTS' ROLE IN PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND MANAGEMENT OF DISEASE AND DISABILITY and RESCIND HEALTH PRIORITIES FOR POPULATIONS AND INDIVIDUALS

1 **Proposed by:** Student Council
2 **Primary Motion Contact:** Ida Hoxha, SPT
3 [Discussion Thread](#)

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

6
7 *This is a motion with two conforming amendments: Parts A–B.*

8
9 **PART A**

10
11
12 **That Physical Therapists' Role In Prevention, Wellness, Fitness, Health Promotion, And**
13 **Management Of Disease And Disability (HOD P06-19-27-12) be amended by substitution:**

14
15 PHYSICAL THERAPISTS' PRACTICE IN PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND
16 MANAGEMENT OF CONDITIONS AND DISABILITY

17
18 Physical therapist services extend beyond rehabilitation and habilitation to include prevention,
19 lifestyle and behavioral interventions, and the promotion of wellness and fitness. These services aim
20 to treat or prevent health conditions or injuries that may lead to disability.

21
22 As movement system experts, physical therapists may serve as primary care providers within a health
23 care team to preserve long-term health outcomes. Physical therapists and physical therapist
24 assistants are essential in promoting access to preventive services through education, screening,
25 referral, direct intervention, research, advocacy, and collaborative consultation. Within these roles,
26 they implement evidence-informed lifestyle and behavioral interventions that address modifiable risk
27 factors for chronic conditions and functional decline, including secondary prevention strategies.

28
29 When providing preventive health services, physical therapists and physical therapist assistants
30 account for the social drivers of health and their impact on function and participation. This approach

31 enables the adaptation of health care recommendations in ways that are practical, sustainable, and
32 culturally responsive, advancing lasting functional and health outcomes across populations.

33
34 ~~PHYSICAL THERAPISTS' ROLE IN PREVENTION, WELLNESS, FITNESS, HEALTH PROMOTION, AND~~
35 ~~MANAGEMENT OF DISEASE AND DISABILITY~~

36 ~~Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion,~~
37 ~~and management of disease and disability by serving as a dynamic bridge between health and~~
38 ~~health services delivery for individuals and populations. This means that although physical therapists~~
39 ~~are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to~~
40 ~~help individuals and populations improve overall health and avoid preventable health conditions.~~
41 ~~Physical therapists' roles may include education, direct intervention, research, advocacy, and~~
42 ~~collaborative consultation. These roles are essential to the profession's vision of transforming society~~
43 ~~by optimizing movement to improve the human experience.~~

44
45 ~~Physical therapists, like most health professionals, are educated to provide services in the health~~
46 ~~services delivery environment. Physical therapists also are uniquely educated and trained to adapt~~
47 ~~health recommendations to the community environment where individuals live, work, learn, and~~
48 ~~play. Importantly, physical therapists consider and account for the social determinants of health in~~
49 ~~the provision of clinical and community services. This knowledge and ability enables physical~~
50 ~~therapists to adapt medical recommendations to specific environments, to meaningfully interpret~~
51 ~~health recommendations, to create targeted approaches to help individuals modify their health~~
52 ~~behaviors, and to ensure clinical and community services are integrated, available, and mutually~~
53 ~~reinforcing~~

54
55
56 ~~For their role in prevention, wellness, fitness, and health promotion, physical therapists:—~~

- 57 ~~1.—— Integrate decision-making skills across all dimensions and contextual factors of the~~
58 ~~International Classification of Function—~~
- 59 ~~2.—— Incorporate health history into a plan of care that includes data related to body~~
60 ~~functions and structures, activities and participation, and relevant personal and~~
61 ~~environmental factors, including social determinants of health (economic stability, education,~~
62 ~~social and community context, health and health care, neighborhood, and built~~
63 ~~environment)—~~
- 64 ~~3.—— Integrate scientific principles of movement, function, and exercise progression to~~
65 ~~promote physical activity and improve health outcomes for individuals and populations—~~
- 66 ~~4.—— Incorporate concepts of prevention, wellness, fitness, and health promotion with every~~
67 ~~patient or client as appropriate—~~
- 68 ~~5.—— Integrate and interpret the elements of medical, biopsychosocial, and health~~
69 ~~promotion models that allow them to monitor health status over time—~~
- 70 ~~6.—— Design and develop integrated clinical and community screening programs to prevent~~
71 ~~and manage disease and disability, and refer as appropriate, as part of a community-based~~
72 ~~integrated team that is focused on healthy lifestyles—~~

- 73 7.—— Apply the best available evidence in selecting and prescribing exercise for individuals,
74 and planning physical activity and injury prevention programs for individuals and
75 communities—
- 76 8.—— Use skills in behavior change to promote healthy lifestyles in individuals and
77 communities—
- 78 9.—— Adapt tasks and the environment to promote healthy behaviors and improved health
79 outcomes for individuals and populations of all ages, including those with complex health
80 and functional needs, as part of a community-based integrated team—
- 81 10. Adopt healthy lifestyle choices for themselves that include engaging in active forms of
82 transportation and meeting national guidelines for participation in physical activity and
83 exercise—

84 -

85 For their role in management of disease and disability, physical therapists:—

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

100 -

101 For their role as a dynamic link between health and health services delivery, physical therapists:—

- 102 1.—— Apply their expertise in exercise and physical activity to adapt health
103 recommendations for individuals and populations, from clinical settings to the home and
104 community—
- 105 2.—— Function as a member of an interprofessional team of health providers, wellness and
106 fitness providers, community health workers, public health providers, and other diverse
107 professionals to help individuals and populations reduce their disease risk and improve their
108 health and quality of life—
- 109 3.—— Communicate and collaborate with relevant health professionals to help individuals
110 and populations receive appropriate health services—

111 -

112 For their role as advocates for prevention, wellness, fitness, health promotion, and management of
113 disease and disability, physical therapists:—

- 114 1.—— Support scientific, educational, legislative, and other policy initiatives that promote
115 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 safe physical activity and active forms of transportation for individuals and populations of all ages and abilities—
- 4.——Advocate for strategies that reduce inequities and barriers related to social determinants of health

PART B

That Health Priorities For Populations And Individuals (HOD P06-19-41-15) be rescinded.

HEALTH PRIORITIES FOR POPULATIONS AND INDIVIDUALS

The American Physical Therapy Association (APTA) supports the following health priorities for populations and individuals in the areas of prevention, wellness, fitness, health promotion, and management of disease and disability. The population health priorities that most relate to physical therapist practice in primary and secondary prevention and in disease management are active living, injury prevention, and secondary prevention in chronic disease and disability management.

I. Physical therapists have unique opportunities with the following populations identified by the US National Prevention Strategy (USNPS):-

A.——Aging individuals and populations (risk of falls, more individuals living longer with chronic diseases and conditions, impact of reduced physical fitness on quality of life)

B.——Individuals and populations of all ages with health disparities

C.——Individuals and populations of all ages with chronic conditions, disabilities, and diseases that impact their ability to remain independent and physically active

II. Physical therapists have unique opportunities in the following areas of injury prevention identified by USNPS:-

A.——Falls prevention

B.——Workplace injury prevention

C.——Community-based injury prevention

III. Priorities for physical therapists in secondary prevention in chronic disease and disability management include:-

A.——Diseases and disabilities that impair an individual's body function or structure

B.——Diseases and disabilities that limit an individual's activity

C.——Diseases and disabilities that restrict an individual's participation in society

D.——Diseases and disabilities that require modification of environmental factors to allow for full participation in society

Physical therapists provide education, behavioral strategies, patient advocacy, referral opportunities, and identification of supportive resources after screening for the following additional USNPS health priorities:-

- Tobacco-Free Living—
- Preventing Drug Abuse and Excessive Alcohol Use—

- 159 • ~~Healthy Eating~~
- 160 • ~~Active Living~~
- 161 • ~~Mental and Emotional Well-Being~~
- 162 • ~~Reproductive and Sexual Health~~
- 163 • ~~Injury and Violence Free Living~~

166 Support Statement

168 What is this motion seeking to achieve?

169 Inclusion of Physical Therapists and Physical Therapist Assistants The explicit inclusion of both
170 physical therapists and physical therapist assistants is necessary to accurately reflect the full care
171 team responsible for the delivery of physical therapy services. Naming both roles promotes
172 professional unity, enhances role clarity, and ensures alignment of APTA policy with contemporary
173 care delivery across practice settings. Current models of care rely on coordinated PT-PTA
174 collaboration to expand access, improve efficiency, and optimize patient outcomes. This update
175 corrects a meaningful omission in prior language and strengthens equitable representation of all
176 licensed providers contributing to patient care and advancement of the profession. Lifestyle and
177 Behavioral Interventions The incorporation of lifestyle and behavioral intervention language
178 reinforces the role of physical therapists and physical therapist assistants as leaders in prevention,
179 health promotion, and long-term health outcomes beyond rehabilitation. This update aligns with
180 value-based care and population health models, where behavior change and prevention are central
181 to improving outcomes and reducing healthcare costs. Furthermore, it reflects a robust and growing
182 body of evidence supporting the effectiveness of lifestyle and behavioral interventions in reducing
183 chronic disease risk and improving overall health outcomes. Clear and Concise Language This
184 motion enhances clarity and usability by reducing redundancy and replacing lengthy, enumerated
185 lists with more concise and adaptable language. These revisions improve readability and applicability
186 for members, policymakers, and external stakeholders, while fully preserving the original intent and
187 scope of the policy. Essential Role and First-Contact Practitioners Previous language describing
188 physical therapists as having a “unique role” in prevention and health promotion does not fully
189 capture the profession’s impact. The proposed revisions appropriately position physical therapy
190 services as essential within these domains and recognize physical therapists as part of the healthcare
191 team who may serve as first-contact practitioners. This supports timely access to care, early
192 intervention, and improved health outcomes across the lifespan, while reinforcing the profession’s
193 role within evolving, prevention-focused healthcare systems. Alignment with the International
194 Classification of Functioning, Disability and Health (ICF) The updated language is consistent with
195 the World Health Organization’s International Classification of Functioning, Disability and Health
196 framework, ensuring alignment with a globally recognized model of health. This approach
197 emphasizes function, participation, and contextual factors, and supports a shift toward a
198 biopsychosocial model of care. Integrating ICF language enhances clinical decision-making by
199 accounting for environmental and personal factors, including social drivers of health, and positions

200 the profession in accordance with international standards and contemporary best practice. Rescind
201 Health Priorities For Populations and Individuals Position Statement Rescinding the existing health
202 priorities language is necessary to eliminate redundancy and ensure consistency across APTA policy.
203 The current language contains overlapping concepts that are more clearly and comprehensively
204 addressed within updated policy statements, and maintaining both creates unnecessary duplication
205 and potential confusion for members, policymakers, and external stakeholders. Importantly, the
206 foundational principles previously outlined within the health priorities language have not been lost.
207 Instead, they have been intentionally incorporated and strengthened within the revised policy
208 through broader, more adaptable concepts, including screening, referral processes, intervention
209 planning, and prevention strategies. This approach ensures these essential elements remain central
210 to practice while allowing for flexibility across diverse patient populations, practice settings, and
211 evolving models of care.

212
213 **How does this motion contribute to achieving the Vision?**

214 Prevention is a foundational component of establishing and maintaining optimized movement and
215 health across the lifespan. Further, physical therapist and physical therapist assistant involvement in
216 preventive care strengthens the professions' ability to reduce disability, address health inequities,
217 and improve quality of life at both individual and population levels, particularly for populations
218 disproportionately affected by chronic disease and social drivers of health. This motion advances
219 APTA's vision by clearly defining and elevating the role of physical therapists and physical therapist
220 assistants in prevention, health promotion, and long term population health, recognizing that they
221 do not solely contribute to establishing and maintaining optimized movement through episodic
222 rehabilitation.

223
224 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

225 This motion directly supports the three core components of the APTA Strategic Framework:
226 advancing payment, empowering members, and evolving practice. First, it advocates for advancing
227 payment by formally recognizing physical therapists and physical therapist assistants as essential
228 providers of preventive health services. By establishing prevention, wellness, and health promotion
229 as core components of physical therapist practice, this motion strengthens the profession's position
230 in reimbursement discussions across public and private payers, including value-based and
231 population health payment models. Second, this motion supports the evolution of clinical practice
232 by clearly outlining the role of PTs and PTAs in preventive health. It highlights opportunities for
233 engagement in health promotion, wellness, early intervention, and disease prevention, reinforcing
234 PT-first care models that emphasize proactive, movement-based, nonpharmacological care across
235 care settings and across the lifespan. Third, this motion empowers members by providing a clear
236 and consistent framework for policy initiatives, interprofessional collaboration, and public education.

237
238 **How is this motion's subject national in scope and importance?**

239 This motion is national in scope and importance because it addresses significant public health
240 challenges including physical inactivity, chronic disease prevalence, falls, disability, and health

241 inequities. By clarifying and expanding the role of physical therapists and physical therapist assistants
242 in prevention, wellness, and health promotion, this motion supports consistent nationwide physical
243 therapy practice expectations, reducing variation in how preventive physical therapy services are
244 delivered and recognized across jurisdictions. Establishing physical therapists and physical therapist
245 assistants as integral members of the preventive health workforce supports early intervention and
246 risk reduction strategies that improve population health outcomes across the lifespan. In addition,
247 outlining how preventive physical therapy services can improve access to healthcare, particularly in
248 underserved, rural, and high-risk communities, has the potential to increase utilization of these
249 services by healthcare companies, thus reducing overall healthcare costs, unnecessary referrals and
250 downstream interventions, and improving patient satisfaction through timely patient-centered care.
251 This motion aligns physical therapy practice with national public health priorities, including
252 increasing physical activity, preventing falls and injury, and addressing chronic disease through
253 nonpharmacological, movement-based interventions. It complements federal legislative efforts such
254 as the Stopping Addiction and Falls for the Elderly (SAFE) Act and Senate legislation focused on fall
255 prevention by reinforcing the role of physical therapists in evidence-based, system-level strategies to
256 reduce fall risk and injury nationwide. Standardizing preventive health roles for physical therapists
257 and physical therapist assistants across states strengthens the profession's capacity to contribute
258 meaningfully to federal and state health initiatives and reinforces their role as essential partners in
259 addressing the nation's most pressing health challenges.

261 **What previous or current initiatives and positions of the Association address this topic?**

262 Several existing House of Delegates policies and Association initiatives already support the concepts
263 advanced in this motion, demonstrating strong alignment with APTA's established direction while
264 highlighting the need for further clarification and integration. P06-19-26-11 P06-19-41-15 P07-24-
265 05-07 P07-24-20-06 P08-22-12-14 Collectively, these policies reflect APTA's longstanding support
266 for prevention, wellness, population health, and practice evolution. This motion strengthens and
267 unifies these positions by eliminating ambiguity, explicitly recognizing the PT-PTA care team, and
268 embedding lifestyle and behavioral health more clearly into policy.

270 **What interested parties will be impacted by this motion?**

271 Primarily, physical therapists and physical therapist assistants will benefit from expanded recognition
272 of their scope, which may increase opportunities in prevention- and wellness-focused practice, and
273 enhanced professional visibility within evolving care models. However, other parties may be
274 interested in this motion if the outcome leads to increased advocacy and utilization of preventive
275 physical therapy services. For instance, patients and the public may gain earlier access to preventive,
276 movement-centered care, reducing the risk of chronic disease, functional decline, and avoidable
277 disability while improving long-term health outcomes and quality of life. Payers and insurers may
278 experience increased short-term utilization of services for preventive care, with anticipated long-term
279 cost savings through reduced chronic disease burden and health care utilization. Physicians and
280 other health care professionals can benefit from improved interprofessional collaboration, reduced

281 system burden, and enhanced population health outcomes. Community and public health
282 organizations may be strengthened through expanded interdisciplinary partnerships, while
283 underserved and high-risk populations, caregivers, and families may benefit from improved access
284 to early intervention, reduced health disparities, and sustained functional independence over time.

285 **Additional background information:**

287 The healthcare delivery system is shifting toward prevention, early intervention, and long term health
288 optimization. APTA policy language does not fully reflect how PT is currently practiced and their role
289 in preventative health remains underrepresented in formal policy. It clarifies the role of the PT-PTA
290 care team, reinforces prevention as a core component of physical therapy, and strengthens
291 alignment with value-based and population health approaches. Ultimately, it ensures that APTA
292 policy not only reflects current practice, but actively positions the profession to lead in a healthcare
293 system increasingly focused on prevention and long term outcomes

294 **References:**

- 296 1. American Physical Therapy Association. Vision 2030: Transforming Society Through
297 Optimized Movement. APTA, 2023.
- 298 2. APTA Guide to Physical Therapist Practice 4.0. American Physical Therapy Association, 2023
- 299 3. APTA Standards of Practice for Physical Therapy. American Physical Therapy Association. 2020
- 300 4. Centers for Medicare & Medicaid Services. Medicare Program; Calendar Year 2026 Physician
301 Fee Schedule Final Rule. 89 Fed Reg (Nov 2025).
- 302 5. Centers for Medicare & Medicaid Services. Medicare Program; Annual Wellness Visit—Health
303 Risk Assessment Requirements. 42 CFR § 410.15.
- 304 6. National Diabetes Prevention Program Act, Pub. L. No. 115-270, § 101, 132 Stat 3894 (2018).
- 305 7. Nadal IP, Angkurawaranon C, Singh A, et al. Effectiveness of behaviour change techniques in
306 lifestyle interventions for non-communicable diseases: an umbrella review. BMC Public
307 Health. 2024;24(1):3082. Published 2024 Nov 7. doi:10.1186/s12889-024-20612-8
- 308 8. Personal Health Investment Today Act of 2025 (PHIT Act of 2025), H.R.2369, 119th Cong
309 (2025-2026).
- 310 9. Sherrington, C., et al. Exercise for Preventing Falls in Older Adults: An Evidence-Based Review.
311 Cochrane Database of Systematic Reviews, 2019.
- 312 10. Stopping Addiction and Falls for the Elderly Act (SAFE Act), H.R. 1171, 119th Cong
313 (2025-2026).
- 314 11. Stand Strong Falls Prevention Act, S. 2833, 119th Cong (2025–2026).
- 315 12. Supporting Older Americans Act of 2020, Pub L No. 116-131, § 401–§ 403, 134 Stat 240, 274-
316 279.
- 317 13. Warburton, D. E., & Bredin, S. S. D. Health Benefits of Physical Activity: A Systematic Review of
318 Current Evidence. CMAJ, 2017.
- 319 14. World Health Organization. Social Determinants of Health. WHO, 2021.

320 **Last Updated:** 5/8/2026
321

322 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 20-26 RECOMMEND: ADVANCING DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES PRESCRIPTIVE AUTHORITY

1 **Proposed by:** Pennsylvania; Hand and Upper Extremity

2 **Primary Motion Contact:** Claire McCann, PT, DPT, PhD

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That the American Physical Therapy Association, consistent with existing House of Delegates
8 position [Access to Durable Medical Equipment](#) (HOD P06-18-19-29) supporting physical therapists
9 as authorized prescribers of durable medical equipment, shall:

- 10 • Pursue statutory or regulatory change through federal legislation to recognize physical
11 therapists as authorized prescribers of durable medical equipment, prosthetics, orthotics, and
12 supplies, or DMEPOS, as part of their professional service under the Medicare program.
- 13 • Develop and pursue a phased legislative strategy for expanding physical therapist
14 prescriptive authority for DMEPOS that includes collaboration with components, relevant
15 professional organizations, and states in which such authority is already explicitly recognized.

16

17

18 **Support Statement**

19

20 **What is this motion seeking to achieve?**

21 Under current Medicare statutes and regulations, physical therapists are qualified providers of
22 durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as part of their
23 professional service but are not listed as prescribing/ordering providers. In 2013, the House
24 approved [Access To Durable Medical Equipment](#) (HOD P06-13-28-28), which affirmed that APTA
25 supports physical therapists as authorized prescribers of durable medical equipment DME.
26 Prescription of DEMPOS is currently included within the Commission on Physical Therapy Education
27 (CAPTE) education standards and Federation of State Boards of Physical Therapy's (FSBPT) Model
28 Practice Act, confirming that DEMPOS prescription is within physical therapist scope of practice for
29 entry-level practitioners (APTA Task Force Report, 2025) Since 2013, APTA has engaged in
30 advocacy focusing on patient and client access to affordable DMEPOS but has not pursued
31 legislative or regulatory changes that would allow physical therapists to be recognized as authorized

32 prescribers or ordering providers, in part due to competing priorities (APTA Task Force Report, 2025).
33 With this motion, we are seeking for APTA to actively pursue prioritize state and federal legislative
34 and regulatory changes that would incrementally move the profession to broader recognition as
35 authorized prescribers of DMEPOS.

36 Examples of work that we expect to see from this motion include but are not limited to:

- 37 • Partnering with State Chapters to pursue practice act changes that explicitly add the ability of
- 38 physical therapists to prescribe DMEPOS, as APTA Colorado did in 2024 (HB24-1327)
- 39 • Exploring opportunities to partner with other professional organizations to advocate for
- 40 Federal legislative and regulatory changes that would allow physical therapists to be recognized as
- 41 authorized for prescribers or ordering providers of DMEPOS.

- 42 o A current example is HR4475/S2329 Medicare Orthotics and Prosthetics Patient-Centered
- 43 Care Act, which seeks to exempt custom fabricated or custom fitted orthoses from the Reasonable
- 44 Useful Lifetime statute.

45 Current bill language permits only physicians to approve orthosis or prosthesis replacement prior to
46 the five-year covered replacement timeframe under Medicare. Physical therapists evaluate, design
47 and fabricate or provide these items and are best positioned to determine if the device no longer
48 effectively meets medically necessary objectives and requires replacement. Prescriptive authority in
49 these circumstances allows for more expedient replacement, avoiding delays seeking orders from a
50 third-party. APTA, in collaboration with partnering organizations, could explore opportunities to
51 advocate for inclusion of PTs, OTs, orthotists and prosthetists.

52
53 **How does this motion contribute to achieving the Vision?**

54 This motion supports APTA's strategic priority of evolving practice by advancing timely, efficient, and
55 patient-centered delivery of services. Enabling physical therapists to prescribe DMEPOS aligns scope
56 of practice with entry-level physical therapist education and clinical expertise, reduces unnecessary
57 administrative barriers, and improves access to essential equipment needed to support movement,
58 function, and participation.

59
60 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

61 This motion supports APTA's strategic priority of evolving practice by advancing timely, efficient, and
62 patient-centered delivery of services. Enabling physical therapists to prescribe DMEPOS aligns scope
63 of practice with entry-level physical therapist education and clinical expertise, reduces unnecessary
64 administrative barriers, and improves access to essential equipment needed to support movement,
65 function, and participation.

66
67 **How is this motion's subject national in scope and importance?**

68 This motion asks APTA to pursue legislative and regulatory changes that would apply to physical
69 therapists nationwide. As the population ages and the prevalence of chronic conditions and mobility
70 limitations increases, timely access to appropriate DMEPOS is essential to prevent falls, reduce
71 hospitalizations, and support safe participation in home and community life. Ordering equipment
72 based on demonstrated functional level and patient safety, consistent with the patient's

73 environment, by the practitioners most skilled in making these determinations, has the potential to
74 be more cost effective by reducing waste due to inappropriate prescriptions.
75

76 **What previous or current initiatives and positions of the Association address this topic?**

77 [Access to Durable Medical Equipment](#) (HOD P06-18-19-29)
78

79 **What interested parties will be impacted by this motion?**

- 80 • State Chapters
- 81 • Physical therapists
- 82 • Patients and clients
- 83 • Referring providers
- 84 • Professional partners involved in the provision of DMEPOS

85
86 **Additional background information:**
87

88 **References:**

- 89 1. APTA (2025). Feasibility of Expanding Prescriptive Authority Within Physical Therapist Scope
90 of Practice: APTA Task Force Report.
- 91 2. Fisk, J. R., DeMuth, S., Campbell, J., DiBello, T., Esquenazi, A., Lin, R. S., Malas, B., McGuigan, F.
92 X., & Fise, T. F. (2016).
- 93 3. Suggested Guidelines for the Prescription of Orthotic Services, Device Delivery, Education,
94 and Follow-up Care: A Multidisciplinary White Paper. *Military medicine*, 181(2 Suppl), 11–17.
95 <https://doi.org/10.7205/MILMED-D-15-00542> Michael, E., Sytsma, T., & Cowan, R. E. (2020).
- 96 4. A Primary Care Provider's Guide to Wheelchair Prescription for Persons With Spinal Cord
97 Injury. *Topics in spinal cord injury rehabilitation*, 26(2), 100–107.
98 <https://doi.org/10.46292/sci2602-100> Teel, J., Wang, J. Y., & Loschiavo, M. (2021).
- 99 5. Durable Medical Equipment: A Streamlined Approach. *Family practice management*, 28(2),
100 15–20.

101
102 **Last Updated:** 5/8/2026

103 **Contact:** governancehouse@apta.org
104

Motion to 2026 House of Delegates

Main Motion:

RC 21-26 RECOMMEND: EVALUATION OF EDUCATIONAL AND REGULATORY FRAMEWORKS FOR PHYSICAL THERAPIST MEDICATION PRESCRIPTIVE AUTHORITY

1 **Proposed by:** Pennsylvania

2 **Primary Motion Contact:** Claire McCann, PT, DPT, PhD

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That the American Physical Therapy Association, consistent with its position [Pharmacotherapeutics](#)
8 [and Supplements in Physical Therapist Practice](#) (HOD P07-25-71-60) and the recommendations of
9 the Task Force on Feasibility of Expansion of Prescriptive Authority, evaluate:

- 10 • The categories of medication and the clinical contexts of medication prescription that are
11 appropriate and within the scope of physical therapist services.
- 12 • Suitable educational and competency-based pathways for physical therapists who seek
13 authorization to prescribe medications.
- 14 • The regulatory and legislative pathways, including state and federal models, that may support
15 the pursuit of prescriptive authority.
- 16 • The safeguards, ethical considerations, and ongoing competency requirements for physical
17 therapists necessary to ensure patient safety when prescribing medications and supplements.

18

19

20 [Support Statement](#)

21

22 **What is this motion seeking to achieve?**

23 The 2025 report of the APTA Task Force on Feasibility of Expanding Prescriptive Authority Within
24 Physical Therapist Scope of Practice concluded that expansion of physical therapist scope of practice
25 into medication prescription is feasible. However, the report also identified substantial unanswered
26 questions related to education, regulation, and implementation that must be addressed before the
27 profession can responsibly move in that direction. The goal of this motion is to follow up on the
28 work of the Feasibility Task Force by initiating structured evaluation of potential educational,
29 regulatory, and legislative pathways. This work would establish foundational guidance for the
30 profession should future House action support pursuing medication prescriptive authority.

31

32 **How does this motion contribute to achieving the Vision?**

33 This motion supports APTA's strategic priority of evolving practice by evaluating pathways toward
34 medication prescriptive authority that may advance timely, efficient, and patient-centered care while
35 maintaining high standards of safety, competence, and ethical practice.

36

37 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

38 This motion supports APTA's strategic priority of evolving practice by evaluating pathways toward
39 medication prescriptive authority that may advance timely, efficient, and patient-centered care while
40 maintaining high standards of safety, competence, and ethical practice.

41

42 **How is this motion's subject national in scope and importance?**

43 The question of medication prescriptive authority for physical therapists is national in scope because
44 it implicates professional education standards, licensure regulation, federal and state law, and the
45 role of physical therapists within the U.S. health care system. Decisions related to scope of practice,
46 educational pathways, and regulatory models cannot be effectively addressed by individual states or
47 components in isolation. As demonstrated in the 2025 APTA Feasibility of Expanding Prescriptive
48 Authority report, potential expansion of medication prescriptive authority would require coordinated
49 consideration of national educational standards, competency expectations, federal regulatory
50 frameworks, and interprofessional impacts. Without national evaluation and guidance, states
51 pursuing changes independently risk inconsistency, inefficiency, and patient safety concerns. This
52 motion seeks to ensure that any future consideration of medication prescriptive authority is
53 informed by a unified, evidence-based, and strategically coordinated national approach that
54 supports patient safety, professional accountability, and equitable access to care across jurisdictions.

55

56 **What previous or current initiatives and positions of the Association address this topic?**

57 The Task Force on the Feasibility of Expansion of Prescriptive Authority Within Physical Therapist
58 Scope of Practice, established by charge of the House of Delegates (RC 17-22), evaluated the
59 feasibility of expanding physical therapist prescriptive authority across multiple domains, including
60 medication. The Task Force's final report to the 2025 House of Delegates concluded that expansion
61 of medication prescriptive authority is feasible, while identifying the need for further evaluation of
62 educational pathways, regulatory models, and safeguards prior to implementation. In addition, the
63 Association's position on Pharmacotherapeutics and Supplements in Physical Therapist Practice
64 (HOD P07-25-71-60) was amended in 2025 to explicitly recognize that, where permitted by law or
65 regulation, physical therapists may prescribe, store, and administer medication to optimize patient
66 and client management and health. The position further affirms the role of physical therapists in
67 medication reconciliation, monitoring for therapeutic benefit and adverse effects, and engaging in
68 team-based collaboration with other medication-prescribing practitioners. This motion is
69 consistent with and builds upon these existing Association positions by seeking to evaluate the
70 educational, regulatory, and legislative frameworks necessary to responsibly operationalize
71 medication prescriptive authority should the profession choose to pursue it in the future. The motion

72 does not propose immediate changes to scope of practice, but rather supports informed, evidence-
73 based decision-making by the House and the Association.
74

75 **What interested parties will be impacted by this motion?**

- 76 • State Chapters
- 77 • Physical therapists
- 78 • Patients and clients
- 79 • Referring providers and interprofessional partners

80

81 **Additional background information:**

82

83 **References:**

84

85 **Last Updated:** 5/8/2026

86 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 22-26 RECOMMEND: CREATION OF EDUCATIONAL RESOURCES FOR THE PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT REGARDING PSILOCYBIN THERAPY

1 **Proposed by:** Oregon
2 **Primary Motion Contact:** Gavin McBride, PT, DPT, MS
3 [Discussion Thread](#)

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

6
7 That the American Physical Therapy Association provide resources to educate physical therapists,
8 physical therapist assistants, and students on the effects, clinical applications, methods of delivery,
9 and current best evidence related to clients' use of psilocybin therapy for health-related conditions,
10 with a focus on patient safety.

11
12
13 **Support Statement**

14
15 **What is this motion seeking to achieve?**

16 This motion is intended to ensure that physical therapists and physical therapist assistants have
17 standardized, evidence-informed educational resources to support safe communication and clinical
18 decision-making when patients ask about or disclose psilocybin use. If adopted, the APTA would
19 provide educational resources, similar in purpose to its existing Physical Therapy and Patient
20 Cannabis Use resource, developed following RC 67-19, so that clinicians can respond appropriately
21 when encountering patients who are currently using or considering psilocybin therapy. The
22 psilocybin landscape is evolving rapidly. Without standardized resources, PTs and PTAs lack guidance
23 to navigate these clinical encounters safely.

24
25 **How does this motion contribute to achieving the Vision?**

26 This motion advances the profession's Vision by equipping PTs and PTAs to optimize movement and
27 improve the human experience safely when patients are using or considering psilocybin therapy.
28 Patients presenting for rehabilitation may have recent or planned psilocybin exposure that produces
29 physiological and psychological effects directly relevant to physical therapy. Without standardized
30 resources, PTs and PTAs lack guidance to appropriately screen, modify interventions, or coordinate

31 care when patients ask about or disclose psilocybin use. By providing essential resources, clinicians
32 will be better prepared to respond and deliver safe, evidence-informed, patient-centered care.
33

34 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

35 This motion supports two strategic priorities in the APTA Strategic Framework for 2030. It supports
36 Empowering Our Members by creating a practice-relevant resource that can be used across career
37 stages and settings, delivering value when and how members need it through standardized guidance
38 for safe, evidence-based patient conversations about psilocybin therapy. It also supports Evolving
39 Our Practice by helping PTs and PTAs operate safely in existing and emerging care models that
40 intersect with psilocybin services. This motion provides practical tools that improve care and patient
41 safety as these environments continue to evolve. The level of professional interest is already evident,
42 as more than 200 attendees participated in the CSM panel discussion on cannabis, opioids, and
43 psilocybin, demonstrating member demand for this type of education.
44

45 **How is this motion's subject national in scope and importance?**

46 This subject is national in scope because psilocybin use is no longer limited to a single state. Oregon,
47 Colorado, and New Mexico have implemented state-regulated psilocybin service models, and
48 fourteen additional states currently have active legislation related to psilocybin use. A 2026 JAMA
49 study reported that more than 7 million Americans used psilocybin outside any regulated framework,
50 and the 2025 RAND Psychedelics Survey estimated approximately 11 million total past-year users. A
51 University of California Berkeley national survey found 61% public support for legalizing regulated
52 therapeutic use. This shows a growing patient population that will present for rehabilitation with
53 recent or planned psilocybin exposure, questions about therapeutic effects and safety, and a need
54 for modified care. The APTA is well positioned to provide standardized guidance that improves
55 safety and reduces practice variability.
56

57 **What previous or current initiatives and positions of the Association address this topic?**

58 To date, none, only the existing Physical Therapy and Patient Cannabis Use resource from RC 67-19
59 is relevant.
60

61 **What interested parties will be impacted by this motion?**

62 Physical Therapists and Physical Therapist Assistants are the primary stakeholders impacted by this
63 motion. PTs and PTAs across all practice settings may encounter patients who ask about, disclose, or
64 present with recent or planned psilocybin exposure. Clinicians currently have no APTA guidance to
65 inform screening, intervention modification, or within-scope communication during these
66 encounters. This motion would provide standardized educational resources to support safe,
67 evidence-based clinical decision-making. APTA Staff would be responsible for developing the
68 requested resources. Importantly, this motion does not require financial investment or extensive staff
69 time. The Board's own staff assessment identified the possibility of an educational practice brief that
70 provides a high-level description of the issue, a summary of available evidence, and emphasis on
71 safety. This is consistent with the intent of the motion. The precedent set by the cannabis resources

72 following RC 67-19, a webpage compiling links to existing external resources from organizations
73 such as the CDC, FDA, NIH, and National Academies, demonstrates this type of resource can be
74 developed by curating and organizing existing evidence.
75

76 **Additional background information:**

77 The psilocybin therapy landscape is evolving rapidly across the United States. Oregon, Colorado, and
78 New Mexico have already implemented legalized state-regulated psilocybin services. Beyond these,
79 fourteen additional states currently have active legislation regarding psilocybin use (1). A 2026 JAMA
80 study reported that more than 7 million Americans used psilocybin outside of any regulated
81 framework in the past year (2), while the 2025 RAND Psychedelics Survey, a nationally representative
82 probability-based survey of more than 10,000 U.S. adults, estimated approximately 11 million total
83 past-year users (3). Furthermore, there are currently 290 registered clinical trials on ClinicalTrials.gov
84 related to psilocybin therapy (4). A University of California Berkeley national survey found 61% public
85 support for legalizing regulated therapeutic use (5). As this landscape expands, PTs and PTAs will
86 increasingly encounter patients who ask about, disclose, or present for rehabilitation with recent or
87 planned psilocybin exposure.

88 Just as cannabis use raised questions PTs and PTAs were not initially prepared to answer, psilocybin
89 use presents a similar and growing clinical reality. Patients presenting for rehabilitation may have
90 recent or planned psilocybin exposure that may produce physiological and psychological effects
91 directly relevant to physical therapy. Without standardized resources, PTs and PTAs lack guidance to
92 appropriately screen, modify interventions, or coordinate care when patients ask about or disclose
93 psilocybin use. The level of professional interest is already evident, as more than 200 attendees
94 participated in the CSM panel discussion on Cannabis, Opioids and Psilocybin (6).

95 This motion asks the APTA to take the same practical, patient safety-oriented approach it has applied
96 to cannabis. APTA's existing "Physical Therapy and Patient Cannabis Use" resource, developed
97 following RC 67-19, recognizes that patient substance use can affect physical therapy outcomes and
98 that changing state laws and regulations make it imperative for PTs and PTAs to stay informed. This
99 motion extends that established model to psilocybin therapy by providing standardized educational
100 resources that help clinicians summarize current best evidence on clinical applications and effects,
101 risks and benefits, and relevant state-specific regulations. These resources would support clinicians in
102 responding within scope, communicating safely, and coordinating care appropriately.
103

104 **References:**

- 105 1. Psychedelic Alpha. Psychedelics legalization & decriminalization tracker. Updated 2026.
106 Accessed March 31, 2026. <https://psychedelicalpha.com/data/psychedelic-laws>
- 107 2. Hutchison KE, Hooper JF, Karoly HC. Psilocybin outside the clinic: public health challenges of
108 increasing publicity, accessibility, and use. *JAMA Psychiatry*. 2026;83(1):78-84.
109 doi:10.1001/jamapsychiatry.2025.3038
- 110 3. Priest M, Kilmer B, Senator B, Setodji CM. U.S. Psychedelic Use and Microdosing in 2025:
111 Insights from a Probability-Based and Nationally Representative Survey. RAND Corporation;

112 2026. RR-A4334-1. Accessed March 31, 2026.

113 https://www.rand.org/pubs/research_reports/RRA4334-1.html

114 4. U.S. National Library of Medicine. ClinicalTrials.gov search results: psilocybin. Accessed March
115 31, 2026. <https://clinicaltrials.gov/search?term=Psilocybin>

116 5. UC Berkeley Center for the Science of Psychedelics. UC Berkeley Center for the Science of
117 Psychedelics unveils results of the first-ever Berkeley Psychedelics Survey. Published July 12,
118 2023. Accessed March 31, 2026. [https://psychedelics.berkeley.edu/event/uc-berkeley-center-
119 for-the-science-of-psychedelics-unveils-results-of-the-first-ever-berkeley-psychedelics-
120 survey/](https://psychedelics.berkeley.edu/event/uc-berkeley-center-for-the-science-of-psychedelics-unveils-results-of-the-first-ever-berkeley-psychedelics-survey/)

121 6. American Physical Therapy Association. This Talk Is All Substance: TED Talks and Panel
122 Discussion on Cannabis, Opioids and Psilocybin. Presented at: APTA Combined Sections
123 Meeting, Leadership & Innovation; 2026; Anaheim, CA.

124 **Last Updated:** 5/8/2026

125 **Contact:** governancehouse@apta.org
126

Motion to 2026 House of Delegates

Main Motion:

RC 23-26 AMEND: DIAGNOSIS BY PHYSICAL THERAPISTS

1 **Proposed by:** New York

2 **Primary Motion Contact:** Theresa Marko, PT, DPT, MS

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That Diagnosis by Physical Therapists (HOD P07-25-70-57), second paragraph, be amended by
8 inserting the words “and the presence of impairments, activity limitations, or participation
9 restrictions” after the word “disease” so that it would read:

10

11 DIAGNOSIS BY PHYSICAL THERAPISTS

12

13 Physical therapists shall establish a diagnosis¹ for each patient/client.

14

15 A diagnosis¹ is a label identifying the nature and cause of injury, ~~or~~ disease², and the presence of
16 impairments, activity limitations, or participation restrictions^{3,4}. It is the decision reached as a result
17 of the diagnostic process, which is the evaluation of information obtained from the patient/client
18 history and physical examination and other available information. The purpose of the diagnosis is to
19 guide the physical therapist in determining the most appropriate management for each
20 patient/client.

21

22 When indicated, physical therapists order diagnostic tests/studies, including but not limited to
23 imaging and laboratory tests. Physical therapists may also perform or interpret selected imaging or
24 other tests/studies.

25

26 **References**

27 1. Centers for Disease Control and Prevention, National Center for Health Statistics. Diagnosis.
28 Accessed October 2, 2025. <https://www.cdc.gov/nchs/hus/sources-definitions/diagnosis.htm>

29

30 2. National Cancer Institute. Disease. Accessed October 2, 2025.

31 <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/disease>

32 ~~3. World Health Organization. International Classification of Functioning, Disability and Health.~~
33 ~~Accessed March 3, 2026. [https://www.who.int/standards/classifications/international-classification-](https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health)~~
34 ~~[of-functioning-disability-and-health](https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health)~~
35 ~~4. World Health Organization. *ICF Checklist: Version 2.1a, Clinician Form for International*~~
36 ~~*Classification of Functioning, Disability and Health (ICF)*. Geneva, Switzerland: World Health~~
37 ~~Organization; 2003. Accessed March 10, 2026. [https://www.who.int/docs/default-](https://www.who.int/docs/default-source/classification/icf/icfchecklist.pdf)~~
38 ~~[source/classification/icf/icfchecklist.pdf](https://www.who.int/docs/default-source/classification/icf/icfchecklist.pdf)~~

39
40

41 **Support Statement**

42

43 **What is this motion seeking to achieve?**

44 This motion seeks to address a limitation in the current diagnostic framework that does not
45 adequately capture the clinical complexity of physical therapist management. Reliance on disease-
46 based or injury-based diagnoses alone fails to communicate patient-specific functional needs and
47 does not reflect how physical therapists determine plans of care. A medical diagnosis, such as
48 Parkinson’s disease, identifies the condition but does not convey the patient’s functional stage or
49 complexity, which directly dictates intervention selection. For example, the management of a patient
50 with early-stage Parkinson’s disease differs significantly from that of a patient with advanced disease,
51 despite use of the same disease diagnosis. By explicitly including impairments, activity limitations,
52 and participation restrictions within the definition of diagnosis, this motion allows physical therapists
53 to more accurately describe patient presentation, justify interventions, and document the clinical
54 reasoning that guides care.

55 Examples of ICD-10 diagnostic codes in each of the three areas of impairments, functional
56 limitations, and participation restrictions are below.

- 57 • M25.5 (joint stiffness)
- 58 • Z74.09 (general reduced mobility)
- 59 • M62.81 (muscle weakness)
- 60 • R26x (gait impairments)
- 61 • R26.2 (difficulty in walking)
- 62 • Z73.6 (limitation of activities due to disability)
- 63 • Z02.5 (encounter for examination for participation in sport)

64

65 **How does this motion contribute to achieving the Vision?**

66 The Vision of transforming society by optimizing movement requires diagnostic frameworks that
67 reflect how conditions affect movement, function, and participation across stages of disease and
68 across the lifespan. A disease label alone does not convey how a condition limits mobility,
69 independence, or engagement in daily and societal roles. For example, a 40-year-old with single-
70 joint osteoarthritis presents with different intervention needs than an 80-year-old with multi-joint
71 involvement, despite similar diagnostic labels. By supporting diagnoses that incorporate
72 impairments, activity limitations, and participation restrictions, this motion enables physical

73 therapists to target interventions that directly improve movement, participation, and quality of life in
74 ways that align with real-world patient experience.

75

76 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

77 This motion directly supports all three pillars of APTA’s Strategic Framework for 2030:

78 **Advancing Our Payment:** Payment models rely on clear justification of medical necessity. Disease-
79 based diagnoses alone do not adequately explain why specific physical therapy interventions are
80 required, particularly when patients with the same medical diagnosis present with vastly different
81 impairments and functional limitations. Functional and impairment-based diagnoses strengthen
82 documentation by clearly linking patient presentation to required interventions, supporting
83 outcomes-driven care and fair payment advocacy.

84 **Empowering Our Members:** This motion empowers physical therapists by aligning Association policy
85 with how clinicians already examine and manage patients. Physical therapists routinely identify
86 impairments, activity/functional limitations, and participation restrictions to determine plans of
87 management care. Recognizing these elements within diagnosis(es) supports professional judgment,
88 improves communication with payers and other providers, and reinforces the role of physical
89 therapists as autonomous practitioners.

90 **Evolving Our Practice:** As practice continues to move toward value-based and patient-centered
91 services, diagnostic frameworks must extend beyond static disease labels. ICD-10 codes already exist
92 to describe impairments and functional limitations (e.g., muscle weakness, gait impairment, difficulty
93 walking, limitations in activities due to disability). This motion supports modern practice models by
94 ensuring that the diagnosis reflects clinical complexity, patient goals, and participation demands
95 rather than relying solely on disease classification.

96

97 **How is this motion’s subject national in scope and importance?**

98 Physical therapists across the country face the same challenge when disease-based diagnoses fail to
99 reflect functional complexity. A single diagnosis code does not distinguish between early and
100 advanced neurologic disease, nor between younger and older adults with differing levels of
101 impairment and participation restriction. This lack of specificity affects documentation, payment
102 justification, and interprofessional communication nationwide. Incorporating impairments,
103 activity/functional limitations, and participation restrictions into the diagnostic framework ensures
104 consistency, accuracy, and relevance across all practice settings and aligns national policy with how
105 physical therapists deliver care.

106

107 **What previous or current initiatives and positions of the Association address this topic?**

108 This motion builds upon existing APTA positions and recent House actions that recognize physical
109 therapists as autonomous practitioners responsible for examination, diagnosis, and management of
110 movement dysfunction. The House has previously affirmed diagnostic authority and continues to
111 refine policy language to ensure it reflects contemporary physical therapist practice. During the
112 2025 House of Delegates cycle, the House adopted amendments related to diagnosis by physical
113 therapists, with implementation activities extending into 2026, including updates to the Guide to

114 Physical Therapist Practice and related APTA resources. In addition, the House has charged
115 committees with developing contemporary operational definitions of terminology impacting APTA
116 documents, reflecting an ongoing commitment to clarity, consistency, and relevance in Association
117 policy. This motion complements and strengthens these initiatives by further clarifying the
118 diagnostic framework to explicitly include impairments, activity/functional limitations, and
119 participation restrictions. In doing so, it supports ongoing Association efforts to advance payment,
120 reduce administrative burden, and align policy language with the realities of physical therapists'
121 clinical reasoning, documentation, and patient-centered services across practice settings.
122

123 **What interested parties will be impacted by this motion?**

124 Physical Therapists: Gain clearer policy support for diagnostic reasoning and patient-specific services.
125 Patients: Benefit from diagnoses that reflect functional needs and participation goals rather than
126 disease labels alone.
127 Payers: Receive more precise documentation that clarifies medical necessity and treatment rationale.
128 Interprofessional Teams: Experience improved communication and understanding of physical
129 therapist decision-making.

130

131 **Additional background information:**

132

133 **References:**

- 134 1. American Physical Therapy Association. (2025). House of Delegates RC 30-25: Diagnosis
135 by physical therapists.
- 136 2. American Physical Therapy Association. (2025). House of Delegates Year in Review.
- 137 3. American Physical Therapy Association. (2023). APTA Strategic Framework for 2030.

138

139 **Last Updated:** 5/8/2026

140 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 24-26 AMEND: CARDIOPULMONARY RESUSCITATION

1 **Proposed by: New Jersey, Cardiovascular and Pulmonary, Acute Care**

2 **Primary Motion Contact: Kaitlyn Hanelt, PT, DPT**

3 [Discussion Thread](#)

4

5 **Required for Adoption: Majority Vote**

6

7 **That Cardiopulmonary Resuscitation (HOD P06-18-23-31) be amended by substitution.**

8

9 **CARDIOPULMONARY RESUSCITATION**

10

11 **Basic Life Support**

12

13 The American Physical Therapy Association supports the requirement and the maintenance of a
14 certification in basic life support of the adult, child, and infant for all physical therapists, physical
15 therapist assistants, student physical therapists, and student physical therapist assistants.

16

17 ~~In addition, APTA recommends~~ supports a requirement that all health care and wellness facilities
18 providing physical therapist services have an automated external defibrillator available for use by
19 trained personnel during first-response cardiopulmonary resuscitation efforts.

20

21 **Advanced Cardiac Life Support**

22

23 APTA recommends that physical therapists and physical therapist assistants certified in advanced
24 cardiac life support, or ACLS, be authorized to perform ACLS procedures as allowable by
25 jurisdictional law.

26

27

28 **Support Statement**

29

30 **What is this motion seeking to achieve?**

31 Supporting Basic Life Support (BLS) certification as a requirement for licensure strengthens the
32 professional standards of the physical therapy profession and aligns regulatory expectations with
33 those of other healthcare disciplines. It reinforces the vital role that physical therapists (PTs) and
34 physical therapist assistants (PTAs) play in promoting patient safety and responding to medical

35 emergencies, ensuring that all licensed practitioners are prepared to act swiftly and competently in
36 life-threatening situations. Physical therapists and physical therapist assistants practice across the
37 lifespan and across care settings in which sudden cardiac arrest may occur, including outpatient
38 clinics, inpatient hospitals, skilled nursing facilities, home health, community environments, and
39 school- and sports-related settings. Contemporary epidemiologic data demonstrate that sudden
40 cardiac arrest affects adults across a wide age range, including working-age and older adults, as well
41 as youth and young athletes during physical exertion. Given the nature of physical therapy
42 interventions—which frequently involve physical activity, exertion, and cardiovascular stress—
43 baseline preparedness to recognize and respond to sudden cardiac arrest is an essential component
44 of safe and competent practice. By establishing CPR and BLS certification as a licensure
45 requirement, the profession reinforces its commitment to a high level of clinical readiness and
46 interprofessional consistency. This standard would promote greater uniformity across state practice
47 acts, reduce variability in emergency preparedness, and reflect the evolving expectations of patients,
48 employers, and healthcare systems. Ultimately, this position supports the profession’s public
49 protection mandate by ensuring that all PTs and PTAs maintain critical, evidence-based life-saving
50 skills regardless of practice setting or population served.

51
52 **How does this motion contribute to achieving the Vision?**

53 The language supports its vision by emphasizing patient safety, professional responsibility, and the
54 role of physical therapists as essential members of the healthcare system. By requiring certification in
55 basic life support for all physical therapists, physical therapist assistants, and students, it ensures that
56 providers are prepared to respond effectively to emergencies, reinforcing a commitment to high-
57 quality, safe care. The recommendation that facilities offering physical therapy services maintain
58 access to automated external defibrillators further promotes a culture of preparedness and
59 comprehensive care across all settings. Together, these expectations highlight the importance of
60 ongoing competence, support public trust, and position physical therapy professionals as key
61 contributors to improving the health and safety of society.

62
63 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

64 The language from the American Physical Therapy Association supports its strategic framework by
65 advancing key priorities such as quality, safety, professional competence, and value within the
66 healthcare system. Requiring basic life support certification for all physical therapy professionals
67 reinforces a commitment to clinical excellence and lifelong learning, which are central components
68 of the framework. It also strengthens the profession’s role in interprofessional, patient-centered care
69 by ensuring PTs and PTAs are prepared to respond to emergencies alongside other healthcare
70 providers. Additionally, recommending access to automated external defibrillators in all facilities
71 enhances the quality and safety of care environments, aligning with efforts to improve outcomes and
72 reduce risk. Altogether, this language helps operationalize the strategic framework by promoting
73 consistent standards, elevating professional accountability, and demonstrating the value of physical
74 therapy in protecting and improving patient health

75

76 **How is this motion's subject national in scope and importance?**

77 This motion is national in scope and importance because it establishes consistent expectations for
78 safety, preparedness, and professional competence across all individuals and settings associated with
79 the American Physical Therapy Association. By recommending universal basic life support
80 certification for physical therapists, physical therapist assistants, and students, it promotes a
81 standardized level of emergency readiness regardless of geographic location or practice setting.
82 Similarly, the recommendation that all facilities providing physical therapy services maintain access
83 to automated external defibrillators ensures a uniform approach to patient safety nationwide.
84 Because these measures impact education programs, clinical practice environments, regulatory
85 considerations, and patient outcomes across the country, the motion extends beyond local or
86 regional concerns and contributes to a cohesive, high standard of care throughout the profession in
87 the United States.

88
89 **What previous or current initiatives and positions of the Association address this topic?**

90 Several existing initiatives and positions from the American Physical Therapy Association support the
91 emphasis on BLS certification and AED availability by reinforcing the profession's commitment to
92 safety, competence, and high-quality care. APTA's focus on continued competence and lifelong
93 learning aligns with maintaining current life-saving certifications as part of professional
94 responsibility. Its standards of practice and ethical guidelines prioritize patient safety and risk
95 management, which naturally include emergency preparedness. Additionally, APTA's vision for the
96 profession highlights physical therapists as essential, autonomous healthcare providers, a role that
97 requires readiness to respond to emergencies across the lifespan. The association also promotes
98 interprofessional collaboration, where skills like CPR and AED use are critical for effective team-based
99 care. Together, these initiatives demonstrate that the motion builds on and strengthens existing
100 priorities related to clinical excellence, patient safety, and the overall value of physical therapy in the
101 healthcare system.

102
103 **What interested parties will be impacted by this motion?**

104 This motion from would impact a wide range of internal and external stakeholders by shaping
105 expectations for safety, training, and facility preparedness. Internally, physical therapists, physical
106 therapist assistants, and students would be directly affected through the requirement to obtain and
107 maintain basic life support certification, increasing their responsibility for ongoing competence and
108 emergency readiness. Academic programs would need to ensure that students are trained and
109 certified, potentially adjusting curricula and resources. Employers and physical therapy practices
110 would be impacted by the recommendation to maintain automated external defibrillators, which
111 may involve financial costs, staff training, and policy updates to ensure compliance and proper use.
112 Externally, patients would benefit from increased safety and confidence knowing that providers are
113 prepared to respond to emergencies. Healthcare systems and interprofessional teams would also be
114 positively affected, as PT professionals would be better equipped to contribute during critical
115 situations, enhancing coordinated care. Regulatory bodies and accrediting organizations may
116 consider these expectations when shaping standards or guidelines, potentially influencing broader

117 healthcare policy. Additionally, payers and insurers could view these measures as contributing to
118 improved outcomes and reduced risk. Overall, the motion strengthens accountability and
119 preparedness across the profession while improving safety and trust for those receiving care.
120

121 **Additional background information:**

122 Each year, an estimated 350,000 individuals in the United States experience sudden cardiac arrest
123 outside of a hospital setting, with survival highly dependent on immediate bystander intervention.
124 Early initiation of cardiopulmonary resuscitation (CPR) and rapid defibrillation with an automated
125 external defibrillator (AED) can double or triple survival, particularly when provided within the first
126 few minutes of collapse.¹ Sudden cardiac arrest and sudden cardiac death occur across the adult
127 lifespan and disproportionately affect working-age and older adults, populations that comprise a
128 substantial proportion of patients treated by physical therapists and physical therapist assistants in
129 outpatient clinics, inpatient hospitals, skilled nursing facilities, home health, and community-based
130 settings. National mortality data demonstrate that among adults aged 25 to 44 years, more than
131 10,500 sudden cardiac deaths occurred in the United States between 1999 and 2020, representing an
132 average of approximately 480 deaths per year. During this period, sudden cardiac death–related
133 mortality in this age group increased by approximately 28%, with disproportionate increases
134 observed among Black and Hispanic/Latinx adults and individuals residing in rural communities.²
135 Although the incidence of sudden cardiac arrest increases with advancing age, adults aged 25 to 44
136 years are often perceived as lower risk despite experiencing sudden cardiac arrest during daily
137 activities, physical exertion, and community participation. The majority of these events occur outside
138 of hospitals, frequently in homes or public settings, where rapid recognition and immediate CPR are
139 critical to survival.² Physical therapists and physical therapist assistants routinely engage adults
140 across this age spectrum in interventions that impose cardiovascular demand, underscoring the
141 importance of universal emergency preparedness across practice settings. Sudden cardiac arrest and
142 sudden cardiac death also occur in youth, scholastic, and collegiate athletes, frequently during
143 physical exertion. Prospective U.S. surveillance data collected between 2014 and 2018 identified 331
144 confirmed cases of sudden cardiac arrest or death among young competitive athletes, with 61.6%
145 occurring in high school athletes and 13.3% in collegiate athletes. The overall incidence was
146 approximately 1 sudden cardiac arrest or death per 65,000 athlete-years at the high school level and
147 1 per 50,000 athlete-years at the collegiate level, with substantially higher risk observed among male
148 athletes, Black athletes, and those participating in basketball and football.³ More recent national
149 surveillance examining survival outcomes among young competitive athletes from 2014 to 2023
150 identified 641 cases of sudden cardiac arrest, with an overall survival rate of 49%. Survival was
151 significantly higher for events occurring during exercise (57%), and survival improved steadily over
152 the study period, reflecting the impact of early CPR, AED access, and coordinated emergency
153 response systems. High school athletes accounted for the majority of cases (61%), followed by
154 collegiate athletes (15%). Persistent disparities in survival outcomes underscore the importance of
155 universal preparedness across all populations and care environments.⁴ Physical therapists and
156 physical therapist assistants practice across the lifespan and across settings in which sudden cardiac
157 arrest may occur. Establishing BLS certification as a requirement for licensure ensures that all licensed

158 PTs and PTAs are prepared to respond effectively to these time-sensitive, life-threatening events,
159 reinforcing the profession’s commitment to patient safety, public protection, and emergency
160 readiness

161

162 **References:**

- 163 1. Benjamin EJ, Muntner P, Alonso A, et al. Heart disease and stroke statistics—2019 update:
164 a report from the American Heart Association. *Circulation*. 2019;139(10):e56–e528.
165 doi:10.1161/CIR.0000000000000659
- 166 2. Zuin M, Mohanty S, Aggarwal R, et al. Trends in sudden cardiac death among adults
167 aged 25 to 44 years in the United States: an analysis of 2 large US databases. *J Am Heart*
168 *Assoc*. 2025;14:e035722. doi:10.1161/JAHA.124.035722 Accessed January 10, 2026.
- 169 3. Peterson DF, Kucera KL, Thomas LC, et al. Aetiology and incidence of sudden cardiac
170 arrest and death in young competitive athletes in the USA: a 4-year prospective study. *Br*
171 *J Sports Med*. 2021;55(21):1196–1203. doi:10.1136/bjsports-2020-102666
- 172 4. Petek BJ, Churchill TW, Moulson N, et al. Survival outcomes after sudden cardiac arrest in
173 young competitive athletes from the United States. *J Am Coll Cardiol*. 2025;85(17):1682–
174 1692. doi:10.1016/j.jacc.2025.03.006
- 175 5. Delaware Department of State, Division of Professional Regulation. Examining Board of
176 Physical Therapists and Athletic Trainers Rules and Regulations. 24 Del Admin Code
177 §2600 (21 DE Reg 960, June 1, 2018). Accessed January 10, 2026.
178 <https://regulations.delaware.gov/AdminCode/title24/2600.shtml>
- 179 6. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; Reform of
180 Requirements for Long-Term Care Facilities. 42 CFR §483. Accessed January 10, 2026.
181 <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483>
- 182 7. Centers for Medicare & Medicaid Services. State Operations Manual (SOM), Appendix
183 PP—Guidance to Surveyors for Long-Term Care Facilities. Accessed January 10, 2026.
184 [https://www.cms.gov/medicare/provider-enrollment-and-](https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations)
185 [certification/guidanceforlawsandregulations](https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations)
- 186 8. The Joint Commission. Human Resources Standards. Updated 2024. Accessed January
187 10, 2026. <https://www.jointcommission.org>

188

189 **Last Updated:** 5/8/2026

190 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 25-26 RESCIND: OPPOSITION TO PHYSICIAN OWNERSHIP OF PHYSICAL THERAPIST SERVICES AND SELF-REFERRAL BY PHYSICIANS

1 **Proposed by:** North Carolina
2 **Primary Motion Contact:** Elizabeth Nixon, PT, DPT
3 [Discussion Thread](#)

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

6
7 **That Opposition To Physician Ownership Of Physical Therapist Services And Self-Referral By Physicians (HOD P06-19-16-46) be rescinded.**

8
9
10 ~~OPPOSITION TO PHYSICIAN OWNERSHIP OF PHYSICAL THERAPIST SERVICES AND SELF-REFERRAL~~
11 ~~BY PHYSICIANS~~

12
13 ~~Whereas, The American Physical Therapy Association advocates for a healthy society, for patient and~~
14 ~~client engagement in health services, and for direct access to physical therapist services;~~

15
16 ~~Whereas, Physical therapists and physicians collaboratively provide patient-centered services in~~
17 ~~practice models that may include mutual-referral, co-management, and consultation;~~

18
19 ~~Whereas, Physician self-referral to physical therapist services in which an ownership interest by the~~
20 ~~physician is an avoidable conflict of interest that may restrain patient choice in services;~~

21
22 ~~Whereas, Federal law prohibits, with some exceptions, physician self-referral for various designated~~
23 ~~health services¹;~~

24
25 ~~Whereas, Evidence suggests that there is greater cost per patient encounter and for the entire~~
26 ~~episode of care in self-referral situations²; and~~

27
28 ~~Whereas, Evidence also suggests that patients in self-referral situations receive more passive~~
29 ~~treatment that is performed by persons not licensed as physical therapists and that non-self-referred~~
30 ~~physical therapist services include more active, hands-on, and one-to-one services that promote~~
31 ~~greater patient independence and a return to performing routine activities without pain³;~~

32
33 ~~Resolved, That the American Physical Therapy Association opposes ownership of and self-referral to~~
34 ~~physical therapist services by physicians, and supports federal and state laws and regulations that~~
35 ~~prohibit physician ownership of physical therapist services.~~

36
37 REFERENCES

- 38 1. ——— Centers for Medicare & Medicaid Services. Physician Self-Referral webpage.
39 <https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/index.html>.
40 2. ——— Mitchell J, Reschovsky J, Franzini L, et al. Physician Self-Referral of Physical Therapy Services
41 for Patients with Low Back Pain: Implications for Use, Types of Treatments Received and
42 Expenditures. *Forum for Health Economics and Policy*, 2015;19(2):179-199. doi:10.1515/fhep-2015-
43 0026.
44 3. ——— Mitchell JM, Reschovsky JD, Reicherter EA. Use of Physical Therapy Following Total Knee
45 Replacement Surgery: Implications of Orthopedic Surgeons' Ownership of Physical Therapy Services.
46 *Health Serv Res*, 2016;51: 1838-1857. doi:10.1111/1475-6773.12465.

47
48
49 **Support Statement**

50
51 **What is this motion seeking to achieve?**

52 This motion seeks to rescind an APTA position that opposes one specific business model: physician-
53 owned physical therapy practices. While the original stance reflected concerns at the time,
54 particularly related to therapist autonomy and potential overutilization, it has not met its intended
55 objectives and no longer reflects the realities of today's healthcare environment. The core issue is
56 not physician ownership itself, but unethical or exploitative practices, which can occur under any
57 ownership model. Singling out physician-owned practices is unnecessarily divisive, particularly in a
58 profession grounded in strong ethical standards. Unethical behavior should be addressed
59 consistently and principle-based, rather than by targeting a single practice structure. In 2020, the
60 APTA House of Delegates adopted the motion Practice and Business Financial Arrangements for
61 Physical Therapists, stating that "The American Physical Therapy Association supports collaborative
62 practice and business models that are innovative, ethical, and person-centered, and that advance the
63 health of individuals, patient and client populations, and communities." This policy, together with the
64 APTA Code of Ethics, already provides a robust framework to guide professional conduct across all
65 business models, including physician-owned practices. Rescinding the 2003 position would remove
66 a longstanding stigma that has discouraged many PTs and PTAs from engaging with the Association.
67 It would affirm the legitimacy of diverse, ethical practice models and welcome a significant segment
68 of the workforce that has often felt excluded - strengthening professional unity and supporting
69 membership growth. This change directly advances APTA's Vision by promoting inclusivity and
70 recognizing a broad spectrum of patient-centered business models. It also aligns with APTA's
71 Strategic Framework for 2030, specifically the priority of Empowering Our Members, which calls to
72 "Build an APTA where all PTs, PTAs, and students want to and can belong." Lowering perceived

73 barriers to participation expands opportunities for all professionals to engage, contribute, and lead.
74 This is a national issue. PTs and PTAs practice in physician-owned settings in every state except one.
75 Medicare data demonstrate that private-equity-owned chains, not physician-owned clinics, now
76 represent the highest utilizers in cost per patient. Moreover, internal referrals are common across all
77 integrated health systems, including nonprofit organizations and hospitals. These trends reflect
78 broader industry dynamics rather than concerns unique to physician-owned PT practices. Federal
79 laws, including the Stark Law and its exceptions, permit physician-owned practices to operate legally
80 in 49 states under strict compliance requirements. In this context, physician ownership is no longer
81 the primary driver of financial conflict concerns. Ethical, patient-centered care must remain the
82 standard across all ownership models. Maintaining a position that targets one practice structure
83 limits APTA's relevance and reach. Rescinding the 2003 stance would encourage broader
84 engagement and allow more professionals to participate meaningfully in shaping the Association's
85 future. Additionally, the original position has contributed to internal policies that restrict member
86 opportunities based solely on employment setting; for example, prohibiting members in physician-
87 owned practices from advertising or exhibiting at CSM. Until 2020, these practices were also
88 ineligible to host residencies or fellowships through ABPTRFE. Such exclusions are inconsistent with
89 the Association's stated commitments to equity and inclusion. Ultimately, this motion represents a
90 shift from exclusion to equity. It supports a principle-based approach that upholds ethical standards
91 across all settings and ensures that all qualified PTs and PTAs feel welcome within the APTA
92 community.

93
94 **How does this motion contribute to achieving the Vision?**

95 The motion advances APTA's Vision by promoting inclusivity, professional unity, and ethical, patient-
96 centered care regardless of practice setting. It recognizes diverse, collaborative practice models and
97 supports physical therapist autonomy without singling out one ownership structure as inherently
98 unethical.

99
100 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

101 This motion aligns directly with the Strategic Framework for 2030, particularly the priority of
102 Empowering Our Members, which calls on APTA to "build an APTA where all PTs, PTAs, and students
103 want to and can belong." Rescinding this position lowers perceived barriers to engagement and
104 supports broader participation, leadership, and membership growth.

105
106 **How is this motion's subject national in scope and importance?**

107 Physician-owned physical therapy practices exist in 49 states and employ PTs and PTAs nationwide.
108 Federal laws (Stark Law and Anti-Kickback Statutes) already regulate referral for profit. Internal
109 referrals also occur broadly across integrated health systems, hospitals, and nonprofit organizations.
110 The issue is national, systemic, and not limited to a single state or practice model.

111
112 **What previous or current initiatives and positions of the Association address this topic?**

113 2003 House/Board Action

114 The Board of Directors adopted the task force’s recommendation to implement the Strategic Plan to
115 Address Referral for Profit Including Physician Ownership of Physical Therapy Services (BOD 03-06-
116 11-22). 2019 House Action
117 RC 9-19 AMEND: Opposition to Physician Ownership of Physical Therapy Services (HOD P06-03-27-
118 25).
119 The House amended the language by changing the term “therapy” to “therapist.” 2024 House
120 Motion – Withdrawn
121 RC 11-23 RESCIND: Opposition to Physician Ownership of Physical Therapist Services and Self-
122 Referral by Physicians (HOD P06-19-16-46), Annex C.
123 This motion, introduced by the Illinois delegation, was withdrawn prior to a vote. Board of
124 Directors Actions Resulting from the Original Motion 2003 – Board Action
125 In response to the original motion, the Board appointed a task force in fall 2003 to develop and
126 assist in implementing a strategic plan to prohibit physician ownership of physical therapy services.
127 The Board adopted the task force’s strategic plan titled Strategic Plan to Address Referral for Profit
128 Including Physician Ownership of Physical Therapy Services (BOD 03-06-11-22). 2007 – Board Action
129 The task force was formalized as a standing committee of the Board of Directors, known as the
130 Referral for Profit Committee. 2011 – Board Action
131 As part of broader organizational alignment, the Board disbanded the Referral for Profit Committee
132 and reassigned the policy issue to the Public Policy and Advocacy Committee (PPAC). 2019 – Board
133 Action
134 In March 2019, as part of efforts to streamline policies, the Board rescinded the strategic plan, citing
135 that the specific activities and projects outlined had been completed and that legislative advocacy
136 related to referral for profit had been fully operationalized.
137

138 **What interested parties will be impacted by this motion?**

- 139 • PTs and PTAs practicing in physician-owned settings: increased inclusion and engagement
140 with APTA
- 141 • Physician partners: support interdisciplinary collaboration and diverse practice models
142 including physician owned.
- 143 • APTA as an organization: improved relevance, consistency, broader participation and
144 professional unity

146 **Additional background information:**

147 Laws and Regulations Addressing Physician Ownership and Referral for Profit The Stark Law,
148 introduced by Representative Pete Stark in 1988 and enacted in 1990, prohibits physicians from
149 referring Medicare patients to entities in which they or their immediate family members have a
150 financial interest. Initially limited to clinical laboratory services, the law was later expanded to include
151 Medicaid patients and additional designated health services, including physical therapy. The intent of
152 the law is to prevent financial incentives from influencing referral patterns. Over time, seven key
153 exceptions have been added to the Stark Law, allowing for lawful business arrangements that may

154 include physician ownership of physical therapy practices. These exceptions require, among other
155 elements, written agreements, compensation at fair market value, commercially reasonable
156 arrangements, pre-established terms, and the separation of payment from the volume or value of
157 referrals. In 2020, an additional exception further expanded flexibility within the law, resulting in
158 physician-owned physical therapy practices being legally permissible in 49 states. These practices
159 remain subject to Federal Anti-Kickback Statutes, which continue to regulate financial relationships
160 and safeguard against fraud and abuse.

161

162 **References:**

- 163 1. Opposition To Physician Ownership Of Physical Therapist Services and Self-Referral By
164 Physicians (APTA Position);
- 165 2. Practice and Business Financial Arrangements for Physical Therapists (APTA Position)
- 166 3. APTA Strategic Framework for 2030
- 167 4. APTA Librarian report on RC 30-03 and 31-03 from the Archives.
- 168 5. History of ABPTFRE reversing policy against physician-owned PT services hosting residencies
169 and fellowships.
- 170 6. Federal Fraud & Abuse Laws
- 171 7. Court overturns physical therapy decision (South Carolina). September, 2016.
- 172 8. Employment of PTs by Medical Corporations (California), Simas & Associates LTD, 2024;
- 173 9. Medicare data usage by patient per type of PT business
- 174 10. Mitchell, J. M., & Scott, E. (1992). Physician ownership of physical therapy services. Effects on
175 charges, utilization, profits, and service characteristics. JAMA, 268(15), 2055–2059.

176

177 **Last Updated:** 5/8/2026

178 **Contact:** governancehouse@apta.org

179

Motion to 2026 House of Delegates

Main Motion:

RC 26-26 AMEND: OPPOSITION TO PHYSICIAN OWNERSHIP OF PHYSICAL THERAPIST SERVICES AND SELF-REFERRAL BY PHYSICIANS

1 **Proposed by:** Florida

2 **Primary Motion Contact:** Amanda Williamson, PT, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 **That Opposition To Physician Ownership Of Physical Therapist Services And Self-Referral By**
8 **Physicians** (HOD P06-19-16-46) be amended by substitution so that it would read:

9

10 ~~Opposition To Physician Ownership Of Referral-for-Profit Arrangements in Physical Therapist~~
11 ~~Services And Self-referral By Physicians~~

12

13 That the American Physical Therapy Association believes that referrals to physical therapist services
14 be grounded in patient need, sound clinical judgment, and evidence-based care, and must remain
15 free from financial influence, ownership pressure, or incentives that could compromise independent
16 decision-making or patient choice.

17

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

20

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

23

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

26

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

29

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

32

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

37

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

41

42

43 REFERENCES

44 Centers for Medicare & Medicaid Services. Physician Self-Referral webpage.

45 <https://www.cms.gov/medicare/fraud-and-abuse/physiciansselfreferral/index.html>.

46 Mitchell J, Reschovsky J, Franzini L., et al. Physician Self-Referral of Physical Therapy Services for
47 Patients with Low Back Pain: Implications for Use, Types of Treatments Received and Expenditures.

48 *Forum for Health Economics and Policy*, 2015;19(2):179-199. doi:10.1515/fhep-2015-0026.

49 Mitchell JM, Reschovsky JD, Reicherter EA. Use of Physical Therapy Following Total Knee
50 Replacement Surgery: Implications of Orthopedic Surgeons' Ownership of Physical Therapy Services.

51 *Health Serv Res*, 2016;51: 1838-1857. doi:10.1111/1475-6773.12465.

52

53

54 Support Statement

55

56 What is this motion seeking to achieve?

57 The Florida delegation intends to broaden the scope of this motion and avoid opposing a single
58 business practice, instead speaking to behaviors. Our intent is to broaden the scope to have a
59 position that opposes procedural and operational barriers that reduce (strategically, intentionally or
60 unintentionally) patient access and undermine PT autonomy. This motion concept focuses on
61 financial conflicts of interest, patient choice, and unbiased clinical decision-making. The intent of the
62 motion is to de-emphasizing specific ownership models and instead identify problematic practices
63 limiting patient choice, equitable access, and integrity to patient care. This position will complement,
64 support, and reinforce HOD P06-20-39-31 Practice and Business Financial Arrangements for Physical
65 Therapists as well as the APTA Code of Ethics. specifically Principle 6, Responsible Business and
66 Organizational Practices.

67

68 How does this motion contribute to achieving the Vision?

69 This motion supports the Vision to ensure that patient access to physical therapy care is based on
70 patient need and not financial relationships or organizational pressures. Emphasizing that referrals to
71 physical therapist services remain free from financial influence, ownership pressure, or incentives that
72 could compromise independent decision-making or patient choice.

73

74 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

75 This motion supports evolving our practice, ensuring that patient access to care is free from financial
76 influence and ownership pressure. The motion also supports clinicians referring to appropriate
77 providers who may be outside of their institution in accordance with other federal and state laws.

78

79 **How is this motion's subject national in scope and importance?**

80 This motion is national in scope in that it speaks to referral behaviors for patient access to physical
81 therapist services regardless of geographic location or specific discipline.

82

83 **What previous or current initiatives and positions of the Association address this topic?**

84 APTA Code of Ethics, Principle 6 and HOD P06-20-39-31: Practice and Business Financial
85 Arrangements for Physical Therapists

86

87 **What interested parties will be impacted by this motion?**

88 Patient/clients referred for physical therapist services, physical therapist providers, physicians and
89 other professionals referring for PT services

90

91 **Additional background information:**

92

93 **References:**

94

95 **Last Updated:** 5/8/2026

96 **Contact:** governancehouse@apta.org

97

Motion to 2026 House of Delegates

Main Motion:

RC 27-26 RECOMMEND: EVALUATE REVISIONS TO THE GUIDE TO PHYSICAL THERAPIST PRACTICE 4.0 AS RELATED TO ENVIRONMENTAL FACTORS

1 **Proposed by:** Maryland

2 **Primary Motion Contact:** Mike Ukoha, PT, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 The American Physical Therapy Association will evaluate revisions to the [APTA Guide to Physical](#)
8 [Therapist Practice](#) 4.0 to recognize environmental factors across the lifespan and across physical
9 therapy populations that impact health services and physical therapy best practice.

10

11

12 **Support Statement**

13

14 **What is this motion seeking to achieve?**

15 Expected outcomes: 1) To educate physical therapists, physical therapist assistants, and students
16 about environment-informed physical therapy practice, including awareness of how climate and
17 other environmental factors impact human health and healthcare needs and delivery. 2) To facilitate
18 update to APTA Guide 4.0 foundational concepts within the social determinants of health section to
19 include recommended practice modifications 3) Adaptation of clinical practice minimizing patient
20 risk to environmental stressors such as air pollution associated with wildfires, heat centered stressors,
21 and cold centered stressors 4) Provide a resource [for physical therapists, physical therapist
22 assistants, and students] optimizing emergency preparedness for patients, communities, and
23 healthcare entities 5) Recommending a mitigation plan reducing carbon footprint from larger
24 medical systems within our profession.

25

26 Potential changes to the Guide may include:

27 • Introduction >> Social Determinants of Health:

28 ○ Expand the environmental factors paragraph (paragraph 3) to include climate change.

29 Add the following:

30 Physical therapists will provide client education on environmental changes, such as air

31 pollution and extreme weather events, the risk it poses to human health, and counsel
32 clients on how to respond.

- 33 • Introduction >> More Information about Social Determinants of Health >> Examples in
34 physical therapist practice that impact social determinants of health, add the following
35 examples:
 - 36 ○ Recycle or re-use adaptive equipment, mobility devices, orthoses, and prostheses
37 rather than disposing of such equipment.
 - 38 ○ Educate patients on common physiological responses to extreme cold, potential
39 influence on clinical presentations, and safety recommendations for extreme cold
40 environmental conditions to reduce fall risk.
- 41 • Introduction >> Roles in Prevention and in the Promotion of Health, Wellness, and Fitness:
 - 42 ○ Screen for health risks posed by environmental changes for vulnerable populations to
43 counsel or refer clients to resources to address identified risks

44
45 **How does this motion contribute to achieving the Vision?**

46 This motion would contribute to the innovation principle for achieving the Vision by offering creative
47 and proactive solutions to enhance health services delivery while considering environmental factors.
48 The motion would contribute to the access/equity principle for achieving the Vision by offering
49 recognition of health inequities and disparities vulnerable populations face due to environmental
50 factors with intentions to work to alleviate them through innovative models of service delivery,
51 advocacy, and attention. This motion would contribute to the advocacy principle for achieving the
52 Vision by offering concise and clear advocacy efforts for patients, clients, consumers both as
53 individuals and as a population, in practice, education, and research settings to manage and
54 promote change, adopt best practice standards with environmental considerations.

55
56 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

57 Directly addresses at least two of the three goals of the Strategic Plan Elevating Our Practice: This
58 motion elevates the quality of care provided by PTs and PTAs to improve health outcomes for
59 populations, communities, and individuals with considerations for environmental factors. This motion
60 looks to accelerate the transformation of practice models and services to better serve society and the
61 profession Empowering Our Members: This motion would provide APTA an opportunity to
62 empower our members with evidence-based information to educate consumers and effectively
63 support vulnerable populations more widely impacted by adverse environmental factors.

64
65 **How is this motion's subject national in scope and importance?**

66 Evidence increasingly demonstrates profound health – environment connections across the lifespan
67 and across physical therapy populations impacting health services needed and physical therapy best
68 practice. Climate change is reportedly “the greatest threat to human health of the 21st century”, a
69 concern stated by the World Health Organization (WHO) and by many health professional

70 associations. International climate change statements by the WHO and United Nations call on health
71 professionals to take immediate actions while promoting the right to health for all.

72

73 **What previous or current initiatives and positions of the Association address this topic?**

74 HOD P06-20-26-22: Describes the association's position on environmental stewardship.

75

76 **What interested parties will be impacted by this motion?**

77 1st - Clinicians (including students)

78 2nd - Clients & Community -(population health)

79 3rd - Larger medical systems

80 See above

81

82 **Additional background information:**

83 American Occupational Therapy Association (AOTA) - (2022, Occupational Therapy's Commitment to
84 Sustainability and Climate Change - Policy, E16 policy-e16-20220908.pdf Purpose - The purpose

85 of this policy is to articulate the Association's commitment to addressing occupational needs in a
86 manner that considers future generations and marginalized communities' ability to mitigate and
87 adapt to the harmful health impacts of climate change through education, practice, research, policy,
88 and advocacy American Medical Association (AMA) - (2024, AMA Advocacy for Environmental

89 Sustainability and Climate H-135.923) H-135.923 AMA Advocacy for Environmental Sustainability
90 and Cli | AMA Purpose -Provide eight deliverable strategies to support environmental sustainability

91 and climate health. Two highlights: Our AMA supports physicians in adopting programs for
92 environmental sustainability in their practices and help physicians to share these concepts with their
93 patients and with their communities. Our AMA supports a resilient, accountable health care system
94 capable of delivering effective and equitable care in the face of changing health care demands due
95 to climate change. American Medical Association (AMA) -(2019, Climate Change Education Across

96 the Medical Education Continuum H-135.919) H-135.919 Climate Change Education Across the
97 Medical Education | AMA Our AMA: (1) supports teaching on climate change in undergraduate,

98 graduate, and continuing medical education such that trainees and practicing physicians acquire a
99 basic knowledge of the science of climate change, can describe the risks that climate change poses

100 to human health, and counsel patients on how to protect themselves from the health risks posed by
101 climate change; (2) will make available a prototype presentation and lecture notes on the

102 intersection of climate change and health for use in undergraduate, graduate, and continuing
103 medical education; and (3) will communicate this policy to the appropriate accrediting organizations

104 such as the Commission on Osteopathic College Accreditation and the Liaison Committee on
105 Medical Education. United Nations Environment Programme (UNEP) - (2026, Validated Terminal

106 Review of the UNEP Project Environment, Health and Pollution (PIMS 02021) Validated Terminal
107 Review of the UNEP Project Environment, Health and Pollution (PIMS 02021) 2018 – 2023 Purpose

108 - The project's overall goal was to enhance the capacity of member states, stakeholders and citizens
109 to prevent and address pollution in an integrated manner to improve environmental quality and the

110 health of all

111

112 **References:**

- 113 1. Alexander, Marcalee, et al. "A bellweather for climate change and disability: educational
114 needs of rehabilitation professionals regarding disaster management and spinal cord
115 injuries." *Spinal cord series and cases* 5.1 (2019): 94.
- 116 2. Astell-Burt, Thomas, et al. "Nature prescriptions for community and planetary health:
117 unrealised potential to improve compliance and outcomes in physiotherapy." *J Physiother*
118 68.3 (2022): 151-52.
- 119 3. Breakey, Suellen, et al. "Health effects at the intersection of Climate Change and Structural
120 Racism in the United States: a scoping review." *The Journal of Climate Change and Health* 20
121 (2024): 100339.
- 122 4. Brouillette, Monique. "Medical schools are updating their curricula as climate change
123 becomes impossible to ignore." *JAMA* 332.10 (2024): 775-776.
- 124 5. Li, LS Katrina, et al. "Physiotherapy and planetary health: a scoping review." *European Journal*
125 *of Physiotherapy* 27.1 (2025): 20-30.
- 126 6. Salas, Renee N. "The climate crisis and clinical practice." *New England Journal of Medicine*
127 382.7 (2020): 589-591.
- 128 7. Stanhope, Jessica, et al. "Physiotherapy and ecosystem services: improving the health of our
129 patients, the population, and the environment." *Physiotherapy Theory and Practice* 39.2
130 (2023): 227-240.
- 131 8. Toner, Adam, et al. "Prescribing active transport as a planetary health intervention—benefits,
132 challenges and recommendations." *Physical Therapy Reviews* 26.3 (2021): 159-167.
- 133 9. Uddin, Taslim, et al. "Health impacts of climate-change related natural disasters on persons
134 with disabilities in developing countries: A literature review." *The Journal of Climate Change*
135 *and Health* 19 (2024): 100332.
- 136 10. Covert, Hannah H., et al. "Climate change impacts on respiratory health: exposure,
137 vulnerability, and risk." *Physiological reviews* (2023).
- 138 11. Figueroa, Robert Melchior. "Environmental justice." *The Routledge companion to*
139 *environmental ethics*. Routledge, 2022. 767-782.
- 140 12. Kazi, Dhruv S., et al. "Climate change and cardiovascular health: a systematic review." *JAMA*
141 *cardiology* 9.8 (2024): 748-757.
- 142 13. Khraishah, Haitham, et al. "Climate change and cardiovascular disease: implications for global
143 health." *Nature Reviews Cardiology* 19.12 (2022): 798-812.
- 144 14. Ordway A, et al. Durable medical equipment reuse and recycling: uncovering hidden
145 opportunities for reducing medical waste. *Disabil Rehabil Assist Technol*. 2020 Jan;15(1):21-
146 28. Epub 2018 Oct 14. PMID: 30318953.

147

148 **Last Updated:** 5/8/2026149 **Contact:** governancehouse@apta.org

150

Motion to 2026 House of Delegates

Main Motion:

RC 28-26 RECOMMEND: ADVOCATING FOR EVIDENCE-INFORMED ENHANCEMENTS TO THE NATIONAL PHYSICAL THERAPY EXAMINATION

1 **Proposed by:** Hawaii

2 **Primary Motion Contact:** Douglas White, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That the American Physical Therapy Association shall advocate for the Federation of State Boards of
8 Physical Therapy to evaluate and, as appropriate, implement evidence-informed enhancements to
9 the National Physical Therapy Examination, including:

- 10 a. Weighting of exam content based on public safety risk.
11 b. Weighting of exam content based on frequency of use in contemporary practice.
12 c. Weighting of exam content based on the knowledge and skill level needed to safely perform
13 physical therapist services.
14 d. Refining methodologies used in the Practice Analysis to enhance transparency, rigor, and
15 objectivity.
16 e. Updating NPTE terminology and content to reflect current physical therapist practice
17 standards, including relevant APTA documents (Code of Ethics for the Physical Therapy
18 Profession, Standards of Practice for Physical Therapy, Guide to Physical Therapist Practice)
19 and peer-reviewed literature.
20 f. Ensuring physical therapists and physical therapist assistants retain primary professional
21 authority in the development, review, and approval of NPTE content and structure.

22

23

24 **Support Statement**

25

26 **What is this motion seeking to achieve?**

27 Have the NEPT more accurately reflect the full scope of practice in 2026. Remove the burden on DPT
28 programs to cover content which are low risk and infrequently performed.

29

30 **How does this motion contribute to achieving the Vision?**

31 Elevates the level of practice and education of DPTs.

32

33 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

34 Support current practice models. Move away from outdated practice.

35

36 **How is this motion's subject national in scope and importance?**

37 Every graduate DPT has to take the NEPT to become licensed. Every DPT program has to address the
38 content of the NPTE.

39

40 **What previous or current initiatives and positions of the Association address this topic?**

41 None

42

43 **What interested parties will be impacted by this motion?**

44 FSBPT, DPT programs, CAPTE. All will have to adjust their standards to meet any new NPTE
45 content/format.

46

47 **Additional background information:**

48 Currently the NPTE weights each item on the NPTE equally (one item = one point). Items addressing
49 content which have a low public safety risk if done incorrectly are weighted the same as items
50 addressing content which have a high public safety risk. E.g. Testing knowledge of therapeutic
51 ultrasound is one point and understanding the medical implications of arterial blood gases is one
52 point.

53

54 Aspects of practice which occur at low frequency and are in areas of practice few PT/PTAs work are
55 also given equal weight. Therefore, an exam item addressing content which is low risk and skill in an
56 area of practice few work (lymphatic system) is weighted the same as an item of high risk in an area
57 of practice (musculoskeletal) where a large percentage practice.

58

59 The result is exam takers must consider all aspects of the NPTE content area equally. In an exam
60 appropriately weighted the exam taker should be most knowledgeable of content which is high risk
61 and occurs at a high frequency in practice.

62

63 Appropriate weighting of the NPTE will free DPT and PTA educational programs from devoting a
64 disproportionate amount of time teaching content which is of little significance to where and how
65 PTs and PTAs work, and the risk to the public. The curriculum can be weighted based on real life
66 practice and public safety risk, thus producing more qualified, safe, and competent PTs and PTAs.

67

68 The NPTE uses a subjective committee approach to determining what content should be surveyed.
69 This approach is lacking in rigor. Practice areas which should be surveyed can, and are, omitted from
70 the practice analysis (PA). Survey responses are not sorted and analyzed based on the practice
71 setting of the respondent. Therefore, a PT who practices in critical care is responding to practice
72 areas mainly found in pediatric school settings. That critical care PT's responses are given equal
73 weight as the pediatric PT.

74

75 The content breakdown of the NPTE is approved by the FSBPT Board of Directors who is comprised
76 of several non-PT members. These non-PT members lack the expertise to determine the NPTE
77 content.

78

79 The FSBPT PA is based on non-contemporary practice and terminology. It is decades old and has
80 changed little over time. This is largely due to methodological flaws in the PA. Some examples
81 follow. The model does not adequately recognize the roles of PTs as:

82

- Consultants
- Co-managers of patient care
- In health and wellness models
- Ordering diagnostic testing, including imaging
- Ordering/reconciling pharmacotherapy
- Ordering DME
- Primary Care Providers
- Elite performance providers
- Austere Environment providers
- Rural and Indigenous Health Providers

83

84

85

86

87

88

89

90

91

92

93 The NPTE states: "develop physical therapy diagnosis by integrating system and non-system data."
94 There is no such thing as a "physical therapy diagnosis." There are only one or multiple diagnoses.
95 There is no resource of "physical therapy diagnoses."

96

97 The PA uses terminology such as "plan of care." This terminology and the practice model it implies
98 omits a wide range of PT practice, is antiquated, and originates with Medicare payer language, not
99 scope of practice.

100

101 A significant proportion of PTs do not practice in models where there is an evaluation, treatment
102 over a period of time, perhaps a reevaluation, more treatment, and ultimately discharge.

103

104 The current NPTE does not optimally discern those test takers who are not at entry-level, nor does it
105 capture the full breadth and depth of the entry-level work of PTs and PTAs.

106

107 **References:**

- 108 1. [https://www.fsbpt.org/Portals/0/documents/free-resources/FSBPT-PT%202022-FINAL-](https://www.fsbpt.org/Portals/0/documents/free-resources/FSBPT-PT%202022-FINAL-REPORT.pdf)
109 [REPORT.pdf](https://www.fsbpt.org/Portals/0/documents/free-resources/FSBPT-PT%202022-FINAL-REPORT.pdf)

110

111 **Last Updated:** 5/8/2026

112 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 29-26 AMEND: EDUCATIONAL DEGREE QUALIFICATIONS AND NOMENCLATURE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

1 **Proposed by:** Georgia

2 **Primary Motion Contact:** Jacob Irwin, PT, DPT

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 **That Educational Degree Qualifications And Nomenclature For Physical Therapists And Physical**
8 **Therapist Assistants (HOD P06-18-33-38), second paragraph be amended by substitution.**

9

10 EDUCATIONAL DEGREE QUALIFICATIONS AND NOMENCLATURE FOR PHYSICAL THERAPISTS AND
11 PHYSICAL THERAPIST ASSISTANTS

12

13 Consistent with current Commission on Accreditation in Physical Therapy Education, or CAPTE,
14 criteria, the American Physical Therapy Association shall consider attainment of a ~~the~~ Doctor of
15 ~~Physical Therapy~~ degree the minimum professional education qualification for physical therapists
16 who graduate from a program accredited by CAPTE in 2018 or thereafter.

17

18 ~~When the DPT degree is awarded, it represents professional (entry-level) qualifications only,~~
19 ~~whether obtained following a professional (entry-level) education program or as part of a~~
20 ~~transition program, and is considered "physical therapist professional education."~~

21 The Doctor of Physical Therapy, or DPT, is the terminal professional degree for the professional
22 practice of physical therapy whether obtained following a professional (entry-level) education
23 program or as part of a postprofessional program. APTA supports recognition of the DPT as the
24 terminal professional degree.

25

26 The term "physical therapist postprofessional education" is used to refer to degree- and nondegree-
27 based professional development for the physical therapist to enhance professional knowledge, skills,
28 and abilities.

29

30 APTA shall consider attainment of an associate degree from a program accredited by CAPTE the
31 minimum educational qualification for a physical therapist assistant.

32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71

Support Statement

What is this motion seeking to achieve?

The DPT is currently the degree awarded by all accredited entry-level physical therapist education programs in the United States. It encompasses rigorous academic coursework, advanced clinical reasoning, and over 30 weeks of supervised clinical education—preparing graduates for autonomous practice in a variety of settings. While the DPT has become the universal standard for educational preparation of new U.S.-trained physical therapists, APTA’s current position language reflects only that the DPT is the minimum required degree—not its standing as the terminal professional degree. This lack of explicit recognition contributes to inconsistencies in licensure messaging, academic hiring practices, and public understanding. This motion brings APTA policy into alignment with that educational reality by affirming the DPT as the terminal professional degree—complementing, not replacing, the association’s current language on degree qualifications. It aligns physical therapy with other doctoral-level health professions such as medicine (MD), pharmacy (PharmD), dentistry (DDS/DMD), and nursing (DNP)—all of which recognize their respective professional doctorates as terminal degrees, even when post-professional academic or clinical training is pursued.

Amending the existing position in this way will:

- Clarify the educational endpoint for professional clinical preparation;
- Support consistency in how institutions evaluate faculty qualifications;
- Align APTA’s terminology with that of other health professions;
- Reinforce public understanding of physical therapists as doctoral-level providers;
- Strengthen APTA’s advocacy efforts related to licensure, regulation, and interprofessional recognition.

This amendment does not diminish the value of post-professional academic or clinical credentials such as PhD, EdD, ScD, residencies, or fellowships. Rather, it affirms the DPT as the foundational professional degree while encouraging academic and clinical advancement for those seeking roles in research, teaching, or specialty care. Importantly, it is not intended to prescribe hiring criteria or override institutional or accreditor autonomy. Ultimately, this policy refinement is not symbolic—it is strategic. It closes a gap in APTA’s language, strengthens our public and academic posture, and positions physical therapy in line with its peer professions in title, recognition, and advocacy impact.

What is this motion seeking to achieve? This motion seeks to establish formal recognition by the American Physical Therapy Association (APTA) of the Doctor of Physical Therapy (DPT) as the terminal professional degree for the profession of physical therapy.

By formally recognizing the DPT as the terminal professional degree, APTA will position the profession to advance in four strategic domains:

1. **Academic Alignment Without Compromising Faculty Quality:** This motion supports academic institutions that choose to recognize the DPT as a terminal degree for faculty roles related to clinical education and professional instruction. It reflects the educational structure used in all

72 current accredited entry-level DPT programs. However, this recognition is not intended to
73 override or replace the role of post-professional academic doctorates.

74 2. Public Recognition and Interprofessional Equity: The motion reinforces that physical
75 therapists are doctoral-level providers, helping the profession gain parity in how it is viewed
76 by patients, healthcare systems, and other professions. This recognition strengthens public
77 trust, enhances interprofessional credibility, and clarifies the level of expertise DPT graduates
78 bring to professional practice.

79 3. Respect for Post-Professional Scholarship and Specialization: This motion explicitly affirms
80 the continued importance of academic doctorates, residency and fellowship training, and
81 clinical board certification. It distinguishes between the professional degree required for
82 practice (DPT) and the advanced credentials professionals may pursue based on career goals.
83 This layered approach mirrors that of other health professions and promotes academic and
84 professional excellence without conflating degree levels.

85
86 **How does this motion contribute to achieving the Vision?**

87 The APTA Vision—Transforming society by optimizing movement to improve the human
88 experience—calls on the profession to lead with clarity, consistency, and credibility across all areas of
89 practice, education, and public service. This motion advances that vision by affirming the Doctor of
90 Physical Therapy (DPT) as the terminal professional degree for the profession, helping to position
91 physical therapists as fully recognized movement experts across society. This motion empowers
92 future generations of physical therapists. By affirming the DPT as the terminal professional degree,
93 we reinforce the value of the education that students and academic programs commit to. It signals
94 to aspiring physical therapists—and the patients they will one day serve—that this profession is
95 unified, respected, and aligned with APTA’s vision of improving the human experience at scale.

96
97 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

98 This motion aligns with and advances several key priorities outlined in APTA’s Strategic Plan as
99 outlined below.

100 Evolving practice: By formally recognizing the Doctor of Physical Therapy (DPT) as the terminal
101 professional degree, this motion reinforces the profession's commitment to high educational
102 standards. This acknowledgment supports efforts to ensure fair compensation and reduce
103 administrative burdens, contributing to the long-term evolution of the profession. It also aids in
104 addressing workforce challenges by clarifying the professional identity of physical therapists, which is
105 essential for recruitment and retention.

106 Empowering Members: Clarifying the DPT as the terminal professional degree enhances the
107 professional identity of physical therapists, which can lead to increased recognition and respect
108 within the healthcare system. This recognition supports career advancement opportunities and
109 professional development, thereby increasing the value of APTA membership and empowering
110 members to act with the knowledge that the professional association respects the degree it requires
111 to be conferred. It also aligns with APTA's goal to provide unmatched opportunities for members to
112 belong, engage, and contribute.

113 Advancing Payment: Establishing the DPT as the terminal professional degree strengthens advocacy
114 efforts aimed at increasing public awareness and understanding of physical therapy services. This
115 clarity can lead to greater consumer confidence and utilization of physical therapy as a primary entry
116 point for care, thereby driving demand and improving access to services.

117
118 **How is this motion's subject national in scope and importance?**

119 This motion addresses a policy gap that affects the physical therapy profession at a national level.
120 While the Doctor of Physical Therapy (DPT) is now the standard degree awarded by all accredited
121 entry-level physical therapist education programs in the United States, APTA has not formally
122 recognized the DPT as the terminal professional degree for the profession. This absence of a unified
123 national position leads to inconsistencies in licensure communication, academic credentialing, and
124 public representation of the profession. Across all 50 states and U.S. territories, this issue intersects
125 with three critical domains: licensure and regulatory consistency, academic recognition and hiring
126 practices, and public trust in the profession. Academic Recognition and Institutional Variability:
127 Currently, institutions across the country vary in how they classify the DPT. Some consider it a
128 terminal degree for faculty hiring in clinical education, while others require academic doctorates
129 regardless of teaching focus. This inconsistency limits opportunities for well-qualified DPTs to
130 contribute meaningfully in academic settings and weakens the faculty pipeline. National recognition
131 from APTA would give academic institutions a credible, policy-backed reference point to support
132 equitable evaluation of DPT-prepared educators for clinical and professional teaching roles, without
133 infringing on institutional autonomy or existing CAPTE standards. Finally, this motion positions the
134 profession to lead with one voice in national conversations. Without clear APTA policy recognizing
135 the DPT as the terminal professional degree, physical therapy remains vulnerable to fragmented
136 messaging—whether in federal advocacy, payer negotiations, workforce development policy, or
137 interprofessional collaboration. By adopting this motion, APTA equips its leaders, members, and
138 academic institutions with a unified statement of professional identity that reflects the current
139 educational landscape and enables stronger engagement at every level of the healthcare system.

140
141 **What previous or current initiatives and positions of the Association address this topic?**

142 The American Physical Therapy Association (APTA) has a longstanding history of initiatives and
143 policies that support the recognition of the Doctor of Physical Therapy (DPT) as the terminal
144 professional degree for physical therapists. These efforts have been instrumental in shaping the
145 profession's educational standards and public identity. In 2000, APTA's House of Delegates
146 adopted Vision 2020, which articulated the goal that by the year 2020, physical therapy would be
147 provided by physical therapists who are doctors of physical therapy. This vision emphasized the
148 importance of the DPT in advancing the profession and enhancing patient care. To support this
149 transition, APTA developed resources for postprofessional education, enabling licensed physical
150 therapists with bachelor's or master's degrees to attain the DPT credential through structured
151 programs. These programs were designed to bridge the gap between previous educational models
152 and the current DPT standards, ensuring consistency in the profession's qualifications.
153 Furthermore, APTA has advocated for the use of "DPT" as a professional designation. While

154 recognizing the importance of state regulations, APTA supports the use of "DPT" in jurisdictions
155 where it is authorized, promoting uniformity in professional titles and enhancing public recognition
156 of the physical therapist's role. While APTA has long supported the DPT as the standard for entry-
157 level education, the association has not yet included language identifying it as the terminal
158 professional degree within its formal policy structure. This motion amends the existing position to
159 close that gap. Adopting this motion would align APTA's policies with the current educational
160 landscape, providing clarity and reinforcing the profession's commitment to excellence.

161
162 **What interested parties will be impacted by this motion?**

163 This motion will have a positive, clarifying impact on a wide range of stakeholders across the physical
164 therapy profession and healthcare ecosystem by aligning policy with the profession's current
165 educational standard and reinforcing a consistent professional identity. Physical Therapists (DPTs,
166 legacy degree holders, and internationally-trained clinicians): For DPT-prepared physical therapists,
167 this motion affirms the degree they earned as the terminal professional degree for the profession—
168 supporting consistency in professional identity, advocacy, and credential recognition. It strengthens
169 how physical therapists are represented in interprofessional environments and public-facing roles.
170 The motion does not change licensure eligibility for those with legacy degrees (e.g., MPT, BSPT) or
171 internationally-trained professionals. Instead, it clarifies that the DPT is the standard for new U.S.
172 graduates while preserving inclusivity in existing licensure pathways. This motion supports
173 clinicians, educators, academic leaders, regulators, employers, and patients by providing a consistent,
174 forward-looking statement of professional identity—one that strengthens alignment across all areas
175 of the profession.

176
177 **Additional background information:**

178 APTA has long recognized the DPT as the standard degree for entry-level physical therapist
179 education. However, the current position does not explicitly state that the DPT is the terminal
180 professional degree for the profession. This omission has led to unintended consequences in
181 academic hiring, regulatory clarity, and public-facing communication. This motion seeks to build
182 upon APTA's existing policy infrastructure by affirming what has become the educational reality: the
183 DPT is both the minimum qualification for U.S. entry-level practice and the terminal professional
184 degree for the field. Clarifying this distinction helps align APTA's language with that of other
185 healthcare professions and provides clarity for employers, institutions, and licensing bodies.
186 Importantly, this motion does not attempt to diminish the role of post-professional academic or
187 clinical education. It affirms that academic doctorates (e.g., PhD, EdD, ScD), residencies, fellowships,
188 and board certifications continue to serve a vital role in professional development, scholarship, and
189 specialty practice. The motion ensures that while those credentials represent advancement beyond
190 entry-level practice, they do not displace the DPT's standing as the professional endpoint for those
191 entering the field. This clarification is particularly important in regulatory and academic contexts.
192 Licensing boards vary in their treatment of professional credentials, and some academic institutions
193 still do not consider the DPT a terminal degree for hiring or promotion purposes. APTA's formal
194 policy recognition will provide a clear and consistent reference to support alignment across

195 jurisdictions and institutions—without prescribing specific hiring criteria or interfering with academic
196 governance. Public-facing title confusion (e.g., “PT, DPT” vs. “DPT”) has also contributed to
197 uncertainty about physical therapists’ qualifications, especially compared to other doctoral-level
198 providers. While this motion does not dictate credential formatting, it lays the foundation for future
199 efforts related to credential clarity, title protection, and consumer trust. This concept has received
200 broad support from clinicians, educators, and professional leaders who view this amendment as a
201 logical next step following the successful implementation of Vision 2020. The profession has already
202 transitioned to the DPT; this motion simply ensures that APTA’s policy language reflects that
203 evolution in a way that supports academic legitimacy, public trust, and long-term advocacy success.
204

205 References:

- 206 1. Accreditation Council for Pharmacy Education. Accreditation standards for PharmD degree
207 programs. Published 2021. <https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf>
- 208 2. Jette AM. A vision for excellence in physical therapy education: implications for the
209 professional doctorate and beyond. *J Phys Ther Educ.* 2021;35(3):1-4.
210 doi:10.1097/JTE.000000000000202
- 211 3. Peterson LE, Blackburn BE, Puffer JC. Predictors of research productivity among physical
212 therapy faculty. *Phys Ther.* 2020;100(7):1174-1183. doi:10.1093/ptj/pzaa058
- 213 4. Commission on Accreditation in Physical Therapy Education. Standards and Required
214 Elements for Accreditation of Physical Therapist Education Programs. 2024.
215 [https://www.capteonline.org/globalassets/capte-docs/2024-capte-pt-standards-required-](https://www.capteonline.org/globalassets/capte-docs/2024-capte-pt-standards-required-elements.pdf)
216 [elements.pdf](https://www.capteonline.org/globalassets/capte-docs/2024-capte-pt-standards-required-elements.pdf)
- 217 5. Dunleavy K, Embry K, Topp R. The impact of faculty credentials on student outcomes in
218 physical therapist education programs. *J Allied Health.* 2019;48(2):e47-e53.
- 219 6. Marcoux BC, Johnson B, Wise S, Bahner C. Importance of terminal academic degreed core
220 faculty in physical therapist education. *J Phys Ther Educ.* 2018;32(3):208-212.
221 doi:10.1097/JTE.000000000000067
- 222 7. Hinman MR, Brown T. Motives and barriers to pursuing academic doctorates among physical
223 therapy faculty. *Int Res High Educ.* 2025;10(1):1-12. doi:10.5430/irhe.v10n1p1
- 224 8. American Council of Academic Physical Therapy (ACAPT). Autonomy in Determining
225 Qualification of Core Doctor of Physical Therapy Faculty. 2023. [https://acapt.org/news/news-](https://acapt.org/news/news-detail/2023/07/18/acapt-survey-results-statement-re-rc-8-23-adopt-autonomy-in-determining-qualification-of-core-dpt-faculty)
226 [detail/2023/07/18/acapt-survey-results-statement-re-rc-8-23-adopt-autonomy-in-](https://acapt.org/news/news-detail/2023/07/18/acapt-survey-results-statement-re-rc-8-23-adopt-autonomy-in-determining-qualification-of-core-dpt-faculty)
227 [determining-qualification-of-core-dpt-faculty](https://acapt.org/news/news-detail/2023/07/18/acapt-survey-results-statement-re-rc-8-23-adopt-autonomy-in-determining-qualification-of-core-dpt-faculty)
- 228 9. Southern Association of Colleges and Schools Commission on Colleges. Resource Manual for
229 the Principles of Accreditation. Section 6.2. 2023.
230 <https://sacscoc.org/app/uploads/2023/01/Resource-Manual.pdf>
- 231 10. American Physical Therapy Association. Consumer Protection Through Licensure of Physical
232 Therapists and Physical Therapist Assistants. [https://www.apta.org/apta-and-you/leadership-](https://www.apta.org/apta-and-you/leadership-and-governance/policies/consumer-protection-through-licensure)
233 [and-governance/policies/consumer-protection-through-licensure](https://www.apta.org/apta-and-you/leadership-and-governance/policies/consumer-protection-through-licensure)
- 234 11. American Physical Therapy Association. Transition DPT FAQs. [https://www.apta.org/your-](https://www.apta.org/your-career/career-advancement/postprofessional-degree/transition-dpt-faqs)
235 [career/career-advancement/postprofessional-degree/transition-dpt-faqs](https://www.apta.org/your-career/career-advancement/postprofessional-degree/transition-dpt-faqs)

236 12. Murray CM, Stanley M, Wright S. The transition from student to health professional: a
237 theoretical perspective. J Allied Health. 2014;43(1):36-42.
238

239 **Last Updated:** 5/8/2026

240 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 30-26 ADOPT: CLASSIFICATION OF THE DOCTOR OF PHYSICAL THERAPY DEGREE AS A PROFESSIONAL DEGREE

1 **Proposed by:** APTA Board of Directors
2 **Primary Motion Contact:** Kyle Covington, PT, DPT, PhD
3 [Discussion Thread](#)

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

6
7 **That the following be adopted:**

CLASSIFICATION OF THE DOCTOR OF PHYSICAL THERAPY DEGREE AS A PROFESSIONAL DEGREE

10
11 The American Physical Therapy Association supports the Doctor of Physical Therapy, or DPT, as the
12 professional degree required for graduation and eligibility for licensure as a physical therapist in the
13 United States, and asserts that the United States Department of Education and other governmental
14 agencies should classify the DPT as a professional degree for all federal policy purposes, including
15 the determination of federal student loan eligibility and limits. This classification does not limit those
16 physical therapists who earned other degrees in the profession prior to the requirement of the DPT
17 or have earned an internationally equivalent degree.

Support Statement

20
21
22 **What is this motion seeking to achieve?**

23 The proposal of the United States Department of Education to classify the doctor of physical therapy
24 degree as a “graduate” rather than “professional” for the purpose of federal loan eligibility limits
25 created the need for continued public awareness and education about the rigor of physical therapist
26 education and the scope of practice and public need that requires a professional level of education.
27 The purpose of this motion is to state that the professional degree in physical therapy, the DPT,
28 should be treated similarly to other professional doctoral degrees that are recognized in the
29 “professional degree” category by the USDE (i.e., PharmD, OD, DC, etc.).

30
31 **How does this motion contribute to achieving the Vision?**

32 The minimum length and scope of the DPT degree is grounded in the needs of society from the
33 physical therapist profession and the profession's continually evolving professional and jurisdictional
34 scopes of practice. This framing directly supports APTA's vision of "transforming society by
35 optimizing movement to improve the human experience."
36

37 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

38 This motion corresponds to the Evolving our Practice outcome: Society benefits from greater access
39 to high-quality physical therapist services. Physical therapist entry-level professional education is the
40 front line of ensuring that graduates, who are directly eligible for licensure upon graduation, are
41 prepared to deliver high-quality care. Given the known workforce shortages, it will be difficult to
42 accelerate the transformation of practice models and services to better serve society and the
43 profession if the number of graduates declines as a result of reduced federal loan amounts and
44 reduced access to private loans.
45

46 **How is this motion's subject national in scope and importance?**

47 The cost of higher education in the United States has grown significantly over the years, regardless
48 of major or degree type, and is not a concern of the physical therapy profession alone. By
49 categorizing physical therapist education as a graduate degree rather than a professional degree for
50 the purposes of federal loan accessibility is significant. The current allotted amount for federal loan
51 accessibility beginning July 1, 2026 is:

- 52 •Graduate: \$100,000 total (\$20,500 per year maximum).
- 53 •Professional: \$200,000 total (\$50,000 per year maximum).

54 Categorizing DPT education at the graduate level is more than an access to education issue—it's a
55 workforce issue. The cost of higher education in the United States has increased steadily for the past
56 25 years as a result of significant economic events like the Dot-com Recession in 2001, the Great
57 Recession of 2007-2009, and the Covid-19 Recession. As a result of each of those events, legislative
58 funding for public colleges and university declined, as did the endowments of private institutions. To
59 compensate for losses, colleges and universities increased tuition and fees. These changes in
60 higher education costs are beyond the control of any one profession, as is the cost of living. While
61 some believe the lower federal loan limit amount will result in DPT programs reducing tuition and
62 fees, the reality is that colleges, universities, and university systems will not react to a limit change in
63 DPT programs only, as many of its other programs and students are also affected. Rather, colleges
64 and universities will observe the impact of this change on student enrollment and then determine
65 whether a program remains to be a viable option for the institution. The cost of living in
66 geographic locations where many DPT programs are housed will exceed the \$20,500 annual federal
67 loan funding limit for graduate education (<https://livingwage.mit.edu/>) and will require students who
68 do not have independent or family funding to support their education into a private loan market,
69 which can be volatile. Additionally, students who will need to seek private loan funds may be
70 required to have individual or family/co-signer credit ratings that are deemed credit worthy, which
71 could limit access to DPT education for many. To compound this challenge, private loans are not
72 eligible for federal public service loan forgiveness programs. Additionally, DPT graduates who

73 choose to pursue graduate education after graduation (e.g., EdD, PhD, ScD) would only have access
74 to the amount of federal loan funds remaining, and will be limited to \$20,500 annually for that level
75 of education as well. For those DPT students who received federal loan funding for a graduate
76 degree prior to enrollment in a DPT program, the amount of funding already received would count
77 toward the \$100,000 maximum. The USDE's Reimaging and Improving Student Education publication
78 in the Federal Register on Jan. 30, 2026, reported 24,276 annual DPT borrowers who had average
79 annual loan disbursements of \$38,361 using data from the National Student Loan Data System for
80 the 2023-2024 award year. The average disbursement is significantly above the \$20,500 annual limit.
81 The Commission on Accreditation has published information related to the total cost of education
82 (minus room and board) in its DPT Fact Sheet for the past three years.
83

84 **What previous or current initiatives and positions of the Association address this topic?**

85 [Accreditation Of Physical Therapy Education Programs](#) HOD P06-19-64-28

86 [Educational Degree Qualifications And Nomenclature For Physical Therapists And Physical Therapist](#)
87 [Assistants](#) HOD P06-18-33-38

88
89 **What interested parties will be impacted by this motion?**

- 90 Society: Access to physical therapists services.
91 Profession: Workforce sufficiency (i.e., ability to meet societal needs).
92 Potential DPT students: Access to education.
93 Employers: Workforce sufficiency (i.e., ability to meet workload needs).
94

95 **Additional background information:**

- 96 • Physical therapist education has been offered at a postbaccalaureate level since 2002.
- 97 • Prior to the first DPT program graduates in 1996, physical therapist education programs often
98 exceeded the credits required for a master's degree (i.e., 120-124 undergraduate + 30-36
99 graduate compared to 90-120 preprofessional and 60-90 plus professional). Thus, some were
100 receiving a degree level that did not accurately reflect their education.
- 101 • When CAPTE mandated the DPT degree in 2016, which came into effect in 2018), almost all
102 programs had already begun awarding the DPT or planned to do so. Thus, CAPTE's DPT
103 degree requirement was applied after educational programs had already made the change.
- 104 • CAPTE requires a minimum a of 96 weeks of instruction to be completed in a minimum of 6
105 semesters; a level of post-baccalaureate academic rigor comparable to other professional
106 doctorates. According to CAPTE's 2024 Fact Sheet, the majority of programs (58%) are 4+3
107 year programs and have a total semester credit mean of 117.5.
- 108 • For approximately the past decade, DPT education has been classified as "Doctor's Degree--
109 Professional Practice" by the National Center for Education Statistics for the purposes of
110 information provided by the Integrated Postsecondary Education Data System (IPEDS).
- 111 • Since 2018, the DPT degree has been required for licensure eligibility for all graduates from
112 CAPTE accredited programs.

- 113 • The DPT degree meets the USDE negotiated rulemaking committee's definition of
114 "professional degree" in all conditions except the arbitrary four-digit Classification of
115 Instructional Programs (CIP) assignment, as it:
- 116 ○ Indicates completion of the academic requirements for beginning practice in a
117 particular profession and a level of professional skill beyond that typically required for
118 a bachelor's degree; ○ Is generally at the doctoral level and requires at least six
119 academic years of postsecondary education coursework for completion, at least two
120 years of which must be postbaccalaureate level coursework; and
 - 121 ○ Generally requires professional licensure to begin practice.
- 122

123 **References:**

- 124 1. CAPTE DPT Fact Sheet: [https://www.capteonline.org/faculty-and-program-resources/data-](https://www.capteonline.org/faculty-and-program-resources/data-and-research/aggregate-program-data)
125 [and-research/aggregate-program-data](https://www.capteonline.org/faculty-and-program-resources/data-and-research/aggregate-program-data)
- 126 2. USDE. Notice of Proposed Rulemaking: Reimagining and Improving Student Education:
127 [https://public-inspection.federalregister.gov/2026-](https://public-inspection.federalregister.gov/2026-01912.pdf?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov)
128 [01912.pdf?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=](https://public-inspection.federalregister.gov/2026-01912.pdf?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov)
129 [federalregister.gov](https://public-inspection.federalregister.gov/2026-01912.pdf?utm_campaign=pi+subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov)
- 130

131 **Last Updated:** 5/8/2026

132 **Contact:** governancehouse@apta.org

133

Motion to 2026 House of Delegates

Main Motion:

RC 31-26 AMEND: PREFERRED NOMENCLATURE FOR THE PROVISION OF PHYSICAL THERAPIST SERVICES

1 **Proposed by:** APTA Board of Directors

2 **Primary Motion Contact:** Kyle Covington, PT, DPT, PhD

3 [Discussion Thread](#)

4

5 **Required for Adoption:** Majority Vote

6

7 That Preferred Nomenclature for the Provision of Physical Therapist Services (HOD P06-18-15-13)
8 **be amended by substitution.**

9

10 PREFERRED NOMENCLATURE FOR THE PROVISION OF PHYSICAL THERAPIST SERVICES

11

12 The American Physical Therapy Association defines and uses the following terms in its documents
13 and publications to promote consistency and a common understanding and use of these terms
14 external to APTA regarding the provision of physical therapist services.

15

16 1. "Physical therapy" or "physiotherapy" - A health profession that encompasses the
17 examination, diagnostic testing, evaluation, diagnosis, prognosis, and management of
18 movement, function, health, and wellness, as well as the prevention of disease and disability
19 across the lifespan. The practice of physical therapy is provided by a person who is a physical
20 therapist and assisted by a person who is a physical therapist assistant working in accordance
21 with established standards and professional direction. Physical therapy includes education,
22 health promotion, advocacy, research, and community responsibility as essential components
23 of professional practice as outlined in the Standards of Practice for Physical Therapy.

24

25 2. ~~4.~~"Physical therapist" – A person who is a the professional practitioner of physical therapist
26 services.

27

28 3. ~~2.~~"Physical therapist assistant" – ~~the only individual~~ A person who assists the physical
29 therapist in practice.

30

- 31 4. ~~3.~~ "Physical therapist services" - Services provided by a person who is a physical therapist and,
32 under the direction of a physical therapist, a person who is a physical therapist assistant,
33 within the scope of their professional practice and in accordance with ethical and legal
34 standards.
- 35
- 36 5. "Physical therapy services" - Entity in which physical therapist services are provided, as
37 outlined in the Standards of Practice for Physical Therapy.
38 ~~3. "Physical therapist services" or "physical therapist practice" – preferred nomenclature~~
39 ~~when referring to the provision of physical therapy. The term "physical therapy service" is~~
40 ~~appropriate when referring to a facility or a department in which physical therapist~~
41 ~~services are provided.~~
- 42
- 43 6. 4. Professional titles – Physical therapists are identified by their professional title, ~~"physical~~
44 ~~therapist" or "doctor of physical therapy"~~ "doctor of physical therapy" or "physical therapist."
- 45
- 46 7. "Client" or "Patient" - An individual, group, or entity who engages the services of a physical
47 therapist or physical therapist assistant. A client may also be known as a patient, consumer,
48 partner, person, animal owner, or other appropriate nomenclature, selected by the PT or PTA,
49 which is reflective of the client's preference as well as context, organization, setting, and
50 ethical or legal standards. While family members, caregivers, or others involved in the
51 individual's care are not considered clients themselves, they may be engaged as valued
52 members of the care team. PTs and PTAs may provide education or guidance to supporters to
53 help them better assist the client in achieving their goals.
- 54
- 55

56 Support Statement

58 What is this motion seeking to achieve?

59 This motion responds to RC 21-24 CHARGE: DEVELOP CONTEMPORARY OPERATIONAL
60 DEFINITIONS OF TERMINOLOGY IMPACTING APTA DOCUMENTS That APTA develop contemporary
61 operational definitions of terminology impacting APTA documents including, but not limited to
62 "physical therapy," "patient," "client," "patient care," "physical therapist services," and "patient-
63 physical therapist relationship", and forward motions to a future session of the House. The APTA
64 has responded to this charge and made recommendations for new or amended operational
65 definitions using the following steps:

- 66 • Structured investigation: Gathered relevant information from multiple sources.
- 67 • Multiple iterations: Solicited targeted feedback on proposed ideas and definitions.
- 68 • Regulatory clarification: Consulted the Federation of State Boards of Physical Therapy.
- 69 • Perspectives: Invited and received peer review from 38 individuals representing 29 APTA
70 member groups and communities.
- 71 • Further revisions: Edited the draft definitions and solicited additional feedback.

72 • Additional review by APTA legal, governance and communications staff.

73 In cases where the consideration process resulted in a recommendation of not creating a definition,
74 those were not included in this proposed amendment.

75
76 **How does this motion contribute to achieving the Vision?**

77 Having a standard nomenclature for these operational definitions promotes consistency and
78 common understanding in the use of these terms.

79
80 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

81 This motion operationally defines terms that are directly related to practice and payment.

82
83 **How is this motion's subject national in scope and importance?**

84 If adopted, this amended language would apply to internal and external constituents.

85
86 **What previous or current initiatives and positions of the Association address this topic?**

87 • Preferred Nomenclature for the Provision of Physical Therapist Services (HOD P16-18-15-13).

88 • Access to Physical Therapists as Entry-Point Practitioners For Activity Participation, Wellness,
89 Health, And Disability Determination (HOD P08-22-12-14)

90 • Annual Visit with a Physical Therapist (HOD P06-18-22-30)

91 • Delivery of Value-Based Physical Therapist Services (HOD P07-25-77-21)

92 • Digital Health Technologies, Digital Therapeutics, and Artificial Intelligence in Physical
93 Therapist Practice (HOD P07-24-12-11)

94 • Electrophysiologic Examination And Evaluation (HOD P06-18-35-24)

95 • Physical Therapist's Role in Management of Individuals With Concussion (HOD P06-19-40-14)

96 • Physical Therapist Services in Primary Care (HOD P07-24-05-07)

97 • Physical Therapists as Practitioners of Choice to Rehabilitate and Manage Persons with
98 Disorders of Vestibular Function Related Balanced Disorders (HOD P07-24-07-05)

99 • Physical Therapists' Role in Prevention, Wellness, Fitness, Health Promotion, and
100 Management of Disease and Disability (HOD P06-19-27-12)

101 • Physical Therapy For Individuals With Disabilities: Practice in Educational Settings (HOD P06-
102 95-14-03)

103 • Physical Therapy For Older Adults (HOD P06-19-39-13)

104 • Support of Emergency Physical Therapist Practice (HOD P06-20-42-35)

105 • Telehealth (HOD P06-19-15-09)

106
107 **What interested parties will be impacted by this motion?**

108 These standard definitions of terms describing the profession and service provision impact society,
109 the profession, employers, and payers.

110
111 **Additional background information:**

112 After extensive review, the recommendation is to not define “patient care” or “patient-physical
113 therapist relationship” in House policy. The rationale for these recommendations are: Patient Care
114 or Client Care: Neither APTA nor the Model Practice Act currently define these terms. Similarly, the
115 international physiotherapy associations and associations of other healthcare professions queried do
116 not provide definitions. The working group examined the definitions of two related terms: “patient or
117 client instruction” (defined in the Guide to PT Practice, 4.0) and “patient- and family-centered care
118 (offered by the American Academy of Pediatrics). They then considered the multiple perspectives,
119 settings and opportunities within the profession. Recommendation to leave undefined:
120 Development of a specific definition risks creating redundancies as care of the patient or client is
121 part of physical therapy and physical therapist services. Furthermore, care can continually change
122 across an episode of care based on the presentation and needs of the patient or client. Patient or
123 Client-Physical Therapist or Physical Therapist Assistant Relationship: APTA does not currently
124 define the relationship between a patient or client and a PT or PTA. The Federation of State Boards
125 of Physical Therapy has indicated that defining this relationship is of key importance for regulatory
126 standards and it is defined in the Model Practice Act. The working group reviewed the definitions in
127 the model practice act and various state practice acts, then queried international physiotherapy
128 associations and other healthcare professions for similar definitions or related terms.
129 Recommendation to leave undefined: Interactions may be highly variable based on the context and
130 setting of care. Furthermore, development of a specific definition risks creating inconsistencies with
131 jurisdictional regulations and reinforcing outdated hierarchies rather than advancing collaborative
132 partnerships. For guidance on this topic, members should look to jurisdictional regulations, the APTA
133 Code of Ethics and Standards of Practice, and other resources from national patient and family-
134 centered organizations that emphasize authentic engagement and shared decision-making.

135
136 This motion responds to RC 21-24 CHARGE: DEVELOP CONTEMPORARY OPERATIONAL
137 DEFINITIONS OF TERMINOLOGY IMPACTING APTA DOCUMENTS to examine commonly used
138 definitions used for practice and the description of our services which was referred to the Board of
139 Directors, the Board assigned the Scientific and Practice Affairs Committee (SPAC) to provide the
140 definitions. SPAC engaged in a year long process to collect input and refine definitions. The process
141 involved in depth discussions within the group and with others outside SPAC. SPAC presented the
142 recommendations to the Board of Directors in November of 2025 which was approved to move
143 forward as a motion for the 2026 House of Delegates in order to answer the charge.
144 The language and concepts have been further refined during the motion discussion phase with the
145 final language presented with some further changes to clarify the definitions.

146
147 The APTA has responded to this charge from the 2021 House of Delegates and made
148 recommendations for new or amended operational definitions using the following steps:
149 • Structured investigation: Gathered relevant information from multiple sources.
150 • Multiple iterations: Solicited targeted feedback on proposed ideas and definitions.
151 • Regulatory clarification: Consulted the Federation of State Boards of Physical Therapy.

- Perspectives: Invited and received peer review from 38 individuals representing 29 APTA member groups and communities.
- Further revisions: Edited the draft definitions and solicited additional feedback.
- Additional review by APTA legal, governance and communications staff.
- Input from 2026 APTA House of Delegates delegations.

Operational Definition: “Physical Therapy/Physiotherapy”

Two changes are recommended:

- Adding “is a health profession” in the first sentence affirms physical therapy as a health profession provided by physical therapists and physical therapist assistants before describing what physical therapy entails. This additional language puts the people of the profession front and center.
- Adding “diagnostic testing” to the list detailing the provision of physical therapy in the second paragraph explicitly states that diagnostic testing is part of physical therapy, which may assist with current and future policy and payment challenges and opportunities.

Operational Definition: “Physical Therapist Assistant”

Language replacement is recommended:

- Replace the words “the only individual who assists the physical therapist in practice” with “a licensed or certified individual who assists the physical therapist” in recognition of collaborative relationships that exist with other members of the healthcare team.

Operational Definition: Professional titles

Amended language is recommended:

- Reverse the order of the reference to “Physical therapist” or “Doctor of Physical Therapy” so that “doctor of physical therapy” comes first in order to reflect the growing percentage of DPTs in the profession.

Operational Definitions: “Patient” and “Client”

In recommending that the operational definitions of “patient” and “client” be defined as substantively equivalent, the Board, in consultation with SPAC, undertook a deliberate, inclusive, and forward-looking review process. The intent of this work is to provide clarity without constraint and to ensure that Association policy continues to support the full breadth of physical therapist practice—now and in the future.

The Board believes this approach best positions the Association—and the profession—to adapt, innovate, and continue to serve the public effectively in a rapidly changing health care environment, as this recommendation is based on:

- Comprehensive due diligence
- Broad and representative stakeholder input
- Rigorous review of regulatory, professional, and international sources
- A deliberate commitment to protecting current and future practice flexibility

194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237

Rationale for Similar Definitions

The Board recognizes that the terms *patient* and *client* are used across physical therapist practice settings in ways that are often overlapping, context-dependent, and evolving. The absence of a rigid distinction between these terms is not a limitation of this recommendation, but a deliberate safeguard against unintentionally constraining clinical practice, reimbursement, or regulatory interpretation as the profession continues to evolve.

While some may express preference for one term over the other based on setting, philosophical orientation, or professional culture, extensive review by SPAC identified that there is no consistent or authoritative distinction between the two terms across regulation, professional guidance, or health care systems.

Importantly, attempting to introduce a narrow or artificial distinction between *patient* and *client*—for example, based on medical versus wellness models—carries a meaningful risk of unintentionally limiting practice, particularly as care delivery, payment models, regulatory frameworks, and professional roles continue to evolve. Additionally, a special interest group of APTA Orthopedics explained that separating patient as an “individual” and client as a “group or entity” legally excludes animal PT from these definitions. The Board was especially attentive to concerns that overly prescriptive wording could create downstream challenges for emerging models of care that cannot yet be fully anticipated.

Accordingly, this recommendation reflects a deliberate decision to preserve flexibility, inclusivity, and practice neutrality, while remaining aligned with ethical standards, legal requirements, and person-centered care principles.

To ensure that this recommendation was well-informed and broadly representative, SPAC engaged in a formal peer review process and consultation strategy that included:

- Invitations for nominations from:
 - Federation of State Boards of Physical Therapy (FSBPT)
 - All APTA components
 - All APTA Board-appointed committees
 - Selected APTA communities representing diverse and future-focused perspectives (including Alternative Payment Models, Digital Care Providers, and Innovation in PT)
- Nominees and feedback received from:
 - FSBPT
 - Multiple APTA components spanning clinical practice areas, education, leadership, innovation, and population health
 - Board-appointed committees addressing specialty certification, ethics, diversity, public policy, education, and student perspectives
 - Future-focused communities engaged in alternative and emerging models of care

Response rate of participating groups: 74.5%, providing the Board with a strong and credible sample of informed perspectives across the profession.

238
239 This level of engagement ensured that views from regulatory, clinical, academic, ethical, policy, and
240 innovation-oriented stakeholders were meaningfully represented.

241
242 In parallel with consultation, SPAC conducted an extensive environmental scan and document
243 review, examining definitions and usage of *patient* and *client* across:

- 244 • Professional organizations within and beyond physical therapy
- 245 • State practice acts and regulatory frameworks
- 246 • National and international physical therapy associations
- 247 • Other health professions (including medicine, nursing, occupational therapy, psychology, and
248 speech-language pathology)
- 249 • Consumer- and person-centered care organizations
- 250 • Research bodies and national health institutions

251
252 Collectively, this review encompassed dozens of authoritative sources across regulatory, professional,
253 ethical, and international contexts. The findings reinforced several key conclusions:

- 254 • Regulatory language frequently uses *patient* and *client* interchangeably or defines one
255 without clarifying distinctions.
- 256 • Where differences appear, they are inconsistent across jurisdictions and professions.
- 257 • Many organizations increasingly emphasize person-centered language and preference, rather
258 than rigid terminology.
- 259 • No dominant framework exists that would support a uniform, future-proof distinction
260 between the two terms.

261
262 The intent of this approach is not to diminish the value or meaning of either term, nor to prescribe
263 what terminology must be used in a given setting. Rather, the intent is to:

- 264 • Acknowledge real-world usage across diverse practice environments
- 265 • Respect individual and contextual preferences
- 266 • Avoid creating unintended constraints on practice scope or innovation
- 267 • Ensure that Association policy remains adaptable as care delivery continues to evolve

268
269 By defining *patient* and *client* as similar in substance, the Board affirms that physical therapists and
270 physical therapist assistants must retain the ability to meet the needs of the individuals, groups, and
271 entities they serve—regardless of setting, diagnosis, payment model, or future practice paradigm. By
272 using a flexible and inclusive definition, the profession maintains clarity while allowing for
273 adaptability across legal, clinical, and collaborative care environments.

274 In accordance with this definition, APTA documents would not be standardized to reflect the use of
275 one term over another. Position statements, reports, and other documents of the association would
276 use the most appropriate term(s).

277
278 **References:**

- 279 1. APTA. Guide to Physical Therapist Practice, 4.0. 2023. APTA. Standards of Practice for Physical
280 Therapy (HOD S06-20-35-29). 2020.

- 281 2. FSBPT. The Model Practice Act for Physical Therapy, 7th edition. 2022. National Academies of
282 Sciences, Engineering and Medicine, (formerly Institute of Medicine).
- 283 3. Defining Primary Care: An Interim Report. 1994. Patient-Centered Outcomes Research
284 Institute. Patient-Centered Outcomes Research Definition Revision: Response to Public Input.
285 2012.

286

287 **Last Updated:** 5/8/2026

288 **Contact:** governancehouse@apta.org

Motion to 2026 House of Delegates

Main Motion:

RC 32-26 RECOMMEND: DEMOGRAPHIC REPRESENTATION OF THE PROFESSION ON THE APTA BOARD OF DIRECTORS AND HOUSE OF DELEGATES

1 **Proposed by:** Hawaii

2 **Primary Motion Contact:** Douglas White, DPT

3 [Discussion Thread](#)

4

5 *The Reference Committee determined this motion did not meet the main motion criteria. Therefore, a*
6 *majority vote is required to consider this motion.*

7

8 **Required for Adoption:** Majority Vote

9

10 That the American Physical Therapy Association shall develop, publish, and execute a strategic plan
11 to effectuate representation of the APTA Board of Directors and House of Delegates that
12 substantially represents the demographics of the profession.

13

14

15 **Support Statement**

16

17 **What is this motion seeking to achieve?**

18 Have the demographics of APTA leadership be representative of the profession

19

20 **How does this motion contribute to achieving the Vision?**

21 If APTA leadership does not reflect the profession it cannot adequately represent and meet the
22 needs of the profession.

23

24 **How does this motion support APTA priorities as reflected in the current APTA Framework?**

25 This motion will empower members

26

27 **How is this motion's subject national in scope and importance?**

28 APTA represents the entire profession and its leadership should reflect the entire profession.

29

30 **What previous or current initiatives and positions of the Association address this topic?**

31 None

32
33 **What interested parties will be impacted by this motion?**

34 All members of the profession particularly APTA members

35

36 **Additional background information:**

37 APTA BOD and the HOD does not, and has not potentially ever, reflected the demographics of the
38 profession. (2025 House of Delegates Cycle: A Year in Review Appendix A p. 7-12) Despite many years
39 of awareness of this issue nothing has changed, and APTA has done little to facilitate change in this
40 regard. In fact, this year the demographic information has been further buried in an appendix
41 released after the HOD cycle. APTA should not be burying this important issue. The disparity of
42 representation in the BOD and the HOD calls into question the legitimacy of APTA. Members report
43 APTA doesn't represent them or the issues that concern them. Academics compromise ~40% of the
44 HOD. Members who are not academics feel they are outsiders to a club whose membership is the
45 academy. They feel disenfranchised. Those members who overcome the barriers of participation
46 (barriers which are much lower for academics) in the HOD often are so put off they decline to return.

47

48 In addition to practice setting other aspects of BOD and HOD demographics does not reflect APTA
49 membership.

50

51 Membership surveys and post-HOD surveys do not capture the full dissatisfaction of the majority of
52 the profession with APTA, its leadership, and the priorities for the APTA. Institutional tension is
53 healthy but to move the profession forward all voices must be given an opportunity to be heard
54 proportionally and their perspectives given due consideration. APTA leadership must reflect the
55 demographics of the membership which is overwhelmingly clinicians.

56

57 APTA and components can do many things to influence and change the dynamics of the situation.
58 To give due credit, APTA has taken many steps to reduce the barriers to HOD participation. APTA
59 and components need to expand these initiatives to facilitate actual changes in demographics. A
60 plan which has measurable goals is necessary to focus APTA and components efforts to address this
61 issue.

62

63 **References:**

64

65 **Last Updated:** 5/8/2026

66 **Contact:** governancehouse@apta.org