



Today's Physical Therapist: A Comprehensive Review of a 21st-Century Health Care Profession

*Prepared by the American Physical Therapy Association
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Foreword

The American Physical Therapy Association (APTA) created *Today's Physical Therapist: A Comprehensive Review of a 21st-Century Health Care Profession* to provide accurate information for government entities and the public about the history, role, educational preparation, laws governing practice, standards of practice, evidence base of the profession, payment for physical therapy services, and workforce issues unique to the physical therapy profession. As government, private health care entities, and provider groups pursue solutions to the considerable health care provision challenges the United States faces, it is imperative that accurate information about the qualifications and roles of specific providers, in this case physical therapists, be available to inform all entities as they engage in these discussions.

APTA is the national professional association representing more than 77,000 physical therapists, physical therapist assistants, and students nationwide. The association acknowledges and thanks the Federation of State Boards of Physical Therapy, the national organization representing 51 boards of physical therapy licensure, for input and assistance with this document.

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Executive Summary

From its beginnings “by a small band of daring young reconstruction aide/technicians,” the physical therapy profession today boasts confident, accomplished, professional practitioners on the cutting edge of health care, and it consistently ranks as one of the nation’s most desirable careers. Physical therapists (PTs) play essential roles in today’s health care environment and are recognized as vital providers of rehabilitation and habilitation services, and prevention and risk-reduction services.

In the 21st century, **the profession has continued to grow substantially** from those beginnings, influenced early on by the polio epidemics and world wars, and later as it developed the scientific basis for its services, created entry-level education standards to keep apace with the demands of the health care system

and the needs of members of society, worked to create federal and state laws that accurately reflect contemporary practice, promoted its role in improving function and quality of life, increased access to physical

therapy through the addition of the physical therapist assistant, and created mechanisms to further develop the knowledge, skills, and abilities of the physical therapist.

Physical therapists are health care professionals who maintain, restore, and improve movement, activity, and health enabling individuals of all ages to have optimal functioning and quality of life, while ensuring patient safety and applying evidence to provide efficient and effective care. In addition, physical therapists are involved in promoting health, wellness, and fitness through risk factor identification and the implementation of services to reduce risk, slow the progression of or prevent functional decline and disability, and enhance participation in chosen life situations.

The profession has outlined the following elements of patient/client management: examination, evaluation, diagnosis, prognosis, intervention, and outcome assessment. Through execution of this process, the physical therapist determines whether physical therapy services are needed and develops the plan of care in collaboration with the patient/client/caregiver.

To ensure that physical therapist graduates are competent to safely provide evidence-based and effective physical therapy services, **the profession has responded to advances in research, technology, science, health care, and access to care with changes in the academic and clinical curriculum.** Over more than a 100-year period, physical therapy education has evolved from early training programs for reconstruction aides to **its current status as the doctor of physical therapy (DPT) degree.** As of January 1, 2016, the DPT will be the required degree for all entry-level physical therapist education programs. As of year-end 2010 there are 213 accredited programs (of which 206 offer the DPT), there are 13 developing DPT programs, and there are 33,800 entry-level DPT graduates.

Physical therapy education programs are accredited by the Commission on Accreditation of Physical Therapy Education (CAPTE), which uses the Evaluative Criteria for Accreditation of Education Programs for the Preparation of Physical Therapists to assess the quality of physical therapist education programs. The Evaluative Criteria includes a list of 98 skills that graduates of accredited physical therapist programs are expected to achieve, organized into 3 groupings: *professional practice expectations* (such as accountability, altruism, integrity, communication, clinical reasoning, and education); *patient/client management expectations* (screening, examination, evaluation, diagnosis, prognosis, plan of care, and outcomes assessment); and *practice management expectations* (such as prevention, health promotion, management of care delivery, practice consultation, social responsibility, and advocacy).

33,800
entry-level
DPT graduates
*as of 12/21/10

Advancement of the profession to the doctoral degree has not been limited solely to the next generation of practitioners. Licensed practitioners with professional baccalaureate, post-baccalaureate certificate, and master's degrees are earning postprofessional DPT degrees. More than 11,000 practitioners have earned a "transition" DPT degree as of January 2010.

PTs recognize professional development, continuing competence, and lifelong learning as integral to the provision of current, evidence-based, high-quality patient care. Physical therapist practice crosses the entire human lifespan from neonate to frail elderly, addressing most of the systems of the human body, including musculoskeletal, neuromuscular, integumentary, and cardiovascular and pulmonary. **Because of the expanse of knowledge and skills involved for such diverse populations and settings, most PTs have a focus or area of practice that allows them to concentrate their expertise.** Programs such as clinical residencies, clinical fellowships, and certified clinical specialization allow PTs to expand their expertise within defined areas of practice, or "specialties."

A *clinical residency program* is designed to substantially advance the resident's expertise in examination, evaluation, diagnosis, prognosis, intervention, and management of patients within a specialty. A *clinical fellowship program* is designed to provide PTs greater depth in a specialty or subspecialty area than that covered in a residency program. *Clinical specialization* is the process by which a PT builds on a broad base of professional education and practice to develop a greater depth of knowledge and skills related to a particular area of practice. Currently the American Board of Physical Therapy Specialties (ABPTS) coordinates and oversees the certified clinical specialization process in 8 clinical specialty areas and as of June 2010 had certified 10,348 physical therapists since it began offering specialist certifications in 1985. These specialty areas include cardiovascular and pulmonary physical therapy, clinical electrophysiology, geriatrics, neurology, orthopedics, pediatrics, sports, and women's health.

Physical therapists, like other health care providers, are seeking diverse, evidence-based approaches to demonstrating safe and effective contemporary practice. Physical therapy state licensure agencies in collaboration with

physical therapists, APTA chapter representatives, the Federation of State Boards of Physical Therapy (FSBPT), citizen advocates, and regulatory agencies are seeking ever-more effective methods of demonstrating and ensuring competence of all health care providers.

Physical therapists in the United States are licensed and regulated in all 50 states and the District of Columbia. **State licensure is required in each state in which a physical therapist practices and must be renewed on a regular basis, with a majority of states requiring continuing education or other continuing competency requirement for renewal.** A physical therapist must practice within the scope of physical therapy practice defined by his or her state licensure law (physical therapy practice act) including supervision of physical therapist assistants (PTAs).

Qualification for licensure includes passing the National Physical Therapy Exam (NPTE) of FSBPT. Another important qualification for licensure is graduation from a CAPTE-accredited physical therapy education program or a program that is deemed substantially equivalent.

Historically, physical therapists emerged as a profession within the medical model, not as an alternative to medical care. Traditionally, physical therapists receive a substantial proportion of their clinical education and training in academic medical centers and hospitals, where team collaboration is paramount. **Both physical therapists and physicians have a mutual respect for, and deep understanding of, their complementary roles in patient care. With that understanding, direct access to physical therapist services—without requirement of a physician referral—does not alter that relationship; it merely allows the collaboration to be initiated by the physical therapist** at a point in the physical therapy episode of care that is most beneficial to the patient and most cost effective for the health care system.

The market for these highly educated and skilled professionals appears to be strong, with potential for demand to increase in the future. In a recently published article in *Time* magazine, physical therapists were listed as the sixth most recession-proof job. Likewise, PTAs were ranked as the 44th most recession-proof job. This list has been reinforced by other reports that speak to the relatively strong job market for health care positions.

Physical therapist is
6th
Most recession-proof job
*per *Time* magazine

Data indicate that between the 2004 and 2009 academic years, the number of applicants to physical therapist education programs increased, on average, by 110%, and actual enrollments increased by 45.3%. However, while the environment for the physical therapy workforce is currently positive, the profession must remain vigilant to ensure an adequate supply of physical therapists to meet the demand for rehabilitation services and physical therapist assistant.

Based on 2009 data on PT members of APTA, 68.1 % are female, 93.0 % are white, and their ages range fairly evenly across the 25- 54-year-old age groups. 81.7 % of PT members are employed full-time, and 16.2 % are employed part-time. At the time of the 2009 survey, 0.5% of PT members were seeking full- or part-time employment. PT members reported employment in all practice settings, with the largest groups working in private outpatient office or group practice (32.4 %), health system or hospital-based outpatient facilities or clinics (21.6 %), and acute care hospitals (11.6 %). PTs reported working in academic institutions (8.7 %), home care (6.5 %), and extended care facilities (5.1 %) as well.

Just as physical therapist education advances with the evolving profession, so does the research and evidence that provides the base for effective patient care. **With a huge push toward expanding physical therapy's evidence base, there is every reason to believe that patients will benefit from interventions that are scientifically sound and appropriately provided, and that produce cost-effective outcomes.**

Initiatives toward this end include the Hooked on Evidence database, a collaborative project among thousands of physical therapists that provides rapid access to nearly 6,000 extracts that highlight the results of intervention studies; the Clinical Research Agenda that identifies the profession's most important research questions to encourage relevant research, to communicate research priorities to funding agencies, and to further the science

of the profession; and the developing National Outcomes Database, which will be the eventual collaboration between researchers and clinicians to create, disseminate, and apply the data to help formulate policy and, most important, to enhance patient care.

These initiatives focus on conducting studies that *can* translate into practice and developing mechanisms that will help ensure that this evidence *does* incorporate into physical therapy services. Much of this success can be attributed to the Foundation for Physical Therapy. Historically, the Foundation has provided seed money to launch PTs' research careers, having funded more 500 individuals and awarding more than \$10 million. In fact, the Foundation is now investing in additional mechanisms that provide more substantial funding than just the seed money that has been its hallmark. Mechanisms provided through the National Institutes of Health and other funding agencies, such as the K12 award, should only increase the number of physical therapist scientists who receive funding to conduct their large-scale studies.

As health care professionals, physical therapists most often are paid for their services by all insurers who cover physical medicine and rehabilitation services. This list of payers includes government and private health insurers, workers' compensation carriers, and automobile liability insurers. In addition, patients may pay directly for their own services.

Physical therapy services are subject to the same insurer cost-sharing strategies as those of other health care professionals. Physical therapists contract with private health care insurers to establish payment levels for the services they deliver, and they must review each insurance plan under which services are reported in order to determine coverage.

As for government health insurers, Medicare currently covers physical therapy services in the following provider settings: skilled nursing facilities (SNFs), home health (HHA), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), acute care hospitals, physical therapist private practice offices, physician's offices, rehabilitation agencies, and comprehensive outpatient rehabilitation facilities (CORFs).

Physical therapy is also a key health service to

Medicaid beneficiaries. Services are provided in a variety of settings including but not limited to home care, intermediate care facilities for people with mental retardation (ICF/MR), and schools. The federal government mandates certain services that every state Medicaid program must cover, although state Medicaid programs may elect to cover other “optional” services as well. Physical therapy is considered “optional.”

Physical therapy is one of the few health care professions that is integrated into a majority of the federal programs that provide health care services to United States veterans, members of the armed services, individuals with disabilities who have been harmed by natural disasters and public health threats, and Native Americans.

The military physical therapy community includes active duty members of the Army, Navy, Air Force, and Marines; the reserve forces/National Guard; and civilian physical therapists. Additionally, with more than 1,000 physical therapists on staff, the Department of Veterans Affairs (VA) is one of the largest employers of physical therapists nationwide.

Physical therapists have a long history among the U.S. Public Health Service (USPHS) essential health care professionals, managing patients in a variety of settings across the lifespan. Physical therapy also is one of the defined related services under the Individuals With Disabilities Education Act (IDEA). Finally, physical therapists are classified as “allied health providers” with the Indian Health Service and provide a full range of culturally sensitive services within the Native American community.

Playing a vital role in providing the public with access to physical therapy services, physical therapist assistants work under the direction and supervision of the physical therapist. The physical therapist directs appropriate physical therapy interventions to the physical therapist assistant. Physical therapist assistants (PTAs) currently are regulated in 48 states and the District of Columbia, with the vast majority of the states requiring licensure. Physical therapist assistants work under the direction and supervision of the physical therapist with the scope of work and supervision requirements defined by the physical therapy practice act in each state.

The physical therapist assistant’s work includes implementing selected components of patient/client interventions; obtaining outcomes data related to the interventions provided; modifying interventions either to progress the patient/client as directed by the physical therapist or to ensure patient/client safety and comfort; educating and interacting with other health care providers, students, aides/technicians, volunteers, and patients/clients and their families and caregivers; and responding to patient/client and environmental emergency situations.

Despite limited opportunities for career development within the job classification, the demand for physical therapist assistants is expected to grow as the aging population seeks or requires physical therapy services.



CHAPTER 1:

History of the Profession of Physical Therapy

From its beginnings “by a small band of daring young reconstruction aide/technicians,” the physical therapy profession today boasts confident, accomplished, professional practitioners on the cutting edge of health care, and is consistently ranked as one of the nation’s most desirable careers.^{1(p245)}

The Past

A confluence of events and developments around the world over centuries of time led to the formal recognition of physical therapy as a health care profession in the second decade of the 20th century. The development and use of the interventions commonly applied by physical therapists today, including exercise, massage and mobilization of tissues, heat, cold, water, and electricity, dates back to Greek culture and Hippocrates’ influence as the father of Western medicine. In the 1500s, 1600s, and 1700s in Europe, the use of exercise to treat muscle and bone disorders and disabilities progressed, and by the 1800s exercise and muscle re-education were being used for a variety of orthopedic diseases and injuries.²

When the polio epidemic became widespread in the United States in 1916, the need for muscle testing and muscle re-education to restore function grew dramatically. The United States entered World War I by declaring war on Germany in 1917, and the Army recognized the need to rehabilitate soldiers injured in

the war. As a result, a special unit of the Army Medical Department, the Division of Special Hospitals and Physical Reconstruction, developed 15 “reconstruction aide” training programs in 1917 to respond to the need for medical workers

with expertise in rehabilitation.^{3(p16)} The profession of physical therapy, as it was later termed, had begun. Appendix A (Histories of APTA and FSBPT) provides details on the concurrent

establishment—in 1921—and growth of the American Physical Therapy Association (APTA).

During the 1920s the partnership of physical therapists with the medical and surgical communities grew, and the profession of physical therapy gained public recognition and validation. Into the 1930s the polio epidemic continued, and the United States’ involvement in World War II at the end of the decade resulted in additional wounded soldiers to rehabilitate.^{4(p79-83)} Wounded veterans who returned home with amputations, burns, cold injuries, wounds, fractures, and nerve and spinal cord injuries required the attention of physical therapists in the first half of the 1940s, with WW II at its peak.^{3(p18)} In 1946 Congress adopted the Hill Burton Act to build hospitals across the country and increase public access to hospitals and health care facilities.^{3(p19)} This legislative action resulted in an increase in hospital-based practice for physical therapists and an increased demand for physical therapy services.

Due to the increased need for physical therapists and the discontinuation of the army-based schools after the war, APTA recognized the need to educate more physical therapists. The Schools Section of APTA made recommendations about admissions, curricula, education, and administration of physical therapy programs, and APTA embarked on an effort to encourage more universities and medical schools to create programs and expand existing programs, including creating opportunities for graduate-level education.^{5(p137)} By 1950 there were 31 accredited schools, 19 offering bachelor’s degree programs and 8 offering post-baccalaureate certification, and the length of programs increased as a result of developments in rehabilitation and medicine.^{5(p137)}

Practice in the 1950s continued to be influenced by war, as the Korean War began in 1950, and by the polio epidemic, which continued to rage. Research that had been initiated in earnest in the 1940s finally paid off with the development of the Salk vaccine, eradicating polio in the United States by the early 1960s. Although individuals who had contracted polio prior to the vaccine continued to need physical therapy treatment, the profession could turn its focus to the rehabilitation of other disabilities as a result of the widespread use of the Salk vaccine and the growth in the availability of physical therapists.^{3(p19)}



The 1950s decade was a critical time for the profession in terms of gaining independence, autonomy, and professionalism. Two events in the 1950s contributed to the progression of the physical therapist from technician to professional practitioner. The Self-Employed Section formed as a component of APTA in 1955 as private practice expanded,^{5(p153)} and the Physical Therapy Fund was created in 1957 to foster science through research and education within the profession.^{5(p144)} Seeking to replace the system of registration that had been created through the American Medical Association (AMA), which required a questionable assessment of professional competence in physical therapy, APTA urged its state chapters to seek licensure through the states, and by 1950, Connecticut, Maryland, and Washington had adopted physical therapy practice acts, joining New York and Pennsylvania, whose initial licensing efforts dated back to 1926 and 1913, respectively.^{5(p141)} State regulation for the physical therapist existed in 45 states by 1959.^{5(p142)} While state regulation was a positive step toward autonomy, the issue of how to assess competency continued to challenge the profession, resulting in APTA creating the first national examination in 1954, partnering with the Professional Examination Service of the American Public Health Association to do so.^{5(p142)}

The efforts to gain state licensure undoubtedly influenced the addition of outpatient physical therapy in the Medicare program in 1967 and 1968, as the majority of states had licensure laws by this time.^{3(p19-20)} Physical therapist practice in the neuromuscular area developed significantly during the 1960s, influenced by the work of Margaret Rood, Margaret Knott, Dorothy Voss, Signe Brunnström, and Berta and Karl Bobath, who developed techniques for adults with stroke, cerebral palsy, and other disorders of the central nervous system.^{3(p20)} The cardiovascular/pulmonary area of practice also developed during this time, as advancements in medicine such as open heart surgery became more commonly practiced.^{3(p20-21)} In the orthopedic practice arena, total joint replacements developed in the 1960s created an additional

need for postoperative physical therapy^{3(p21)} and introduced new options for patients with severe joint restrictions to live more independent and pain-free lives.

Having relied primarily on exercise, massage, functional training, water (hot and cold), heat (heat lamps, paraffin baths, diathermy), simple electrotherapeutic modalities, and assistive devices and equipment (wheelchairs, splints/braces, ambulatory aids) to address patient needs up until the 1950s, physical therapists found new opportunities and more options to improve patient function with developments in interventions between 1950 and 2000.^{3(p21)} Technological advances provided new testing methodologies with more objective outcome measures, and new intervention methodologies expanded practice and

the types of diseases and conditions that physical therapy could positively influence. Congress adopted the Education of All Handicapped Children Act (now known as the Individuals with Disabilities Education Act (IDEA) in 1975, creating new avenues for physical therapists within the public school system.

In the early 1980s APTA adopted a policy indicating that “physical therapy practice independent of practitioner referral was ethical as long as it was legal in the state.”^{3(p22)} Having taken small steps over the previous 50 years to become more independent of the physician, this courageous step punctuated the professionalization of the physical therapist and resulted in states changing their practice acts to provide for the ability to practice without referral.^{3(p23)}

Also significant during that time was the formation of the Federation of State Boards of Physical Therapy (FSBPT) in 1986, providing an organization through which member licensing authorities could coordinate to promote and protect the health, welfare, and safety of the American public. Appendix A (Histories of APTA and FSBPT) provides details on the federation’s history and mission.

Significant changes in the health care delivery system in the country required major association focus in the 1990s, influencing the practice

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... and professionalism.”

of physical therapy in ways that continue today. Managed care, the role of insurers in determining care, corporate and physician ownership of physical therapy services, the Balanced Budget Act of 1997, the Medicare Prospective Payment System (PPS), and the Medicare cap on physical therapy services adopted in 1997 and implemented in 1999 challenged and continue to challenge the physical therapist to provide quality services to patients.^{3(p23)} These health care system changes identified a need to formally define the role of the physical therapist and to describe the practice of physical therapy, which in part motivated the creation of the *Guide to Physical Therapist Practice* (Guide),⁶ published in 1995. This seminal document, currently in its second print edition and available online, clearly describes the role of the physical therapist in the examination, evaluation, diagnosis, prognosis, intervention, re-examination, and assessment of outcomes in the management of patients and clients.⁷

The Present and Future

In the 21st century, the profession has continued to grow substantially, further developed the scientific basis for its services, created entry-level education standards concomitant with the demands of the health care system and the needs of members of society, worked to create federal and state laws that accurately reflect contemporary practice, promoted its role in improving function and quality of life, and created mechanisms to further develop the knowledge, skills, and abilities of the physical therapist and physical therapist assistant. Appendix B (APTA Strategic Plan) outlines these goals and efforts. This vital work will continue into the second decade of the modern century, as the health care system is reformed and the role of the physical therapist in contributing to the health and well-being of members of society becomes ever more important.

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CHAPTER 2:

Description of Physical Therapist Practice

Physical therapists are health care professionals who maintain, restore, and improve movement, activity, and health enabling an individual to have optimal functioning and quality of life, while ensuring patient safety and applying evidence to provide efficient and effective care. Physical therapists evaluate, diagnose, and manage individuals of all ages who have impairments, activity limitations, and participation restrictions. In addition, physical therapists are involved in promoting health, wellness, and fitness through risk factor identification and the implementation of services to reduce risk, slow the progression of or prevent functional decline and disability, and enhance participation in chosen life situations. Physical therapy scope of practice is dynamic, evolving with evidence and societal needs. Appendix C (Physical Therapist Practice Exemplars) contains a sampling of the types of patients and conditions for which physical therapists provide services.

The following description of physical therapist practice is based on the Guide to Physical Therapist Practice.¹

Professional Roles

Physical therapists (PT) play essential roles in today's health care environment and are recognized as vital providers of rehabilitation and habilitation services, and prevention and risk reduction services. Other professional roles of physical therapists include providing consulting, education, research, and administration services.

Role in Patient/Client Management

Physical Therapists provide care to patients/clients of all ages who have impairments, activity limitations, and participation restrictions due to musculoskeletal, neuromuscular, cardiovascular/pulmonary, and/or integumentary disorders. Following the patient/client management model (described below), physical therapists design individualized plans of care based on their clinical judgment and

patient/client goals. Physical therapists collaborate with other health care professionals to address patient needs, increase communication, and provide efficient and effective care across the continuum of health care settings. To facilitate communication among health care disciplines, APTA has adopted the World Health Organization's International Classification of Functioning, Disability and Health (ICF) to provide a standardized language and framework for the description of health and functioning. Appendix D (Use of the International Classification of Functioning, Disability, and Health in Physical Therapy) describes the ICF in further detail.

Role in Prevention and Risk Reduction

In addition, physical therapists provide prevention services and promote health and fitness. Physical therapists can help prevent a targeted health condition in a susceptible or potentially susceptible population or individual through risk identification and mitigation strategies. In populations with identified disease, injury, or illness, physical therapists can decrease the duration, severity, and the sequelae of health conditions through prompt intervention. Finally, physical therapists play an important role in limiting a person's degree of disability, through restoration and maintenance of function in patients/clients with chronic health conditions to allow optimal performance and participation.

Additional Clinical and Non-Clinical Roles

Physical therapists also may assume additional clinical and non-clinical roles including consultation, education, research, and administration. For example, physical therapists provide consultative services to health facilities, educational programs (eg, public schools), other providers, colleagues, businesses, industries, third-party payers, families and caregivers, and community organizations and agencies. They provide education and other professional services to patients/clients, students, facility staff, communities, and organizations and agencies. Physical therapists engage in research activities, including those related to measuring and improving the outcomes of service provision. They administrate in practice, research, and education settings, and they are involved in shaping community services and policies.

The Process of Patient/Client Management

A profession's scope of practice is directly dependent upon the education and skill of the provider, the established history of the practice scope within the profession, supporting evidence, and the regulatory environment.² The foundation of the physical therapist scope of practice is inherently linked to the process required to manage the patient/client. For the physical therapist, the profession has outlined the following elements of patient/client management: examination, evaluation, diagnosis, prognosis, intervention, and outcome assessment. Through execution of this process, the physical therapist determines whether physical therapy services are needed and develops the plan of care in collaboration with the patient/client/caregiver.

Examination

Examination is required prior to the initial intervention and is performed for all patients/clients. The initial examination is a comprehensive screening and specific testing process leading to diagnostic classification and/or, as appropriate, to a referral to another practitioner. The examination has two components: the patient/client history with a systems review, and tests and measures.

History

The history is a systematic gathering of data from both the past and the present, related to why the individual is seeking physical therapist services. The data obtained (eg, through interview, through review of the patient/client record, or from other sources) include personal and environmental information such as demographics, social history, employment and work (defined as activities related to a job, school, or leisure pursuits appropriate to the individual; this usually is termed “job/school/play”), growth and development, physical environment and available resources, general health status, social and health habits (past and current), family history, medical/surgical history, current conditions or chief complaints, functional status such as activity and participation, medications, and other clinical tests.

While taking the history, the physical therapist also identifies health restoration and prevention needs and coexisting health conditions that may have implications for intervention. Data

from the history provide the initial information that the physical therapist uses to hypothesize about health conditions, environmental factors, or personal factors that may influence the: (a) integrity of body structures and functions or their impairments and (b) functioning or activity limitations and/or participation restrictions. The physical therapist may use the information obtained during the history along with epidemiological research that is available regarding activity limitations and participation restrictions of various populations to create a “hypothesis” that would require further, in-depth analysis during the examination's tests and measures.

After reviewing the patient/client history, the physical therapist conducts a systems review. This is a brief or limited examination of: (1) the anatomical and physiological status of the patient's/client's cardiovascular/pulmonary, integumentary, musculoskeletal, and neuromuscular systems; (2) the communication ability, affect, cognition, language, psycho-emotional status (eg, self-efficacy and motivation), and learning style of the patient/client; and (3) review of “red flags” and other screening data. The physical therapist will consider how each of these components affects the patient's/client's ability to initiate, sustain, and modify purposeful movement for carrying out activities and participating in life situations.

The physical therapist may conclude from the history and systems review that further examination and intervention are necessary, and/or that the patient/client should be referred to another practitioner.

Tests and measures

Tests and measures are another means by which the physical therapist gathers data about the patient/client. Using the data from the history and systems review, the physical therapist generates diagnostic hypotheses that he or she further investigates by specific tests and measures. These tests and measures are used to rule in or rule out the presence of and links between impairments in the patient's/client's body function and structure, activity limitations, and participation restrictions; to establish a diagnosis, prognosis, and plan of care; and to select interventions.

The tests and measures that the physical therapist performs as part of an initial examination should (1) confirm or reject a hypothesis

about the factors that contribute to making the current level of patient/client functioning less than optimal and (2) support the physical therapist's clinical judgments regarding appropriate interventions, anticipated goals, and expected outcomes. Before, during, and after administering the tests and measures, the physical therapist gauges responses, assesses physical status, and obtains a more specific understanding of the condition and the diagnostic and therapeutic requirements.

Tests and measures that physical therapists use include, but are not limited to, strength testing; balance and gait analysis; endurance testing; neuromotor, development, and sensory integration; nerve integrity (via EMGs); and adaptive and environmental assessments. Additional listings of common tests and measures can be found in Appendix E (Guidelines: Physical Therapist Scope of Practice).

Evaluation

Physical therapists perform an evaluation based on the data gathered from the examination. The physical therapist synthesizes all of the findings from the history, systems review, and tests and measures to establish the diagnosis, prognosis, and plan of care. The evaluation reflects the chronicity or severity of the current problem, the possibility of multisite or multisystem involvement, the presence of preexisting systemic conditions or diseases, and the stability of the condition. The physical therapist also considers the severity and complexity of the patient's/client's current impairments and the probability of prolonged impairments, activity limitations, participation restrictions, and environmental factors.

Diagnosis

Diagnosis involves both a systematic process and a classification or description of findings related to the patient/client. The diagnostic process includes integrating and evaluating the data obtained during the examination to describe the individual condition in terms that will guide the physical therapist in determining the prognosis, plan of care, and intervention strategies. The diagnostic description or classification relates to the primary impairments, activity limitations, and participation restrictions toward which the physical therapist establishes goals and selects interventions.³ The purpose of the diagnosis is to guide the

physical therapist in determining the most appropriate intervention strategy for the patient/client. As is the case in all clinical care, the determination of a diagnosis is critically important to assist the clinician in providing appropriate, safe, and effective care.

Physical therapists are trained in the diagnostic process, which includes the collection and categorization of data, establishment of hypotheses, testing of the hypothesis by systematically ruling out alternatives, and confirming or refuting the hypothesis. Physical therapists use their knowledge of disease and injury, signs and symptoms, mechanism of injury, outcome and prognosis, treatment response, and the relevant individual and environmental factors to arrive at a diagnosis.⁴

“PTs use their knowledge of disease and injury, signs and symptoms, mechanism of injury, outcome and prognosis, treatment response, and relevant individual and environmental factors to arrive at a diagnosis.”

In performing the diagnostic process, the physical therapist may need to obtain additional information from other health care professionals. In addition, as the diagnostic process continues, the physical therapist may identify findings that should be shared with other professionals, including referral sources, to ensure optimal patient/client care. When the patient/client is referred with a previously established diagnosis, the physical therapist should determine that the clinical findings are consistent with that diagnosis. If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise, the physical therapist refers the patient/client to an appropriate practitioner. If the diagnostic process does not yield an identifiable cluster (eg, of signs or symptoms, impairments, activity limitations, or participation restrictions), syndrome, or category for diagnosis, the physical therapist may administer interventions for the alleviation of symptoms and remediation of impairments, activity limitations, and/or participation restrictions. As in all other cases, individual responses to those interventions guide the physical therapist, who may determine that a reexamination, consultation, or referral is in order and proceed accordingly.

Prognosis and Plan of Care

Once the physical therapist has established the diagnosis, he or she determines the prognosis and develops the plan of care. The plan of care is the culmination of the physical therapist's examination, diagnostic, and prognostic processes and is established in collaboration with the patient/client and/or family/caregiver. The plan of care includes goals and the expected outcomes, predicted level of optimal improvement, specific interventions to be used, and proposed duration and frequency of the interventions that are required to reach the anticipated goals and expected outcomes.

The physical therapist's plan of care also includes the anticipated discharge plans for the patient/client. In consultation with appropriate individuals, the physical therapist plans for discharge and provides for appropriate follow-up or referral. For patients/clients with chronic or recurrent conditions who require multiple episodes of care, periodic follow-up is needed over the individual's life span to ensure safety and effective adaptation following changes in physical status, caregivers, environment, or activity and role demands.

Intervention

Intervention is the purposeful interaction of the physical therapist with the patient/client and, when appropriate, with other individuals involved in patient/client care, using various physical therapy procedures and techniques to produce changes in the condition that are consistent with the diagnosis and prognosis. Decisions about interventions are contingent upon the regular and timely monitoring of patient/client response and the progress made toward achieving the anticipated goals and expected outcomes. Physical therapist interventions include, but are not limited to, therapeutic exercise; training in self-care; home management; work (job/school/play); community integration and reintegration; manual therapy (including mobilization/manipulation); prescription, application, and, as appropriate, fabrication of devices and equipment; airway clearance; integumentary repair and protection techniques; electrotherapeutic modalities; physical agents; and mechanical modalities. Appendix E (Guidelines: Physical Therapist Scope of Practice) includes an additional listing of therapeutic interventions often employed by physical

therapists. Based on patient/client response to interventions, the physical therapist may decide that reexamination is necessary, a decision that may lead to the use of different interventions or, alternatively, the discontinuation of care or referral to another practitioner.

Many factors influence the physical therapist's decision-making process and the complexity, frequency, and duration of an intervention. Among these factors are the following:

- premorbid conditions and overall health status
- age; cognitive status; comorbidities, complications, or secondary impairments; concurrent medical, surgical, and therapeutic interventions; nutritional status
- chronicity or severity of the current condition and multisite or multisystem involvement
- social support, including caregiver consistency or expertise
- stability of the condition
- accessibility and availability of resources; potential discharge destinations
- environmental factors including living environment
- adherence to the intervention program
- decline in function as evidenced by the level of impairment in body functions and structures, activities, and participation
- probability of prolonged impairment in body functions and structures, activity limitation, or participation restrictions
- psychosocial and socioeconomic factors
- psychomotor abilities
- personal factors

Coordination and Communication

Coordination and communication are essential responsibilities of physical therapists and ensure that patients/clients receive safe, appropriate, comprehensive, efficient, and effective care from initial evaluation through discharge. Physical therapists are responsible for coordination and communication across all settings for all patients/clients.

These collaborative processes may include addressing advanced care directives, individualized educational programs (IEPs), or individualized family service plans (IFSPs); informed consent; mandatory communica-

tion and reporting; admission and discharge planning; case management; collaboration and coordination with agencies; communication across settings; cost-effective resource utilization; data collection, analysis, and reporting; documentation across settings; interdisciplinary teamwork; and referrals to other professionals or resources.

Outcomes

Throughout an episode of care and at the time of discharge, the physical therapist measures the impact of the physical therapy interventions through the use of evidenced-based measurement tools. The most commonly used outcomes tools have been tested for reliability and validity and help provide an accurate assessment of the effectiveness of the physical therapy interventions.

Standards of Practice

It is the role of the professional association to outline and promote the expected level of quality of care for that profession. The physical therapy profession's commitment to society is to promote optimal health and functioning in individuals by pursuing excellence in care. As the primary representative body for the physical therapy profession, APTA has established the Standards of Practice for Physical Therapy (see Appendix F) and the corresponding Criteria for Standards of Practice in Physical Therapy (see Appendix G). These are the profession's statements of conditions and performances that are essential for high-quality professional service to individuals in society and the necessary foundation for assessment of physical therapy

practice. Additionally, APTA's Professionalism in Physical Therapy: Core Values document (see Appendix H) addresses the professional traits—accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility—expected of physical therapists graduated from accredited programs.



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CHAPTER 3:

Physical Therapy Education

As a part of the physical therapy profession's social contract with society, there must be assurance that physical therapist graduates are competent to safely provide evidence-based and effective physical therapy services within a dynamic health care system. The profession has responded to advances in research, technology, science, health care, and access to care with changes in the depth, breadth, and length of the academic and clinical curriculum. Physical therapist education programs are accountable for their program outcomes and are required to meet defined quality standards and competencies that systematically and periodically undergo widespread review and revision to ensure currency.

The Past

Critical historical and sociopolitical milestones, advances in technology, and changing demands and needs of society have shaped the evolution of the physical therapy profession. This evolution has been reflected in increased educational requirements and standards, an augmented professional degree consistent with those standards, and concomitant expansion in the scope of physical therapist practice. Over more than a 100-year period, physical therapy education has evolved from early training programs for reconstruction aides to its current status as the doctor of physical therapy (DPT) degree.¹

Education Requirements

Establishing Certificate Programs¹

The early beginnings of the profession emerged from the demands of two worldwide health crises¹: poliomyelitis epidemics (1894, 1916)² required extensive muscle retraining, and World War I (1917-1919) necessitated physical rehabilitation of the wounded.³ In 1917, the US Army's Division of Special Hospitals and Physical Reconstruction, Office of the Surgeon General, established formal 3-month emergency education programs, with concentrations in anatomy and exercise. Graduates were given the official title of "reconstruction aide."^{2,3}

New civilian training programs led to certificate-granting programs that were generally housed in hospitals. By 1918, 13 schools collaborated with the Army to establish 6-month, intensive, certificate-granting physical therapy programs that focused on the study of technical skills rather than essential foundations.² In 1928, the American Physiotherapy Association (APA) established the first Minimum Standards for an Acceptable School for Physical Therapy Technicians² that included a 9-month, 1,200-hour program of instruction. The prerequisite for admission was graduation from a recognized school of physical education or nursing.¹

Transition to Baccalaureate Programs¹

Political and social responses to world events in the 1930s and 1940s, and in particular World War II (1941-1945), kept demand for physical therapy services high. As a result, physical therapy expanded beyond hospital-centered practice, which made establishing and enforcing minimum standards for physical therapy education critical.¹ In 1936, the American Medical Association established the *Essentials for an Acceptable School for Physical Therapy Technicians*, and the first 13 institutions were accredited.^{3,4} The minimum acceptance requirements included 60 college credits or graduation from a 2-year school of nursing or physical education, and the program lengthened to a range of 12 to 24 months.^{3,5} Between 1930 and 1950, 54 physical therapist programs developed—35 offered certificates, 18 offered a certificate or baccalaureate degree, and 1 offered solely a baccalaureate degree. By the 1950s, 37 programs offered the baccalaureate degree, with most newly established programs situated in colleges and universities rather than hospitals.^{3,4}

With the advent of the 1950 poliomyelitis outbreak, wounded veterans of the Korean and Vietnam Wars, advances in medical technology, and doubling of the aging US population, more patients with complex and multisystem health care needs required physical therapy interventions involving advanced problem-solving and analytical skills.^{3,5} In the 1960s, school curricula responded with content such as neuroanatomy, neurophysiology, psychology of individuals with disabilities, research, education, administration, and management, which together formed the foundation for understanding pathology and treatment rationales.³ Even as

the baccalaureate degree became the minimum educational qualification of the physical therapist, there were discussions about advancing to the professional master's degree. By 1972, most programs were affiliated with colleges or universities, with 55 baccalaureate programs and only 15 certificate programs remaining.⁴

Meanwhile, postprofessional advanced degrees for physical therapists began to emerge, with Case Western Reserve University in 1960 becoming the first professional master's physical therapist degree program.⁴ New York University, the University of Southern California, Texas Woman's University, and Boston University developed early postprofessional PhD programs for physical therapists in the mid-1960s.⁴ Today, 42 physical therapist programs offer postprofessional doctoral degrees for physical therapists in a variety of focused areas, such as physical therapy, movement science, clinical investigation, kinesiology, rehabilitation science, health services research.⁶

Transition to the Post-baccalaureate Degree¹

Legislative and health care industry changes have provided opportunities for physical therapy over the past 2 decades. Federal legislation extended physical therapy into public schools to provide support services to children with disabilities (PL-94-142),⁵ the Americans with Disabilities Act (ADA) created a role for physical therapists as consultants and advocates,⁷ and state practice acts began to allow for physical therapist practice without physician referral to varying degrees.⁵ Greater autonomy in the decision-making of physical therapists within their scope of practice and further expansion of settings and areas of practice for physical therapists (eg, primary care, women's health, oncology, ergonomics, emergency department) required concomitant augmentation of knowledge, skills, and professional behaviors in physical therapist curricula.⁶

In 1979, APTA adopted a resolution to require a post-baccalaureate degree to enter physical therapy beginning in 1990.^{3,5} In reality it took 23 years to complete the full transition. In 2000, APTA passed a position identifying the appropriate minimum professional education qualification for a physical therapist post-baccalaureate degree.⁸ Two landmark

APTA documents outlining the practice expectations and the knowledge, skills, and abilities of the physical therapist helped to facilitate the passage of this position. The *Guide to Physical Therapist Practice (Volume I: A Description of Patient Management)* published in August 1995, and *Volumes I and II: Preferred Practice Patterns* published in November 1997⁹ described the breadth, depth, and scope of physical therapist practice across the various systems and lifespan, and outlined the physical therapist's role in patient/client management. *A Normative Model of Physical Therapist Professional Education*¹⁰ defined the preferred curricular content in the foundation, behavioral, and clinical sciences, entry-level practice expectations and associated curricular content, clinical education, and non-curricular components (ie, educational settings, admissions criteria, and qualifications and role of faculty and program administrators).

Transition to the Doctor of Physical Therapy (DPT) Degree

Changes in employers' expectations for the performance of physical therapist graduates at entry level, expanding needs of society for physical therapy services in a broad range of settings, greater evidence available about physical therapy interventions, increased competition among programs for high-quality applicants, augmentation in required basic and applied science curricular coursework, and lengthening of clinical internships spurred discussion about whether the master's or doctorate would better prepare entry-level practitioners to meet contemporary and future health care needs of society. APTA in 2000 passed "Vision 2020," which included:

"By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, ..." ¹¹ Appendix I (Vision Sentence and Vision Statement for Physical Therapy) contains

the full text of APTA's Vision 2020. Even as new accreditation standards were being adopted, some programs already had begun to look toward the DPT as the professional degree in physical therapy.³ In 1995-1996, the University



of Southern California and Creighton University in Nebraska became the first 2 programs to be accredited to award the DPT.³ The voluntary transition to the DPT degree has in fact moved more rapidly than anticipated, with 96.7% of accredited programs offering the DPT as of August 2010.¹²

Accreditation

Physical therapist education programs have been reviewed and recognized in some manner since 1928, beginning with approval by the American Physiotherapy Association (APA), later to become the American Physical Therapy Association (APTA). At APA's request, between 1933 and 1956, the American Medical Association (AMA) Council on Medical Education inspected and approved physical therapist education programs. Between 1957 and 1976 AMA and APTA had first informal and then formal collaborative arrangements for accreditation based on the AMA's 1955 revision of the *Essentials of an Acceptable School of Physical Therapy*.¹³ In 1977, after 10 years of unsuccessful attempts by APTA to garner approval from AMA of proposed revisions to the *Essentials*, APTA severed the relationship with AMA and created a new accrediting body: the Commission on Accreditation in Physical Therapy Education (CAPTE). (In 1983, AMA ceased accrediting physical therapist education programs, leaving CAPTE as the sole accrediting agency for physical therapy programs.¹⁴) Since 1977, CAPTE has been recognized by the US Department of Education (USDE) to accredit physical therapy (physical therapist and physical therapist assistant) programs. In the private sector, CAPTE has been recognized continuously since 1977, first by the Council for Post-Secondary Accreditation (COPA), then by the short-lived Council for Recognition of Post-Secondary Accreditation (CORPA), and currently by the Council for Higher Education Accreditation (CHEA).

The Present

Recognition and Autonomy of CAPTE

By APTA House of Delegates action, CAPTE is solely responsible for “formulating, revising, adopting, and implementing the evaluative criteria for the accreditation of ... physical therapist assistant and physical therapist professional education programs.”¹⁵ Additionally, CAPTE is solely responsible for its accreditation status decisions and its policy

and procedures; these are not ratified by APTA or any other related organization.

CAPTE¹⁶ is an appointed group of APTA, comprising physical therapist and physical therapist assistant educators, physical therapist and physical therapist assistant clinicians, basic scientists, higher education administrators, consumers, and public members. Although USDE requires many accreditors to be independent of related membership organizations, agencies such as CAPTE that accredit programs (not institutions) and whose USDE recognition allows program eligibility for purposes other than those included in the Higher Education Act are exempt.¹⁷ (Other examples include the Accreditation Council for Occupational Therapy Education, the Council on Academic Accreditation in Audiology and Speech-Language Pathology, the Commission on Accreditation for Dietetics Education, and the Commission on Dental Accreditation.)

Evaluative Criteria

The *Evaluative Criteria for Accreditation of Education Programs for the Preparation of Physical Therapists*¹⁸ used by CAPTE to assess the quality of physical therapist education programs are organized around 2 major components: (1) integrity and capacity of the institution and program, and (2) curriculum content and outcomes.

Within these areas, the *Evaluative Criteria* address the following program characteristics, a number of which are required by USDE.¹⁹

- Institutional integrity and capacity
 - Appropriate authority to offer the program
 - Policies and procedures to protect the rights of individuals involved with the program
- Program integrity and capacity
 - Mission, goals, expected outcomes that are transparent
 - Program assessment and planning
 - Policies and procedures to protect the rights of individuals involved with the program, including recruitment and admission, complaints, and information available to students
 - Faculty qualifications, responsibilities and effectiveness
 - Resources: students, student services, support staff, financial support, learning resources, facilities (including

clinical education sites), and materials and equipment.

- Curriculum
 - Curriculum plan
 - Curricular evaluation
 - Curriculum content and learning experiences, including clinical education, leading to specified expected performance outcomes
 - Program length and degree
- Outcomes
 - Actual student outcomes/competencies
 - Graduation rates, licensure exam pass rates, employment rates

In adopting its criteria, CAPTE looks to contemporary documents that describe the state of the physical therapy profession and of professional education. Naturally, APTA, as the only professional organization of physical therapists and physical therapist assistants, produces such documents, among them: *A Normative Model of Physical Therapist Professional Education*,¹⁰ *A Normative Model of Physical Therapist Assistant Education*,²⁰ and *Guide to Physical Therapist Practice, 2nd edition*.²¹ While it may appear so, it is not the case that CAPTE has adopted relevant portions of these APTA documents wholesale: a careful review of the criteria and these documents will reveal subtle but important differences. For example, the Evaluative Criterion “CC-5.40 Determine those components of interventions that may be directed to the physical therapist assistant (PTA) upon consideration of: (1) the needs of the patient/client, (2) the PTA’s ability, (3) jurisdictional law, (4) practice guidelines/policies/codes of ethics, and (5) facility policies”^{18(p45)} is not one of the practice expectations listed in the physical therapist *Normative Model*.

Expected Student Outcomes (Competencies)

CAPTE’s Evaluative Criteria¹⁸ includes a list of 98 skills that graduates of accredited physical therapist programs are expected to achieve. The skills are organized into three groupings:

Professional Practice Expectations: accountability; altruism; compassion/caring; integrity, professional duty; communication; cultural competence; clinical reasoning; evidence-based practice; and education

Patient/Client Management Expectations: screening; examination (including a list of exami-

nation skills); evaluation, diagnosis, prognosis; plan of care; intervention (including a list of intervention skills); and outcomes assessment

Practice Management Expectations: prevention, health promotion, fitness and wellness; management of care delivery; practice management; consultation; and social responsibility and advocacy

CAPTE has chosen to include these specific expectations in its *Evaluative Criteria* to ensure that all program curricula include the content necessary to meet them, unlike some accrediting agencies (such as the Commission on Collegiate Nursing Education and the Liaison Committee for Medical Education) that refer programs to other documents for the specifics of expected outcomes or leave specification of them up to the discretion of the faculty.

Curriculum Standards

The competencies referenced above form the basis of CAPTE’s evaluative criteria regarding curriculum content. In competency-based curricula, the emphasis is less on the courses to be offered or how the content is delivered and more on the outcomes of the educational endeavor. The evaluative criteria, therefore, include the expectation that programs will not only provide relevant content and learning experiences for students in the areas noted above, but they also will have mechanisms in place to assess the degree to which the competencies have been achieved. CAPTE does not specify how a program must go about achieving the expected student outcomes; rather, like other accrediting agencies (such as the Accrediting Commission for Pharmacy Education, the Commission on Dental Accreditation, the Liaison Committee for Medical Education, and the National League for Nursing Accrediting Commission) CAPTE leaves the rightful prerogative of curriculum design and delivery to the program faculty. This flexibility allows programs to develop and implement a curricular design based on institution and program mission, number and expertise of the faculty, and the needs of society; it also allows for innovation in the delivery of physical therapy education.



Current Status of the Professional DPT

In October 2009, after seeking comment from its stakeholders, CAPTE revised the Evaluative Criteria to require the awarding of the doctor of physical therapy degree, effective December 31, 2015. Thus, as of January 1, 2016, the DPT will be the required degree for all entry-level physical therapist education programs. As of year-end 2010 there are 213 accredited programs, of which 206 offer the DPT, there are 13 developing DPT programs,¹² and there are 33,800 entry-level DPT graduates.

Current Status of the Postprofessional DPT

As academic programs transitioned to the professional DPT degree it was incumbent upon the profession to develop an accessible mechanism for licensed physical therapists with professional baccalaureate, post-baccalaureate certificate, and master's degrees to affordably earn a degree commensurate with that of the current professional DPT graduate.²² The development of the postprofessional DPT degree, also known as the transition DPT degree (t-DPT), was created to serve a similar function as other professions, such as pharmacy and audiology that had previously transitioned to the clinical doctorate using varied delivery methods and defined competencies. More than 11,000 practitioners have earned a transition DPT degree as of January 2010.

As of August 2010, 74 academic institutions offer the t-DPT degree, some entirely on campus, some online, and others as an online/on-site combination.²³ The majority of t-DPT degree programs are developed based on their professional DPT program's curriculum, APTA Transition DPT Competencies, APTA Preferred Curricular Model, *A Normative Model of Physical Therapist Professional Education*, and review of other t-DPT curricula.^{24(p4)} Most programs require applicants to provide transcripts (undergraduate, graduate, and professional), a US physical therapist license, the academic institution application, 2 or more letters of recommendation, a written goal/purpose statement, and a curriculum vitae or resume.^{24(p3)}

Although most physical therapist programs use similar learner competencies, require essential core coursework for graduates, and assess graduate outcomes (ie, employer and

graduate satisfaction, achievement of program goals and objectives, career position advancement, graduation rates, and alumni surveys) of t-DPT degree programs, applicants to these programs vary in their earned professional and advanced degrees, clinical practice experiences and areas of practice focus, and teaching and research experiences.^{24(p4)} Therefore, the number of credits required to complete the curriculum varies according to each applicant's background. Those holding professional baccalaureate and certificate degrees are generally required to complete more credits than applicants with professional master's degrees. Given the differences in applicants' backgrounds, learners, on average, may take from 1 to 3 years to complete this program. Today, more than 10,500 licensed physical therapists have earned their t-DPT degree^{24(p2,3)} since the first such program, at the University of Southern California, admitted students in 1994.

Conclusion

In summary, the creation and ongoing evolution of the physical therapy profession has been in response to societal needs for rehabilitation, prevention, and wellness services, most often in conjunction with health and sociopolitical crises. Advancement of the profession to the doctoral degree was not limited solely to the next generation of practitioners, but rather a mechanism was developed for licensed practitioners to obtain essential knowledge in content areas where the curriculum had expanded in order to earn a postprofessional DPT degree. Finally, more than 100 years later, the profession has transitioned its entry-level education from a short technical-training program with highly circumscribed knowledge and skill to a comprehensive, rigorous, 3-year intensive professional education program that typically follows completion of an undergraduate degree and that culminates in the awarding of the doctor of physical therapy degree.

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CHAPTER 4:

Specialization and Continuing Competence

Physical therapists recognize professional development, continuing competence, and lifelong learning as integral to the provision of current, evidence-based, high-quality patient care. The American Physical Therapy Association's core documents, especially the APTA Code of Ethics for the Physical Therapist and corresponding Guide for Professional Conduct, express the significance of these professional responsibilities.

Appendixes I (Code of Ethics for the Physical Therapist) and J (Guide for Professional Conduct) contain the full text of these documents; Principle 6 of the Code of Ethics reads¹:

Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors. (Core Value: Excellence)

- 6A. *Physical therapists shall achieve and maintain professional competence.*
- 6B. *Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.*
- 6C. *Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.*
- 6D. *Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.*

An APTA position statement, Professional Development, Lifelong Learning, and Continuing Competence in Physical Therapy² further delineates the key assumptions that guide the physical therapist's professional responsibility, including a recognition that physical therapists as health care professionals are obligated to engage in lifelong learning and are ultimately

responsible for meeting or exceeding contemporary performance standards within their area(s) of practice.

Areas of Practice in Physical Therapy

Physical therapist practice crosses the entire human lifespan from neonate to frail elderly. It addresses most of the systems of the human body, including musculoskeletal, neuromuscular, integumentary, and cardiovascular and pulmonary. Because of the expanse of knowledge and skills involved for such diverse populations and settings, most physical therapists have a focus or area of practice that allows them to concentrate their expertise. Programs such as clinical residencies, clinical fellowships, and certified clinical specialization allow physical therapists to expand their expertise within defined areas of practice, or "specialties."

Clinical Residency and Fellowship Programs

Two such opportunities are clinical residency or fellowship programs. A clinical residency program is designed to substantially advance the resident's expertise in examination, evaluation, diagnosis, prognosis, intervention, and management of patients within a specialty. This focus also may include community service, patient education, research, and supervision of other health care providers, both professional and technical. The clinical residency program is to be completed within a minimum of 1,500 hours and in no fewer than 9 months and no more than 36 months. Often, the residency experience prepares a physical therapist to become a board-certified clinical specialist.

A clinical fellowship program is designed to provide physical therapists greater depth in a specialty or subspecialty area than that covered in a residency program. Additionally, applicants of a clinical fellowship program must possess one or more of the following qualifications: (1) specialist certification, (2) completion of a residency, or (3) demonstrable clinical skills within a particular specialty. A clinical fellowship program is to be completed within a minimum of 1,000 hours and in no fewer than 6 months and no more than 36 months. Programs with timeframes that fall outside of these parameters are reviewed on a case-by-case basis.

The Past

In November 1996, APTA implemented a voluntary credentialing process for postprofessional clinical residency programs for physical therapists. A new Committee on Clinical Residency Program Credentialing began to develop and implement the process. In 2000, the purpose of the committee expanded to include the credentialing of clinical fellowship programs. In 2002, the American Academy of Orthopaedic Manual Therapists (AAOMPT) and APTA merged their credentialing processes for orthopedic manual therapy fellowships, and in 2004, the Sports Physical Therapy Section and APTA merged their credentialing processes for sports physical therapy residencies. With the continued expansion of physical therapist residency and fellowship program development and credentialing, the committee in 2009 transitioned to a credentialing board, The American Board of Physical Therapy Residency and Fellowship Education.

The Present

The current breakdown of credentialed programs is 79 residencies in the areas of cardiovascular and pulmonary physical therapy, geriatrics, neurology, orthopedics, pediatrics, sports, and women's health; and 25 fellowships in the areas of hand therapy, movement science, orthopedic manual therapy, and sports division I athletics.

Certified Clinical Specialization

Specialization is the process by which a physical therapist builds on a broad base of professional education and practice to develop a greater depth of knowledge and skills related to a particular area of practice.

The Past

APTA approved the concept of specialization in physical therapy in 1976. In 1979 the Commission of Advanced Clinical Competence established and began to oversee a specialization process. The commission became the Board for Certification of Advanced Clinical Competence, and was later renamed the American Board of Physical Therapy Specialties (ABPTS).

The Present

Clinical specialization in physical therapy is a voluntary and unrestrictive process. Individuals initiate their applications, and no attempt is made to prohibit others from practicing in a specified area.

According to the policy Clinical Specialization in Physical Therapy,³ the purposes of the clinical specialization program are to:

1. Assist in the identification and development of appropriate areas of specialty practice in physical therapy.
2. Promote the highest possible level of care for individuals seeking physical therapy services in each specialty area.
3. Promote development of the science and the art underlying each specialty area of practice.
4. Provide a reliable and valid method for certification and recertification of individuals who have attained an advanced level of knowledge and skill in each specialty area.
5. Assist consumers, the health care community, and others in identifying certified clinical specialists in each specialty area.

Currently ABPTS coordinates and oversees the certified clinical specialization process in 8 clinical specialty areas and as of June 2010 had certified 10,348 physical therapists since it began offering specialist certifications in 1985. These specialty areas include cardiovascular and pulmonary physical therapy, clinical electrophysiology, geriatrics, neurology, orthopedics, pediatrics, sports, and women's health. Specialty councils in each of the 8 approved board certification specialty areas define, develop, and modify the requirements for certification and recertification in their respective specialty areas.

The certified clinical specialization program has experienced significant growth over the past 10 years, with the number of physical therapists achieving board certification increasing over 270 percent. According to a 2007 ABPTS survey, certified specialists spend an increased amount of time in research, teaching, consultation, and scholarly and professional activities. Additionally, the survey provided evidence that certification tends to have a positive impact on

the number of consultations, invited presentations, new job opportunities, and opportunity for increased responsibility.

Continuing Competence in Physical Therapy

The past 20 years has brought a steady increase in the number of state licensure agencies that require demonstration of continuing competence for licensure renewal, most often via the accumulation of continuing education hours or continuing education units. Today, the vast majority of physical therapy licensure agencies require an average of about 20 hours a year of continuing education as a minimal requirement for licensure renewal. It has long been realized, however, that continuing education, useful as it may be, is not equivalent to continuing competence. Licensure agencies have been seeking alternative methods that are also cost effective and accessible.

The Future

Physical therapists, like other health care providers, are seeking diverse, evidence-based approaches to demonstrating safe and effective contemporary practice. Physical therapy licensure agencies in collaboration with physical therapists, APTA chapter representatives, citizen advocates, and regulatory agencies are seeking more effective methods of demonstrating and ensuring competence of all health care providers. The Citizen's Advocacy Center

(CAC), serving the public interest since 1987 by enhancing the effectiveness and accountability of health professional oversight bodies, recommends that reform in continuing competence regulations must focus on state government, since it is the states that license health care practitioners and, when necessary, discipline them. The CAC⁴ recommends that state legislative action include the following:

- Eliminate continuing education requirements (as the sole measurements of continued competence).
- Mandate that as a condition of relicensure, licensees participate in continuing professional development programs approved by their respective health care boards.
- Mandate that continuing professional development programs include (a) assessment; (b) development, execution, and documentation of a learning plan based on the assessment; and (c) periodic demonstrations of continuing competence.
- Provide licensure boards with the flexibility to try different approaches to foster continued competence.
- Ensure that the boards' assessments of continuing competence address the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individual's practice at the time of relicensure.
- Require that boards evaluate their approaches to gathering evidence on the effectiveness of methods used for periodic assessment.
- Authorize licensure boards to grant deemed status to continuing competence programs administered by voluntary credentialing and specialty boards, or by hospitals and other health care delivery institutions, when the private programs meet board-established standards.

Physical therapist licensure boards in the states of California, North Carolina, and Minnesota are leading the way in developing new approaches to demonstrate and ensure continuing competence. Licensees engage in a needs-assessment process and build their professional development based on that assessment, and these programs encourage a diversity of approaches to demonstrating competence.



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CHAPTER 5:

Licensure and Regulation

As members of a health care profession, and similar to other health care professions, physical therapists in the United States are licensed and regulated by the states. The information in this chapter reviews the licensure status of physical therapists in all states and the District of Columbia, describes the purpose and requirements

50

states + DC
require licensure

of state licensure, outlines licensing board structure, and provides information about terms and titles. Other than the information specifically about licensure of the physical therapist, the following information also applies to the physical therapist assistant.

Information specific to physical therapist assistant licensure/regulation can be found in the chapter on physical therapist assistants.

State Licensure and Regulation

Physical therapists are licensed in all 50 states and the District of Columbia. State licensure is required in each state in which a physical therapist practices and must be renewed on a regular basis, with a majority of states requiring continuing education or some other continuing competency requirement for renewal. A physical therapist must practice within the scope of physical therapy practice defined by his or her state law governing the licensure and practice of physical therapy (often referred to as the “practice act”). The entire practice act, including accompanying rules, constitutes the law governing physical therapy practice within a state. Appendix L (Definition of Physical Therapy in State Practice Acts) provides details on individual state statutes.

Purpose and Requirements for State Licensure

State licensure is inherently restrictive for the licensee and exclusive to the particular profession. Only those who “meet and maintain prescribed standards” established by the state’s regulatory board will, for the protection and benefit of the public, be allowed to profess

their qualifications and provide their services to the public. The public is dependent upon the state to evaluate and affirm the qualifications for licensure of physical therapists. One of the main tools used by a state’s regulatory entity to determine if a physical therapist has met that threshold is the physical therapist’s passage of the National Physical Therapy Exam (NPTE) of the Federation of State Boards of Physical Therapy (FSBPT). The NPTE is the only examination for licensure of physical therapists—all 50 states and the District of Columbia use it. The NPTE is “competency specific” and covers the entire scope of entry-level practice, including theory, examination and evaluation, diagnosis, prognosis, treatment intervention, prevention, and consultation that are consistent with the exam blueprint. A formal, systematic process referred to as an “analysis of practice” determines the contents of a licensure examination. This process begins with the identification of work requirements for entry-level practitioners and ends with the development of a formal set of test specifications that delineates the knowledge and skills related to safe and effective entry-level practice.

Because physical therapy practice evolves, it is imperative that the licensure examinations be updated on an ongoing basis. Thus, a practice analysis must be conducted periodically to ensure that changes in entry-level requirements are incorporated into the licensure examinations. Revisiting the practice analysis regularly ensures that fewer test questions are included on skill areas of decreasing importance and more test questions address skill areas of increasing importance. The time frame for updating a practice analysis varies by profession; for the physical therapy profession this analysis is conducted at least every 5 years.

Another important qualification for licensure is graduation from an accredited physical therapy education program or a program that is deemed substantially equivalent. The Commission on Accreditation of Physical Therapy Education (CAPTE), recognized by the United States Department of Education as the specialized accrediting agency for physical therapy education programs, sets the quality threshold standards that physical therapist programs must meet in order to be accredited.

State Regulatory Boards

Most jurisdictions have independent state boards of physical therapy, but some jurisdictions' physical therapy boards are part of state medical boards or combined with other professions. There are also a few "super boards," under which all regulatory activities are subordinate to one board, with distinct committees or commissions for the various professions. Independent licensing boards are preferred because they provide the necessary expertise specifically for regulation of physical therapy practice. Most jurisdictions have licensing board members who are appointed by an elected official, usually the governor. Often they include 1 to 2 public members. Smaller jurisdictions may have fewer than 5 total board members, while larger ones have far greater numbers.

When a state's practice act is silent on an issue or intervention, the determination of what constitutes practice "beyond the scope" of physical therapy is predominantly the responsibility of licensing board members. Scope of practice changes as contemporary practice evolves, and boards need the latitude to determine the appropriateness of physical therapy procedures as they relate to both established and evolving scope of practice.

The Model Practice Act for Physical Therapy

Over decades the various physical therapy practice acts have contained functional and useful regulatory language but also some problematic language. Most jurisdictional practice acts had their origins in the 1950s and early 1960s, and amendments turned some practice acts into cobbled-together collections of regulatory language that are very diverse in their approach to the basic board responsibility of protecting the public and regulating the profession.

FSBPT created *The Model Practice Act for Physical Therapy: A Tool for Public Protection and Legislative Change (MPA)* in 1997 as the preferred tool for revising and modernizing physical therapy practice acts. FSBPT encourages jurisdictions to review, improve, and strengthen practice acts, using the latest edition of the MPA as a resource. The continuing movement to update physical therapy practice acts helps ensure that they provide the legal authority to fully protect the public while effectively regulating the profession.

The FSBPT task force that began developing the MPA in 1994 originally envisioned a model act that could be used cafeteria style to allow states to change a specific section of a practice act as needed. While the MPA can be used effectively in this manner, it also is a tightly constructed and integrated model for the regulation of physical therapy. The sections of the MPA complement each other—certain areas of the MPA are indispensable from others, and changes in one area might require modification of a state's practice act in other areas. The commentary sections of the MPA identify important cross-links in statute language. Since 1997 many states have enacted large portions of and, in some instances, nearly the entire Model Practice Act as their state statute.

Terms and Titles of the Physical Therapy Profession

State regulation restricts how licensees represent themselves, including their use of titles and/or letters, so that they do not mislead the public. For example, a medical or osteopathic physician practices and represents to the public that he or she practices medicine but not dentistry. When practitioners other than physical therapists represent that they are providing "physical therapy" or "physiotherapy," they are violating the very spirit and core of licensure law by misrepresenting themselves to the public. A claim that "physical therapy" or "physiotherapy" is a generic term is misleading to the public. The protection of these terms is not referring to protection against the use of various physical agents, modalities, or procedures by others, but rather is against the inappropriate labeling of those modalities and procedures as physical therapy.

In addition the title "PT" is the professional and regulatory designation that practice acts require physical therapists (and no others) in the United States to use to denote licensure. The use of the initials "DPT" by physical therapists indicates that they have obtained a doctoral degree in physical therapy (DPT). Use of the initials "DPT" should be used in conjunction with the licensure designation of "PT."



Direct Access to Physical Therapist Services

The vast majority of U.S. jurisdictions have some form of patient access to evaluation and treatment by licensed physical therapists. Access to physical therapist services is critical to ensuring optimum patient functional status and independence. See Appendix M (Direct Access to Physical Therapy Services, by State) for descriptions of each state statute on direct access.

Throughout the experience of obtaining direct access at the state level, physical therapists have been questioned about their ability to identify a patient's signs and symptoms correctly, especially those that may represent cancer or other life-threatening conditions, if the patient has not first been screened by a physician. The misguided presumption is that physical therapists are not sufficiently educated or clinically trained to correctly diagnose an underlying pathological condition. This argument falsely concludes that direct access to physical therapists is therefore a threat to the safety of the public. However, a closer look at the facts and evidence proves otherwise.

Physical therapists diagnose impairments, functional limitations and disabilities related to medical conditions, movement dysfunction, and other health-related disorders. Physical therapists do not provide a medical diagnosis. However, they are well-prepared to identify when a patient's signs and symptoms potentially lie outside the scope of physical therapist diagnosis and require a referral to a physician

for further diagnostic work-up and identification of underlying pathology. The examination process, routinely employed by physical therapists, ensures that direct access to physical therapists also allows referral to physicians when indicated.

With more than 30 years of experience with direct access in the states that permit it, there is absolutely no evidence that physical therapists misinterpret a patient's signs and symptoms as non-pathological leading to serious injury or death. Physical therapist malpractice rates do not differ between states with patient direct access and those with a physician referral requirement. Furthermore, when the number of complaints against physical therapists filed with state licensure boards were examined prior to and after elimination of the physician referral requirement, no increase of complaints centered on patient harm was found.

In the research study titled "Documentation of red flags by physical therapists for patients with low back pain," Leerar et al¹ studied the frequency of medical screening procedures in 6 private practice clinics. In this retrospective chart review of 160 patients admitted with low back pain, they found that an average of 8 out of the 11 recommended "red flag" screening questions were documented in the chart. The authors noted that this was comparable to or exceeded that of physicians in 5 other studies.

In another study, Boissonnault et al² reported on 81 patients seen under direct access in a nonprofit, hospital-based outpatient department, and found that retrospective physician review of physical therapist management decisions determined that physical therapist decisions were appropriate 100% of the time. These decisions included making referrals for additional imaging studies, medical consultation, and medication for pain management.²

Most referrals from physicians are written as "evaluate and treat." Medical "diagnoses" may only be basket-terms such as "low back pain." Even if a specific medical diagnosis is provided along with an "evaluate and treat" referral, it is incumbent upon the physical therapist to identify the rehabilitation diagnosis. Physical therapists



independently design the plan of care and the schedule of implementation. It is the physical therapist who has ultimate responsibility for what interventions will be provided, how many times a week or month the patient will be seen, and the overall duration of the episode of care.

Improved patient access does not harm or diminish the longstanding collaborative relationships between physical therapists and physicians. Direct access supports a collaborative model of practice between physicians and physical therapists and will create opportunities that can only enhance patient management, safety, and outcomes.

Collaboration is, in many respects, the flip side of the direct access “coin.” Historically, physical therapists emerged as a profession within the medical model, not as an alternative to

medical care. Traditionally, physical therapists receive a substantial proportion of their clinical education and training in academic medical centers and hospitals, where team collaboration is paramount. Both physical therapists and physicians have a mutual respect for, and deep understanding of, their complementary roles in patient care. Direct access does not alter that relationship; it merely allows the collaboration to be initiated by the physical therapist at a point in the physical therapy episode of care that is most beneficial to the patient and most cost effective for the health care system.

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CHAPTER 6:

The Physical Therapy Workforce

The market for physical therapy service providers appears to be strong, with potential for demand to increase in the future. However, potential changes in the supply of physical therapists can affect the health care environment and influence the market. The profession must continually monitor the environment to ensure a sufficient supply of physical therapists so that the health care provided to all clients is of the highest quality.

The Past

During the past 25 years, the physical therapy workforce typically has been characterized by a shortage of providers. Although it appears that this statement is well justified, the data collection methods used in the late 1980s and early 1990s were somewhat rudimentary, at

best. The profession relied on the number of advertisements for physical therapists, as well as salary levels and fringe benefits as a proxy for more refined data about supply and demand. For example, a large number of advertisements for positions appeared in the trade publications, so it was assumed that there was a shortage of physical therapy providers. Also, rural hospitals were providing very attractive salaries and comparatively large sign-on bonuses. The profession reasoned that if these facilities, which arguably did not have large budgets, were willing to provide substantial remuneration to attract staff, it was very likely that a shortage existed.

Balanced Budget Act

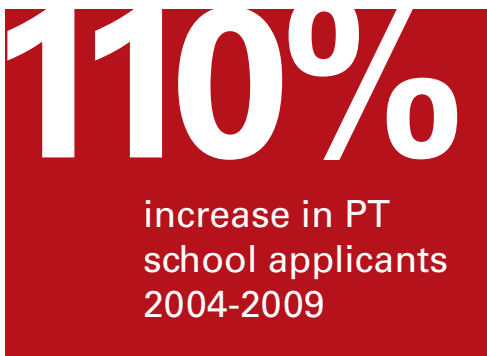
The apparent shortage of physical therapists and physical therapist assistants remained in effect until shortly after 1997, when the landscape was changed as a result of federal legislation.

The Balanced Budget Act of 1997 (PL 105-33), referred to as the BBA, was enacted to produce a projected \$119 billion dollar reduction in Medicare payments and spending. (By 1999, the Congressional Budget Office (CBO) reported that the projected reduction was overestimated by \$88 billion.¹) This rather draconian bill, and its impact, substantially affected physical therapy. A number of settings, especially skilled nursing facilities, received less payment than they had before enactment of the bill. Those facilities' response was to reduce staff to bring expenses more in line with revenue. Thus, a small percentage of physical therapists lost their positions, while larger numbers had their employment status reduced. Overall, the employment market for physical therapists was deleteriously affected.² Reports of a changing job market had repercussions throughout the profession. Of most concern to the potential workforce was the fact that the numbers of applicants and enrollees to professional programs decreased.

The Present

Upon addressing the adverse effects of the BBA in subsequent legislation, in the early 2000s the employment market for physical therapists reverted back to the comparable environment as it had been prior to 1997. Although the American Physical Therapy Association (APTA) has no specific data on either a shortage or surplus of physical therapists, it has collected information that is widely accepted as a proxy for shortage. These data appear in 3 recently conducted reports. The reports deal with vacancy and turnover rates in 3 settings that employ a substantial number of physical therapists and physical therapist assistants: acute care hospitals, private outpatient clinics, and skilled nursing facilities.^{3,4,5} The reports indicate substantial shortages in each of the three settings.

Skilled nursing facilities indicate the most severe shortages, which is not surprising given that this setting treats larger numbers of Medicare patients and was hardest hit by the BBA. What's more, the data indicate that many physical therapists who left this environment chose not to return, given that more than 7% of respondents reported that it has taken them 10 years to fill a position. Because this 10-year period represents the length of time



elapsed between passage of the BBA and the collection of data, it appears that a number of positions have never been filled.

On a more positive note, physical therapy once again seems a popular career choice. Data indicate that between the 2004 and 2009 academic years, the number of applicants to physical therapist education programs increased, on average, by 110%, and actual enrollments increased by 45.3%.⁶ Certainly a valid hypothesis for the cause of this increase is a perception among potential physical therapists that the job market is once again becoming quite attractive.

Based on a 2009 survey of physical therapist members of APTA,⁷ as of 2008, 68.1 % are female, 93.0 % are white, and their ages range fairly evenly across the 25- 54-year-old age groups. 81.7 % of physical therapist members are employed full-time, and 16.2 % are employed part-time. At the time of the 2009 survey, 0.5% of physical therapist members were seeking full- or part-time employment. Physical therapist members reported employment in all practice settings, with the largest groups working in private outpatient office or group practice (32.4 %), health system or hospital-based outpatient facilities or clinics (21.6 %), and acute care hospitals (11.6 %). physical therapists reported working in academic institutions (8.7 %), home care (6.5 %), and extended care facilities (5.1 %) as well.

The 2009 survey also indicates that the physical therapy workforce increasingly comprises physical therapist doctoral degree graduates. (See Chapter 3, Physical Therapy Education, for background on the doctor of physical therapy degree.) As of 2008, 27.3% of physical therapists responded to the practice profile survey question regarding highest earned degree that they have a baccalaureate degree, 37.6% have a master's degree, 4.9% a PhD, 15.7% an entry-level DPT degree, and 11.6% a transition-DPT degree. In 2005 and 2006, 45.9% and 41.8%, respectively, indicated their highest earned degree was a master's degree. The percentage of physical therapists whose highest earned degree is a bachelor's or master's degree is declining concomitant with an increase in the percentage who have earned a DPT degree, either in an entry-level program or a transitional degree program.

All of these signs point to a robust job market for physical therapists and physical therapist assistants. In a recently published article in *Time* magazine, physical therapists were listed as the sixth most recession-proof job,⁸ ranking even higher than physicians, the profession about which shortages are written the most. This list has been reinforced by other reports that speak to the relatively strong job market for health care positions. *Kaiser HealthNews* reported in January 2010 that although the economy tended to shed jobs over the course of the last 2 years, the health care sector grew by 631,000 positions. Indeed, in December 2009 alone, the sector added 22,000 jobs.⁹

This robust environment, however, isn't universal, although exceptions are on a somewhat small scale. Anecdotal reports to APTA indicate that certain facilities have been forced to reduce their staffs, despite the nation's generally high demand for health care professionals. The reasons for a decline in demand at these facilities include a saturation of facilities within a given area or a lower income demographic. The simplest solution for them, as it was in response to the BBA, is to cut staff salary, which tends to be an employer's largest expense.

The Future

Indications are that the demand for physical therapy providers will increase in the future. First, as a result of the 2010 Patient Protection and Affordable Care Act (PL 111-148), referred to as PPACA, the number of Americans who have no health insurance is expected to drop significantly. CBO has estimated that the percentage of uninsured will decrease from 19% in 2010 to 8% in 2019, representing an additional 31 million individuals who will be able to obtain health care services.¹⁰ Further, there is continued attention to the plight of disabled Americans.¹¹ If more services are available to people with disabilities, *and* more of these individuals have health insurance, the demand among this population might increase substantially. Note that this potential increase in services for people with disabilities does not account for parallel increases in recent estimates of people with spinal cord injury (SCI). A report from the Christopher and Dana Reeve Foundation stated that 5 times more people are living with SCI than physicians originally thought.¹²

Further, there is little doubt that the population is aging. A recent study conducted by researchers at the Danish Aging Research Centre concluded that more than half the babies born in rich nations will live to be 100 years old if current life expectancy trends continue.¹³ Projections reported by the American Orthopaedic Association (AOA) indicated that by 2020, 16.3% of the U.S. population and approximately 25% of the Canadian population will be 65 years of age or older, which is double the current number.¹⁴

Clearly, there are opportunities for physical therapists to remain a vital part of the health care team. However, there are threats that must be confronted as well. Student indebtedness is a critical issue facing all postsecondary students, but the problem tends to be especially acute among students educated in the health professions. Data reporting debt among medical students is publicized more often than other professions. A report from the US Government Accountability Office disclosed that medical school graduates from 2008 had incurred an average of \$155,000 in student debt.¹⁵

Although the issue of indebtedness among physical therapist students does not receive the same degree of visibility, the dilemma clearly exists. APTA recently collected data indicating that at the conclusion of his or her physical therapist education program, a student typically incurred more than \$96,000 of debt. Nearly \$64,000 of the total was from student loans. Additionally, slightly more than two-thirds of these same respondents (67%) indicated that the amount of debt accrued would affect the job choice they will make as physical therapists.¹⁶ With this in mind, it is fair to wonder if potential physical therapist students might turn to other professions that would enable them to accrue less debt and reduce the debt burden faster, thus diminishing the potential supply of physical therapists.

Moreover, an apparent shortage of faculty perpetuates the problem. Nursing also generally is characterized by a shortage of practitioners, and a recent article in the *Chicago Tribune*¹⁷ disclosed that nursing programs in the state of Indiana rejected about 2,500 qualified applicants because the schools did not have the full-time faculty needed to

teach them. A parallel issue exists within physical therapist education. The Council on Accreditation of Physical Therapy Education (CAPTE) has reported 103 vacancies in allocated positions across all physical therapist education programs.¹⁸ These vacancies likely diminish class size and, ultimately, the number of graduates who can enter the profession.

Conclusion

The future employment market is generally very positive for physical therapy. It appears that the positions available exceed the supply of providers. There is little reason to expect that this environment will change in the short term. As always, the health of patients/clients is the primary concern for the profession. If debt load or faculty shortages continue to exist, it is conceivable that other providers will try and assume the roles that physical therapists now hold. Should this happen, it is possible that individuals who are less educated will assume these roles, and patient care may suffer. Thus, although the environment for the physical therapy workforce is currently positive, the profession must remain vigilant to ensure an adequate supply of physical therapists and physical therapist assistants to meet the demand for rehabilitation services.



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CHAPTER 7:

Physical Therapy Research

With a huge push toward expanding physical therapy's evidence base, there is every reason to believe that patients will benefit from interventions that are scientifically sound and appropriately provided, and that produce cost-effective outcomes.

The Past

Until the 1990s, physical therapists (PTs) generally treated research as a separate enterprise from practice, conducted by a small proportion of the profession. While PTs believed that their role was to provide the highest-quality care to patients/clients, they often based their care more on art than on science. More recently, the profession has been investing significant resources into expanding its scientific base and educating clinicians on applying the science in practice.

Holcomb, Selker, and Roush reported in 1990 that 30 percent of respondents to a survey of physical therapy faculty in selected schools of allied health had not been listed as an author on

any journal article.¹ This percentage reflects an earlier lack of appreciation for research, and is likely lower than what is an acceptable norm throughout higher education. The authors stated,

among a number of recommendations, that “faculty development programs to increase scholarly activity appear to be warranted.” A 1994 American Physical Therapy Association (APTA) survey indicated that the authors’ call did not necessarily enhance research productivity. Although results of this survey indicated that the cadre of productive researchers (more than 11 publications) increased by slightly more than 10 percent, the number of faculty with at least one publication declined by more than 7 percent.² Thus, it can be argued that the call

for more professional development opportunities did not necessarily increase the number of productive (in terms of publication in peer-reviewed journals) faculty members.

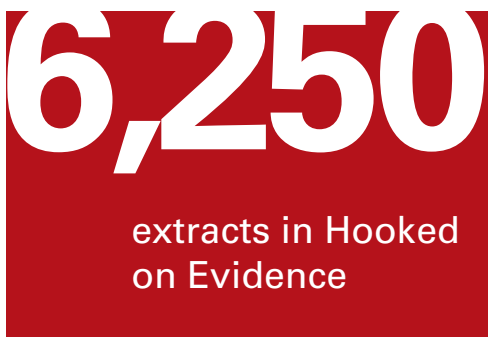
During essentially the same time as the assessment of faculty productivity, the concept of evidence-based practice (EBP) began to emerge in physical therapy patient care. David Sackett and his colleagues³ are chief among the authors who have discussed EBP. A 1994 article appearing in the *Wall Street Journal*, “One Bum Knee Meets Five Physical Therapists,”⁴ illustrated the relevance of EBP to physical therapy. In it, a reporter described her visits to 5 PTs for evaluation and management of chondromalacia of the patella and the 5 plans of treatment she was offered. Not only were these plans different from each other, the implications for cost of treatment varied substantially. The article implied that practices are variable and that treatment is based on biological plausibility, the opinions of “gurus,” and that which seems most comfortable to the provider, rather than on available evidence. This issue is not restricted to physical therapy, however. In fact, McGlynn and colleagues concluded that a random sample of participants in a telephone survey received only 55% of “recommended” medical care (ie, recommendations from the medical community) for various selected conditions.⁵

The Present

Hooked on Evidence

The different modes of behavior between physical therapy's clinical and research communities have been an ongoing challenge. Researchers believed that clinicians generally did not manage patients based on evidence. Clinicians countered that with such large patient loads, they did not have enough time to read the somewhat lengthy peer-reviewed articles that would provide the requisite evidence. To meet this challenge and to inculcate EBP throughout physical therapy, the profession developed the idea of a database describing the intervention literature in rehabilitation. A vehicle to promote the use of evidence in practice, *Hooked on Evidence*, was created in 2002. The idea was for *Hooked* to bridge the perceived behavioral gap between clinicians and researchers.

Hooked on Evidence provides rapid access to extracts highlighting the results of intervention studies. If they choose, clinicians can search



for scenarios that mirror the conditions of their patients and identify interventions that are most effective for a similar patient population. Hooked on Evidence, which has become a collaborative project among thousands of physical therapists and physical therapist students, currently includes nearly 6,250 extractions derived from the intervention literature. The number of extractions is expected to keep climbing and to expand from solely interventions into diagnosis.

The Research Agenda for Physical Therapy

Hooked on Evidence was not the only initiative devised to enhance the scientific foundation of the profession. A process to design a clinical research agenda for physical therapy began in 1998, and it was published in 2000.⁶ Its purpose was to identify and communicate the profession's most important research questions in order to encourage relevant research, to communicate research priorities to funding agencies, and to further the science of the profession. The profession is now revising the original agenda, expanding it to more comprehensively cover the entire continuum of rehabilitation research. The hope is to create new programs of research among junior researchers and expand the number of funding agencies that could potentially support physical therapy research, ultimately generating more evidence describing the provision of physical therapy services.

Vitalizing Practice Through Research and Research Through Practice

Another effort to bridge the communication gap between clinicians and researchers was an APTA-sponsored conference in late 2009, Vitalizing Practice Through Research and Research Through Practice. Four recommendations emerged from the conference:

- The creation of clinical guidelines;
- The development of various sources to collect and store data about various conditions relevant to physical therapy practice;
- A process of collection and storage by a group of experts in research and informatics; and

- The recognition that the consumer must be at the center of efforts to base physical therapy services on evidence.

To ensure that the profession implements these recommendations, APTA will oversee follow-up and development of strategies.

Advocacy Efforts With Funding Agencies

Generally, the initiatives that have been addressed to this point focus on conducting studies that *can* translate into practice and developing mechanisms that will help ensure that this evidence *does* incorporate into physical therapy services. One additional initiative, however, is equally, if not more, important. Recall that this chapter began with information on the relative lack of research productivity of physical therapy faculty. Thanks to an increased appreciation of the importance of research and an expansion of activities coordinated at the national level, this productivity has increased substantially. Scrutiny of the NIH Report database disclosed that during FY 2009, it is estimated that in excess of \$21 million was awarded to physical therapist scientists in the category of rehabilitation research alone.⁷ This figure does not include conditions outside of rehabilitation research; pain, for example,

for which physical therapists received funding from NIH. Nor does this figure reflect funding received from other federal agencies, such as the Agency for Health Care Research and Quality (AHRQ). Further, the funding for PTs is even more impressive given the proportion of successful applicants by discipline or profession. The percentage of PTs who successfully applied to the National Center for Medical Rehabilitation Research (NCMRR) for support during FY 2006 was higher than that of any other discipline or profession applying to NCMRR.⁸

Much of this success can be attributed to the Foundation for Physical Therapy. Historically, the Foundation has provided seed money to launch PTs' research careers, having funded more 500 individuals and awarding more than \$10 million (Karen Chesbrough, scientific program administrator, Foundation for Physical Therapy, oral communication, 2010). All



\$10 million
funded by Foundation
for Physical Therapy
*as of 2010

expectations point to the success of physical therapist research continuing into the future. NIH has developed a mechanism for providing support to an institution for the development of independent clinical scientists. Two recent K12 awards have substantially buttressed the careers of junior investigators in physical therapy. Currently, mentors and scholars from at least 10 universities housing physical therapy education programs have benefited from this award mechanism. On an even more positive note, a number of the scholars recently have received their own funding, independent of the K12 award.

The Future

It seems reasonable to surmise that the future climate for the profession will be characterized by an enhanced scientific base. In 2011 the profession debuts PTNow, an online portal with optimized search technology that will be the profession's entry point to summarized evidence-based clinical summaries and clinical applications, integrating relevant information from multiple expert sources via collaborations between APTA, its specialty sections, other rehabilitation groups, and other health care disciplines around the world.

Based on the number of extractions submitted to the Hooked on Evidence database annually, it appears likely the number of extractions will increase substantially. The Foundation for Physical Therapy continues to thrive. In fact, the Foundation is now investing in additional

mechanisms that provide more substantial funding than just the seed money that has been its hallmark. Mechanisms provided through NIH and other funding agencies, such as the K12 award, should only increase the number of physical therapist scientists who receive funding to conduct their large-scale studies.

Finally, it also appears probable that the evidence created through research will be translated into clinical practice. First, the recommendations from the Revitalizing Practice Through Research and Research Through Practice conference will be implemented, ensuring that translational research becomes apparent throughout the profession.

Second, APTA is developing a plan for creating a National Outcomes Database. Although this project will take a number of years, the preliminary work is beginning immediately. APTA staff and a consultant group of members will work with a consulting firm from Cambridge, Massachusetts, to assess the feasibility of creating a database. Tasks include focused interviews with APTA members and reporting back to staff and its member consultant group. There are also plans to interact with the APTA sections that will likely contribute to the database. The results of these efforts will be the eventual collaboration between researchers and clinicians to create, disseminate, and apply the data to help formulate policy and, most important, to enhance patient care.

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CHAPTER 8:

Payment for Physical Therapist Services

As health care professionals, physical therapists most often are paid for their services by all insurers who cover physical medicine and rehabilitation services. This list of payers includes government and private health insurers, workers' compensation carriers, and automobile liability insurers. In addition, patients may pay directly for their own services.

Payment for Physical Therapist Services by Private Health, Liability, and Workers Compensation Insurers

In private health and automobile liability insurance policies, physical therapist services typically are covered but are not mandated. Physical therapy services are covered in all state workers' compensation systems.

Physical therapists typically use codes in the Physical Medicine section (97001-97799) of the Physician's Current Procedural Terminology coding system (commonly called CPT) to report and bill the services delivered. CPT is a set of codes, descriptions, and guidelines that describe procedures and services performed by physical therapists and other health care professionals when billing services to third parties. The American Medical Association owns CPT and is responsible for organizing the development, revisions, and deletions of CPT codes. Physical therapists may report any code in the CPT manual that appropriately describes the services delivered within their state's scope of practice, as defined by the licensure law. Services delivered by physical therapist assistants are reported by the supervising physical therapist. Other health care professions also use the physical medicine section (97001-97799) to report and bill for services delivered within their scope of practice.

Current Payment Policies for Physical Therapist Services

Physical therapy services are subject to the same insurer cost-sharing strategies as those of

other health care professionals. Insurers also impose a variety of limitations and exclusions on services. Physical therapy benefits usually are limited by the number of visits per year, per episode, or per condition; or by a maximum dollar amount per year. In some cases, physical therapy benefits are included as part of a rehabilitation benefit design, in which the limit includes the aggregate of physical therapy, occupational therapy, and speech-language pathology, and possibly even chiropractic services. Insurers may exclude specific treatment techniques or conditions from coverage. Physical therapists must review each insurance plan under which services are reported in order to determine coverage.

Additional cost-containment strategies that insurers employ include utilization review and audits. Utilization review—an analysis of the necessity, appropriateness, and efficiency of services, procedures, facilities, and practitioners—is applied prospectively, concurrently, and retrospectively, depending on the insurer and the situation. Audits, a process used to determine whether existing standards of care are being met, may focus on the accuracy of the billing compared with the medical record or may focus on the medical necessity of the services delivered.

Physical therapists contract with private health care insurers to establish payment levels for the services they deliver. Automotive and workers' compensation payment levels often are established in state statute or rule, and they vary from state to state. Insurers vary with regard to the benchmarks they use to establish their fee schedules.

Payment for Physical Therapist Services Under Medicare

Medicare currently covers physical therapy services in the following provider settings: skilled nursing facilities (SNFs), home health (HHA), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), acute care hospitals, physical therapist private practice offices, physician's offices, rehabilitation agencies, and comprehensive outpatient rehabilitation facilities (CORFs). To date, Medicare's coverage and payment policies pertaining to physical therapy services have focused on the specific site of services delivered, rather than on the characteristics



and needs of the beneficiary. Thus, Medicare policies related to students, personnel qualifications, documentation, supervision, and other issues differ considerably depending on the setting in which services are provided, even though the services delivered may be very similar.

Medicare has four separate prospective payment systems (PPS) for each post-acute care (PAC) provider setting. These settings include home health, SNFs, IRFs, and acute care hospitals. The home health, SNF, and IRF payment systems rely on standardized data collected by providers using assessment tools developed for multiple purposes, including assessment, quality improvement, and payment. Outpatient therapy services in all settings are billed under the Medicare physician fee schedule.

Skilled Nursing Facilities Medicare Part A Services

Medicare beneficiaries qualify to receive covered SNF Part A services if they need short-term skilled nursing care or rehabilitations services on a daily basis in an inpatient setting. A 3-day prior hospitalization stay is required. Covered SNF services include skilled nursing care, rehabilitation services (physical therapy, occupational therapy, and speech-language pathology), and other ancillary services such as medications and respiratory therapy. Medicare pays 100% of the payment rate for the first 20 days of a SNF stay. From day 21 to day 100, the beneficiary must pay a copayment. Under the PPS system, SNFs are paid a predetermined rate for each day of care, based primarily on the patients' needs.

Home Health Medicare Part A Services

For home health services to be covered, patients must require part-time (fewer than 8 hours per day) or intermittent (temporary but not indefinite) skilled care (nursing or therapy) and must be homebound (cannot leave home without considerable effort). Medicare expenditures for home health services grew dramatically from 1990 to 1997. During this period, the percentage of Medicare beneficiaries receiving home health care nearly doubled. Concerns regarding this rapid growth prompted Congress to enact legislation that replaced the home health agencies' Medicare fee-for-service payment system with a prospective payment system (PPS). Under the prospective payment system, the home health agencies are paid a predetermined rate for each 60-day episode of home health care.

Inpatient Rehabilitation Facilities Medicare Part A Services

IRFs must meet the Medicare conditions of participation for acute care hospitals and must also: (1) have a preadmission screening process to determine if a patient would benefit from an intensive inpatient rehabilitation program; (2) use a coordinated multidisciplinary team approach, including rehabilitation nurses, physical therapists and occupational therapists and speech-language pathologists, and a full-time director of rehabilitation; and (3) have no fewer than 75% of all patients admitted each year with 1 of 13 specified conditions. Beneficiaries generally must be able to tolerate and benefit from 3 hours of therapy per day to receive treatment in an IRF setting. IRFs are paid predetermined prospective per-discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive status, and age) and market conditions in the facility's location.

Acute Care Hospitals Medicare Part A Services

Hospitals provide Medicare patients with inpatient care for the diagnosis and treatment of acute conditions and manifestations of chronic conditions. In addition, they provide ambulatory care through outpatient departments. The inpatient hospital PPS pays predetermined per-discharge rates that are based primarily on the patient's condition and related treatment strategy, and market conditions in the facility's location.

Outpatient Medicare Part B Services

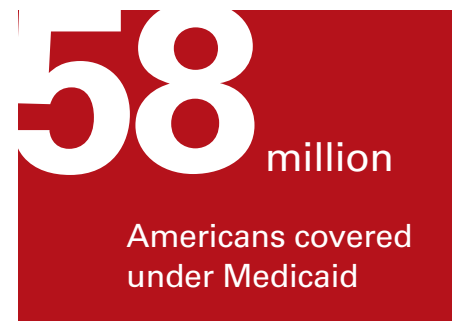
Outpatient physical therapy services are furnished in independent physical therapist private practice offices, physicians' offices, hospitals, rehabilitation agencies, skilled SNFs, and CORFs. Prior to 1999, independent private practice was the only physical therapy setting reimbursed under the physician fee schedule. All other outpatient physical therapy settings were reimbursed under a cost-based system. Starting in 1999, the Balanced Budget Act of 1997 required the Centers for Medicare and Medicaid Services (CMS) to reimburse outpatient physical therapy in all settings under the physician fee schedule. With the exception of outpatient hospitals, outpatient physical therapy services (combined with speech-language pathology) are subject to a \$1870 annual cap. This cap is increased by the Medicare Economic Index (MEI) each year. Under the physician fee schedule, the unit of payment is the individual service (for example, therapeutic exercise for 15 minutes). All services are classified and reported to CMS according to the Healthcare Common Procedure Coding System (HCPCS) based on the American Medical Association's Current Procedural Terminology.

Payment for Physical Therapist Services Under Medicaid

Rehabilitation treatment, specifically physical therapy, is also a key health service to Medicaid beneficiaries. Therapy services are provided in a variety of settings including but not limited to home care, intermediate care facilities for people with mental retardation (ICF/MR), and schools. Specifically, physical therapy services ensure the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

The Medicaid program is a national/state public health insurance program that covers more than 58 million Americans, including 8 million people with disabilities and 6 million low-income people who are frail and elderly, including Medicare beneficiaries. The federal government mandates certain services that every state Medicaid program must cover, although state Medicaid programs may elect to cover other "optional" services as well. Physical therapy is considered "optional" and is covered at varying levels in approximately

39 states. Two exceptions to physical therapy services' "optional" status are when services are found medically necessary under the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) Program within the school setting or when delivered as an inpatient hospital service under Medicaid. These exceptions ensure that physical therapy services reach the most vulnerable Medicaid populations—children and individuals with disabilities.



Payment for Physical Therapist Services Under Other Federal Programs

Physical therapist services are an integral part of the continuum of services provided to active service personnel through the Department of Defense, to veterans in the US Department of Veterans Affairs, and as related services for children with disabilities under the Individuals with Disabilities Education Act (IDEA). The recognition of physical therapist services and physical therapists under federal programs is described in detail in the Chapter on Physical Therapy in Federal Programs.

Direct Payment for Physical Therapist Services

Physical therapists also can be paid directly by the recipients of their services, when insurers don't cover certain services, when insurance benefits are exhausted, or when the physical therapist does not participate in the recipient's health plan. Other situations for which patients pay physical therapists directly include underserved populations and corporate or other organizational arrangements.

While services such as fitness, injury prevention, and sports performance enhancement are within the scope of a physical therapist's practice, most health insurance plans typically do not cover them. In such cases, individuals receiving the service usually pay the physical therapist directly.

In other situations, patients may exhaust their physical therapy insurance benefits but need

or desire continued care. Additionally, some patients with chronic and/or progressively debilitating conditions may continue to benefit from the services of a physical therapist, but their physical therapy care is not eligible for payment under the conditions on their insurance plan's coverage policy. Again, these patients often pay directly for physical therapist services.

For a variety of reasons, some patients choose to receive care from a physical therapist who does not participate in their health plan. In these situations, patients usually pay the physical therapist directly and are reimbursed (often at a lower rate) by their insurance plan, if the plan allows its beneficiaries to receive services from an out-of-network provider. Medicare beneficiaries are an exception to this practice. If the physical therapist provides a service that is covered under the Medicare program, the claim must be submitted to Medicare. This means that the physical therapist must be enrolled in Medicare if he or she will furnish services that would be covered by Medicare to Medicare beneficiaries. The physical therapist may not collect out-of-pocket payment for a Medicare-covered service other than the copayment amount; however, he or she may collect out-of-pocket payments from Medicare beneficiaries for services that Medicare will not cover, such as fitness, prevention, and maintenance care.

Physical therapists frequently provide care to underserved patients who are uninsured. Although this care is sometimes provided pro-bono or for a reduced charge, it is typical for such patients to pay directly for the care they receive.

Finally, physical therapists often provide direct patient care, education, and other consultative services as a part of an arrangement with employers, government agencies, or organizations. Although the services may be provided to individuals within these organizations, the organizations typically are responsible for paying the physical therapist under the terms of the agreement.

CHAPTER 9:

Physical Therapists in Federal Programs

Physical therapists have widespread recognition in programs authorized by the federal government. These programs provide essential health care services to veterans, Native Americans, members of the armed services, and individuals with disabilities. Physical therapists provide patient care management throughout the life span of these patients and clients and for a wide range of diagnoses, impairments, and disabilities. In addition to direct patient care, physical therapists conduct research, serve as consultants, and provide education on prevention and wellness to these programs and the populations they serve. Physical therapists are recognized, represented, and reimbursed as an important part of federal government programs.

Physical Therapists in the Department of Defense

The military physical therapy community includes active duty, reserve forces/National Guard, and civilian physical therapists. There are approximately 230 active duty physical therapists in the Army, 70 active duty physical therapists in the Navy, and 134 active duty physical therapists in the Air Force. Additional physical therapists in the Army Reserve/National Guard, Air Force Reserve and Air National Guard, and Navy Reserve can be activated to serve at home or abroad, including duty in combat zones. Approximately 30 percent of the physical therapists working in Department of Defense (DoD) facilities are civilians.

Physical therapists in the DoD practice in military treatment facilities at home and abroad, including fixed and temporary facilities in the combat environment. In addition to maintaining their clinical skills, physical therapists on active duty and in the reserves/National Guard must demonstrate leadership skills and maintain proficiency in unique military skills. Civilian physical therapists within the DoD are expected to develop and maintain the same clinical and leadership

skills as their active duty and reserves/National Guard counterparts, but they do not have to train in certain unique military skills and do not deploy to combat environments. All DoD physical therapists work with more autonomy than physical therapists in a typical civilian setting. DoD physical therapists, with the appropriate training, credentials, and privileging, are allowed to care for patients without a physician referral, and most are authorized to order diagnostic imaging and/or lab studies and prescribe medications on a limited basis.

Physical therapists can enter into active duty through several routes. Upon graduation from the US Army-Baylor Doctoral Program in Physical Therapy students serve in the Army Medical Specialist Corps, Navy Medical Service Corps, the Air Force Biomedical Sciences Corps, or the Public Health Service, usually starting at the rank of second lieutenant or ensign. Physical therapists also may join military service from the civilian sector. Physical therapists

are selected for active or reserves/ National Guard service through a competitive selection process.

Military physical therapists on active duty, reserve status, or in the National Guard are assigned a rank commensurate with their training and experience. They advance in their careers through a structured rank progression, with commensurate salary increases, based on longevity and performance. Hiring practices for civilian physical therapists (DoD and contract) working in DoD facilities are similar to those in civilian facilities. Like their active duty counterparts, civilian DoD physical therapists advance their careers through a series of pay grades or pay bands based on their training, experience, performance, and longevity. Although DoD civilian physical therapists enjoy many of the same expanded practice parameters and extensive career opportunities of their military member counterparts, recruitment and retention challenges within

230 Army
70 Navy
134 Air Force
active-duty military PTs

the DoD for civilian physical therapists reflect most of the same issues faced by the civilian sector. Similar to many civilian settings, DoD intermittently has position vacancies for civilian physical therapists that are difficult to fill, possibly due to geography, other job requirements, and/or pay considerations.

Physical Therapists in the US Army

Physical therapy in the United States began with the treatment of wounded servicemen during World War I. The Army Medical Department in the early 1920s recognized the need for formalized physical therapy education and began training at Walter Reed General Hospital. Graduates worked as civilians in military hospitals. In 1942, physical therapists were granted relative military rank, and graduates could apply for commissions upon completion of their education. Following World War II, the need for therapists declined, and the training of new therapists stopped. In 1947 physical therapists on active duty were assigned to the newly established Women's Medical Specialist Corps (WMSC). The Army training program was reestablished in 1948 and moved to its current location at Fort Sam Houston, Texas.

In 1955, men were allowed into the Corps, and the name was changed to the Army Medical Specialist Corps (AMSC). The program partnered with Baylor University in 1971 to become a master's degree training program. As a result of the shortage of orthopedic surgeons after the Vietnam War and the demonstrated performance of physical therapists, Army physical therapists took on a new role as physician extenders. As such they are credentialed to evaluate and treat patients with neuromusculoskeletal conditions without physician referral. Since then, Army physical therapists have been providing expert musculoskeletal care and rehabilitative services to all beneficiaries in multiple care settings.

Today, graduates of the Army-Baylor Program receive their doctor of physical therapy degree (DPT). The Army-Baylor program primarily educates physical therapists for the Army but has a small number of seats for Air Force, Navy, and/or Public Health Service. Students in this program are on active duty with their respective branches of military service while in the program and are obligated to 54 months for Army students and 60 months for Air Force

students following graduation in return for their education and training.

In addition to the US Army-Baylor University DPT program, the Army sponsors some postprofessional-level education at Baylor in select fields on a competitive basis. These graduates are obligated to serve additional time in return for their advanced education. Although there are currently no special incentive programs for officers recruited directly from the civilian sector, once on active duty officers can compete for advanced training opportunities.

Physical Therapists in the US Navy

Navy physical therapists are members of the US Navy Medical Service Corps, which has its roots in the Army-Navy Medical Service Corps Act of 1947, signed into law by President Harry Truman. Although Navy physical therapists were not the first members of this unique corps, they followed soon after.

Physical therapists have the opportunity to practice comprehensive orthopedics for sailors and marines in Naval hospitals and clinics in the United States and overseas, on aircraft carriers and in pediatric in-school settings overseas. The Navy recruits most of its physical therapists from the civilian sector as there is only one seat in the Army-Baylor Physical Therapy Program for a Navy physical therapist.

Physical Therapists in the US Air Force

Air Force physical therapists practice comprehensive orthopedic and sports medicine in military hospitals and clinics throughout the world. They treat patients and engage in ergonomic evaluations and preventive medicine activities involving Air Force careers on the ground and in the air alike. The majority of Air Force recruits are from the civilian sector as only two seats in the Army-Baylor Physical Therapy Program are reserved for the Air Force. There are no dedicated Reserve Officer Training Corps (ROTC) physical therapist slots, but ROTC is another accession option. As in all military services, active duty physical therapists may be competitively selected to pursue advanced degrees with tuition and fees paid in return for an active duty service obligation based on the program length.

Opportunities exist for civilians to work in government service and contract positions, and the Air Force currently is recruiting to fill

those vacancies. As of now there are no loan forgiveness opportunities for Air Force physical therapists.

The Air Force is the youngest military service, having grown from the Army Air Corps. The Air Force Medical Service was created in 1949. In the Air Force, most physical therapists work in military treatment facilities (MTFs) and care for patients with orthopedic problems. More generally, physical therapists evaluate, treat, and prevent orthopedic (eg, sprains, strains, fractures), neurologic (eg, multiple sclerosis, spinal cord injuries, cerebral palsy), and cardiovascular/ pulmonary (eg, heart disease) disorders. Air Force personnel command offer this description of the physical therapist: “Plans, develops, and manages physical therapy programs and activities. Implements research activities. Provides and conducts training in physical therapy. Evaluates patients and treats disabilities requiring physical therapy.”

Physical Therapists in the Indian Health Services

Physical therapists have been involved with the Indian Health Service (IHS) since the 1950s and are classified as “allied health providers.” Physical therapists provide a full range of culturally sensitive services within IHS, including community outreach, preventive education, and athletic programs, in addition to clinical specialties in diabetic foot care, hand therapy, health and wellness programs, electromyography (EMG) and nerve conduction velocity (NCV) testing, prosthetic/orthotic clinics, women’s health including urinary incontinence programs, developmental pediatric clinics, and geriatric programs. Rehabilitation departments in IHS also provide facility employees with wellness and fitness initiatives, spine care education, and ergonomic evaluations. IHS employs more than 100 physical therapists, with many more physical therapists providing contract or limited services.

Physical Therapists in the Department of Veterans Affairs

With more than 1,000 physical therapists on staff, the Department of Veterans Affairs (VA) is one of the largest employers of physical therapists nationwide. Physical therapists have a long history of providing care to active duty military personnel and to veterans and many

are recognized leaders in clinical research and education. Physical therapists in the VA practice across the continuum of care, from primary care and wellness programs to disease prevention and post-trauma rehabilitation. They practice in clinical care settings that include inpatient acute care, primary care, comprehensive inpatient and outpatient rehabilitation programs, spinal cord injury centers, and geriatric/extended care.

Two trends increase the need for physical therapist services in the VA. First is an increase in chronic conditions associated with an aging veteran population. For example, physical therapists are specialists in facilitating or regaining mobility and function lost due to diabetes and its complications as well as its prevention strategies.

The second trend involves the complex impairments associated with returning soldiers from Afghanistan and Iraq; physical therapists in the VA are leaders in rehabilitation research and amputee care. Enhancements in battlefield medicine have enabled a larger portion of soldiers to survive their injuries, compared with previous wars. Many recent veterans face unique injuries that require complex rehabilitation services. Physical therapists are a key part of the VA’s specialized amputee rehabilitation centers and polytrauma rehabilitation centers (PRC) caring for traumatic brain injury (TBI) patients. PRCs include expert interdisciplinary teams that provide care for complex patterns of injuries, including TBI, traumatic or partial limb amputation, nerve damage, burns, wounds, fractures, vision and hearing loss, pain, mental health, and readjustment problems.

Physical Therapists Under the Individuals With Disabilities Education Act

The Individuals With Disabilities Education Act (IDEA), Public Law (PL) 101-476, mandates that special education and related service programming be made available to all children and youth with disabilities who require them as part of a free and appropriate public education. The law provides federal funds to help state and local governments establish and maintain special education programs for students with disabilities, as well as provide the related services these students need in

order to benefit from special education. IDEA originally was enacted as the Education of All Handicapped Children Act, PL 94-142, in 1975. The federal law has been re-authorized several times and in 1990 was renamed IDEA.

Physical therapy is one of the defined related services under this law and was one of the 13 original services outlined in PL 94-142. Physical therapists provide services under IDEA at no cost to the student. The services physical therapists provide are essential to helping children and students with disabilities gain maximum benefit from their education.

Physical Therapists in the United States Public Health Service

The U.S. Public Health Service (USPHS), with its Commissioned Corps of health care professionals, has been providing essential health care services for more than 200 years and is the world's largest public health program. The Corps' response to health threats posed by

natural and manmade disasters is one of its primary roles and a value to the nation. The Commissioned Corps consists of more than 6,500 full-time, well-trained, highly qualified public health professionals dedicated to delivering the nation's public health promotion and

disease prevention programs and advancing public health science. The Commissioned Corps is on the frontlines of the nation's fight against disease and poor health conditions and comprises a highly trained, multidisciplinary, and quickly mobilized cadre of medical professionals that includes physical therapists.

As one of America's 7 uniformed services, the Commissioned Corps fills essential public health leadership and service roles within the nation's federal government agencies and programs. Physical therapists have a long history among the USPHS's essential health care professionals, managing patients in a variety of settings across the lifespan. Physical therapists help individuals recover and rehabilitate from injuries and impairments, promote healthier lifestyles via education and prevention initia-

tives, conduct biomedical and clinical research, and develop national health policies. With their colleagues in the Commissioned Corps, physical therapists also have provided critical public health services for many years to other nations' citizens in international health initiatives.

Conclusion

Physical therapy is one of the few health care professions that is integrated into a majority of the federal programs included in providing health care services to United States veterans, members of the armed services, individuals who have been harmed by natural disasters and public health threats, and Native Americans. As leaders in rehabilitation and management of health conditions from prevention to treatment, physical therapists continue to be at the forefront of the United States health care delivery system.

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CHAPTER 10:

The Physical Therapist Assistant

Physical therapist assistants, under the direction and supervision of the physical therapist, play a vital role in providing the public with access to physical therapy services. Despite limited opportunities for career development within the job classification, the demand for physical therapist assistants is expected to grow as the aging population seeks or requires physical therapy services.

APTA policy identifies the physical therapist assistant (PTA) as the *only* individual other than a physical therapist who provides physical therapy services, and physical therapist assistants must provide those services under the direction and supervision of the physical therapist. The physical therapist assistant's work includes implementing selected components of patient/client interventions; obtaining outcomes data related to the interventions provided; modifying interventions either to progress the patient/client as directed by the physical therapist or to ensure patient/client safety and comfort; educating and interacting with other health care providers, students, aides/technicians, volunteers, and patients/clients and their families and caregivers; and responding to patient/client and environmental emergency situations.¹

Just as the APTA Code of Ethics and Guide for Professional Conduct direct the physical therapist, the Standards of Ethical Conduct for the Physical Therapist Assistant (Appendix N) and the Guide for Conduct of the Physical Therapist Assistant (Appendix O) provide guidance on PTA behaviors.

The Past

The passage of the Hill Burton Act in 1946 and the amendments to the Social Security Act of 1967 solidified the role of physical therapy in inpatient and outpatient medical arenas, resulting in increased demand for physical therapy services. With too few physical therapists to ensure access to physical therapy services, APTA's House of Delegates narrowly passed

the recommendation to adopt "Training and Utilization of the Physical Therapy Assistant" in 1967. The name was later changed to physical therapist assistant to clarify that the provider was assisting the physical therapist. This policy provided for the education, supervision, function, and regulation of the physical therapist assistant. The first physical therapist assistants graduated in 1969 from Miami Dade College in Florida and the St Mary's Campus of the College of St Catherine in Minnesota. Since that time, physical therapist assistants have been providing physical therapy interventions under the direction and supervision of a licensed physical therapist.^{2,3}

The Present

Education of the Physical Therapist Assistant

Physical therapist assistant education culminates in a 2-year associate degree obtained in no more than 5 semesters.⁴ The physical therapist assistant curriculum includes general education or foundational content, physical therapy content, and clinical education experiences.¹ The average number of credits is 76, and there are an average of 16 weeks of clinical education experiences. In their 2007-2008 Fact Sheets: Physical Therapist Assistant Education Programs, the Commission on Accreditation in Physical Therapy Education (CAPTE) reported that there are currently 233 accredited and 27 developing physical therapist assistant programs. Eighty-six percent (86%) of physical therapist assistant programs are housed in community colleges or proprietary institutions. Thirty-three (33) PTA programs (14%) are in institutions that offer bachelor and/or higher degrees. Admissions to physical therapist assistant programs have been on an upward trend since 2005.⁵

According to CAPTE, the average number of program graduates per physical therapist assistant program was 17 for 2007 with 20.7% representing minority groups. The total number of graduates for 2007 was 3,843 physical therapist assistants.⁵ Highest earned degrees in any major for physical therapist assistant members in 2009 were distributed as follows: 60.2% associate degree (which is the required entry-level degree); 32.5% bachelor's degree; 6.1% master's degree; and 0.5% doctoral degree.⁶

PTAs as Part of Physical Therapist Practice

Licensure/Certification

Physical therapist assistants are licensed or certified in all jurisdictions except Colorado and Hawaii. Graduation from a CAPTE-accredited physical therapist assistant education program or its equivalency and passage of the national examination is required for licensure. The Federation of State Boards of Physical Therapy (FSBPT) reported that as of June 1, 2009, there are 62,416 licensed physical therapist assistants residing in the jurisdiction in which they are licensed.⁷ The title “PTA” is the regulatory designator physical therapist assistants (and no others) use to denote licensure or certification.

PTA Demographics

Based on 2009 data on physical therapist assistant members of APTA, 79% are female, 93.2% are white, and their ages range fairly evenly across the 25- 54-year-old age groups. 89.3% of PTA members are employed full-time, and 14.4% are employed part-time. At the time of the 2009 survey, 2.7% of physical therapist assistant members were seeking full- or part-time employment. Physical therapist assistant members reported employment in all practice settings, with the largest groups working in private outpatient office or group practice (33.1%), extended care facilities (17.9%), and health system or hospital-based outpatient facilities or clinics (17.3%). Physical therapist assistants reported working in acute care hospitals (8.6%), home care (6.6%), and sub-acute rehab inpatient hospitals (4.8%) as well.⁸ Additionally, 5% of PTAs reported employment in post-secondary academic institutions. PTAs work less frequently in school systems (1.4%), health and wellness facilities (0.4%), and industry (0.2%).⁶

Scope of Work

The scope of work for physical therapist assistants is contained in the intervention component of the patient/client management model⁸ and includes plan of care review, provision of selected procedural interventions, patient/client instruction, data collection, patient/client progression through the intervention within the plan of care, documentation, and emergency response, all as directed and supervised by the physical therapist.¹ APTA

has taken a position on the interventions that should be performed exclusively by the physical therapist, which include joint mobilization, selective sharp debridement, and any other intervention that requires immediate and continuous evaluation and/or the skill of the physical therapist.⁹ While CAPTE has created a minimum standard of education for all physical therapist assistant programs, variation in utilization of physical therapist assistants occurs as a result of interpretation and application of physical therapist assistant education and variation in state practice acts.

Supervision

Supervision requirements vary and are normally determined based on state practice acts and payer supervision requirements. APTA supports at least general supervision,¹⁰ defined as “requiring the initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.” The Centers for Medicare and Medicaid Services (CMS) has generally defined direct supervision to mean that the supervising therapist must be present in the clinic at the time the service is performed (eg, private practice, physician office). Medicare requires either general or direct supervision of physical therapist assistants depending on practice setting.¹¹

Payment for Services

Currently, physical therapy services provided by physical therapist assistants are reimbursed under the physical therapist’s identification number and generally are paid at the same rate as services provided by the physical therapist. Some insurers will not pay for services rendered by physical therapist assistants, including Tricare, which provides coverage to active and retired military staff. Tricare does not cover services rendered by physical therapist assistants in the physical therapist private practice setting. However, Tricare will reimburse for services provided by physical therapist assistants in other settings, such as skilled nursing facilities and inpatient and outpatient hospital departments.¹² Periodically, regional insurers have refused to pay for services rendered by physical therapist assistants or have established a differential payment for services provided by physical therapist assistants.

Liability

Malpractice data support that involvement of physical therapist assistants in patient care does not present an increased risk to the public.¹³ Very few ethics charges are submitted, and few of those have been brought against PTA members, although a fair number of the cases against physical therapists have involved allegations of improper delegation or supervision of work.¹⁴

Patient/Client Outcomes

A search of refereed and non-refereed literature to identify information on the role and practice of physical therapist assistants and other health care extenders such as physician assistants and nurse practitioners showed paucity, bordering on absence, of research addressing the effectiveness of the use of an extender on various patient groups or by provider type. One recent research study found that the quality of care was negatively affected when physical therapist assistants were involved in the delivery of care for patients with low back pain.¹⁵

Career and Leadership Development

Opportunities for formal career development and recognition for PTAs are limited. Physical therapist assistants seek advanced education through continuing education courses, certification courses (eg, APTA Credentialed Clinical Instructors), and other health care related-certifications (eg, certified lymphedema therapist, certified ergonomics specialist, certified strength and conditioning specialist). Since 2005, more than 300 physical therapist assistants have achieved APTA's Recognition of Advanced Proficiency for the PTA.¹⁶ Few physical therapist assistants pursue an education as a physical therapist (less than 1%), although 66% of physical therapist assistants reported that they considered pursuing a DPT.¹⁷

Physical therapist assistants hold positions of leadership within APTA (eg, PTA Caucus Delegates, Advisory Panel of PTAs), within their facilities (eg, department managers), and outside of the association and the profession. For example, 20 jurisdictions have PTA categories on their state boards of physical therapy.⁷

Workforce

The 2008 workforce survey data from APTA revealed a 12.0% vacancy rate (total number

of vacant FTE positions divided by the total number of vacant FTE positions plus the total number of filled FTE positions X 100) for physical therapist assistants in acute care, with a turnover rate (number of employees in a specific category who left in the last year divided by number of employees within each respective category) of 12.5% for full-time and 9.1% for part-time physical therapist assistants in acute care.¹⁸ The vacancy rate in long-term care facilities was the same at 12.0%, but the turnover rate was much higher at 82.4% for full-time and 62.4% for part-time physical therapist assistants.¹⁹ Vacancy rates in outpatient clinics were the lowest at 8.8%, and turnover rates were 13.5% for full-time and 11.2% for part-time physical therapist assistants.²⁰

Employment Rates for PTAs

The 2010-2011 edition of the Occupational Outlook Handbook of the U.S. Bureau of Labor Statistics reports, "Employment of physical therapist assistants is expected to grow by 33 percent from 2008 through 2018, much faster than the average for all occupations," and "Physical therapists are expected to increasingly use assistants and aides to reduce the cost of physical therapy services." The Handbook also reported, "Median annual wages of physical therapist assistants were \$46,140 in May 2008."²¹

Conclusion

Physical therapist assistants, under the direction and supervision of the physical therapist, are a vital part of the physical therapy services available to the public in all clinical settings. Opportunities for career development are limited by the level of education, nature of the work, and supervision requirements. As lower-cost employees, physical therapist assistants benefit the employer's bottom line; however, recent trends indicate that payers, as a cost-cutting measure, are increasingly reducing or eliminating payment for services rendered by a PTA. Despite of this trend, the demand for physical therapist assistants is expected to grow. A recently published article in *Time* magazine ranked physical therapist assistant the 44th most recession-proof job,²² and other similar reports reinforce this position.

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APPENDIX A

About the American Physical Therapy Association and the Federation of State Boards of Physical Therapy

The American Physical Therapy Association

The American Women's Physical Therapeutic Association (AWPTA) was founded in January 1921 in New York City. Membership qualifications included any woman who was trained as a wartime reconstruction aide or whose training was equivalent or surpassed the training of the Army reconstruction aides. Mary McMillan was elected as the first president of the AWPTA in March 1921, and the first publication, the PT Review (precursor to today's journal Physical Therapy, or PTJ) carried the news of the election that same month.¹

The AWPTA constitution and bylaws established the organization's purposes, which were "To establish and maintain a professional and scientific standard for those engaged in the profession of Physical Therapeutics; to increase efficiency among its members by encouraging them in advanced study; to disseminate information by the distribution of medical literature and articles of professional interest; to assist in securing positions for its members; to make available efficiently trained women to the medical profession; and to sustain social fellowship and intercourse upon grounds of mutual interest."¹

The AWPTA changed its name to the American Physiotherapy Association (APA) in 1922, re-elected McMillan as president, and conducted its first annual conference in September at the Boston School of Physical Education.¹ Topics of discussion at the conference included the finances of the association, whether or not qualified men could become members, whether the standards for education and training should be clarified in a constitutional amendment, how to further the status of physical therapy within the medical establishment, and how to bring more members into the association.² Since the early days of APA, chapters (one for each state) were recognized in the association structure. By the late 1920s votes at the annual meetings on policy were taken by chapters rather than polled individually.¹

As APA continued to grow in the 1920s and hired its first paid staff member in 1934 when membership stood at 710.² APA at this time focused on establishing and promoting the science of physical therapy, creating educational and research standards, recruiting individuals into the profession, cooperating with and working under the medical profession, and considering the merits of licensure and registration.³

The first APA House of Delegates met in 1944 and was designated APA's official legislative body.² APA officially changed its name to the American Physical Therapy Association (APTA) in 1946, and the Schools Section, a component of APTA dedicated to advancing the interests of members who were employed by physical therapist education programs, began.² Later, in 1954, the constitution was revised to sections, defining a section as a "group interest by at least 50 members," paving the way for the growth of sections in the decade of the 1950s.⁴

Due to the increased need for physical therapists and the discontinuation of the army-based schools after the war, APTA recognized the need to educate more physical therapists. The Schools Section made recommendations about admissions, curricula, education, and administration of physical therapy programs, and APTA embarked on an effort to encourage more universities and medical schools to create programs and expand existing programs, including creating opportunities for graduate-level education.⁴

APTA established additional sections, influenced both by laws that created new opportunities for physical therapists and the growth of the science of the profession. Sections on sports, pediatrics, cardiovascular/pulmonary, obstetrics and gynecology, clinical electrophysiology, orthopedics, and geriatrics formed to meet the needs of practitioners practicing in these areas.^{3(p22)}

Other significant events occurred within the APTA during the 1970s. The association moved its headquarters to Washington, DC, in 1970 to enhance its ability to influence federal policy making. The House of Delegates created the physical therapist assistant position and granted physical therapist assistants membership in 1973. The Foundation for Physical Therapy was created from the Physical Therapy Fund in 1979 to focus on increasing the science of physical therapy by funding research. And, responding to the growth in sections and the specialization of practice, the first Combined Sections Meeting convened in 1976 in Washington, DC.^{3(p22)} In 1978, the House of Delegates formed a

task force to develop a certified clinical specialist program to recognize individual physical therapists with advanced knowledge, skills, and abilities in a specific area of practice.⁷⁽²⁰¹⁻²⁰²⁾ In 1985, the first 3 physical therapists were certified by the American Board for Physical Therapy Specialties in Cardiopulmonary Physical Therapy.^{3(p22)}

Additional sections emerged in the 1980s, including the Veterans Affairs Section (now called the Federal Physical Therapy Section), the Section on Hand Rehabilitation, the Oncology Section, the Acute Care/Hospital Clinical Practice Section, and the Aquatic Section. Several other sections changed their names to reflect their current focus (Community Health became Community Home Health, which is now Home Health; State Licensure and Regulation became Health Policy, Legislation and Regulation, which is now Health Policy and Administration; and Obstetrics and Gynecology became the Section on Women's Health).^{1(p220-221)} The continued growth in sections reflected APTA's challenge to meet the needs of its diverse membership and the diversity of the practice of physical therapy.^{1(p220-221)}

The Federation of State Boards of Physical Therapy

The Federation of State Boards of Physical Therapy (FSBPT) was formed in 1986 to provide an organization through which member licensing authorities could work together to promote and protect the health, welfare, and safety of the American public. From 22 member states in 1987, FSBPT currently includes regulatory boards in all 50 states, the District of Columbia, Puerto Rico, and the US Virgin Islands. Membership in the federation includes jurisdiction member boards that regulate the practice of physical therapy, affiliate members, associate members, and honorary members. The Canadian Alliance of Physiotherapy Regulators and the Ordre des physiotherapeutes du Quebec are affiliate members.

At the top of the FSBPT organization are the member boards, comprising professionals, public members, and administrators. Each member board elects a delegate and alternate delegate to attend the annual Delegate Assembly, where policy is set and direction is provided to the Board of Directors and staff. The Delegate Assembly elects the Board of Directors, which represents the 53 member boards as a whole. On the Board of Directors are current and former members of member boards, administrators of member boards, and public members. The public member position is relatively new and brings a fresh perspective to the board when it considers what is best for public protection. The board provides ongoing leadership to the federation through a strategic planning and goal-setting process. The Delegate Assembly and Board of Directors also elect or appoint members to committees and task forces. These volunteers take the initiative on various issues facing member boards and provide practical recommendations to the Board of Directors. Between 2000 and 2003, FSBPT brought the National Physical Therapy Examination (NPTE) development process and the item bank itself inhouse. FSBPT developed an online system of tracking exam registrations from the time of registration until the time the candidate's score is reported to the jurisdiction. The federation developed a system for registering online for the exam and has developed an electronic process for writing test items and maintaining the item bank.

The federation's Areas of Focus, developed through membership surveys, two federation summits, and strategic planning sessions of the Board of Directors, guide the mission of the federation. The FSBPT's Areas of Focus include:

Examinations. Ensure the ongoing excellence, reliability, defensibility, security, and validity of the NPTE and related examinations.

Membership. Enhance the federation's value to its members by developing and maintaining programs and services responsive to member needs.

States' Rights, States Responsibilities, and Professional Standards. Identify and promote effective regulation in physical therapy that ensures the delivery of safe and competent physical therapy care, while respecting states' rights and responsibilities.

Education. Provide and promote educational programs and products for board members, administrators, the public, and other stakeholders.

Leadership. Broaden the federation's leadership role and recognition within the regulatory, professional, and related communities.

Organizational and Financial Stability. Ensure the long-term organizational and financial stability and viability of the federation.

APTA STRATEGIC PLAN

Adopted June 12, 2010

ASSOCIATION PURPOSE

The American Physical Therapy Association exists to improve the health and quality of life of individuals in society by advancing physical therapist practice.

ASSOCIATION ORGANIZATIONAL VALUES

Association staff and members working on behalf of the Association...

- are committed to excellence in practice, education, and research;
- respect the dignity and differences of all individuals and commit to being a culturally competent and socially responsible Association;
- act with professionalism, integrity, and honesty; and,
- make decisions that reflect visionary thinking, excellence, innovation, collaboration, and accountability.

ASSOCIATION ENVISIONED FUTURE

APTA Vision Sentence for Physical Therapy 2020 (HOD P06-00-24-35)

By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

APTA Vision Statement for Physical Therapy 2020 (HOD P06-00-24-35)

Physical therapy, by 2020, will be provided by physical therapists who are doctors of physical therapy and who may be board-certified specialists. Consumers will have direct access to physical therapists in all environments for patient/client management, prevention, and wellness services. Physical therapists will be practitioners of choice in patients'/clients' health networks and will hold all privileges of autonomous practice. Physical therapists may be assisted by physical therapist assistants who are educated and licensed to provide physical therapist directed and supervised components of interventions.

Guided by integrity, life-long learning, and a commitment to comprehensive and accessible health programs for all people, physical therapists and physical therapist assistants will render evidence-based services throughout the continuum of care and improve quality of life for society. They will provide culturally sensitive care distinguished by trust, respect, and an appreciation for individual differences.

While fully availing themselves of new technologies, as well as basic and clinical research, physical therapists will continue to provide direct patient/client care. They will maintain active responsibility for the growth of the physical therapy profession and the health of the people it serves.



American Physical Therapy Association ..
www.apta.org/strategicplan

2010–2011 STRATEGIC OUTCOMES AND OBJECTIVES

ACCESS TO PHYSICAL THERAPIST SERVICES

Strategic Outcome: Policy barriers to patient/client access to physical therapist services will be reduced and where possible eliminated.

Objectives:

- a. Increase to 50 the number of states that have, at a minimum, evaluation without referral.
- b. Enact legislation to reduce legal restrictions in 2 of the 29 states that have restrictions on direct access.
- c. Expand available data regarding the impact of referral-for-profit arrangements and direct access in order to support advocacy efforts.
- d. Achieve direct access to physical therapy services for Medicare beneficiaries.
- e. Eliminate referral for profit in order to protect patients from conflict of interests.

EDUCATION

Strategic Outcome: PT and PTA educational opportunities of sufficient quality and number will be available to meet the needs of students, clinicians and society.

Objectives:

- a. Assess current and projected needs in physical therapy academic and clinical education.
- b. Promulgate examples of quality clinical education programs.
- c. Increase the number of APTA-credentialed clinical instructors.
- d. Increase the number of graduates from credentialed postprofessional clinical residency and fellowship programs.
- e. Increase quality continuing education programs that facilitate/advance best practice.
- f. Increase educational resources that support the roles of PTA educators.

PAYMENT FOR SERVICES

Strategic Outcome: Payment policies will reflect the clinical and practice management expertise and resources required to deliver quality physical therapist services to patients and clients.

Objectives:

- a. Improve physical therapists' knowledge to assure compliance with existing payment policy.
- b. Establish appropriate quality measures in all settings in which physical therapists practice and incorporate into payment systems as appropriate.
- c. Improve coverage and payment for physical therapist services by influencing the development and modification of medical policies in federal and private payment systems.
- d. Establish and implement a plan to influence employers' selection and design of health insurance benefits that would promote adequate coverage and access to physical therapist services.
- e. Achieve appropriate payment of physical therapist services under all emerging alternative payment systems.
- f. Promote opportunities for first party (self) payment for physical therapist services.



2010–2011 STRATEGIC OUTCOMES AND OBJECTIVES

PUBLIC AWARENESS/RECOGNITION

Strategic Outcome: Consumer and professional groups will recognize physical therapists' unique contributions and collaborative efforts as self-directed practitioners within patient/client healthcare/provider teams.

Objectives:

- a. Increase utilization of resources that describe the value of physical therapist scope of practice across the continuum of care.
- b. Increase collaboration with other professions and organizations.
- c. Increase media exposure.

RESEARCH

Strategic Outcome: Facilitate creation of and access to new knowledge that informs clinical decision making about the organization and delivery of physical therapist services at the point of care.

Objectives:

- a. Enhance APTA's ability to identify and create the necessary infrastructure to support clinically-oriented data collection and analysis that will lead to the enhancement of the provision of physical therapy services.
- b. Enhance APTA's role in the identification of physical therapy research priorities by researchers and funders.
- c. Increase the productivity of physical therapist researchers.
- d. Increase advocacy for funding from both public and private sources to support physical therapists involved in all aspects of rehabilitation research.
- e. Facilitate creation of and ease of access to, knowledge and resources that facilitate clinical decision making.
- f. Expand APTA's repository of data sets to include information describing the delivery of physical therapy services to be shared with stakeholders both within and outside the profession and used to contribute to the formulation of health care policy to advance the profession.

STANDARDS FOR PRACTICE

Strategic Outcome: Evidence-based practice principles will be routinely identified, applied, and integrated in physical therapist practice.

Objectives:

- a. Increase physical therapists' use of evidence-based practice principles in clinical decision-making.
- b. Describe and promote the appropriate use of applicable evidence-based principles in clinical problem-solving by the physical therapist assistant.



APPENDIX C

Physical Therapy Practice Exemplars

Physical therapists provide patient/client-centered services that include patient care, consultation, prevention, and/or promotion of health, wellness, and fitness throughout the continuum of health and life span. Individuals who have a health condition (disease, disorder, injury, or trauma), body function impairment, body structure impairment, activity limitation, participation restriction, or environmental barrier may benefit from the services of a physical therapist. The common denominator in nearly all cases is an impact on the individuals' quality of life as related to human performance and participation in the activities that are of value to them and to their family or caregivers where they live, work, and play.

In all cases, physical therapists employ a patient/client management model that includes the components of examination, evaluation, diagnosis, prognosis, and intervention. The physical therapist develops a plan of care for each patient/client and modifies it as needed based upon the information gathered during this process. The physical therapist measures outcomes to determine progress toward patient/client goals.

1. Patients With Mechanical Low Back Pain

Physical therapists provide care to individuals with mechanical low back pain to help alleviate symptoms, speed return to work and/or physical activity, prevent recurrence, and avoid unnecessary surgery and long-term use of prescription medications. An important component of the physical therapist's examination and evaluation is a screening of each patient's signs and symptoms to determine if physical therapy is indicated and to assess the need for medical referral or consultation by another health professional. The treatment plan is developed to meet the needs of each patient and may include therapeutic exercise to improve strength and/or range of motion, manual therapy (including spinal manipulation) to improve mobility and relieve pain, and education to encourage return to activity/work and to help prevent recurrence.

Not all types of treatment are effective for all patients with low back pain. Physical therapists use current research findings to determine the most effective treatment plan for each patient and make modifications as needed throughout the episode of care.¹⁻³

2. Patients With Congenital Disorders, Chronic Diseases, and Injury

Physical therapists provide care to individuals with congenital disorder(s), chronic diseases such as diabetes, and long-term injuries such as stroke and spinal cord injury so that these individuals can safely increase or maintain their independence and activity level and reduce the risk for further disease or injury. For example, physical therapists provide therapeutic exercise and functional activity training for post-surgical patients in hospitals, in post-acute settings such as outpatient clinics, and/or in patients' homes. In the acute care setting, the physical therapist evaluates the patient and when indicated develops a plan of care with interventions and education that focus on improving the patient's impairments and activity limitations. Interventions may include proper positioning and education, to prevent secondary impairments such as pressure ulcers; bed mobility; transfer training; functional mobility training; gait training; and evaluation and training in the use of assistive technology. The physical therapist works with other members of the hospital health care team to plan the patient's discharge, including determination of the most appropriate setting after discharge. Such decisions take into account the patient's medical status, functional status, and other factors such as home environment and family support.

A coordinated effort among health care team members is vital throughout the continuum of a patient's care across settings. Physical therapy is essential for many patients following a hospital stay, especially for those with mobility restrictions who are at high risk for hospital readmission. Physical therapy in the acute and post-acute settings is necessary to ensure that patients are safe in their environments and able to perform essential activities of daily living.

Physical therapists also provide assessment and consultation to individuals who are post-acute care. For example, physical therapists consult directly with patients, clients, and/or various agencies to enable individuals to achieve optimal function, improve safety, and increase participation in their residences and/or communities and help them to remain as independent as possible.⁴⁻⁹

3. Residents in Long-Term Care Facilities

Physical therapists provide care to residents in long-term care facilities. Care is directed toward preventing further decline in mobility and reducing the side effects of immobility. In this setting, physical therapists often work with family members to help prepare for a transition to home when the patient's status improves. Physical therapists help prevent injury to both health care providers and family members by teaching safe patient handling methods.

As in all practice settings, the physical therapist may choose to use a physical therapist assistant (PTA) to provide certain patient interventions and related data collection and documentation. Also, a physical therapy aide may provide nonpatient care support for the physical therapist by preparing the environment for treatment, transporting the patient to the clinic, etc. Regardless of the use of supportive personnel, the physical therapist is solely responsible for completion of the evaluation, diagnosis, and prognosis as well as the development and modification of the plan of care. Once the plan of care has been established, the physical therapist considers the following before directing interventions to the PTA:

- Are the interventions within the scope of work of the PTA?
- Is the patient's condition sufficiently stable?
- Are the intervention outcomes sufficiently predictable?
- Is the intervention within the personal knowledge, skills, and abilities of the PTA?
- Are there risks and liabilities that should be considered prior to directing interventions to the PTA?
- Would any payer requirements be affected by the involvement of the PTA in providing interventions?

When the intervention is directed to the PTA, the physical therapist continues to (1) maintain responsibility for patient management; (2) provide direction and supervision to the PTA in accordance with applicable laws and regulations; (3) conduct periodic reassessment/reevaluation of the patient as directed by the needs of the patient and by the requirements of the facility, federal and state regulations, and payers; and (4) provide support to the PTA, and, when appropriate, assist in developing the PTA's knowledge and skills necessary to perform selected interventions and related data collection.^{10,11}

4. Children With Lifelong Disabilities

Physical therapists provide care for children and students with lifelong disabilities by promoting optimal function and active participation in home, school, and community environments. In the school setting, physical therapist intervention is provided in compliance with the Individuals with Disabilities Education Act, (IDEA), a federal law with state education agency oversight that supports the provision of public education for all children, regardless of the nature or severity of the disability. Typically, the physical therapist works collaboratively with a student's Individualized Education Program (IEP) team to design and implement physical therapy interventions, including teaching and training of family and education personnel to achieve the goals of the IEP. The focus of the physical therapist intervention is on helping the student access school environments and benefit from their educational programs. Physical therapists also can provide consultation for schools to ensure that programs and activities are inclusive for all children, regardless of their ability.

5. Individuals With Limited Physical Activity

Physical therapists promote the health and well being of individuals and of the public at large by encouraging healthy levels of physical activity for all individuals. Physical therapists are especially skilled in working with those whose physical conditions affect or limit their ability to engage in many types of physical activity. Individuals who are overweight or obese often experience symptoms such as joint pain or fatigue when they begin an exercise program or increase their activity level. Physical therapists can suggest modifications in factors such as posture, alignment, and shoe choice; can help individuals select an appropriate physical activity; and can suggest a schedule to promote fitness, prevent injury, and encourage compliance.

Individuals with lifelong disabilities such as spinal cord injury and stroke are often at increased risk for disease because of their lack of physical activity. Physical therapists help these individuals choose appropriate types of activities and are able to adapt the activity or the equipment based upon the needs of the individual.

Children with disabilities are typically less active than their non-disabled peers and participate in fewer organized sports and physical activities. Physical therapists work with these children, their family members, and educators to recommend and adapt activities that promote movement and are enjoyable for the children.^{12,13}

6. Workers and Industry

Physical therapists provide care for workers to prevent and treat work-related injuries. Physical therapists combine skills in patient evaluation with knowledge of the critical work demands obtained through job-site analysis, video analysis, written physical job demands analysis, or communication with the employer. The goals of effective physical therapist care of injured workers are to optimize work performance and minimize the development of work-related occupational disability. The physical therapist is uniquely qualified to assess the worker's safe physical work capacities, recommend successful accommodations to normal duty, and suggest alternative or transitional duty options when indicated.

In addition to individualized care, physical therapists may provide services directly to industries that include global injury prevention and ergonomics programs to optimize the health and productivity of workers. The physical therapist develops well-designed and appropriately implemented injury/illness prevention and ergonomics programs to decrease injuries and related costs and to balance the needs of individual employees with those of the employer. The physical therapist's expertise in injury/illness prevention at the work site comes from pairing his or her knowledge of anatomy, kinesiology, and pathology with human performance and the science of ergonomics. With expertise in identification of work-related risks to the neuromusculoskeletal system, the physical therapist can design, implement, and monitor solutions for an individual, group, or larger community of workers.^{14,15}

7. Patients With Integumentary (Skin and Wound) Conditions

Physical therapists provide care for individuals with integumentary conditions such as pressure ulcers and burns to promote optimal healing and to help patients with these conditions safely maintain or increase activity and reduce their risk for further complications. Physical therapists perform selective and nonselective debridement, use electrotherapeutic and mechanical modalities, and/or apply dressings and topical agents/medications. These services may occur in the acute, post-acute, home health, or outpatient settings; for example, a physical therapist identifies the stage of pressure ulcers in an individual with spinal cord injury, provides interventions for integumentary repair and protection, and educates the patient/caregiver on the cause and prevention of pressure ulcers and the risks associated with certain conditions such as spinal cord injury and diabetes.^{16,17}

8. Athletes

Physical therapists help athletes of all abilities improve performance and prevent injury through specialized programs. Using the latest evidence, the physical therapist helps the athlete improve technique, fitness, and sport-specific skills such as jumping, landing, and throwing. The physical therapist bases each program on a detailed evaluation that includes testing of structure, alignment, strength, flexibility, coordination, and cardiovascular and pulmonary performance. The physical therapist also performs a sport-specific performance evaluation and considers each individual's goals in developing and implementing a program. Physical therapists frequently make use of technology such as computerized motion analysis and gait assessment to analyze problems, measure performance, and enhance potential.

Additionally, the physical therapist is able to address injuries, should they arise, and either treat the athlete or refer him or her to an appropriate health care provider for further care and consultation as needed. Physical therapists help individuals safely return to sports and are involved in decisions regarding readiness for competition. They communicate regularly with coaches, trainers, and other health care professionals regarding the needs of each individual athlete.^{11,18}

9. Patients With Pelvic Floor Disorders

Physical therapists provide care for individuals with pelvic floor disorders. These include but are not limited to bladder disorders, such as incontinence or retention; bowel disorders, such as incontinence or constipation; pelvic pain, and sexual dysfunction, such as dyspareunia. The physical therapist who cares for individuals with pelvic floor dysfunction is a highly skilled professional who performs vaginal and/or rectal examinations to assess neuromuscular function and other selected tests and measurements of structure, alignment, strength, and flexibility. Treatment may include therapeutic exercises, manual therapy techniques, biofeedback training, and behavioral modification. Research on the conservative management of pelvic dysfunction supports physical therapist practice for these conditions, even over medical and surgical options for some patients, and has determined that physical therapist interventions are effective in reducing symptoms and improving quality of life for many individuals with pelvic floor disorders.^{19,20,21}

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APPENDIX D

International Classification of Functioning, Disability and Health (ICF)

In 2002, the World Health Organization (WHO) endorsed the International Classification of Functioning, Disability and Health (ICF) to provide a standardized language and framework for the description of health and functioning.¹ With the ICF's focus on function and the components of health rather than on the consequences of disease—the American Physical Therapy Association (APTA) in 2008 embraced the ICF as the conceptual framework for physical therapist practice.

The ICF provides a unified, standard language and framework that facilitates the description of the components of functioning that are associated with a health condition. It enables the collection of data about how people with a health condition function in their daily lives rather than focusing exclusively on their diagnosis. The ICF describes the situation of the individual within health and health-related domains and within the context of environmental and personal factors.¹

The ICF is divided into 2 parts, and each part is composed of 2 components:

Part 1: Functioning and Disability

- **Body Functions and Structures**
 - *Body functions* refer to the physiological and psychological mechanisms of the human organism.
 - *Body structures* refer to the anatomical parts of a human.
- **Activities and Participation**
 - *Activities* are the execution of tasks or actions carried out by an individual.
 - *Participation* is involvement of an individual in a life situation.

Part 2: Contextual Factors

- **Environmental Factors**
 - *Environmental factors* are the physical, social, and attitudinal factors external to the individual and have an impact on the individual's functioning.
- **Personal Factors**
 - *Personal factors* encompass individual characteristics and life circumstances that are not part of the health condition or health state such as age, ethnicity, and social background.

In this framework, disability and functioning exist along a continuum of health as interactive constructs that encompass the health condition and contextual factors.

Key concepts that serve as the foundation of physical therapist practice in the ICF framework include:

- A person's health status, described as the dynamic interaction between the health condition, functioning (encompassing all body functions, structures, activities, and participation), disability (including impairments, activity limitations, or participation restrictions), and contextual factors (environmental and personal) typifies physical therapist practice and provides the model for understanding and organizing practice.
- Within the ICF framework, function and/or disability result from a dynamic interaction between an individual's health-related state and contextual factors. All people who receive physical therapy, whether they have a health condition or not, receive interventions that can serve as preventive, curative, and/or function enhancing. It is in this regard that physical therapist practice addresses the needs of individuals through a continuum of health across a variety of delivery settings.

Reference

1. World Health Organization. International Classification of Functioning, Disability and Health. Geneva: WHO; 2001.

APPENDIX E

Guidelines: Physical Therapist Scope of Practice

APTA Board of Directors Guideline G03-01-09-29

Physical therapy, which is limited to the care and services provided by or under the direction and supervision of a physical therapist, includes:

1. examining (history, system review and tests and measures) individuals with impairment, functional limitation, and disability or other health-related conditions in order to determine a diagnosis, prognosis, and intervention; tests and measures may include the following:
 - aerobic capacity/endurance
 - anthropometric characteristics
 - arousal, attention, and cognition
 - assistive and adaptive devices
 - circulation (arterial, venous, lymphatic)
 - cranial and peripheral nerve integrity
 - environmental, home, and work (job/school/play) barriers
 - ergonomics and body mechanics
 - gait, locomotion, and balance
 - integumentary integrity
 - joint integrity and mobility
 - motor function (motor control and motor learning)
 - muscle performance (including strength, power, and endurance)
 - neuromotor development and sensory integration
 - orthotic, protective, and supportive devices
 - pain
 - posture
 - prosthetic requirements
 - range of motion (including muscle length)
 - reflex integrity
 - self-care and home management (including activities of daily living and instrumental activities of daily living)
 - sensory integrity
 - ventilation, and respiration/gas exchange
 - work (job/school/play), community, leisure integration or reintegration (including instrumental activities of daily living)
2. alleviating impairment and functional limitation by designing, implementing, and modifying therapeutic interventions that include, but are not limited to:
 - coordination, communication and documentation
 - patient/client-related instruction
 - therapeutic exercise
 - functional training in self-care and home management (including activities of daily living and instrumental activities of daily living)
 - functional training in work (job/school/play) and community and leisure integration or reintegration activities (including instrumental activities of daily living, work hardening, and work conditioning)
 - manual therapy techniques (including mobilization/manipulation)
 - prescription, application, and, as appropriate, fabrication of devices and equipment (assistive, adaptive, orthotic, protective, supportive, and prosthetic)
 - airway clearance techniques
 - integumentary repair and protection techniques
 - electrotherapeutic modalities
 - physical agents and mechanical modalities
3. preventing injury, impairment, functional limitation, and disability, including the promotion and maintenance of health, wellness, fitness, and quality of life in all age populations
4. engaging in consultation, education, and research

APPENDIX F

Standards of Practice for Physical Therapy

APTA House of Delegates Standard S06-03-09-10

Preamble

The physical therapy profession's commitment to society is to promote optimal health and functioning in individuals by pursuing excellence in practice. The American Physical Therapy Association attests to this commitment by adopting and promoting the following Standards of Practice for Physical Therapy. These Standards are the profession's statement of conditions and performances that are essential for provision of high quality professional service to society, and provide a foundation for assessment of physical therapist practice.

I. Ethical/Legal Considerations

A. Ethical Considerations

The physical therapist practices according to the *Code of Ethics* of the American Physical Therapy Association.

The physical therapist assistant complies with the *Standards of Ethical Conduct for the Physical Therapist Assistant* of the American Physical Therapy Association.

B. Legal Considerations

The physical therapist complies with all the legal requirements of jurisdictions regulating the practice of physical therapy.

The physical therapist assistant complies with all the legal requirements of jurisdictions regulating the work of the assistant.

II. Administration of the Physical Therapy Service

A. Statement of Mission, Purposes, and Goals

The physical therapy service has a statement of mission, purposes, and goals that reflects the needs and interests of the patients/clients served, the physical therapy personnel affiliated with the service, and the community.

B. Organizational Plan

The physical therapy service has a written organizational plan.

C. Policies and Procedures

The physical therapy service has written policies and procedures that reflect the operation, mission, purposes, and goals of the service, and are consistent with the association's standards, policies, positions, guidelines, and *Code of Ethics*.

D. Administration

A physical therapist is responsible for the direction of the physical therapy service.

E. Fiscal Management

The director of the physical therapy service, in consultation with physical therapy staff and appropriate administrative personnel, participates in the planning for and allocation of resources. Fiscal planning and management of the service is based on sound accounting principles.

F. Improvement of Quality of Care and Performance

The physical therapy service has a written plan for continuous improvement of quality of care and performance of services.

G. Staffing

The physical therapy personnel affiliated with the physical therapy service have demonstrated competence and are sufficient to achieve the mission, purposes, and goals of the service.

H. Staff Development

The physical therapy service has a written plan that provides for appropriate and ongoing staff development.

I. Physical Setting

The physical setting is designed to provide a safe and accessible environment that facilitates fulfillment of the mission, purposes, and goals of the physical therapy service.

The equipment is safe and sufficient to achieve the purposes and goals of physical therapy.

J. Collaboration

The physical therapy service collaborates with all disciplines as appropriate.

III. Patient/Client Management

A. Patient/Client Collaboration

Within the patient/client management process, the physical therapist and the patient/client establish and maintain an ongoing collaborative process of decision making that exists throughout the provision of services.

B. Initial Examination/Evaluation/Diagnosis/Prognosis

The physical therapist performs an initial examination and evaluation to establish a diagnosis and prognosis prior to intervention.

C. Plan of Care

The physical therapist establishes a plan of care and manages the needs of the patient/client based on the examination, evaluation, diagnosis, prognosis, goals, and outcomes of the planned interventions for identified impairments, functional limitations, and disabilities.

The physical therapist involves the patient/client and appropriate others in the planning, implementation, and assessment of the plan of care.

The physical therapist, in consultation with appropriate disciplines, plans for discharge of the patient/client taking into consideration achievement of anticipated goals and expected outcomes, and provides for appropriate follow-up or referral.

D. Intervention

The physical therapist provides or directs and supervises the physical therapy intervention consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care.

E. Reexamination

The physical therapist reexamines the patient/client as necessary during an episode of care to evaluate progress or change in patient/client status and modifies the plan of care accordingly or discontinues physical therapy services.

F. Discharge/Discontinuation of Intervention

The physical therapist discharges the patient/client from physical therapy services when the anticipated goals or expected outcomes for the patient/client have been achieved.

The physical therapist discontinues intervention when the patient/client is unable to continue to progress toward goals or when the physical therapist determines that the patient/client will no longer benefit from physical therapy.

G. Communication/Coordination/Documentation

The physical therapist communicates, coordinates, and documents all aspects of patient/client management including the results of the initial examination and evaluation, diagnosis, prognosis, plan of care, interventions, response to interventions, changes in patient/client status relative to the interventions, reexamination, and discharge/discontinuation of intervention and other patient/client management activities.

IV. Education

The physical therapist is responsible for individual professional development. The physical therapist assistant is responsible for individual career development.

The physical therapist and the physical therapist assistant, under the direction and supervision of the physical therapist, participate in the education of students.

The physical therapist educates and provides consultation to consumers and the general public regarding the purposes and benefits of physical therapy.

The physical therapist educates and provides consultation to consumers and the general public regarding the roles of the physical therapist and the physical therapist assistant.

V. Research

The physical therapist applies research findings to practice and encourages, participates in, and promotes activities that establish the outcomes of patient/client management provided by the physical therapist.

VI. Community Responsibility

The physical therapist demonstrates community responsibility by participating in community and community agency activities, educating the public, formulating public policy, or providing pro bono physical therapy services.

APPENDIX G

Criteria for Standards of Practice for Physical Therapy

APTA Board of Directors Standard BOD S03-06-16-38

The Standards of Practice for Physical Therapy are promulgated by APTA's House of Delegates; Criteria for the standards are promulgated by APTA's Board of Directors. Criteria are italicized beneath the standards to which they apply.

Preamble

The physical therapy profession's commitment to society is to promote optimal health and function in individuals by pursuing excellence in practice. The American Physical Therapy Association attests to this commitment by adopting and promoting the following Standards of Practice for Physical Therapy. These Standards are the profession's statement of conditions and performances that are essential for provision of high quality professional service to society, and provide a foundation for assessment of physical therapist practice.

I. Ethical/Legal Considerations

A. Ethical Considerations

The physical therapist practices according to the Code of Ethics of the American Physical Therapy Association.

The physical therapist assistant complies with the *Standards of Ethical Conduct for the Physical Therapist Assistant* of the American Physical Therapy Association.

B. Legal Considerations

The physical therapist complies with all the legal requirements of jurisdictions regulating the practice of physical therapy.

The physical therapist assistant complies with all the legal requirements of jurisdictions regulating the work of the assistant.

II. Administration of the Physical Therapy Service

A. Statement of Mission, Purposes, and Goals

The physical therapy service has a statement of mission, purposes, and goals that reflects the needs and interests of the patients/clients served, the physical therapy personnel affiliated with the service, and the community.

The statement of mission, purposes, and goals:

- *Defines the scope and limitations of the physical therapy service.*
- *Identifies the goals and objectives of the service.*
- *Is reviewed annually.*

B. Organizational Plan

The physical therapy service has a written organizational plan.

The organizational plan:

- *Describes relationships among components within the physical therapy service and, where the service is part of a larger organization, between the service and the other components of that organization.*
- *Ensures that the service is directed by a physical therapist.*
- *Defines supervisory structures within the service.*
- *Reflects current personnel functions.*

C. Policies and Procedures

The physical therapy service has written policies and procedures that reflect the operation, mission, purposes, and goals of the service, and are consistent with the Association's positions, standards, guidelines,

policies, procedures, and Code of Ethics.

The written policies and procedures:

- *Are reviewed regularly and revised as necessary.*
- *Meet the requirements of federal and state law and external agencies.*
- *Apply to, but are not limited to:*
 - *Care of patients/clients, including guidelines*
 - *Clinical education*
 - *Clinical research*
 - *Collaboration*
 - *Collection of patient data*
 - *Competency assessment*
 - *Criteria for access to care*
 - *Criteria for initiation and continuation of care*
 - *Criteria for referral to other appropriate health care providers*
 - *Criteria for termination of care*
 - *Documentation*
 - *Environmental safety*
 - *Equipment maintenance*
 - *Fiscal management*
 - *Improvement of quality of care and performance of services*
 - *Infection control*
 - *Job/position descriptions*
 - *Medical emergencies*
 - *Personnel-related policies*
 - *Rights of patients/clients*
 - *Staff orientation*

D. Administration

A physical therapist is responsible for the direction of the physical therapy service.

The physical therapist responsible for the direction of the physical therapy service:

- *Ensures compliance with local, state, and federal requirements.*
- *Ensures compliance with current APTA documents, including Standards of Practice for Physical Therapy and the Criteria, Guide to Physical Therapist Practice, Code of Ethics, Guide for Professional Conduct, Standards of Ethical Conduct for the Physical Therapist Assistant, and Guide for Conduct of the Physical Therapist Assistant.*
- *Ensures that services are consistent with the mission, purposes, and goals of the physical therapy service.*
- *Ensures that services are provided in accordance with established policies and procedures.*
- *Ensures that the process for assignment and reassignment of physical therapist staff supports individual physical therapist responsibility to their patients and meets the needs of the patients/clients.*
- *Reviews and updates policies and procedures.*
- *Provides for training of physical therapy support personnel that ensures continued competence for their job description.*
- *Provides for continuous in-service training on safety issues and for periodic safety inspection of equipment by qualified individuals.*

E. Fiscal Management

The director of the physical therapy service, in consultation with physical therapy staff and appropriate administrative personnel participates in planning for, and allocation of, resources. Fiscal planning and management of the service is based on sound accounting principles.

The fiscal management plan:

- *Includes a budget that provides for optimal use of resources.*
- *Ensures accurate recording and reporting of financial information.*
- *Ensures compliance with legal requirements.*
- *Allows for cost-effective utilization of resources.*
- *Uses a fee schedule that is consistent with the cost of physical therapy services and that is within customary norms of fairness and reasonableness.*
- *Considers option of providing pro bono services.*

F. Improvement of Quality of Care and Performance

The physical therapy service has a written plan for continuous improvement of quality of care and performance of services.

The improvement plan:

- *Provides evidence of ongoing review and evaluation of the physical therapy service.*
- *Provides a mechanism for documenting improvement in quality of care and performance.*
- *Is consistent with requirements of external agencies, as applicable.*

G. Staffing

The physical therapy personnel affiliated with the physical therapy service have demonstrated competence and are sufficient to achieve the mission, purposes, and goals of the service.

The physical therapy service:

- *Meets all legal requirements regarding licensure and certification of appropriate personnel.*
- *Ensures that the level of expertise within the service is appropriate to the needs of the patients/clients served.*
- *Provides appropriate professional and support personnel to meet the needs of the patient/client population.*

H. Staff Development

The physical therapy service has a written plan that provides for appropriate and ongoing staff development.

The staff development plan:

- *Includes self-assessment, individual goal setting, and organizational needs in directing continuing education and learning activities.*
- *Includes strategies for lifelong learning and professional and career development.*
- *Includes mechanisms to foster mentorship activities.*
- *Includes knowledge of clinical research methods and analysis.*

I. Physical Setting

The physical setting is designed to provide a safe and accessible environment that facilitates fulfillment of the mission, purposes, and goals of the physical therapy service. The equipment is safe and sufficient to achieve the purposes and goals of physical therapy.

The physical setting:

- *Meets all applicable legal requirements for health and safety.*
- *Meets space needs appropriate for the number and type of patients/clients served.*

The equipment:

- *Meets all applicable legal requirements for health and safety.*
- *Is inspected routinely.*

J. Collaboration

The physical therapy service collaborates with all disciplines as appropriate.

The collaboration when appropriate:

- *Uses a team approach to the care of patients/clients.*
- *Provides instruction of patients/clients and families.*
- *Ensures professional development and continuing education.*

III. Patient/Client Management

A. Patient/Client Collaboration

Within the patient/client management process, the physical therapist and the patient/client establish and maintain an ongoing collaborative process of decision-making that exists throughout the provision of services.

B. Initial Examination/Evaluation/Diagnosis/Prognosis

The physical therapist performs an initial examination and evaluation to establish a diagnosis and prognosis prior to intervention.

The physical therapist examination:

- *Is documented, dated, and appropriately authenticated by the physical therapist who performed it.*
- *Identifies the physical therapy needs of the patient/client.*
- *Incorporates appropriate tests and measures to facilitate outcome measurement.*

- *Produces data that are sufficient to allow evaluation, diagnosis, prognosis, and the establishment of a plan of care.*
- *May result in recommendations for additional services to meet the needs of the patient/client.*

C. Plan of Care

The physical therapist establishes a plan of care and manages the needs of the patient/client based on the examination, evaluation, diagnosis, prognosis, goals, and outcomes of the planned interventions for identified impairments, functional limitations, and disabilities.

The physical therapist involves the patient/client and appropriate others in the planning, implementation, and assessment of the plan of care.

The physical therapist, in consultation with appropriate disciplines, plans for discharge of the patient/client taking into consideration achievement of anticipated goals and expected outcomes, and provides for appropriate follow-up or referral.

The plan of care:

- *Is based on the examination, evaluation, diagnosis, and prognosis.*
- *Identifies goals and outcomes.*
- *Describes the proposed intervention, including frequency and duration.*
- *Includes documentation that is dated and appropriately authenticated by the physical therapist who established the plan of care.*

D. Intervention

The physical therapist provides, or directs and supervises, the physical therapy intervention consistent with the results of the examination, evaluation, diagnosis, prognosis, and plan of care.

The intervention:

- *Is based on the examination, evaluation, diagnosis, prognosis, and plan of care.*
- *Is provided under the ongoing direction and supervision of the physical therapist.*
- *Is provided in such a way that directed and supervised responsibilities are commensurate with the qualifications and the legal limitations of the physical therapist assistant.*
- *Is altered in accordance with changes in response or status.*
- *Is provided at a level that is consistent with current physical therapy practice.*
- *Is interdisciplinary when necessary to meet the needs of the patient/client.*
- *Documentation of the intervention is consistent with the Guidelines: Physical Therapy Documentation of Patient/Client Management.*
- *Is dated and appropriately authenticated by the physical therapist or, when permissible by law, by the physical therapist assistant.*

E. Reexamination

The physical therapist reexamines the patient/client as necessary during an episode of care to evaluate progress or change in patient/client status and modifies the plan of care accordingly or discontinues physical therapy services.

The physical therapist reexamination:

- *Is documented, dated, and appropriately authenticated by the physical therapist who performs it.*
- *Includes modifications to the plan of care.*

F. Discharge/Discontinuation of Intervention

The physical therapist discharges the patient/client from physical therapy services when the anticipated goals or expected outcomes for the patient/client have been achieved.

The physical therapist discontinues intervention when the patient/client is unable to continue to progress toward goals or when the physical therapist determines that the patient/client will no longer benefit from physical therapy.

Discharge documentation:

- *Includes the status of the patient/client at discharge and the goals and outcomes attained.*
- *Is dated and appropriately authenticated by the physical therapist who performed the discharge.*
- *Includes, when a patient/client is discharged prior to attainment of goals and outcomes, the status of the patient/client and the rationale for discontinuation.*

G. Communication/Coordination/Documentation

The physical therapist communicates, coordinates and documents all aspects of patient/client management including the results of the initial examination and evaluation, diagnosis, prognosis, plan of care, interventions, response to interventions, changes in patient/client status relative to the interventions, reexamination, and discharge/discontinuation of intervention and other patient/client management activities.

Physical therapist documentation:

- *Is dated and appropriately authenticated by the physical therapist who performed the examination and established the plan of care.*
- *Is dated and appropriately authenticated by the physical therapist who performed the intervention or, when allowable by law or regulations, by the physical therapist assistant who performed specific components of the intervention as selected by the supervising physical therapist.*
- *Is dated and appropriately authenticated by the physical therapist who performed the reexamination, and includes modifications to the plan of care.*
- *Is dated and appropriately authenticated by the physical therapist who performed the discharge, and includes the status of the patient/client and the goals and outcomes achieved.*
- *Includes, when a patient/client is discharged prior to achievement of goals and outcomes, the status of the patient/client and the rationale for discontinuation.*
- *As appropriate, records patient data using a method that allows collective analysis.*

IV. Education

The physical therapist is responsible for individual professional development. The physical therapist assistant is responsible for individual career development.

The physical therapist, and the physical therapist assistant under the direction and supervision of the physical therapist, participate in the education of students.

The physical therapist educates and provides consultation to consumers and the general public regarding the purposes and benefits of physical therapy.

The physical therapist educates and provides consultation to consumers and the general public regarding the roles of the physical therapist and the physical therapist assistant.

The physical therapist:

- *Educates and provides consultation to consumers and the general public regarding the roles of the physical therapist, the physical therapist assistant, and other support personnel.*

V. Research

The physical therapist applies research findings to practice and encourages, participates in, and promotes activities that establish the outcomes of patient/client management provided by the physical therapist.

The physical therapist:

- *Ensures that their knowledge of research literature related to practice is current.*
- *Ensures that the rights of research subjects are protected, and the integrity of research is maintained.*
- *Participates in the research process as appropriate to individual education, experience, and expertise.*
- *Educates physical therapists, physical therapist assistants, students, other health professionals, and the general public about the outcomes of physical therapist practice.*

VI. Community Responsibility

The physical therapist demonstrates community responsibility by participating in community and community agency activities, educating the public, formulating public policy, or providing pro bono physical therapy services.

The physical therapist:

- *Participates in community and community agency activities.*
- *Educates the public, including prevention, education, and health promotion.*
- *Helps formulate public policy.*
- *Provides pro bono physical therapy services.*

PROFESSIONALISM IN PHYSICAL THERAPY: CORE VALUES



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American Physical Therapy Association

PROFESSIONALISM IN PHYSICAL THERAPY: CORE VALUES

Introduction

In 2000, the House of Delegates adopted Vision 2020 and the Strategic Plan for Transitioning to A Doctoring Profession (RC 37-01). The Plan includes six elements: Doctor of Physical Therapy, Evidenced-based Practice, Autonomous Practice, Direct Access, Practitioner of Choice, and Professionalism, and describes how these elements relate to and interface with the vision of a doctoring profession. In assisting the profession in its transition to a doctoring profession, it seemed that one of the initiatives that would be beneficial was to define and describe the concept of professionalism by explicitly articulating what the graduate of a physical therapist program ought to demonstrate with respect to professionalism. In addition, as a byproduct of this work, it was believed that practitioner behaviors could be articulated that would describe what the individual practitioner would be doing in their daily practice that would reflect professionalism.

As a part of the preparation for this consensus conference, relevant literature was reviewed to facilitate the development of the conference structure and consensus decision-making process. Literature in medicine^{3, 18, 19, 25, 27} reveals that this profession continues to be challenged to define professionalism, describe how it is taught, and determine how it can be measured in medical education. The groundwork and advances that medicine laid was most informative to the process and product from this conference. Physical therapy acknowledges and is thankful for medicine's research efforts in professionalism and for their work that guided this conference's structure and process.

Eighteen physical therapists, based on their expertise in physical therapist practice, education, and research, were invited to participate in a consensus-based conference convened by APTA's Education Division on July 19-21, 2002. The conference was convened for the purpose of:

1. Developing a comprehensive consensus-based document on Professionalism that would be integrated into *A Normative Model of Physical Therapist Professional Education, Version 2004* to include a) core values of the profession, b) indicators (judgments, decisions, attitudes, and behaviors) that are fully consistent with the core values, and c) a professional education matrix that includes educational outcomes, examples of Terminal Behavioral Objectives, and examples of Instructional Objectives for the classroom and for clinical practice.
2. Developing outcome strategies for the promotion and implementation of the supplement content in education and, where feasible, with practice in ways that are consistent with physical therapy as a doctoring profession.

The documentation developed as a result of this conference is currently being integrated into the next version of *A Normative Model of Physical Therapist Professional Education: Version 2004*. The table that follows is a synopsis of a portion of the conference documentation that describes what the physical therapist would be doing in his or her practice that would give evidence of professionalism.

In August 2003, **Professionalism in Physical Therapy: Core Values** was reviewed by the APTA Board of Directors and adopted as a core document on professionalism in physical therapy practice, education, and research. (V-10; 8/03)

We wish to gratefully acknowledge the efforts of those participants who gave their time and energies to this challenging initiative; a first step in clearly articulating for the physical therapist what are the core values that define professionalism and how that concept would translate into professional education.

PROFESSIONALISM IN PHYSICAL THERAPY: CORE VALUES

Seven core values were identified during the consensus-based conference that further defined the critical elements that comprise professionalism. These core values are listed below in alphabetical order with no preference or ranking given to these values. During the conference many important values were identified as part of professionalism in physical therapy, however not all were determined to be core (at the very essence; essential) of professionalism and unique to physical therapy. The seven values identified were of sufficient breadth and depth to incorporate the many values and attributes that are part of physical therapist professionalism. The group made every effort to find the optimum nomenclature to capture these values such that physical therapists could resonate with each value and would clearly understand the value as provided by the accompanying definition and indicators.

For each core value listed, the table that follows explicates these values by providing a core value definition and sample indicators (not exhaustive) that describe what the physical therapist would be doing in practice, education, and/or research if these core values were present.

1. **Accountability**
2. **Altruism**
3. **Compassion/Caring**
4. **Excellence**
5. **Integrity**
6. **Professional Duty**
7. **Social Responsibility**

PROFESSIONALISM IN PHYSICAL THERAPY: CORE VALUES

For each core value listed, a definition is provided with sample indicators (not exhaustive) that describe what one would see if the physical therapist were demonstrating that core value in his/her daily practice.

Core Values	Definition	Sample Indicators
Accountability	Accountability is active acceptance of the responsibility for the diverse roles, obligations, and actions of the physical therapist including self-regulation and other behaviors that positively influence patient/client outcomes, the profession and the health needs of society.	<ol style="list-style-type: none"> 1. Responding to patient's/client's goals and needs. 2. Seeking and responding to feedback from multiple sources. 3. Acknowledging and accepting consequences of his/her actions. 4. Assuming responsibility for learning and change. 5. Adhering to code of ethics, standards of practice, and policies/procedures that govern the conduct of professional activities. 6. Communicating accurately to others (payers, patients/clients, other health care providers) about professional actions. 7. Participating in the achievement of health goals of patients/clients and society. 8. Seeking continuous improvement in quality of care. 9. Maintaining membership in APTA and other organizations. 10. Educating students in a manner that facilitates the pursuit of learning.
Altruism	Altruism is the primary regard for or devotion to the interest of patients/clients, thus assuming the fiduciary responsibility of placing the needs of the patient/client ahead of the physical therapist's self interest.	<ol style="list-style-type: none"> 1. Placing patient's/client's needs above the physical therapists. 2. Providing pro-bono services. 3. Providing physical therapy services to underserved and underrepresented populations. 4. Providing patient/client services that go beyond expected standards of practice. 5. Completing patient/client care and professional responsibility prior to personal needs.
Compassion/ Caring	Compassion is the desire to identify with or sense something of another's experience; a precursor of caring.	<ol style="list-style-type: none"> 1. Understanding the socio-cultural, psychological and economic influences on the individual's life in their environment. 2. Understanding an individual's perspective. 3. Being an advocate for patient's/client's needs.

Core Values	Definition	Sample Indicators
Compassion/ Caring (continued)	Caring is the concern, empathy, and consideration for the needs and values of others.	<ol style="list-style-type: none"> 4. Communicating effectively, both verbally and non-verbally, with others taking into consideration individual differences in learning styles, language, and cognitive abilities, etc. 5. Designing patient/client programs/interventions that are congruent with patient/client needs. 6. Empowering patients/clients to achieve the highest level of function possible and to exercise self-determination in their care. 7. Focusing on achieving the greatest well-being and the highest potential for a patient/client. 8. Recognizing and refraining from acting on one's social, cultural, gender, and sexual biases. 9. Embracing the patient's/client's emotional and psychological aspects of care. 10. Attending to the patient's/client's personal needs and comforts. 11. Demonstrating respect for others and considers others as unique and of value.
Excellence	Excellence is physical therapy practice that consistently uses current knowledge and theory while understanding personal limits, integrates judgment and the patient/client perspective, embraces advancement, challenges mediocrity, and works toward development of new knowledge.	<ol style="list-style-type: none"> 1. Demonstrating investment in the profession of physical therapy. 2. Internalizing the importance of using multiple sources of evidence to support professional practice and decisions. 3. Participating in integrative and collaborative practice to promote high quality health and educational outcomes. 4. Conveying intellectual humility in professional and interpersonal situations. 5. Demonstrating high levels of knowledge and skill in all aspects of the profession. 6. Using evidence consistently to support professional decisions. 7. Demonstrating a tolerance for ambiguity. 8. Pursuing new evidence to expand knowledge. 9. Engaging in acquisition of new knowledge throughout one's professional career. 10. Sharing one's knowledge with others. 11. Contributing to the development and shaping of excellence in all professional roles.

Core Values	Definition	Sample Indicators
Integrity	Steadfast adherence to high ethical principles or professional standards; truthfulness, fairness, doing what you say you will do, and “speaking forth” about why you do what you do.	<ol style="list-style-type: none"> 1. Abiding by the rules, regulations, and laws applicable to the profession. 2. Adhering to the highest standards of the profession (practice, ethics, reimbursement, Institutional Review Board [IRB], honor code, etc). 3. Articulating and internalizing stated ideals and professional values. 4. Using power (including avoidance of use of unearned privilege) judiciously. 5. Resolving dilemmas with respect to a consistent set of core values. 6. Being trustworthy. 7. Taking responsibility to be an integral part in the continuing management of patients/clients. 8. Knowing one’s limitations and acting accordingly. 9. Confronting harassment and bias among ourselves and others. 10. Recognizing the limits of one’s expertise and making referrals appropriately. 11. Choosing employment situations that are congruent with practice values and professional ethical standards. 12. Acting on the basis of professional values even when the results of the behavior may place oneself at risk.
Professional Duty	Professional duty is the commitment to meeting one’s obligations to provide effective physical therapy services to individual patients/clients, to serve the profession, and to positively influence the health of society.	<ol style="list-style-type: none"> 1. Demonstrating beneficence by providing “optimal care”. 2. Facilitating each individual’s achievement of goals for function, health, and wellness. 3. Preserving the safety, security and confidentiality of individuals in all professional contexts. 4. Involved in professional activities beyond the practice setting. 5. Promoting the profession of physical therapy. 6. Mentoring others to realize their potential. 7. Taking pride in one’s profession.

Core Values	Definition	Sample Indicators
Social Responsibility	Social responsibility is the promotion of a mutual trust between the profession and the larger public that necessitates responding to societal needs for health and wellness.	<ol style="list-style-type: none"> 1. Advocating for the health and wellness needs of society including access to health care and physical therapy services. 2. Promoting cultural competence within the profession and the larger public. 3. Promoting social policy that effect function, health, and wellness needs of patients/clients. 4. Ensuring that existing social policy is in the best interest of the patient/client. 5. Advocating for changes in laws, regulations, standards, and guidelines that affect physical therapist service provision. 6. Promoting community volunteerism. 7. Participating in political activism. 8. Participating in achievement of societal health goals. 9. Understanding of current community wide, nationwide and worldwide issues and how they impact society's health and well-being and the delivery of physical therapy. 10. Providing leadership in the community. 11. Participating in collaborative relationships with other health practitioners and the public at large. 12. Ensuring the blending of social justice and economic efficiency of services.

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APPENDIX I

American Physical Therapy Association Vision 2020

APTA House of Delegates Position HOD P06-00-24-35

Vision Sentence for Physical Therapy

By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

Vision Statement for Physical Therapy

Physical therapy, by 2020, will be provided by physical therapists who are doctors of physical therapy and who may be board-certified specialists. Consumers will have direct access to physical therapists in all environments for patient/client management, prevention, and wellness services. Physical therapists will be practitioners of choice in patients'/clients' health networks and will hold all privileges of autonomous practice. Physical therapists may be assisted by physical therapist assistants who are educated and licensed to provide physical therapist directed and supervised components of interventions.

Guided by integrity, life-long learning, and a commitment to comprehensive and accessible health programs for all people, physical therapists and physical therapist assistants will render evidence-based services throughout the continuum of care and improve quality of life for society. They will provide culturally sensitive care distinguished by trust, respect, and an appreciation for individual differences. While fully availing themselves of new technologies, as well as basic and clinical research, physical therapists will continue to provide direct patient/client care. They will maintain active responsibility for the growth of the physical therapy profession and the health of the people it serves.

Elements of Vision 2020

The following working operational definitions of the elements of Vision 2020 were established by the Task Force on Strategic Plan to Achieve Vision 2020 in June 2007.

Autonomous Physical Therapist Practice

Physical therapists accept the responsibility to practice autonomously and collaboratively in all practice environments to provide best practice to the patient/client. Autonomous physical therapist practice is characterized by independent, self-determined, professional judgment and action.

Direct Access

Every consumer has the legal right to directly access a physical therapist throughout his/her lifespan for the diagnosis of, interventions for, and prevention of, impairments, functional limitations, and disabilities related to movement, function and health.

Doctor of Physical Therapy and Lifelong Education

The Doctor of Physical Therapy (DPT) is a clinical doctoral degree (entry level degree) that reflects the growth in the body of knowledge and expected responsibilities that a professional physical therapist must master to provide best practice to the consumer. All physical therapists and physical therapist assistants are obligated to engage in the continual acquisition of knowledge, skills, and abilities to advance the science of physical therapy and its role in the delivery of health care.

Evidence-Based Practice

Evidence-based practice is access to, and application and integration of evidence to guide clinical decision making to provide best practice for the patient/client. Evidence-based practice includes the integration of best available research, clinical expertise, and patient/client values and circumstances related to patient/client management, practice manage-

ment, and health care policy decision making. Aims of evidence-based practice include enhancing patient/client management and reducing unwarranted variation in the provision of physical therapy services.

Practitioner of Choice

Physical therapists personify the elements of Vision 2020 and are recognized as the preferred providers among consumers and other health care professionals for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

Professionalism

Physical therapists and physical therapist assistants consistently demonstrate core values by aspiring to and wisely applying principles of altruism, excellence, caring, ethics, respect, communication and accountability, and by working together with other professionals to achieve optimal health and wellness in individuals and communities.¹

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Code of Ethics for the Physical Therapist

Code of Ethics for the Physical Therapist

HOD S06-09-07-12 [Amended HOD S06-00-12-23; HOD 06-91-05-05; HOD 06-87-11-17; HOD 06-81-06-18; HOD 06-78-06-08; HOD 06-78-06-07; HOD 06-77-18-30; HOD 06-77-17-27; Initial HOD 06-73-13-24] [Standard]



Preamble

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Principles

Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals.

(Core Values: Compassion, Integrity)

- 1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.
- 1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.

(Core Values: Altruism, Compassion, Professional Duty)

- 2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.
- 2B. Physical therapists shall provide physical therapy services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/clients.
- 2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.

2D. Physical therapists shall collaborate with patients/clients to empower them in decisions about their health care.

2E. Physical therapists shall protect confidential patient/client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

Principle #3: Physical therapists shall be accountable for making sound professional judgments.

(Core Values: Excellence, Integrity)

- 3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.
- 3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.
- 3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.
- 3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.
- 3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

(Core Value: Integrity)

- 4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.
- 4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (eg, patients/clients, students, supervisees, research participants, or employees).
- 4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.
- 4D. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.
- 4E. Physical therapists shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.
- 4F. Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.

Principle #5: Physical therapists shall fulfill their legal and professional obligations.

(Core Values: Professional Duty, Accountability)

- 5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.
- 5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.
- 5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.
- 5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
- 5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.
- 5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient/client continues to need physical therapy services.

Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.

(Core Value: Excellence)

- 6A. Physical therapists shall achieve and maintain professional competence.

6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.

(Core Values: Integrity, Accountability)

- 7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.
- 7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.
- 7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.
- 7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.
- 7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.
- 7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients/clients.

Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.

(Core Value: Social Responsibility)

- 8A. Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
- 8B. Physical therapists shall advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.
- 8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or underutilization of physical therapy services.
- 8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

APPENDIX K

APTA Guide for Professional Conduct

Purpose

This Guide for Professional Conduct (Guide) is intended to serve physical therapists in interpreting the Code of Ethics for the Physical Therapist (Code) of the American Physical Therapy Association (APTA) in matters of professional conduct. The APTA House of Delegates in June of 2009 adopted a revised Code, which became effective on July 1, 2010.

The Guide provides a framework by which physical therapists may determine the propriety of their conduct. It is also intended to guide the professional development of physical therapist students. The Code and the Guide apply to all physical therapists. These guidelines are subject to change as the dynamics of the profession change and as new patterns of health care delivery are developed and accepted by the professional community and the public.

Interpreting Ethical Principles

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist in applying general ethical principles to specific situations. They address some but not all topics addressed in the Principles and should not be considered inclusive of all situations that could evolve.

This Guide is subject to change, and the Ethics and Judicial Committee will monitor and timely revise the Guide to address additional topics and Principles when necessary and as needed.

Preamble to the Code

The Preamble states as follows:

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Interpretation: Upon the Code of Ethics for the Physical Therapist being amended effective July 1, 2010, all the lettered principles in the Code contain the word “shall” and are mandatory ethical obligations. The language contained in the Code is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Code. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word “shall” serves to reinforce and clarify existing ethical obligations. A significant reason that the Code was revised was to provide physical therapists with a document that was clear enough such that they can read it standing alone without the need to seek extensive additional interpretation.

The Preamble states that “[n]o Code of Ethics is exhaustive nor can it address every situation.” The Preamble also states that physical therapists “are encouraged to seek additional advice or consultation in instances in which the guidance of the Code may not be definitive.” Potential sources for advice and counsel include third parties and the myriad resources available on the APTA Web site. Inherent in a physical therapist’s ethical decision-making process is the examination of his or her unique set of facts relative to the Code.

Topics

Respect

Principle 1A states as follows:

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

Interpretation: Principle 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

Altruism

Principle 2A states as follows:

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.

Interpretation: Principle 2A reminds physical therapists to adhere to the profession’s core values and act in the best interest of patients/clients over the interests of the physical therapist. Often this is done without thought, but sometimes, especially at the end of the day when the physical therapist is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

Patient Autonomy

Principle 2C states as follows:

2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.

Interpretation: The underlying purpose of Principle 2C is to require a physical therapist to respect patient autonomy. In order to do so, a physical therapist shall communicate to the patient/client the findings of his/her examination, evaluation, diagnosis, and prognosis. A physical therapist shall use sound professional judgment in informing the patient/client of any substantial risks of the recommended examination and intervention and shall collaborate with the patient/client to establish the goals of treatment and the plan of care. Ultimately, a physical therapist shall respect the patient’s/client’s right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.

Professional Judgment

Principles 3, 3A, and 3B state as follows:

3. Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)

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

3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

Interpretation: Principles 3, 3A, and 3B state that it is the physical therapist's obligation to exercise sound professional judgment, based upon his/her knowledge, skill, training, and experience. Principle 3B further describes the physical therapist's judgment as being informed by three elements of evidence-based practice.

With regard to the patient/client management role, once a physical therapist accepts an individual for physical therapy services he/she shall be responsible for: the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; re-examination and modification of the plan of care; and the maintenance of adequate records, including progress reports. A physical therapist shall establish the plan of care and shall provide and/or supervise and direct the appropriate interventions. Regardless of practice setting, a physical therapist has primary responsibility for the physical therapy care of a patient and shall make independent judgments regarding that care consistent with accepted professional standards.

If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise or that indicate the need for care outside the scope of physical therapy, the physical therapist shall so inform the patient/client and shall refer the patient/client to an appropriate practitioner.

A physical therapist shall determine when a patient/client will no longer benefit from physical therapy services. When a physical therapist's judgment is that a patient will receive negligible benefit from physical therapy services, the physical therapist shall not provide or continue to provide such services if the primary reason for doing so is to further the financial self-interest of the physical therapist or his/her employer. A physical therapist shall avoid overutilization of physical therapy services. See Principle 8C.

Supervision

Principle 3E states as follows:

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Interpretation: Principle 3E describes an additional circumstance in which sound professional judgment is required; namely, through the appropriate direction of and communication with physical therapist assistants and support personnel. Further information on supervision via applicable local, state, and federal laws and regulations (including state practice acts and administrative codes) is available. Information on supervision via APTA policies and resources is also available on the APTA Web site. See Principles 5A and 5B.

Integrity in Relationships

Principle 4 states as follows:

4. Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)

Interpretation: Principle 4 addresses the need for integrity in relationships. This is not limited to relationships with patients/clients, but includes everyone physical therapists come into contact with professionally. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

Principle 4C states as follows:

4C. Physical therapists shall discourage misconduct by healthcare professionals and report illegal or unethical acts to the relevant authority, when appropriate.

Interpretation: When considering the application of "when appropriate" under Principle 4C, keep in mind that not all allegedly illegal or unethical acts should be reported immediately to an agency/authority. The determination of when to do so depends upon each situation's unique set of facts, applicable laws, regulations, and policies.

Depending upon those facts, it might be appropriate to communicate with the individuals involved. Consider whether

the action has been corrected, and in that case, not reporting may be the most appropriate action. Note, however, that when an agency/authority does examine a potential ethical issue, fact finding will be its first step. The determination of ethicality requires an understanding of all of the relevant facts, but may still be subject to interpretation.

The EJC Opinion titled Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Exploitation

Principle 4E states as follows:

4E. Physical therapists shall not engage in any sexual relationship with any of their patient/clients, supervisees or students.

Interpretation: The statement is fairly clear – sexual relationships with their patients/clients, supervisees or students are prohibited. This component of Principle 4 is consistent with Principle 4B, which states:

Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g. patients/clients, students, supervisees, research participants, or employees).

Next, consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients/Former Patients:

A physical therapist stands in a relationship of trust to each patient and has an ethical obligation to act in the patient's best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist has natural feelings of attraction toward a patient, he/she must sublimate those feelings in order to avoid sexual exploitation of the patient.

One's ethical decision making process should focus on whether the patient/client, supervisee or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient/client relationship ends. To this question, the EJC has opined as follows:

The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible.

The Committee imagines that in some cases a romantic/sexual relationship would not offend ... if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

Colleague Impairment

Principle 5D and 5E state as follows:

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report the information to the appropriate authority.

Interpretation: The central tenet of Principles 5D and 5E is that inaction is not an option for a physical therapist when faced with the circumstances described. Principle 5D states that a physical therapist shall encourage colleagues to seek assistance or counsel while Principle 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination on your part. This may be challenging in the sense that you might not know or it might be difficult for you to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to determine whether such impairment may be adversely affecting his or her professional responsibilities.

Moreover, once you do make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance. However, the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform, whereas 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect his or her professional responsibilities. So, 5D discusses something that may be affecting performance, whereas 5E addresses a situation in which someone is clearly unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom you report; it gives you discretion to determine the appropriate authority.

The EJC Opinion titled: Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Professional Competence

Principle 6A states as follows:

6A. Physical therapists shall achieve and maintain professional competence.

Interpretation: 6A requires a physical therapist to maintain professional competence within one's scope of practice throughout one's career. Maintaining competence is an ongoing process of self-assessment, identification of strengths and weaknesses, acquisition of knowledge and skills based on that assessment, and reflection on and reassessment of performance, knowledge and skills. Numerous factors including practice setting, types of patients/clients, personal interests and the addition of new evidence to practice will influence the depth and breadth of professional competence in a given area of practice. Additional resources on Continuing Competence are available on the APTA Web site.

Professional Growth

Principle 6D states as follows:

6D. Physical therapists shall cultivate practice environments that support professional development, life-long learning, and excellence.

Interpretation: 6D elaborates on the physical therapist's obligations to foster an environment conducive to professional growth, even when not supported by the organization. The essential idea is that this is the physical therapist's responsibility, whether or not the employer provides support.

Charges and Coding

Principle 7E states as follows:

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.

Interpretation: Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed. In this context, where charges cannot be determined because of payment methodology, physical therapists may review the House of Delegates policy titled Professional Fees for Physical Therapy Services. Additional resources on documentation and coding include the House of Delegates policy titled Documentation Authority for Physical Therapy Services and the Documentation and Coding and Billing information on the APTA Web site.

Pro Bono Services

Principle 8A states as follows:

8A. Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

Interpretation: The key word in Principle 8A is "or." If a physical therapist is unable to provide pro bono services he or she can fulfill ethical obligations by supporting organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured. In addition, physical therapists may review the House of Delegates guidelines titled Guidelines: Pro Bono Physical Therapy Services. Additional resources on pro bono physical therapy services are available on the APTA Web site.

8A also addresses supporting organizations to meet health needs. In terms of supporting organizations, the principle does not specify the type of support that is required. Physical therapists may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues.

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APPENDIX L

Definition of Physical Therapy in State Practice Acts

Current as of November 1, 2010

State	Definition of physical therapy and/or practice of physical therapy	Citation
Alabama	The treatment of a human being by the use of exercise, massage, heat, cold, water, radiant energy, electricity or sound for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability, or the performance of neuro-muscular-skeletal tests and measurements to determine the existence and extent of body malfunction; provided, that physical therapy shall be practiced only upon the referral of a physician licensed to practice medicine or surgery and a dentist licensed to practice dentistry and shall not include radiology or electrosurgery.	34-24-191
Alaska	“Physical therapy” means the examination, treatment and instruction of human beings to detect, assess, prevent, correct, alleviate and limit physical disability, bodily malfunction, pain from injury, disease and other bodily or mental conditions and includes the administration, interpretation and evaluation of tests and measurements of bodily functions and structures; the planning, administration, evaluation and modification of treatment and instruction including the use of physical measures, activities and devices for preventive and therapeutic purposes; the provision of consultative, educational and other advisory services for the purpose of reducing the incidence and severity of physical disability, bodily malfunction and pain; “physical therapy” does not include the use of roentgen rays and radioactive materials for diagnosis and therapeutic purposes, the use of electricity for surgical purposes, and the diagnosis of disease.	08.84.190
Arizona	<p>“Practice of physical therapy” means:</p> <ul style="list-style-type: none"> (a) Examining, evaluating and testing persons who have mechanical, physiological and developmental impairments, functional limitations and disabilities or other health and movement related conditions in order to determine a diagnosis, a prognosis and a plan of therapeutic intervention and to assess the ongoing effects of intervention. (b) Alleviating impairments and functional limitations by managing, designing, implementing and modifying therapeutic interventions including: <ul style="list-style-type: none"> (viii) Therapeutic exercise. (ix) Functional training in self-care and in home, community or work reintegration. (x) Manual therapy techniques. (xi) Therapeutic massage. (xii) Assistive and adaptive orthotic, prosthetic, protective and supportive devices and equipment. (xiii) Pulmonary hygiene. (xiv) Debridement and wound care. (xv) Physical agents or modalities. (xvi) Mechanical and electrotherapeutic modalities. (xvii) Patient related instruction. (c) Reducing the risk of injury, impairments, functional limitations and disability by means that include promoting and maintaining a person’s fitness, health and quality of life. (d) Engaging in administration, consultation, education and research. 	A.R.S. 32-2001

<p>Arkansas</p>	<p>“Physical therapy” means the care and services and provided by or under the direction and supervision of a physical therapist who is licensed under this chapter;</p> <p>“Practice of physical therapy” means:</p> <p>(A) Examining and evaluating patients with mechanical, physiological, and developmental impairments, functional limitations, and disability or other health-related conditions in order to determine a physical therapy diagnosis, prognosis, and planned therapeutic intervention;</p> <p>(B) (i) Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic interventions that include:</p> <ul style="list-style-type: none"> (a) Therapeutic exercise; (b) Functional training in self-care as it relates to patient mobility and community access; (c) Manual therapy techniques, including soft tissue massage, manual traction, connective tissue massage, therapeutic massage, and mobilization, i.e., passive movement accomplished within normal range of motion of the joint, but excluding spinal manipulation and adjustment; (d) Assistive and adaptive devices and equipment as they relate to patient mobility and community access; (e) Physical agents; (f) Mechanical and electrotherapeutic modalities; and (g) Patient-related instruction. <p>(ii) The therapeutic intervention of bronchopulmonary hygiene and debridement of wounds require a physician referral before initiation of treatment.</p> <p>(iii) Physical therapy does not include radiology or electrosurgery;</p> <p>(C) Preventing injury, impairments, functional limitations, and disability, including the promotion and maintenance of fitness, health, and quality of life in all age populations; and</p> <p>(D) Engaging in consultation, testing, education, and research;</p>	<p>A.C.A § 17-93-102</p>
<p>California</p>	<p>“Physical therapy” means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term “physical therapy” as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease.</p>	<p>Cal Bus & Prof. Code 2620</p>

<p>Colorado</p>	<p>(A) The administration, evaluation, and interpretation of tests and measurements of bodily functions and structures;</p> <p>(B) The planning, administration, evaluation, and modification of treatment and instruction;</p> <p>(C) The use of physical agents, measures, activities, and devices for preventive and therapeutic purposes, subject to the requirements of section <u>12-41-113</u>;</p> <p>(D) The administration of topical and aerosol medications consistent with the scope of physical therapy practice subject to the requirements of section <u>12-41-113</u>; and</p> <p>(E) The provision of consultative, educational, and other advisory services for the purpose of reducing the incidence and severity of physical disability, movement dysfunction, bodily malfunction, and pain.</p> <p>(I) “Physical agents” includes, but is not limited to, heat, cold, water, air, sound, light, compression, electricity, and electromagnetic energy.</p> <p>(II) (A) “Physical measures, activities, and devices” includes, but is not limited to, resistive, active, and passive exercise, with or without devices; joint mobilization; mechanical stimulation; biofeedback; postural drainage; traction; positioning; massage; splinting; training in locomotion; other functional activities, with or without assistive devices; and correction of posture, body mechanics, and gait. (B) “Biofeedback,” as used in this subparagraph (II), means the use of monitoring instruments by a physical therapist to detect and amplify internal physiological processes for the purpose of neuromuscular rehabilitation.</p> <p>(III) “Tests and measurements” includes, but is not limited to, tests of muscle strength, force, endurance, and tone; reflexes and automatic reactions; movement skill and accuracy; joint motion, mobility, and stability; sensation and perception; peripheral nerve integrity; locomotor skill, stability, and endurance; activities of daily living; cardiac, pulmonary, and vascular functions; fit, function, and comfort of prosthetic, orthotic, and other assistive devices; posture and body mechanics; limb length, circumference, and volume; thoracic excursion and breathing patterns; vital signs; nature and locus of pain and conditions under which pain varies; photosensitivity; and physical home and work environments.</p>	<p>C.R.S. 12-41-103</p>
<p>Connecticut</p>	<p>“Physical therapy” means the evaluation and treatment of any person by the employment of the effective properties of physical measures, the performance of tests and measurements as an aid to evaluation of function and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting or alleviating a physical or mental disability. “Physical therapy” includes the establishment and modification of physical therapy programs, treatment planning, instruction, wellness care, peer review and consultative services, but does not include surgery, the prescribing of drugs, the development of a medical diagnosis of disease, injury or illness, the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes;</p>	<p>Conn. Gen. Stat. §20-66</p>

<p>Delaware</p>	<p>“Physical therapy” means the evaluation, instruction or treatment of any person to detect, assess, prevent, correct, alleviate or limit physical disability from injury or disease and any other physical and or mental condition, by the utilization of the effective properties of physical measures, activities and devices such as heat, cold, light, air, water, sound, electricity, massage, mobilization, therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices. Physical therapy also includes the supervision of physical therapy activities, physical therapy consultation and the establishment and modification of physical therapy programs. Physical therapy shall not include radiology, surgery, drugs or authorize the medical diagnosis of disease.</p>	<p>24 Del. C. § 2602</p>
<p>District of Columbia</p>	<p>“Practice of physical therapy” means the independent evaluation of human disability, injury, or disease by means of noninvasive tests of neuromuscular functions and other standard procedures of physical therapy, and the treatment of human disability, injury, or disease by therapeutic procedures, embracing the specific scientific application of physical measures to secure the functional rehabilitation of the human body. These measures include the use of therapeutic exercise, therapeutic massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or preventing the development of any physical or mental disability, or the performance of noninvasive tests of neuromuscular functions as an aid to the detection or treatment of any human condition.</p>	<p>DC Code § 3-1201.02</p>
<p>Florida</p>	<p>“Practice of physical therapy” means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other condition of health, and rehabilitation as related thereto by the use of the physical, chemical, and other properties of air; electricity; exercise; massage; the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs; the use of radiant energy, including ultraviolet, visible, and infrared rays; ultrasound; water; the use of apparatus and equipment in the application of the foregoing or related thereto; the performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or the performance of electromyography as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine. A physical therapist may implement a plan of treatment for a patient. The physical therapist shall refer the patient to or consult with a health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466, if the patient’s condition is found to be outside the scope of physical therapy. If physical therapy treatment for a patient is required beyond 21 days for a condition not previously assessed by a practitioner of record, the physical therapist shall obtain a practitioner of record who will review and sign the plan. A health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 and engaged in active practice is eligible to serve as a practitioner of record. The use of roentgen rays and radium for diagnostic and therapeutic purposes and the use of electricity for surgical purposes, including cauterization, are not authorized under the term “physical therapy” as used in this chapter. The practice of physical therapy as defined in this chapter does not authorize a physical therapy practitioner to practice chiropractic medicine as defined in chapter 460, including specific spinal manipulation. For the performance of specific chiropractic spinal manipulation, a physical therapist shall refer the patient to a health care practitioner licensed under chapter 460. Nothing in this subsection authorizes a physical therapist to implement a plan of treatment for a patient currently being treated in a facility licensed pursuant to chapter 395.</p>	<p>FL Stat. § 486.021</p>

<p>Georgia</p>	<p>“Physical therapy” means the examination, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction and pain from injury, disease, and any other bodily and mental conditions and includes the administration, interpretation, documentation, and evaluation of tests and measurements of bodily functions and structures; the planning, administration, evaluation, and modification of treatment and instruction, including the use of physical measures, activities, and devices, for preventative and therapeutic purposes; and the provision of consultative, educational, and other advisory services for the purpose of preventing or reducing the incidence and severity of physical disability, bodily malfunction, and pain.</p>	<p>O.C.G.A. § 43-33-3</p>
<p>Hawaii</p>	<p>“Physical therapy” or “physical therapy services” means the examination, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction, pain from injury, disease, and any other physical or mental condition as performed by a physical therapist appropriately licensed under this chapter. It includes but is not limited to:</p> <ol style="list-style-type: none"> (1) Administration, evaluation, modification of treatment, and instruction involving the use of physical measures, activities, and devices, for preventive and therapeutic purposes; provided that should the care or treatment given by the physical therapist contravene treatment diagnosed or prescribed by a medical doctor, osteopath, or as determined by the board, the physical therapist shall confer with the professional regarding the manner or course of treatment in conflict and take appropriate action in the best interest of the patient; and (2) The provision of consultative, educational, and other advisory services for the purpose of reducing the incidence and severity of physical disability, bodily malfunction, or pain. <p>“Practice of physical therapy” includes, but is not limited to, the use of the following:</p> <ol style="list-style-type: none"> (1) Physical agents, such as heat, cold, water, air, sound, compression, light, electricity, and electromagnetic radiation; (2) Exercise with or without devices, joint mobilization, mechanical stimulation; biofeedback; postural drainage; traction; positioning, massage, splinting, training in locomotion, and other functional activities with or without assisting devices; and correction of posture, body mechanics, and gait; (3) Tests and measurements of: muscle strength, force, endurance, and tone; joint motion, mobility, and stability; reflexes and automatic reaction; movement skill and accuracy; sensation and perception; peripheral nerve integrity; locomotor skill, stability, and endurance; activities of daily living; cardiac, pulmonary, and vascular functions; and fit, function, and comfort of prosthetic, orthotic, and other assisting devices; posture and body mechanics; limb strength, circumference, and volume; thoracic excursion and breathing patterns; vital signs; nature and locus of pain and conditions under which pain varies; photosensitivity; and the home and work physical environments. 	<p>HRS § 461J-1</p>

<p>Idaho</p>	<p>“Physical therapy” means the care and services provided by or under the direction and supervision of a physical therapist.</p> <p>The “practice of physical therapy” means the exercise of the profession of physical therapy by a person who engages in the following health care activities:</p> <ul style="list-style-type: none"> (a) Examining, evaluating and testing individuals with mechanical, physiological and developmental impairments, functional limitations, and disability or other health and movement related conditions in order to determine a diagnosis for physical therapy and prognosis for physical therapy, plan of therapeutic intervention, and to assess the ongoing effects of intervention. (b) Alleviating impairments and functional limitations by designing, implementing and modifying therapeutic interventions that include, but are not limited to: therapeutic exercise; functional mobility training in self-care and in-home, community or work reintegration; manual therapy; assistive, adaptive, protective and supportive devices and equipment; bronchopulmonary hygiene; debridement and wound care; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient related instruction; and to reduce the risk of injury, impairment, functional limitation, and disability, including the promotion and maintenance of fitness, health, and quality of life in all age populations. The practice of physical therapy shall not include the use of radiology, surgery or medical diagnosis of disease. (c) Engaging in administration, consultation, testing, education and research as related to paragraphs (a) and (b) of this subsection. 	<p>Idaho Code § 54-2203</p>
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<p>Illinois</p>	<p>“Physical therapy” means all of the following:</p> <ul style="list-style-type: none"> (A) Examining, evaluating, and testing individuals who may have mechanical, physiological, or developmental impairments, functional limitations, disabilities, or other health and movement-related conditions, classifying these disorders, determining a rehabilitation prognosis and plan of therapeutic intervention, and assessing the on-going effects of the interventions. (B) Alleviating impairments, functional limitations, or disabilities by designing, implementing, and modifying therapeutic interventions that may include, but are not limited to, the evaluation or treatment of a person through the use of the effective properties of physical measures and heat, cold, light, water, radiant energy, electricity, sound, and air and use of therapeutic massage, therapeutic exercise, mobilization, and rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental impairment, functional limitation, or disability. (C) Reducing the risk of injury, impairment, functional limitation, or disability, including the promotion and maintenance of fitness, health, and wellness. (D) Engaging in administration, consultation, education, and research. <p>Physical therapy includes, but is not limited to: (a) performance of specialized tests and measurements, (b) administration of specialized treatment procedures, (c) interpretation of referrals from physicians, dentists, advanced practice nurses, physician assistants, and podiatrists, (d) establishment, and modification of physical therapy treatment programs, (e) administration of topical medication used in generally accepted physical therapy procedures when such medication is prescribed by the patient’s physician, licensed to practice medicine in all its branches, the patient’s physician licensed to practice podiatric medicine, the patient’s advanced practice nurse, the patient’s physician assistant, or the patient’s dentist, and (f) supervision or teaching of physical therapy. Physical therapy does not include radiology, electrosurgery, chiropractic technique or determination of a differential diagnosis; provided, however, the limitation on determining a differential diagnosis shall not in any manner limit a physical therapist licensed under this Act from performing an evaluation pursuant to such license. Nothing in this Section shall limit a physical therapist from employing appropriate physical therapy techniques that he or she is educated and licensed to perform. A physical therapist shall refer to a licensed physician, advanced practice nurse, physician assistant, dentist, or podiatrist any patient whose medical condition should, at the time of evaluation or treatment, be determined to be beyond the scope of practice of the physical therapist.</p>	<p>225 ILCS 90/1</p>
<p>Indiana</p>	<p>“Physical therapy” means the evaluation of, administration of, or instruction in physical rehabilitative and habilitative techniques and procedures to evaluate, prevent, correct, treat, alleviate, and limit physical disability, pathokinesiological function, bodily malfunction, pain from injury, disease, and any other physical disability or mental disorder, including:</p> <ul style="list-style-type: none"> (A) the use of physical measures, agents, and devices for preventive and therapeutic purposes; (B) neurodevelopmental procedures; (C) the performance, interpretation, and evaluation of physical therapy tests and measurements; and (D) the provision of consultative, educational, and other advisory services for the purpose of preventing or reducing the incidence and severity of physical disability, bodily malfunction, and pain. 	<p>IC 25-27-1-1</p>

Iowa	Physical therapy is that branch of science that deals with the evaluation and treatment of human capabilities and impairments. Physical therapy uses the effective properties of physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound, and therapeutic exercises, and rehabilitative procedures to prevent, correct, minimize, or alleviate a physical impairment. Physical therapy includes the interpretation of performances, tests, and measurements, the establishment and modification of physical therapy programs, treatment planning, consultative services, instructions to the patients, and the administration and supervision attendant to physical therapy facilities.	Iowa Code § 148A.1
Kansas	“Physical therapy” means examining, evaluating and testing individuals with mechanical, anatomical, physiological and developmental impairments, functional limitations and disabilities or other health and movement-related conditions in order to determine a diagnosis solely for physical therapy, prognosis, plan of therapeutic intervention and to assess the ongoing effects of physical therapy intervention. Physical therapy also includes alleviating impairments, functional limitations and disabilities by designing, implementing and modifying therapeutic interventions that may include, but are not limited to, therapeutic exercise; functional training in community or work integration or reintegration; manual therapy; therapeutic massage; prescription, application and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic, protective and supportive devices and equipment; airway clearance techniques; integumentary protection and repair techniques; debridement and wound care; physical agents or modalities; mechanical and electrotherapeutic modalities; patient-related instruction; reducing the risk of injury, impairments, functional limitations and disability, including the promotion and maintenance of fitness, health and quality of life in all age populations and engaging in administration, consultation, education and research. Physical therapy also includes the care and services provided by a physical therapist or a physical therapist assistant under the direction and supervision of a physical therapist that is licensed pursuant to this act. Physical therapy does not include the use of roentgen rays and radium for diagnostic and therapeutic purposes, the use of electricity for surgical purposes, including cauterization, the practice of any branch of the healing arts and the making of a medical diagnosis.	K.S.A § 65-2901
Kentucky	“Physical therapy” means the use of selected knowledge and skills in planning, organizing and directing programs for the care of individuals whose ability to function is impaired or threatened by disease or injury, encompassing preventive measures, screening, tests in aid of diagnosis by a licensed doctor of medicine, osteopathy, dentistry, chiropractic or podiatry and evaluation and invasive or noninvasive procedures with emphasis on the skeletal system, neuromuscular and cardiopulmonary function, as it relates to physical therapy. Physical therapy includes screening or evaluations performed to determine the degree of impairment of relevant aspects such as, but not limited to, nerve and muscle function including subcutaneous bioelectrical potentials, motor development, functional capacity and respiratory or circulatory efficiency. Physical therapy also includes physical therapy treatment performed upon referral by a licensed doctor of medicine, osteopathy, dentistry, chiropractic or podiatry including, but not limited to, exercises for increasing or restoring strength, endurance, coordination and range of motion, stimuli to facilitate motor activity and learning, instruction in activities of daily living and the use of assistive devices and the application of physical agents to relieve pain or alter physiological status. The use of roentgen rays and radium for diagnostic or therapeutic purposes, the use of electricity for surgical purposes, including cauterization and colonic irrigations are not authorized under the term “physical therapy” as used in this chapter.	KRS § 327.010

<p>Louisiana</p>	<p>(1) "Initial physical therapy evaluation" means the physical therapy assessment and resulting interpretation of a patient's condition through use of patient history, signs, symptoms, objective tests, or measurements to determine neuromusculoskeletal and biomechanical dysfunctions to determine the need for physical therapy. The conclusions of such initial physical therapy evaluation may be reported to the patient and may be used to establish treatment goals. The results of an initial physical therapy evaluation or physical therapy consultation shall be reported to the referring or treating physician, dentist, chiropractor, or podiatrist. (2) "Physical therapist" includes equally physiotherapist, physical therapist, and P.T. and is a person who is a graduate of an accredited school of physical therapy, which school, at the time of graduation was approved by the Commission on Accreditation in Physical Therapy Education or the board and who practices physical therapy as defined in this Chapter. (3) "Physical therapist assistant" includes equally physical therapist assistant, physiotherapist assistant, and P.T.A., and is a person who is a graduate of an accredited school of physical therapist assisting, which school, at the time of graduation, was approved by the Commission on Accreditation in Physical Therapy Education or the board. A physical therapist assistant assists in the practice of physical therapy in accordance with the provisions of this Chapter, and works under the supervision of a physical therapist by performing such patient-related activities assigned by a physical therapist which are commensurate with the physical therapist assistant's education, training, and experience. (4) "Physical therapy," noun and adjective, means equally physiotherapy and physical therapy. (5) "Practice of physical therapy" is the health care profession practiced by a physical therapist licensed under this Chapter and means the holding out of one's self to the public as a physical therapist and as being engaged in the business of, or the actual engagement in, the evaluation and treatment of any physical or medical condition to restore normal function of the neuromuscular and skeletal system, to relieve pain, or to prevent disability by use of physical or mechanical means, including therapeutic exercise, mobilization, passive manipulation, therapeutic modalities, and activities or devices for preventative, therapeutic, or medical purposes, and further shall include physical therapy evaluation, treatment planning, instruction, consultative services, and the supervision of physical therapy supportive personnel, including physical therapist assistants.</p> <p>B. As used in this Chapter, "physical therapy" does not include the use of roentgen rays and radium, isotopes, and ionizing radiation for diagnostic and therapeutic purposes.</p>	<p>LRS 29, §2407</p>
<p>Maine</p>	<p>"Physical therapy" is the practice the scope of which is set forth in section 3111-A. 3111-A The practice of physical therapy includes the evaluation, treatment and instruction of human beings to detect, assess, prevent, correct, alleviate and limit physical disability, bodily malfunction and pain from injury, disease and any other bodily condition; the administration, interpretation and evaluation of tests and measurements of bodily functions and structures for the purpose of treatment planning; the planning, administration, evaluation and modification of treatment and instruction; and the use of physical agents and procedures, activities and devices for preventive and therapeutic purposes; and the provision of consultative, educational and other advisory services for the purpose of reducing the incidence and severity of physical disability, bodily malfunction and pain.</p> <p>"Practice of physical therapy" means the rendering or offering to render any service involving physical therapy for a fee, salary or other compensation, monetary or otherwise, paid directly or indirectly.</p>	<p>32 MRS § 3111 and 3111-A</p>

<p>Maryland</p>	<p>(1) "Practice physical therapy" means to practice the health specialty concerned with:</p> <ul style="list-style-type: none"> (i) The prevention of disability in patients or clients; and (ii) The physical rehabilitation of patients or clients with a congenital or acquired disability. <p>(2) "Practice physical therapy" includes:</p> <ul style="list-style-type: none"> (i) Performing an evaluation of the physical therapy needs of patients or clients; (ii) Performing and interpreting tests and measurements of neuromuscular and musculoskeletal functions to aid treatment; (iii) Planning treatment programs that are based on test findings; and (iv) Except as provided in paragraph (3) of this subsection, administering treatment with therapeutic exercise, therapeutic massage, mechanical devices, or therapeutic agents that use the physical, chemical, or other properties of air, water, electricity, sound, or radiant energy. <p>(3) "Practice physical therapy" does not include using:</p> <ul style="list-style-type: none"> (i) X-rays; (ii) Radioactive substances; or (iii) Electricity for cauterization or surgery 	<p>MD Health Occupations Code §13-101</p>
<p>Massachusetts</p>	<p>"Physical therapy," a health profession that utilizes the application of scientific principles for the identification, prevention, remediation and rehabilitation of acute or prolonged physical dysfunction thereby promoting optimal health and function. Physical therapy practice is evaluation, treatment and instruction related to neuromuscular, musculoskeletal, cardiovascular and respiratory functions. Such evaluation shall include but is not limited to performance and interpretation of tests as an aid to the diagnosis or planning of treatment programs. Such treatment shall include but is not limited to the use of therapeutic exercise, physical activities, mobilization, functional and endurance training, traction, bronchopulmonary hygiene postural drainage, temporary splinting and bracing, massage, heat, cold, water, radiant energy, electricity or sound. Such instruction shall include teaching both patient and family physical therapy procedures as part of a patient's ongoing program. Physical therapy also shall include the delegating of selective forms of treatment to physical therapist assistants and physical therapy aides; provided, however, that the physical therapist so delegating shall assume the responsibility for the care of the patient and the supervision of the physical therapist assistant or physical therapy aide.</p> <p>Physical therapy shall also include the providing of consultation services for health, educational, and community agencies.</p>	<p>M.G.L. ch. 112 § 23a</p>
<p>Michigan</p>	<p>"Practice of physical therapy" means the evaluation of, education of, consultation with, or treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes treatment planning, performance of tests and measurements, interpretation of referrals, initiation of referrals, instruction, consultative services, and supervision of personnel. Physical measures include massage, mobilization, heat, cold, air, light, water, electricity, and sound. Practice of physical therapy does not include the identification of underlying medical problems or etiologies, establishment of medical diagnoses, or the prescribing of treatment.</p>	<p>MCL § 333.17801</p>

<p>Minnesota</p>	<p>The term “physical therapy” means the evaluation or treatment or both of any person by the employment of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Physical measures shall include but shall not be limited to heat or cold, air, light, water, electricity and sound. Physical therapy includes evaluation other than medical diagnosis, treatment planning, treatment, documentation, performance of appropriate tests and measurement, interpretation of orders or referrals, instruction, consultative services, and supervision of supportive personnel. “Physical therapy” does not include the practice of medicine as defined in section 147.081, or the practice of chiropractic as defined in section 148.01.</p>	<p>Minn. Stat. § 148.65</p>
<p>Mississippi</p>	<p>“Physical therapy” or “physiotherapy,” which terms are deemed identical and interchangeable, means the art and science of a health specialty concerned with the prevention of disability, and the physical rehabilitation for congenital or acquired physical or mental disabilities, resulting from or secondary to injury or disease. The “practice of physical therapy” means the practice of the health specialty and encompasses physical therapy evaluation, treatment planning, treatment administration, instruction and consultative services, including:</p> <ul style="list-style-type: none"> (i) Performing and interpreting tests and measurements as an aid to physical therapy treatment, for the purpose of correcting or alleviating any physical condition and to prevent the development of any physical or mental disability within the scope of physical therapy; and the performance of neuromuscular-skeletal tests and measurements as an aid in diagnosis, evaluation or determination of the existence of and the extent of any body malfunction; (ii) Planning initial and subsequent treatment programs, on the basis of test findings; and (iii) Administering treatment by therapeutic exercise, neurodevelopmental procedures, therapeutic massage, mechanical devices and therapeutic agents which employ the physical, chemical and other properties of air, water, heat, cold, electricity, sound and radiant energy for the purpose of correcting or alleviating any physical condition or preventing the development of any physical or mental disability. The use of roentgen rays and radium for any purpose, and the use of electricity for surgical purposes including cauterization, are not part of physical therapy. 	<p>MS Code § 73-23-33</p>
<p>Missouri</p>	<p>“Practice of physical therapy”; the examination, treatment and instruction of human beings to assess, prevent, correct, alleviate and limit physical disability, movement dysfunction, bodily malfunction and pain from injury, disease and any other bodily condition, such term includes, but is not limited to, the administration, interpretation and evaluation of physical therapy tests and measurements of bodily functions and structures; the planning, administration, evaluation and modification of treatment and instruction, including the use of physical measures, activities and devices, for preventive and therapeutic purposes; and the provision of consultative, educational, research and other advisory services for the purpose of reducing the incidence and severity of physical disability, movement dysfunction, bodily malfunction and pain does not include the use of surgery or obstetrics or the administration of x-radiation, radioactive substance, diagnostic x-ray, diagnostic laboratory electrocautery, electrosurgery or invasive tests or the prescribing of any drug or medicine or the administration or dispensing of any drug or medicine other than a topical agent administered or dispensed upon the direction of a physician. Physical therapists may perform electromyography and nerve conduction tests but may not interpret the results of the electromyography or nerve conduction test. Physical therapists shall practice physical therapy within the scope of their education and training as provided in sections 334.500 to 334.620.</p>	<p>334.500 § R.S.Mo</p>
<p>Montana</p>	<p>“Physical therapy” means the evaluation, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction and pain, injury, and any bodily or mental conditions by the use of therapeutic exercise, prescribed topical medications, and rehabilitative procedures for the purpose of preventing, correcting, or alleviating a physical or mental disability.</p>	<p>§ 37-11-101, M.C.A.</p>

<p>Nebraska</p>	<p>“Physical therapy” or “physiotherapy” means:</p> <ol style="list-style-type: none"> (1) Examining, evaluating, and testing individuals with mechanical, physiological, and developmental impairments, functional limitations, and disabilities or other conditions related to health and movement and, through analysis of the evaluative process, developing a plan of therapeutic intervention and prognosis while assessing the ongoing effects of the intervention; (2) Alleviating impairment, functional limitation, or disabilities by designing, implementing, or modifying therapeutic interventions which may include any of the following: Therapeutic exercise; functional training in home, community, or work integration or reintegration related to physical movement and mobility; therapeutic massage; mobilization or manual therapy; recommendation, application, and fabrication of assistive, adaptive, protective, and supportive devices and equipment; airway clearance techniques; integumentary protection techniques; nonsurgical debridement and wound care; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient-related instruction; but which does not include the making of a medical diagnosis; (3) Purchasing, storing, and administering topical and aerosol medication in compliance with applicable rules and regulations of the Board of Pharmacy regarding the storage of such medication; (4) Reducing the risk of injury, impairment, functional limitation, or disability, including the promotion and maintenance of fitness, health, and wellness; and (5) Engaging in administration, consultation, education, and research. 	<p>Neb. Rev. Stat. § 71-1,376</p>
<p>Nevada</p>	<p>“Physical therapy” means the specialty in the field of health which is concerned with prevention of disability and physical rehabilitation of persons having congenital or acquired disabilities.</p> <p>“Practice of physical therapy”:</p> <ol style="list-style-type: none"> (1) Includes: <ol style="list-style-type: none"> (a) The performing and interpreting of tests and measurements as an aid to evaluation or treatment; (b) The planning of initial and subsequent programs of treatment on the basis of the results of tests; and (c) The administering of treatment through the use of therapeutic exercise and massage, the mobilization of joints by the use of therapeutic exercise without chiropractic adjustment, mechanical devices, and therapeutic agents which employ the properties of air, water, electricity, sound and radiant energy. (2) Does not include: <ol style="list-style-type: none"> (a) The diagnosis of physical disabilities; (b) The use of roentgenic rays or radium; (c) The use of electricity for cauterization or surgery; or (d) The occupation of a masseur who massages only the superficial soft tissues of the body. 	<p>NSR § 640.022</p>

<p>New Hampshire</p>	<p>“Physical therapy” or “physiotherapy” means the care and services provided by or under the direction and supervision of a physical therapist who is licensed pursuant to this chapter.</p> <p>“Practice of physical therapy” or “practice of physiotherapy” means:</p> <ul style="list-style-type: none"> (a) Testing, examining and evaluating impairments, movement dysfunctions, and disabilities or other health and movement-related conditions in order to determine a diagnosis, prognosis, and plan of intervention, and to assess the outcomes of intervention. (b) Alleviating impairments, movement dysfunctions, and disabilities by designing and implementing, and modifying interventions that include, but are not limited to therapeutic exercise; training related to movement dysfunctions in self care and in home, community or work integration or reintegration; manual therapy including soft tissue and joint mobilization; therapeutic massage; assistive and adaptive orthotic, prosthetic, protective and supportive devices and equipment related to movement dysfunctions; airway clearance techniques; integumentary protection and repair techniques; debridement and wound care; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient-related instruction. (c) Reducing the risk of injury, impairment, movement dysfunctions and disability, including the promotion and maintenance of health, wellness, and fitness in populations of all ages. (d) Engaging in administration, consultation, education and research. 	<p>New Hampshire RSA 328-A:2</p>
<p>New Jersey</p>	<p>“Physical therapy” and “physical therapy practice” mean the identification of physical impairment or movement-related functional limitation that occurs as a result of injury or congenital or acquired disability, or other physical dysfunction through examination, evaluation and diagnosis of the physical impairment or movement-related functional limitation and the establishment of a prognosis for the resolution or amelioration thereof, and treatment of the physical impairment or movement-related functional limitation, which shall include, but is not limited to, the alleviation of pain, physical impairment and movement-related functional limitation by therapeutic intervention, including treatment by means of manual therapy techniques and massage, electro-therapeutic modalities, the use of physical agents, mechanical modalities, hydrotherapy, therapeutic exercises with or without assistive devices, neurodevelopmental procedures, joint mobilization, movement-related functional training in self-care, providing assistance in community and work integration or reintegration, providing training in techniques for the prevention of injury, impairment, movement-related functional limitation, or dysfunction, providing consultative, educational, other advisory services, and collaboration with other health care providers in connection with patient care, and such other treatments and functions as may be further defined by the board by regulation.</p>	<p>NJ Stat § 45:9-37.13</p>
<p>New Mexico</p>	<p>“Practice of physical therapy” means</p> <ul style="list-style-type: none"> (1) examining and evaluating patients with mechanical, physiological and developmental impairments, functional limitations and disabilities or other health-related conditions in order to determine a physical therapy diagnosis, prognosis and planned therapeutic intervention; (2) alleviating impairments and functional limitations by designing, implementing and modifying therapeutic interventions that include therapeutic exercise; functional training in self-care and community or work reintegration; manual therapy techniques, including soft tissue and joint mobilization and manipulation; therapeutic massage; assistive and adaptive devices and equipment; bronchopulmonary hygiene; debridement and wound care; physical agents; mechanical and electrotherapeutic modalities; and patient-related instruction; (3) preventing injury, impairments, functional limitations and disability, including the promotion and maintenance of fitness, health and quality of life in all age populations; and (4) engaging in consultation, testing, education and research. 	<p>NM State. § 61-12D-3</p>

<p>New York</p>	<p>“Physical therapy” is defined as:</p> <ol style="list-style-type: none"> 1. The evaluation, treatment or prevention of disability, injury, disease, or other condition of health using physical, chemical, and mechanical means including, but not limited to heat, cold, light, air, water, sound, electricity, massage, mobilization, and therapeutic exercise with or without assistive devices, and the performance and interpretation of tests and measurements to assess pathophysiological, pathomechanical, and developmental deficits of human systems to determine treatment, and assist in diagnosis and prognosis. 2. The use of roentgen rays or radium, or the use of electricity for surgical purposes such as cauterization shall not be included in the practice of physical therapy. 	<p>NY Educ. § 6731</p>
<p>North Carolina</p>	<p>“Physical therapy” means the evaluation or treatment of any person by the use of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes the performance of specialized tests of neuromuscular function, administration of specialized therapeutic procedures, interpretation and implementation of referrals from licensed medical doctors or dentists, and establishment and modification of physical therapy programs for patients. Evaluation and treatment of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. Physical therapy education and training shall include study of the skeletal manifestations of systemic disease. Physical therapy does not include the application of roentgen rays or radioactive materials, surgery, manipulation of the spine unless prescribed by a physician licensed to practice medicine in North Carolina, or medical diagnosis of disease.</p>	<p>NC Stat §90-270.24</p>
<p>North Dakota</p>	<p>“Physical therapy” means the care and services provided by or under the direction and supervision of a physical therapist licensed under this chapter.</p> <p>“Practice of physical therapy” means:</p> <ol style="list-style-type: none"> a. Examining, evaluating, and testing individuals with mechanical, physiological, and developmental impairments, functional limitations in movement and mobility, and disabilities or other health and movement-related conditions in order to determine a diagnosis for physical therapy, prognosis, and plan of therapeutic intervention, and to assess the ongoing effects of intervention. b. Alleviating impairments, functional limitations in movement and mobility, and disabilities by designing, implementing and modifying therapeutic interventions that may include, but are not limited to, therapeutic exercise; neuromuscular education; functional training related to positioning, movement, and mobility in self-care and in-home, community, or work integration or reintegration; manual therapy; therapeutic massage; prescription, application and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic, protective, and supportive devices and equipment related to positioning, movement, and mobility; airway clearance techniques; integumentary protection and repair techniques; debridement and wound care; physiotherapy; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient-related instruction. c. Engaging as a physical therapist in reducing the risk of injury, impairment, functional limitation and disability, including the promotion and maintenance of fitness, health, and wellness in populations of all ages. d. Engaging as a physical therapist in administration, consultation, education, and research. 	<p>N.C. Cent. Code, § 43-26.01-01</p>

<p>Ohio</p>	<p>“Physical therapy” means the evaluation and treatment of a person by physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating any disability. If performed by a person who is adequately trained, physical therapy includes all of the following:</p> <ol style="list-style-type: none"> (1) The design, fabrication, revision, education, and instruction in the use of various assistive devices including braces, splints, ambulatory or locomotion devices, wheelchairs, prosthetics, and orthotics; (2) The administration of topical drugs that have been prescribed by a licensed health professional authorized to prescribe drugs, as defined in section 4729.01 of the Revised Code; (3) The establishment and modification of physical therapy programs, treatment planning, patient education and instruction, and consultative services; (4) Physiotherapy. <p>Physical measures include massage, heat, cold, air, light, water, electricity, sound, and the performance of test of neuromuscular function as an aid to such treatment.</p> <p>Physical therapy does not include the medical diagnosis of a patient’s disability, the use of Roentgen rays or radium for diagnostic or therapeutic purposes, or the use of electricity for cauterization or other surgical purposes.</p>	<p>ORC Ann. 4755.40</p>
<p>Oklahoma</p>	<p>“Physical therapy” means the use of selected knowledge and skills in planning, organizing and directing programs for the care of individuals whose ability to function is impaired or threatened by disease or injury, encompassing preventive measures, screening, tests in aid of diagnosis by a licensed doctor of medicine, osteopathy, chiropractic, dentistry or podiatry, or a physician assistant, and evaluation and invasive or noninvasive procedures with emphasis on the skeletal system, neuromuscular and cardiopulmonary function, as it relates to physical therapy.</p> <p>Physical therapy includes screening or evaluations performed to determine the degree of impairment of relevant aspects such as, but not limited to, nerve and muscle function including transcutaneous bioelectrical potentials, motor development, functional capacity and respiratory or circulatory efficiency.</p> <p>Physical therapy also includes physical therapy treatment performed upon referral by a licensed doctor of medicine, osteopathy, dentistry, chiropractic or podiatry, or a physician assistant including, but not limited to, exercises for increasing or restoring strength, endurance, coordination and range of motion, stimuli to facilitate motor activity and learning, instruction in activities of daily living and the use of assistive devices and the application of physical agents to relieve pain or alter physiological status. The use of roentgen rays and radium for diagnostic or therapeutic purposes, the use of electricity for surgical purposes, including cauterization and colonic irrigations are not authorized under the term “physical therapy” as used in this chapter;</p>	<p>59 Okla. Stat. § 887.2</p>

<p>Oregon</p>	<p>“Physical therapy” means the care and services provided by a physical therapist or by a physical therapist assistant under the supervision and direction of a physical therapist.</p> <p>(5) “Practice of physical therapy” means:</p> <ul style="list-style-type: none"> (a) Examining, evaluating and testing for mechanical, physiological and developmental impairments, functional limitations and disabilities or other neuromusculoskeletal conditions in order to determine a physical therapy diagnosis or prognosis or a plan of physical therapy intervention and to assess the ongoing effects of physical therapy intervention. (b) Alleviating impairments and functional limitations by designing, implementing, administering and modifying physical therapy interventions. (c) Reducing the risk of injury, impairment, functional limitation and disability by physical therapy interventions that may include as a component the promotion and maintenance of health, fitness and quality of life in all age populations. (d) Consulting or providing educational services to a patient for the purposes of paragraphs (a),(b) and (c) of this subsection. 	<p>ORS § 688.010</p>
<p>Pennsylvania</p>	<p>“Physical therapy” means any of the following:</p> <ul style="list-style-type: none"> (1) The evaluation, examination and testing of individuals with mechanical, physiological and developmental impairments, functional limitations and disabilities, other health-related or movement-related conditions, performed to determine a diagnosis, prognosis and plan of treatment intervention within the scope of this act or to assess the ongoing effects of intervention. (2) The performance of tests and measurements as an aid in diagnosis or evaluation of function and the treatment of the individual through the utilization of the effective properties of physical measures such as mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage or mobilization-manual therapy. (3) The use of therapeutic exercises and rehabilitative procedures, including training in functional activities, with or without the utilization of assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or mental conditions. (4) Reducing the risk of injury, impairment, functional limitation and disability, including the promotion and maintenance of fitness, health and wellness in populations of all ages as well as engaging in administration, consultation, education and research. 	<p>63 PS § 1302</p>
<p>Rhode Island</p>	<p>“Practice of physical therapy” means the examination, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate and limit physical disability, physical dysfunction, and pain from injury, disease and any other bodily conditions, and includes the administration, interpretation, and evaluation of tests and measurements of bodily functions and structures; the planning, administration, evaluation, and modification of treatment and instruction, including the use of physical measures, activities, and devices, for preventive and therapeutic purposes; and the provision of consultative, educational, and other advisory services for the purpose of reducing the incidence and severity of physical disability, physical dysfunction and pain.</p> <p>(ii) The practice of physical therapy does not include the practice of medicine as defined in chapter 37 of this title.</p>	<p>R.I. Gen. Laws § 5-40-1</p>

<p>South Carolina</p>	<p>“The practice of physical therapy” means the evaluation and treatment of human beings to detect, assess, prevent, correct, alleviate, and limit physical disability, bodily malfunction, and pain from injury, disease, and any other bodily or mental condition and includes the administration, interpretation, documentation, and evaluation of physical therapy tests and measurements of bodily functions and structures; the establishment, administration, evaluation, and modification of a physical therapy treatment plan which includes the use of physical, chemical, or mechanical agents, activities, instruction, and devices for prevention and therapeutic purposes; and the provision of consultation and educational and other advisory services for the purpose of preventing or reducing the incidence and severity of physical disability, bodily malfunction, and pain. The use of roentgen rays and radium for diagnostic or therapeutic purposes and the use of electricity for surgical purposes, including cauterization and colonic irrigations, are not authorized under the term “physical therapy” as used in this chapter, and nothing in this chapter shall be construed to authorize a physical therapist to prescribe medications or order laboratory or other medical tests.</p>	<p>SC Code § 40-45-20</p>
<p>South Dakota</p>	<p>“Physical therapy,” the care and services provided by or under the direction and supervision of a physical therapist;</p> <p>Physical therapy defined. For the purposes of this chapter, the practice of physical therapy is the examination and evaluation of patients with mechanical, physiological, and developmental impairments, functional limitation, and disability or other similar conditions in order to determine a diagnosis, prognosis, and therapeutic intervention; alleviation of impairments and functional limitations by designing, implementing, and modifying therapeutic interventions that include therapeutic exercise, functional training in community or work reintegration, manual therapy techniques including soft tissue and joint mobilization, assistive and adaptive devices and equipment, brochopulmonary hygiene, debridement and wound care, physical agents and mechanical modalities, therapeutic massage, electrotherapeutic modalities, and patient-related instruction; prevention of injury, impairments, functional limitations, and disability including the promotion and maintenance of fitness, health, and quality of life in all age populations; and consultation, education, and research.</p>	<p>S.D. Codified Laws § 36-10-18 and 36-10-18.1</p>
<p>Tennessee</p>	<p>“Practice of physical therapy” means:</p> <ul style="list-style-type: none"> (a) Examining, evaluating and testing individuals with mechanical, physiological and developmental impairments, functional limitations, and disability or other health and movement-related conditions in order to determine a physical therapy treatment diagnosis, prognosis, a plan of therapeutic intervention, and to assess the ongoing effect of intervention; (b) Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic interventions that include, but are not limited to: therapeutic exercise; functional training; manual therapy; therapeutic massage; assistive and adaptive orthotic, prosthetic, protective and supportive equipment; airway clearance techniques; debridement and wound care, physical agents or modalities, mechanical and electrotherapeutic modalities; and patient-related instruction; (c) Reducing the risk of injury, impairments, functional limitation and disability, including the promotions and maintenance of fitness, health and quality of life in all age populations; and (d) Engaging in administration, consultation, education and research. 	<p>TN Code § 63-13-103</p>

<p>Texas</p>	<p>“Physical therapy” means a form of health care that prevents, identifies, corrects, or alleviates acute or prolonged movement dysfunction or pain of anatomic or physiologic origin.</p> <p>The practice of physical therapy includes:</p> <ol style="list-style-type: none"> (1) measurement or testing of the function of the musculoskeletal, neurological, pulmonary, or cardiovascular system; (2) rehabilitative treatment concerned with restoring function or preventing disability caused by illness, injury, or birth defect; (3) treatment, consultative, educational, or advisory services to reduce the incidence or severity of disability or pain to enable, train, or retrain a person to perform the independent skills and activities of daily living; and (4) delegation of selective forms of treatment to support personnel while a physical therapist retains the responsibility for caring for the patient and directing and supervising the support personnel. 	<p>TX Occupational Code § 453.001</p>
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<p>Utah</p>	<p>“Physical therapy” or “physiotherapy” means:</p> <ul style="list-style-type: none"> (i) examining, evaluating, and testing an individual who has a physical impairment or injury; (ii) identifying or labeling a physical impairment or injury; (iii) formulating a therapeutic intervention plan for the treatment of a physical impairment, injury, or pain; (iv) assessing the ongoing effects of therapeutic intervention for the treatment of a physical impairment or injury; (v) treating or alleviating a physical impairment by designing, modifying, or implementing a therapeutic intervention; (vi) reducing the risk of an injury or physical impairment; (vii) providing instruction on the use of physical measures, activities, or devices for preventative and therapeutic purposes; (viii) promoting and maintaining health and fitness; (ix) the administration of a prescription drug pursuant to Section 58-24b-403; (x) engaging in the functions in relation to an animal, in accordance with the requirements of Section 58-24b-405; and (xi) engaging in administration, consultation, education, and research relating to the practices described in this Subsection (11)(a). <p>(b) “Physical therapy” or “physiotherapy” does not include:</p> <ul style="list-style-type: none"> (i) diagnosing disease; (ii) performing surgery; (iii) performing acupuncture; (iv) taking x-rays; or (v) prescribing or dispensing a drug, as defined in Section 58-37-2. <p>Testing includes measurement or evaluation of:</p> <ul style="list-style-type: none"> (i) muscle strength, force, endurance, or tone; (ii) cardiovascular fitness; (iii) physical work capacity; (iv) joint motion, mobility, or stability; (v) reflexes or autonomic reactions; (vi) movement skill or accuracy; (vii) sensation; (viii) perception; (ix) peripheral nerve integrity; (x) locomotor skills, stability, and endurance; (xi) posture; (xii) body mechanics; (xiv) limb length, circumference, and volume; (xv) biofeedback; (xvi) thoracic excursion and breathing patterns; (xvii) activities of daily living related to physical movement and mobility; and (xviii) functioning in the physical environment at home or work, as it relates to physical movement and mobility. <p>“Therapeutic intervention” includes:</p> <ul style="list-style-type: none"> (a) therapeutic exercise, with or without the use of a device; (b) functional training in self-care, as it relates to physical movement and mobility; (c) community or work integration, as it relates to physical movement and mobility; (d) manual therapy, including: (i) soft tissue mobilization; (ii) therapeutic massage; or (iii) joint mobilization, as defined by the division, by rule; (e) prescribing, applying, or fabricating an assistive, adaptive, orthotic, prosthetic, protective, or supportive device; (f) airway clearance techniques, including postural drainage; (g) integumentary protection and repair techniques; (h) wound debridement, leansing, and dressing; (i) the application of a physical agent, including: (i) light; (ii) heat; (iii) cold; (iv) water; (v) air; (vi) sound; (vii) compression; (viii) electricity; and (ix) electromagnetic radiation; (j) mechanical or electrotherapeutic modalities; (k) positioning; (l) instructing or training a patient in locomotion or other functional activities, with or without an assistive device; (m) manual or mechanical traction; and (n) correction of posture, body mechanics, or gait 	<p>UT Code §58-24b-102</p>
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<p>Vermont</p>	<p>“Physical therapy” means the care and services provided by or under the direction and supervision of a physical therapist who is licensed pursuant to this chapter.</p> <p>“Practice of physical therapy” means:</p> <p>(A) examining, evaluating, and testing, in order to determine a plan of care inclusive of appropriate therapeutic interventions and expected outcome and effect of the interventions of individuals with:</p> <ul style="list-style-type: none"> (i) mechanical, physiological, and developmental impairments; (ii) functional limitations in physical movement and mobility; (iii) disabilities; and (iv) other movement-related conditions; <p>(B) alleviating impairments and functional limitations in physical movement and mobility and disabilities by developing, implementing, and modifying treatment interventions; or</p> <p>(C) reducing the risk of injury, impairment, functional limitation, and disability related to physical movement and mobility, including the promotion and maintenance of fitness, health, and wellness related to movement and function.</p>	<p>26 V.S.A. § 2081a</p>
<p>Virginia</p>	<p>“Practice of physical therapy” means that branch of the healing arts that is concerned with, upon medical referral and direction, the evaluation, testing, treatment, reeducation and rehabilitation by physical, mechanical or electronic measures and procedures of individuals who, because of trauma, disease or birth defect, present physical and emotional disorders. The practice of physical therapy also includes the administration, interpretation, documentation, and evaluation of tests and measurements of bodily functions and structures within the scope of practice of the physical therapist. However, the practice of physical therapy does not include the medical diagnosis of disease or injury, the use of Roentgen rays and radium for diagnostic or therapeutic purposes or the use of electricity for shock therapy and surgical purposes including cauterization.</p>	<p>Va. Code Ann. § 54.1-3473</p>

<p>Washington</p>	<p>“Physical therapy” means the care and services provided by or under the direction and supervision of a physical therapist licensed by the state. The use of Roentgen rays and radium for diagnostic and therapeutic purposes, the use of electricity for surgical purposes, including cauterization, and the use of spinal manipulation, or manipulative mobilization of the spine and its immediate articulations, are not included under the term “physical therapy” as used in this chapter.</p> <p>“Practice of physical therapy” is based on movement science and means:</p> <ul style="list-style-type: none"> (a) Examining, evaluating, and testing individuals with mechanical, physiological, and developmental impairments, functional limitations in movement, and disability or other health and movement-related conditions in order to determine a diagnosis, prognosis, plan of therapeutic intervention, and to assess and document the ongoing effects of intervention; (b) Alleviating impairments and functional limitations in movement by designing, implementing, and modifying therapeutic interventions that include therapeutic exercise; functional training related to balance, posture, and movement to facilitate self-care and reintegration into home, community, or work; manual therapy including soft tissue and joint mobilization and manipulation; therapeutic massage; assistive, adaptive, protective, and devices related to postural control and mobility except as restricted by (c) of this subsection; airway clearance techniques; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient-related instruction; (c) Training for, and the evaluation of, the function of a patient wearing an orthosis or prosthesis as defined in RCW 18.200.010. Physical therapists may provide those direct-formed and prefabricated upper limb, knee, and ankle-foot orthoses, but not fracture orthoses except those for hand, wrist, ankle, and foot fractures, and assistive technology devices specified in RCW 18.200.010 as exemptions from the defined scope of licensed orthotic and prosthetic services. It is the intent of the legislature that the unregulated devices specified in RCW 18.200.010 are in the public domain to the extent that they may be provided in common with individuals or other health providers, whether unregulated or regulated under Title 18 RCW, without regard to any scope of practice; (d) Performing wound care services that are limited to sharp debridement, debridement with other agents, dry dressings, wet dressings, topical agents including enzymes, hydrotherapy, electrical stimulation, ultrasound, and other similar treatments. Physical therapists may not delegate sharp debridement. A physical therapist may perform wound care services only by referral from or after consultation with an authorized health care practitioner; (e) Reducing the risk of injury, impairment, functional limitation, and disability related to movement, including the promotion and maintenance of fitness, health, and quality of life in all age populations; and (f) Engaging in administration, consultation, education, and research. 	<p>ARCW § 18.74.010</p>
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<p>West Virginia</p>	<p>A physical therapist may:</p> <ol style="list-style-type: none"> (1) Examine, evaluate and test patients or clients with mechanical, physiological and developmental impairments, functional limitations, and disabilities or other health and movement related conditions in order to determine a diagnosis, prognosis and plan of treatment intervention, and to assess the ongoing effects of intervention: Provided, That electromyography examination and electrodiagnostic studies other than the determination of chronaxia and strength duration curves shall not be performed except under the supervision of a physician electromyographer and electrodiagnostician; (2) Alleviate impairments, functional limitations and disabilities by designing, implementing and modifying treatment interventions that may include, but are not limited to: therapeutic exercise; functional training in self-care in relation to motor control function; mobility; in home, community or work integration or reintegration; manual therapy techniques including mobilization of the joints; therapeutic massage; fabrication of assistive, adaptive, orthotic, prosthetic, protective and supportive devices and equipment; airway clearance techniques; integumentary protection and repair techniques; patient-related instruction; mechanical and electrotherapeutic modalities; and physical agent or modalities including, but not limited to, heat, cold, light, air, water and sound; (3) Reduce the risk of injury, impairment, functional limitation and disability, including the promotion and maintenance of fitness, health and wellness in populations of all ages; and (4) Engage in administration, consultation and research. 	<p>WV Code §30-20-9</p>
<p>Wisconsin</p>	<p>“Physical therapy” means, except as provided in par. (b), any of the following:</p> <ol style="list-style-type: none"> 1. Examining, evaluating, or testing individuals with mechanical, physiological, or developmental impairments, functional limitations related to physical movement and mobility, disabilities, or other movement-related health conditions, in order to determine a diagnosis, prognosis, or plan of therapeutic intervention or to assess the ongoing effects of intervention. In this subdivision, “testing” means using standardized methods or techniques for gathering data about a patient. 2. Alleviating impairments or functional limitations by instructing patients or designing, implementing, or modifying therapeutic interventions. 3. Reducing the risk of injury, impairment, functional limitation, or disability, including by promoting or maintaining fitness, health, or quality of life in all age populations. 4. Engaging in administration, consultation, or research that is related to any activity specified in subds. 1. to 3. <p>(b) “Physical therapy” does not include using roentgen rays or radium for any purpose, using electricity for surgical purposes, including cauterization, or prescribing drugs or devices.</p>	<p>Wis. Stat. § 448.50</p>

<p>Wyoming</p>	<p>“Physical therapy” or “physiotherapy” means the care and services provided by or under the direction and supervision of a physical therapist or physiotherapist who is licensed pursuant to this act. The practice of physical therapy includes:</p> <p>(A) Examining, evaluating and testing persons with mechanical, physiological or developmental impairments, functional limitations, disabilities or other health or movement related conditions to determine a physical therapy diagnosis, prognosis or plan of treatment and assessing the ongoing effects of intervention;</p> <p>(B) Alleviating impairments, functional limitations or disabilities by designing, implementing or modifying treatment interventions that may include but are not limited to:</p> <ul style="list-style-type: none"> (I) Therapeutic exercise; (II) Functional activities in the home; (III) Community or work integration or reintegration; (IV) Manual therapy, which includes mobilization and grades I through IV manipulation of joints and soft tissue but does not include grade V manipulations without completion of advanced training requirements as determined by the board; (V) Therapeutic massage; (VI) Prescription, application or fabrication of appropriate assistive, adaptive, protective or supportive devices or equipment; (VII) Airway clearance techniques; (VIII) Integumentary protection or repair techniques; (IX) Wound care; (X) Application of physical agents or modalities; (XI) (XI) Mechanical modalities; (XII) Patient related instruction. <p>(C) Reducing the risk of injury, impairment, functional limitation or disability, including the promotion and maintenance of fitness, health and wellness.</p>	<p>Wyo. Stat. § 33-25-101</p>
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APPENDIX M

Direct Access to Physical Therapist Services, by State

Current as of January 2011

Direct patient access to physical therapy services is legal in the majority of U.S. jurisdictions. Treatment may be provided without a referral and without restrictions in 16 states (“unrestricted”); and without a referral but with certain restrictions in 29 states (“limited”). Three states permit a physical therapist to conduct a patient evaluation without a referral but do not permit treatment without a referral. Two states require a referral for evaluation as well as treatment. While state law may permit treatment without a referral, payers may still require a referral.

Physical therapists must determine a diagnosis regarding the patient’s specific condition for which they will be providing treatment intervention before making patient management decisions. A diagnosis from a referral source does not negate the physical therapist’s responsibility to arrive at a diagnosis specific to the condition for which the therapist’s treatment plan and intervention will be directed. The evaluative and diagnostic process should also include a prognosis or an expectation of outcome, and the time needed to achieve it, associated with treatment intervention. The end result of the evaluative process is the design of the treatment intervention. The physical therapist regularly assesses the effects of the treatment intervention, making any needed modifications to the intervention to achieve the desired outcome.

State	Type	Year	Provisions	Citation
Alabama	No Direct Access		No access	
Alaska	Unlimited	1986	No restrictions to access.	
Arizona	Unlimited	1983	No restrictions to access.	
Arkansas	Limited	1997	The therapeutic intervention of bronchopulmonary hygiene and debridement of wounds require a physician referral before initiation of treatment.	A.C.A § 17-93-102
California	Limited	1968	No referral requirement in statute or board regulations. 1965 California Attorney General Opinion (AG Opinion No. 65-21) states that a physical therapist may practice without a physician’s referral provided that a diagnosis is obtained from a diagnostician.	
Colorado	Unlimited	1988	No restrictions to access.	

Connecticut	Limited	2006	<p>(b)(1) The treatment of human ailments by physical therapy shall only be performed by a person licensed under the provisions of this chapter as a physical therapist or physical therapist assistant. Except as otherwise provided in subdivisions (2) and (3) of this subsection, such treatment may be performed by a licensed physical therapist without an oral or written referral by a person licensed in this state to practice medicine and surgery, podiatry, naturopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d, provided the licensed physical therapist (A) was admitted to a bachelor's degree program prior to January 1, 1998, and has practiced physical therapy for at least four out of the most recent six years of his or her clinical practice, or earned a master's degree or higher in physical therapy from an accredited institution of higher education, (B) requires any person receiving such treatment to disclose or affirmatively confirm the identity of such person's primary care provider or health care provider of record upon each initial visit for treatment without an oral or written referral, (C) provides information to any person seeking such treatment regarding the need to consult with such person's primary care provider or health care provider of record regarding such person's underlying medical condition if the condition is prolonged, does not improve within a thirty-day period, or continues to require ongoing continuous treatment, and (D) refers any person receiving such treatment to an appropriate licensed practitioner of the healing arts if, upon examination or reexamination, the same condition for which the person sought physical therapy does not demonstrate objective, measurable, functional improvement in a period of thirty consecutive days or at the end of six visits, whichever is earlier.</p> <p>(2) In any case in which a person seeking such treatment requires a Grade V spinal manipulation, such treatment shall only be performed (A) upon the oral or written referral of a person licensed in this state, or in a state having licensing requirements meeting the approval of the appropriate examining board in this state, to practice medicine and surgery, podiatry, naturopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d, and (B) by a licensed physical therapist who (i) was admitted to a bachelor's degree program prior to January 1, 1998, and has practiced physical therapy for at least four out of the most recent six years of his or her clinical practice, or earned a master's degree or higher in physical therapy from an accredited institution of higher education, and (ii) holds a specialist certification in orthopedic physical therapy from the American Physical Therapy Association, or proof of completion of forty hours of course work in manual therapy, including Grade V spinal manipulation. Nothing in this section shall prevent a physical therapist from providing wellness care within the scope of physical therapy practice to asymptomatic persons without a referral. Nothing in this section shall require an employer or insurer to pay for such wellness care.</p> <p>(3) In any case involving an injury, as described in section 31-275, such treatment shall only be performed upon the oral or written referral of a person licensed in this state or in a state having licensing requirements meeting the standards set by the Department of Public Health and the appropriate examining board in this state to practice medicine and surgery, podiatry, naturopathy, chiropractic or dentistry, or an advanced practice registered nurse licensed to prescribe in accordance with section 20-94a or a physician assistant licensed to prescribe in accordance with section 20-12d.</p>	Conn. Gen. Stat. §20-73
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Delaware	Limited	1993	<p>Section 1.0 Definitions</p> <p>Consultation (24 Del.C. § 2612):</p> <p>1.1.1 - Consultation in direct access. A physician must be consulted if a patient is still receiving physical therapy after 30 calendar days have lapsed from the date of the initial assessment. This consultation must be documented and could take place at any time during the initial thirty day period. The consultation can be made by telephone, fax, in writing, or in person. There is nothing in these rules and regulations or in the Physical Therapy Law that limits the number of consultations the Physical Therapist can make on the patient's behalf. The consult should be with the patient's personal physician. If the patient does not have a personal physician, the Physical Therapist is to offer the patient at least three physicians from which to choose. The referral to a physician after the initial thirty day period must not be in conflict with 24 Del.C. § 2616 (a)(8) which deals with referral for profit. If no physician consult has been made in this initial thirty day period, treatment must be terminated and no treatment may be resumed without a physician consult.</p> <p>1.1.2 - Consultation with written prescription from a physician, dentist, podiatrist, or chiropractor. A prescription accompanying a patient must not be substantially modified without documented consultation with the referring practitioner. The consultation can be made by telephone, fax, in writing, or in person.</p> <p>1.5 - Unprofessional Conduct (24 Del.C. § 2616 (7)):</p> <p>Unprofessional conduct shall include departure from or the failure to conform to the minimal standards of acceptable and prevailing physical therapy practice or athletic training practice, in which proceeding actual injury to a patient need not be established. 24 Del.C. § 2616 (7). Such unprofessional conduct shall include, but not be limited to, the following:</p> <p>1.5.20 - Continuing to treat a patient, who initiated treatment without a formal referral, for longer than thirty days without a physician consult.</p> <p>1.5.21 - Substantially modifying a treatment prescription without consulting the referring physician.</p>	24 Del.C. § 26
District of Columbia	Limited	2007	6710.13 If a physical therapy patient fails to respond to treatment within thirty (30) days after being seen by a physical therapist for the first time, the physical therapist shall refer the patient to an appropriate health care provider for assessment, medical diagnosis, intervention, or referral.	Chapter 67
Florida	Limited	1992	<p>Section 486.021 Definitions.</p> <p>(11) A physical therapist may implement a plan of treatment for a patient. The physical therapist shall refer the patient to or consult with a health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466, if the patient's condition is found to be outside the scope of physical therapy. If physical therapy treatment for a patient is required beyond 21 days for a condition not previously assessed by a practitioner of record, the physical therapist shall obtain a practitioner of record who will review and sign the plan. A health care practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 and engaged in active practice is eligible to serve as a practitioner of record.</p>	Chapter 486.021

Georgia	Limited	2006	<p>Section 43-33-18:</p> <p>(a) The board shall have authority to refuse to grant or restore a license to an applicant or to discipline a physical therapist or physical therapist assistant licensed under this chapter or any antecedent law upon a finding by the board that the licensee or applicant has:</p> <p>(1)(A) Implemented or continued a program of physical therapy treatment without consultation with an appropriate licensed practitioner of the healing arts; except that a physical therapist may implement a program of physical therapy treatment without consultation with an appropriately licensed practitioner of the healing arts when:</p> <p>(i) Services are provided for the purpose of fitness, wellness, or prevention that is not related to the treatment of an injury or ailment; or</p> <p>(ii)(I) The patient was previously diagnosed and received treatment or services for that diagnosis and the patient returns to physical therapy within 60 days of discharge from physical therapy for problems and symptoms that are related to the initial referral to the physical therapist. In such a situation the physical therapist shall notify the original referral source of the return to physical therapy within five business days; and</p> <p>(II) The physical therapist holds a master or doctorate degree from a professional physical therapy program that is accredited by a national accreditation agency recognized by the United States Department of Education and approved by the Georgia State Board of Physical Therapy or the physical therapist has completed at least two years of practical experience as a licensed physical therapist. If after 90 days of initiating physical therapy services the physical therapist determines that no substantial progress has been made with respect to the primary complaints of the patient, the physical therapist shall refer the patient to an appropriately licensed practitioner of the healing arts. If at any time the physical therapist has reason to believe that the patient has symptoms or conditions that require treatment or services beyond the scope of practice of the physical therapist, the physical therapist shall refer the patient to an appropriately licensed practitioner of the healing arts;"</p>	Code Section 43-33-18
Hawaii	Unlimited	2010	No restrictions to access.	
Idaho	Unlimited	1987	No restrictions to access.	Idaho Code § 54-2216

Illinois	Limited	1988	<p>(225 ILCS 90/1)</p> <p>Sec. 1. Definitions. As used in this Act:</p> <p>(1) "Physical therapy" means all of the following: ...</p> <p>A physical therapist shall refer to a licensed physician, advanced practice nurse, physician assistant, dentist, or podiatrist any patient whose medical condition should, at the time of evaluation or treatment, be determined to be beyond the scope of practice of the physical therapist.</p> <p>(6) "Referral" means a written or oral authorization for physical therapy services for a patient by a physician, dentist, advanced practice nurse, physician assistant, or podiatrist who maintains medical supervision of the patient and makes a diagnosis or verifies that the patient's condition is such that it may be treated by a physical therapist.</p> <p>(7) "Documented current and relevant diagnosis" for the purpose of this Act means a diagnosis, substantiated by signature or oral verification of a physician, dentist, advanced practice nurse, physician assistant, or podiatrist, that a patient's condition is such that it may be treated by physical therapy as defined in this Act, which diagnosis shall remain in effect until changed by the physician, dentist, advanced practice nurse, physician assistant, or podiatrist.</p> <p>A physical therapist shall refer to a licensed physician, advanced practice nurse, physician assistant, dentist, or podiatrist any patient whose medical condition should, at the time of evaluation or treatment, be determined to be beyond the scope of practice of the physical therapist.</p> <p>(225 ILCS 90/17)</p> <p>Sec. 17. (1)The Department may refuse to issue or to renew, or may revoke, suspend, place on probation, reprimand, or take other disciplinary action as the Department deems appropriate, including the issuance of fines not to exceed \$5000, with regard to a license for any one or a combination of the following:...</p> <p>V. Having treated ailments of human beings otherwise than by the practice of physical therapy as defined in this Act, or having treated ailments of human beings as a licensed physical therapist independent of a documented referral or a documented current and relevant diagnosis from a physician, dentist, advanced practice nurse, physician assistant, or podiatrist, or having failed to notify the physician, dentist, advanced practice nurse, physician assistant, or podiatrist who established a documented current and relevant diagnosis that the patient is receiving physical therapy pursuant to that diagnosis;</p>	225 ILCS 90
Indiana	No Direct Access		No access.	IC 25-27-1-2
Iowa	Unlimited	1988	<p>No restrictions to access.</p> <p>DEFINITIONS -- REFERRAL -- AUTHORIZATION.</p> <p>2. Physical therapy evaluation and treatment may be rendered by a physical therapist with or without a referral from a physician, podiatric physician, dentist, or chiropractor, except that a hospital may require that physical therapy evaluation and treatment provided in the hospital shall be done only upon prior review by and authorization of a member of the hospital's medical staff.</p>	Iowa Code § 148A.1

Kansas	Limited	2007	<p>Evaluation and treatment by physical therapists; when referral is required; exceptions. (a) Except as otherwise provided in subsection (b), (c) or (d), a physical therapist may evaluate patients without physician referral but may initiate treatment only after approval by a licensed physician, a licensed podiatrist, a licensed physician assistant or an advanced registered nurse practitioner working pursuant to the order or direction of a licensed physician, a licensed chiropractor, a licensed dentist or licensed optometrist in appropriately related cases. Physical therapists may initiate physical therapy treatment with the approval of a practitioner of the healing arts duly licensed under the laws of another state and may provide such treatment based upon an order by such practitioner in any setting in which physical therapists would be authorized to provide such treatment with the approval of a physician licensed by the board, notwithstanding any provisions of the Kansas healing arts act or any rules and regulations adopted by the board thereunder.</p> <p>(b) Physical therapists may evaluate and treat a patient for no more than 30 consecutive calendar days without a referral under the following conditions: (1) The patient has previously been referred to a physical therapist for physical therapy services by a person authorized by this section to approve treatment; (2) the patient's referral for physical therapy was made within one year from the date a physical therapist implements a program of physical therapy treatment without a referral; (3) the physical therapy being provided to the patient without referral is for the same injury, disease or condition as indicated in the referral for such previous injury, disease or condition; and (4) the physical therapist transmits to the physician or other practitioner identified by the patient a copy of the initial evaluation no later than five business days after treatment commences. Treatment for more than 30 consecutive calendar days of such patient shall only be upon the approval of a person authorized by this section to approve treatment.</p> <p>(c) Physical therapists may provide, without a referral, services which do not constitute treatment for a specific condition, disease or injury to: (1) Employees solely for the purpose of education and instruction related to workplace injury prevention; or (2) the public for the purpose of fitness, health promotion and education.</p> <p>(d) Physical therapists may provide services without a referral to special education students who need physical therapy services to fulfill the provisions of their individualized education plan (IEP) or individualized family service plan (IFSP).</p>	K.S.A § 65-2921
Kentucky	Unlimited	1987	No restrictions to access.	

Louisiana	Limited	2003	<p>§2410. Practice</p> <p>A. ...A person licensed under this Chapter may perform an initial evaluation or consultation of a screening nature to determine the need for physical therapy without referral or prescription, but implementation of physical therapy treatment to individuals for their specific condition or conditions shall be based on the prescription or referral of a person licensed to practice medicine, surgery, dentistry, podiatry, or chiropractic.</p> <p>D. A physical therapist licensed under this Chapter shall not perform physical therapy services without a prescription or referral from a person licensed to practice medicine, surgery, dentistry, podiatry, or chiropractic. However, a physical therapist licensed under this Chapter may perform physical therapy services without a prescription or referral under the following circumstances:</p> <p>(1) To Children with a diagnosed disability pursuant to the patient's plan of care.</p> <p>(2) As a part of a home health care agency pursuant to the patient's plan of care.</p> <p>(3) To a patient in a nursing home pursuant to the patient's plan of care.</p> <p>(4) Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention reduction of stress, or promotion of fitness.</p> <p>(5) (a) To an individual for a previously diagnosed condition or conditions for which physical therapy services are appropriate after informing the health care provider rendering the diagnosis. The diagnosis shall have been made within the previous ninety days. The physical therapist shall provide the health care provider who rendered such diagnosis with a plan of care for physical therapy services within the first fifteen days of physical therapy intervention.</p>	Chapter 29 §2410
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Maine	Limited	1991	<p>License required; limitations and exceptions</p> <p>Physical therapists may not apply manipulative thrust to the vertebrae of the spine except upon consultation with, and referral by, a duly licensed doctor of medicine, surgery, chiropractic or osteopathy. A licensed physical therapist or physical therapist assistant may not administer drugs except upon the referral of a duly licensed doctor of medicine, surgery, osteopathy, podiatry or dentistry, and may not use roentgen rays or radium or use electricity for surgical purposes.</p> <p>When treating a patient without referral from a doctor of medicine, osteopathy, podiatry, dentistry or chiropractic, the physical therapist or physical therapist assistant is subject to the following requirements.</p> <ol style="list-style-type: none"> 1. No medical diagnosis. A physical therapist or physical therapist assistant may not make a medical diagnosis. The physical therapist or physical therapist assistant shall refer to a licensed doctor of medicine, osteopathy, podiatry, dentistry or chiropractic a patient whose physical condition, either at the initial evaluation or during subsequent treatment, the physical therapist or physical therapist assistant determines to be beyond the scope of the practice of the physical therapist or physical therapist assistant. 2. No improvement. If no improvement in the patient is documented by the physical therapist or physical therapist assistant within 30 days of initiation of treatment, the physical therapist or physical therapist assistant shall refer the patient to a licensed doctor of medicine, osteopathy, podiatry, dentistry or chiropractic. 3. Length of treatment. For treatment required beyond 120 days, the physical therapist or physical therapist assistant shall consult with, or refer the patient to, a licensed doctor of medicine, surgery, osteopathy, podiatry, dentistry or chiropractic. The physical therapist or physical therapist assistant shall document the action taken. <p>An employer is not liable under Title 39-A, section 206 for charges for services of a physical therapist or physical therapist assistant unless the employee has been referred to that practitioner by a licensed doctor of medicine, surgery, osteopathy, chiropractic, podiatry or dentistry.</p>	32 MRS § 3113-A
Maryland	Unlimited	1979	No restrictions to access.	
Massachusetts	Unlimited	1982	No restrictions to access.	
Michigan	Evaluation Only		<p>Practice of physical therapy or physical therapist assistant; license or authorization required; engaging in actual treatment upon prescription of certain license holders; use of words, titles, or letters.</p> <p>(1) A person shall not engage in the practice of physical therapy or practice as a physical therapist assistant unless licensed or otherwise authorized under this part. A person shall engage in the actual treatment of an individual only upon the prescription of an individual holding a license issued under part 166, 170, 175, or 180, or the equivalent license issued by another state.</p>	MCL § 333.17820

<p>Minnesota</p>	<p>Limited</p>	<p>1988; Revised 2008</p>	<p>DISCIPLINARY ACTION.</p> <p>(a) The board may impose disciplinary action specified in paragraph (b) against an applicant or licensee whom the board, by a preponderance of the evidence, determines:</p> <p>(8) has treated human ailments by physical therapy after an initial 90-day period of patient admittance to treatment has lapsed, except by the order or referral of a person licensed in this state in the practice of medicine as defined in section 147.081, the practice of chiropractic as defined in section 148.01, the practice of podiatry as defined in section 153.01, or the practice of dentistry as defined in section 150A.05, or the practice of advance practice nursing as defined in section 148.111, subdivision 3, when orders or referrals are made in and whose license is in collaboration with a physician, chiropractor, podiatrist, or dentist, and whose license is in good standing; or when a previous diagnosis exists indicating an ongoing condition warranting physical therapy treatment, subject to periodic review defined by board of physical therapy rule. The 90-day limitation of treatment by a physical therapist without an order or referral does not apply to prevention, wellness, education, or exercise;</p> <p>(9) for a physical therapist licensed less than one year, has treated human ailments, without referral, by physical therapy treatment without first having practiced one year in collaboration with a physical therapist with more than one year of experience or under a physician's orders or referrals as verified by the board's records;</p> <p>(10) has failed to consult with the patient's licensed health care provider, or licensed health care professional, who prescribed the physical therapy treatment if the treatment is altered by the physical therapist from the original written order. The provision does not include written orders to "evaluate and treat";</p> <p>(12) has practiced as a physical therapist performing medical diagnosis, the practice of medicine as defined in section 147.081, or the practice of chiropractic as defined in section 148.01;</p> <p>(16) has failed to refer to a licensed health care professional a patient whose medical condition has been determined by the physical therapist to be beyond the scope of practice of a physical therapist;</p> <p>PROHIBITED CONDUCT</p> <p>Subd. 2. Prohibitions. (a) No physical therapist may:</p> <p>(1) treat human ailments by physical therapy after an initial 90-day period of patient admittance to treatment has lapsed, except by the order or referral of a person licensed in this state to practice medicine as defined in section 147 .081, the practice of chiropractic as defined in section 148.01, the practice of podiatry as defined in section 153.01, the practice of dentistry as defined in section 150A.05, or the practice of advanced practice nursing as defined in section 62A.15, subdivision 3a, when orders or referrals are made in collaboration with a physician, chiropractor, podiatrist, or dentist, and whose license is in good standing; or when a previous diagnosis exists indicating an ongoing condition warranting physical therapy treatment, subject to periodic review defined by Board of Physical Therapy rule. The 90-day limitation of treatment by a physical therapist without an order or referral does not apply to prevention, wellness, education, or exercise;</p> <p>(b) No physical therapist licensed less than one year may treat human ailments, without referral, by physical therapy treatment without first having practiced one year in collaboration with a physical therapist with more than one year of experience or under a physician's orders or referrals as verified by the board's records.</p>	<p>Minn. Stat. § 148.65</p>
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Mississippi	Limited	2006	<p>SEC. 73-23-35. (3) A physical therapist licensed under this chapter shall not perform physical therapy services without a prescription or referral from a person licensed as a physician, dentist, osteopath, podiatrist, chiropractor or nurse practitioner. However, a physical therapist licensed under this chapter may perform physical therapy services without a prescription or referral under the following circumstances:</p> <p>(a) To children with a diagnosed developmental disability pursuant to the patient's plan of care.</p> <p>(b) As part of a home health care agency pursuant to the patient's plan of care.</p> <p>(c) To a patient in a nursing home pursuant to the patient's plan of care.</p> <p>(d) Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress or promotion of fitness.</p> <p>(e)(i) To an individual for a previously diagnosed condition or conditions for which physical therapy services are appropriate after informing the health care provider rendering the diagnosis. The diagnosis must have been made within the previous one hundred eighty (180) days. The physical therapist shall provide the health care provider who rendered the diagnosis with a plan of care for physical therapy services within the first fifteen (15) days of physical therapy intervention. (ii) Nothing in this chapter shall create liability of any kind for the health care provider rendering the diagnosis under this paragraph (e) for a condition, illness, or injury that manifested itself after the diagnosis, or for any alleged damages as a result of physical therapy services performed without a prescription or referral from a person licensed as a physician, dentist, osteopath, podiatrist, chiropractor or nurse practitioner, the diagnosis and/or prescription for physical therapy services having been rendered with reasonable care.</p> <p>(4) Physical therapy services performed without a prescription or referral from a person licensed as a physician, dentist, osteopath, podiatrist, chiropractor or nurse practitioner shall not be construed to mandate coverage for physical therapy services under any health care plan, insurance policy, or workers' compensation or circumvent any requirement for preauthorization of services in accordance with any health care plan, insurance policy or workers' compensation.</p>	Title 73, Chapter 023
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<p>Missouri</p>	<p>Limited</p>	<p>1999</p>	<p>Physical therapists may provide certain services without prescription or direction of an approved health care provider, when—limitations.</p> <p>334.506. 1. As used in this section, “approved health care provider” means a person holding a current and active license as a physician and surgeon under this chapter, a chiropractor under chapter 331, RSMo, a dentist under chapter 332, RSMo, a podiatrist under chapter 330, RSMo, a physician assistant under this chapter, or any licensed and registered physician, chiropractor, dentist, or podiatrist practicing in another jurisdiction whose license is in good standing.</p> <p>2. A physical therapist shall not initiate treatment for a new injury or illness without a prescription from an approved health care provider.</p> <p>3. A physical therapist may provide educational resources and training, develop fitness or wellness programs for asymptomatic persons, or provide screening or consultative services within the scope of physical therapy practice without the prescription and direction of an approved health care provider.</p> <p>4. A physical therapist may examine and treat without the prescription and direction of an approved health care provider any person with a recurring self-limited injury within one year of diagnosis by an approved health care provider or a chronic illness that has been previously diagnosed by an approved health care provider. The physical therapist shall:</p> <p>(1) Contact the patient’s current approved health care provider within seven days of initiating physical therapy services under this subsection;</p> <p>(2) Not change an existing physical therapy referral available to the physical therapist without approval of the patient’s current approved health care provider;</p> <p>(3) Refer to an approved health care provider any patient whose medical condition at the time of examination or treatment is determined to be beyond the scope of practice of physical therapy;</p> <p>(4) Refer to an approved health care provider any patient whose condition for which physical therapy services are rendered under this subsection has not been documented to be progressing toward documented treatment goals after six visits or fourteen days, whichever first occurs;</p> <p>(5) Notify the patient’s current approved health care provider prior to the continuation of treatment if treatment rendered under this subsection is to continue beyond thirty days. The physical therapist shall provide such notification for each successive period of thirty days.</p> <p>5. The provision of physical therapy services of evaluation and screening pursuant to this section shall be limited to a physical therapist, and any authority for evaluation and screening granted within this section may not be delegated. Upon each reinitiation of physical therapy services, a physical therapist shall provide a full physical therapy evaluation prior to the reinitiation of physical therapy treatment. Physical therapy treatment provided pursuant to the provisions of subsection 4 of this section may be delegated by physical therapists to physical therapist assistants only if the patient’s current approved health care provider has been so informed as part of the physical therapist’s seven-day notification upon reinitiation of physical therapy services as required in subsection 4 of this section. Nothing in this subsection shall be construed as to limit the ability of physical therapists or physical therapist assistants to provide physical therapy services in accordance with the provisions of this chapter, and upon the referral of an approved health care provider. Nothing in this subsection shall prohibit an approved health care provider from acting within the scope of their practice as defined by the applicable chapters of RSMo.</p> <p>6. No person licensed to practice, or applicant for licensure, as a physical therapist or physical therapist assistant shall make a medical diagnosis.</p>	<p>334.506 § R.S.Mo</p>
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Montana	Unlimited	1987	No restrictions to access.	
Nebraska	Unlimited	1957	No restrictions to access.	
Nevada	Unlimited	1985	No restrictions to access.	
New Hampshire	Limited	1988	<p>Lawful Practice.</p> <p>II. A physical therapist shall refer a patient or client to appropriate health care practitioners when:</p> <p>(a) The physical therapist has reasonable cause to believe symptoms or conditions are present that require services beyond the scope of practice; or</p> <p>(b) Physical therapy is contraindicated; or</p> <p>(c) There is no documented improvement within 25 calendar days of the initiation of treatment.</p>	New Hampshire RSA328-A9w
New Jersey	Limited	2003	<p>DIRECT ACCESS REQUIRMENTS</p> <p>Within 180 days of the effective date of P.L. c. (pending before the Legislature as this bill), establish standards in accordance with the provisions of section 22 of P.L.c. (C.) (pending before the Legislature as this bill), in collaboration with the State Board of Medical Examiners and other appropriate professional licensing boards established pursuant to Title 45 of the Revised Statutes, setting forth the conditions under which a physical therapist is required to refer an individual being treated by a physical therapist to or consult with a practitioner licensed to practice dentistry, podiatry or medicine and surgery in this State, or other appropriate licensed health care professional. Pending adoption of the standards: (a) a physical therapist shall refer any individual who has failed to demonstrate reasonable progress within 30 days of the date of initial treatment to a licensed health care professional; and (b) a physical therapist, not more than 30 days from the date of initial treatment of functional limitation or pain, shall consult with the individual's licensed health care professional of record as to the appropriateness of the treatment, or, in the event that there is no identified licensed health care professional of record, recommend that the individual consult with a licensed health care professional of the individual's choice;</p> <p>Board of PT Regulations (adopted standards related to direct access):</p> <ul style="list-style-type: none"> • A physical therapist shall refer a patient to a health care professional licensed to practice dentistry podiatry or medicine and surgery in this State or other appropriate licensed health care professional: • When the physical therapist doing the examination evaluation or intervention has reason to believe that physical therapy is contraindicated or symptoms or conditions are present that require services outside the scope of practice of the physical therapist; or • When the patient has failed to demonstrate reasonable progress within 30 days of the date of the initial treatment. <p>(b) Not more than 30 days from the date of initial treatment of functional limitation or pain, a physical therapist shall inform the patient's licensed health care professional of record regarding the patient's plan of care. In the event there is no identified licensed health care professional of record, the physical therapist shall recommend that the patient consult with a licensed health care professional of the patient's choice. In a school setting, the schedule of physical therapy services shall be reported to tile child study team by the physical therapist within 30 days of the date of initial treatment.</p>	Title 45 Chapter 9

New Mexico	Limited	1989	<p>16.20.10.8 DIRECT CARE REQUIREMENTS:</p> <p>A. A physical therapist shall not accept a patient for treatment without an existing medical diagnosis for the specific medical or physical problem made by a licensed primary care provider, except for those children participating in special education programs in accordance with Section 22-13-5 NMSA 1978 and for acute care within the scope of practice of physical therapy. For the purposes of this subsection, "existing medical diagnosis" means substantive signs and symptoms consistent with the episode from a previous primary care provider diagnosis made or confirmed by that provider within the past twelve (12) months.</p> <p>B. When physical therapy services are commenced under the same diagnosis, such diagnosis and plan of treatment must be communicated to the patient's primary health care provider at intervals of at least once every sixty (60) days, unless otherwise indicated by the primary care provider. Such communication will be deemed complete as noted in the patient's medical record by the physical therapist.</p>	Title 16, Chapter 20
New York	Limited	2006	<p>Physical therapy is defined as:</p> <p>(c) Such treatment shall be rendered pursuant to a referral which may be directive as to treatment by a licensed physician, dentist, podiatrist, nurse practitioner or licensed midwife, each acting within his or her lawful scope of practice, and in accordance with their diagnosis, except as provided in subdivision d of this section.</p> <p>(d) Such treatment may be rendered by a licensed physical therapist for ten visits or thirty days, whichever shall occur first, without a referral from a physician, dentist, podiatrist, nurse practitioner or licensed midwife provided that:</p> <ol style="list-style-type: none"> 1. The licensed physical therapist has practiced physical therapy on a full time basis equivalent to not less than three years. 2. Each physical therapist licensed pursuant to this article shall provide written notice to each patient receiving treatment absent a referral from a physician, dentist, podiatrist, nurse practitioner or licensed midwife that physical therapy may not be covered by the patient's health care plan or insurer without such a referral and that such treatment may be a covered expense if rendered pursuant to a referral. The physical therapist shall keep on file with the patient's records a form attesting to the patient's notice of such advice. Such form shall be in duplicate, with one copy to be retained by the patient, signed and dated by both the physical therapist and the patient in such form as prescribed pursuant to regulations promulgated by the commissioner. 	NY Educ. § 6731
North Carolina	Limited	1985	<p>90-270.24. Definitions</p> <p>Physical therapy does not include the application of roentgen rays or radioactive materials, surgery, manipulation of the spine unless prescribed by a physician licensed to practice medicine in North Carolina, or medical diagnosis of disease.</p> <p>90-270.35. Unlawful practice</p> <p>(4) Practice physical therapy and fail to refer to a licensed medical doctor or dentist any patient whose medical condition should have, at the time of evaluation or treatment, been determined to be beyond the scope of practice of a physical therapist;</p>	Article 18B
North Dakota	Unlimited	1989	No restrictions to access.	N.D. Cent. Code, § 43-26.1-13

Ohio	Limited	2004	<p>Practice without a prescription or referral.</p> <p>(A) If a physical therapist evaluates and treats a patient without the prescription of, or the referral of the patient by, a person who is licensed to practice medicine and surgery, chiropractic, dentistry, osteopathic medicine and surgery, podiatric medicine and surgery, or to practice nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, all of the following apply:</p> <p>(1) The physical therapist shall, upon consent of the patient, inform the patient's physician, chiropractor, dentist, podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner of the evaluation not later than five business days after the evaluation is made.</p> <p>(2) If the physical therapist determines, based on reasonable evidence, that no substantial progress has been made with respect to that patient during the thirty-day period immediately following the date of the patient's initial visit with the physical therapist, the physical therapist shall consult with or refer the patient to a licensed physician, chiropractor, dentist, podiatrist, certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner, unless either of the following applies:</p> <p>(a) The evaluation, treatment, or services are being provided for fitness, wellness, or prevention purposes.</p> <p>(b) The patient previously was diagnosed with chronic, neuromuscular, or developmental conditions and the evaluation, treatment, or services are being provided for problems or symptoms associated with one or more of those previously diagnosed conditions</p> <p>(3) If the physical therapist determines that orthotic devices are necessary to treat the patient, the physical therapist shall be limited to the application of the following orthotic devices:</p> <ul style="list-style-type: none"> (a) Upper extremity adaptive equipment used to facilitate the activities of daily living; (b) Finger splints; (c) Wrist splints; (d) Prefabricated elastic or fabric abdominal supports with or without metal or plastic reinforcing stays and other prefabricated soft goods requiring minimal fitting; (e) Nontherapeutic accommodative inlays; (f) Shoes that are not manufactured or modified for a particular individual; (g) Prefabricated foot care products; (h) Custom foot orthotics; (i) Durable medical equipment. <p>(4) If, at any time, the physical therapist has reason to believe that the patient has symptoms or conditions that require treatment or services beyond the scope of practice of a physical therapist, the physical therapist shall refer the patient to a licensed health care practitioner acting within the practitioner's scope of practice.</p>	ORC Ann. 4755.481
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<p>Oklahoma</p>	<p>Evaluation Only</p>		<p>Referrals by physicians and surgeons - Agents – Exceptions</p> <p>A. 1. Any person licensed under this act as a physical therapist or physical therapist</p> <p>Assistant shall treat human ailments by physical therapy only under the referral of a person licensed as a physician or surgeon with unlimited license, or the physician assistant of the person so licensed, and Doctors of Dentistry, Chiropractic and Podiatry, with those referrals being limited to their respective areas of training and practice; provided, however, a physical therapist may provide services within the scope of physical therapy practice without a physician referral to children who receive physical therapy services pursuant to the Individuals with Disabilities Education Improvement Act of 2004, as may be amended, and the Rehabilitation Act of 1973, Section 504, as may be amended. Provided further, a plan of care developed by a person authorized to provide services within the scope of the Physical Therapy Practice Act shall be deemed to be a prescription for purposes of providing services pursuant to the provisions of the Individuals with Disabilities Education Improvement Act of 2004, as may be amended, and Section 504 of the Rehabilitation Act of 1973, as may be amended.</p> <p>2. Nothing in this act shall prevent a physical therapist from performing screening and educational procedures within the scope of physical therapy practice without a physician referral.</p>	<p>59 Okla. Stat. § 887.17</p>
<p>Oregon</p>	<p>Limited</p>	<p>1993; Revised 2005, 2007</p>	<p>688.132 Duty to refer person; exceptions; when personal injury protection benefits available.</p> <p>(1) If a licensed physical therapist administers physical therapy to a person as authorized in ORS 688.130 (1)(a), the physical therapist must immediately refer the person to a medical doctor, osteopathic physician, chiropractic physician, podiatric physician and surgeon, naturopathic physician, dentist, physician assistant or nurse practitioner if:</p> <p>(a) Signs and symptoms are present that require treatment or diagnosis by such providers or for which physical therapy is contraindicated or for which treatment is outside the knowledge of the physical therapist or scope of practice of physical therapy; or</p> <p>(b) The physical therapist continues therapy and 60 days have passed since the initial physical therapy treatment has been administered, unless:</p> <p>(A) The individual is a child or a student eligible for special education, as defined by state or federal law, and is being seen pursuant to the child's or the student's individual education plan or individual family service plan;</p> <p>(B) The individual is a student athlete at a public or private school, college or university and is seeking treatment in that role as athlete; or</p> <p>(C) The individual is a resident of a long term care facility as defined in ORS 442.015, a residential facility as defined in ORS 443.400, an adult foster home as defined in ORS 443.705 or an intermediate care facility for mental retardation pursuant to federal regulations.</p>	

Pennsylvania	Limited	2002	<p>Licensee may apply to the board for a certificate of authorization to practice physical therapy under this act without the required referral.</p> <p>A certificate of authorization to practice physical therapy without a referral under subsection (a) shall not authorize a physical therapist either to treat a condition in any person which is a nonneurologic, nonmuscular or nonskeletal condition or to treat a person who has an acute cardiac or acute pulmonary condition unless the physical therapist has consulted with the person's licensed physician, dentist or podiatrist regarding the person's condition and the physical therapy treatment plan or has referred the person to a licensed physician, dentist or podiatrist for diagnosis and referral.</p> <p>The certificate of authorization shall be issued only to licensed physical therapists practicing physical therapy.</p> <p>The certificate of authorization shall be displayed by the certificate holder in a manner conspicuous to the public. The renewal of the certificate of authorization shall coincide with the renewal of the license of the licensee.</p>	PL. 383, as amended, 63 PS. § 1301 et seq.
Rhode Island	Limited	1992	<p>Grounds for discipline of licensees.</p> <p>(b) Whenever a patient seeks or receives treatment from a physical therapist without referral from a doctor of medicine, osteopathy, dentistry, podiatry, chiropractic, physician assistant, or certified registered nurse practitioner, the physical therapist shall:</p> <p>(1) Disclose to the patient, in writing, the scope and limitations of the practice of physical therapy and obtain their consent in writing; and</p> <p>(2) Refer the patient to a doctor of medicine, osteopathy, dentistry, podiatry, or chiropractic within ninety (90) days after the date treatment commenced; provided, that a physical therapist is not required to make this a referral after treatment is concluded;</p> <p>(3) No physical therapist who has less than one year clinical experience as a physical therapist shall commence treatment on a patient without a referral from a doctor of medicine, osteopathy, dentistry, podiatry, chiropractic, physician assistant, or certified registered nurse practitioner.</p>	R.I. Gen. Laws § 5-40-13
South Carolina	Limited	1998	<p>SECTION 40-45-110. Refusal to grant licenses; suspensions, revocations, or other restrictions; grounds; mental and physical exams allowed; evidentiary use of records; opportunity to demonstrate ability to practice.</p> <p>(A) In addition to other grounds provided for in Section 40-1-110, the board, after notice and hearing, may restrict or refuse to grant a license to an applicant and may refuse to renew the license of a licensed person, and may suspend, revoke, or otherwise restrict the license of a licensed person who:</p> <p>(4) in the absence of a referral from a licensed medical doctor or dentist, provides physical therapy services beyond thirty days after the initial evaluation and/or treatment date without the referral of the patient to a licensed medical doctor or dentist;</p> <p>(5) changes, or in any way modifies, any specific patient care instructions or protocols established by an appropriate health care provider without prior consultation with and approval by the appropriate health care provider.</p>	
South Dakota	Unlimited	1986	No restrictions to access.	S.D. Codified Laws § 36-10

<p>Tennessee</p>	<p>Limited</p>	<p>1999; Revised 2007</p>	<p>SECTION 10.</p> <p>(a) Nothing in this definition shall be construed as allowing physical therapists to practice medicine, osteopathy, podiatry, chiropractic, or nursing.</p> <p>(b) The scope of practice of physical therapy shall be under the written or oral referral of a licensed doctor of medicine, chiropractic, dentistry, podiatry or osteopathy, with exceptions as stated in 63-13-301.</p> <p>SECTION 13.</p> <p>(a) A physical therapist shall refer persons under his or her care to appropriate health care practitioners, after consultation with the referring practitioner, if the physical therapist has reasonable cause to believe symptoms or conditions are present which require services beyond the scope of practice or when physical therapy treatment is contraindicated.</p> <p>SECTION 14.</p> <p>The practice of physical therapy shall be under the written or oral referral of a licensed doctor of medicine, chiropractic, dentistry, podiatry or osteopathy, except for the following:</p> <p>(1) The initial evaluation which may be conducted without such referral;</p> <p>(2) A licensed physical therapist may treat a patient for an injury or condition that was the subject of a prior referral if all of the following conditions are met:</p> <p>(A) The physical therapist, within four (4) business days of the commencement of therapy, consults with the referring licensed physician, osteopathic physician, dentist, chiropractor, podiatrist, or other referring practitioner;</p> <p>(B) For all episodes of physical therapy subsequent to that which was initiated by the referral, the physical therapist treats the patient for not more than ten (10) treatment sessions or fifteen (15) consecutive calendar days, whichever occurs first, whereupon the physical therapist must confer with the referring practitioner in order to continue the current episode of treatment; and</p> <p>(C) The physical therapist commences any episode of treatment provided pursuant to this subsection within one (1) year of the referral by the referring practitioner.</p> <p>(4) A licensed physical therapist may provide physical assessments or instructions including recommendation of exercise to an asymptomatic person without the referral of a referring practitioner.</p> <p>(5) In emergency circumstances, including minor emergencies, a licensed physical therapist may provide assistance to a person to the best of a therapist's ability without the referral of a referring practitioner. Provided, the physical therapist shall refer to the appropriate health care practitioner, as indicated, immediately thereafter. For the purposes of this subsection, emergency circumstances means instances where emergency medical care is called for. Emergency medical care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:</p> <p>(A) Placing the patient's health in serious jeopardy;</p> <p>(B) Serious impairment to bodily functions; or</p> <p>(C) Serious dysfunction of any bodily organ or part.</p>	<p>Title 63, Chapter 258</p>
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Texas	Limited	1991	<p>Sec. 453.301. TREATING PATIENT UNDER PRIOR REFERRAL.</p> <p>(a) A physical therapist may treat a patient for an injury or condition that was the subject of a prior referral if the physical therapist:</p> <p>(1) has been licensed to practice physical therapy for at least one year;</p> <p>(2) notifies the referring practitioner of the therapy not later than the fifth business day after the date therapy is begun;</p> <p>(3) begins any episode of treatment before the first anniversary of the referral by the referring practitioner;</p> <p>(4) for physical therapy episodes subsequent to the episode which was initiated by the referral, treats the patient for not more than 20 treatment sessions or 30 consecutive calendar days, whichever occurs first; and</p> <p>(5) satisfies any other requirement set by the board.</p> <p>Sec. 453.302. TREATING PATIENT WITHOUT REFERRAL</p> <p>(a) In this section:</p> <p>(1) "Emergency circumstance" means an instance in which emergency medical care is necessary.</p> <p>(2) "Emergency medical care" means a bona fide emergency service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:</p> <p>(A) serious jeopardy to the patient's health;</p> <p>(B) serious dysfunction of any bodily organ or part; or</p> <p>(C) serious impairment to bodily functions.</p> <p>(b) In an emergency circumstance, including a minor emergency, a physical therapist may provide emergency medical care to a person to the best of the therapist's ability without a referral from a referring practitioner.</p> <p>(c) A physical therapist may provide physical assessments or instructions to an asymptomatic person without a referral from a referring practitioner.</p>	Title 3, Subtitle H, Chapter 453
Utah	Unlimited	1985	No restrictions to access.	
Vermont	Unlimited	1988	No restrictions to access.	

<p>Virginia*</p>	<p>Limited</p>	<p>2001; Revised 2007</p>	<p>§ 54.1-3482. Certain experience and referrals required; unlawful to practice physical therapist assistance except under the direction and control of a licensed physical therapist.</p> <p>A. It shall be unlawful for a person to engage in the practice of physical therapy except as a licensed physical therapist, upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician, except as provided in this section.</p> <p>B. A physical therapist who has obtained a certificate of authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient for no more than 14 consecutive business days after evaluation without a referral under the following conditions:</p> <p>(i) the patient at the time of presentation to a physical therapist for physical therapy services is not being currently cared for, as attested to in writing by the patient, by a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician for the symptoms giving rise to the presentation;</p> <p>(ii) the patient identifies a practitioner from whom the patient intends to seek treatment if the condition for which he is seeking treatment does not improve after evaluation and treatment by the physical therapist during the 14-day period of treatment;</p> <p>(iii) the patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner; and</p> <p>(iv) the physical therapist notifies the practitioner identified by the patient no later than three days after treatment commences and provides the practitioner with a copy of the initial evaluation along with a copy of the patient history obtained by the physical therapist. Evaluation and treatment may not be initiated by a physical therapist if the patient does not identify a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician to manage the patient's condition. Treatment for more than 14 consecutive business days after evaluation of such patient shall only be upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician. A physical therapist may contact the practitioner identified by the patient at the end of the 14-day period to determine if the practitioner will authorize additional physical therapy services until such time as the patient can be seen by the practitioner. A physical therapist shall not perform an initial evaluation of a patient under this subsection if the physical therapist has performed an initial evaluation of the patient under this subsection within the immediately preceding three months. For the purposes of this subsection, business days means Monday through Friday of each week excluding state holidays.</p> <p>C. After completing a three-year period of active practice upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician, a physical therapist may conduct a one-time evaluation, that does not include treatment, of a patient who does not meet the conditions established</p>	<p>Va. Code Ann. § 54.1-3482 18VAC112- 20-81</p>
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<p>Virginia*</p>	<p>Limited</p>	<p>2001; Revised 2007</p>	<p>in (i) through (iv) of subsection B without the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician; if appropriate, the physical therapist shall immediately refer such patient to the appropriate practitioner.</p> <p>D. Invasive procedures within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician.</p> <p>E. It shall be unlawful for any licensed physical therapist to fail to immediately refer any patient to a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, or a licensed nurse practitioner as authorized in his practice protocol, whose medical condition is determined, at the time of evaluation or treatment, to be beyond the physical therapist's scope of practice. Upon determining that the patient's medical condition is beyond the scope of practice of a physical therapist, a physical therapist shall immediately refer such patient to an appropriate practitioner.</p> <p>F. Any person licensed as a physical therapist assistant shall perform his duties only under the direction and control of a licensed physical therapist.</p> <p>G. However, a licensed physical therapist may provide, without referral or supervision, physical therapy services to</p> <p>(i) a student athlete participating in a school-sponsored athletic activity while such student is at such activity in a public, private, or religious elementary, middle or high school, or public or private institution of higher education when such services are rendered by a licensed physical therapist who is certified as an athletic trainer by the National Athletic Trainers' Association Board of Certification or as a sports certified specialist by the American Board of Physical Therapy Specialties;</p> <p>(ii) employees solely for the purpose of evaluation and consultation related to workplace ergonomics;</p> <p>(iii) special education students who, by virtue of their individualized education plans (IEPs), need physical therapy services to fulfill the provisions of their IEPs;</p> <p>(iv) the public for the purpose of wellness, fitness, and health screenings;</p> <p>(v) the public for the purpose of health promotion and education; and</p> <p>(vi) the public for the purpose of prevention of impairments, functional limitations, and disabilities.</p> <p>*Requirements for direct access certification.</p> <p>A. An applicant for certification to provide services to patients without a referral as specified in § 54.1-3482.1 of the Code of Virginia shall hold an active, unrestricted license as a physical therapist in Virginia and shall submit evidence satisfactory to the board that he has one of the following qualifications:</p> <ol style="list-style-type: none"> 1. Completion of a doctor of physical therapy program approved by the American Physical Therapy Association; 2. Completion of a transitional program in physical therapy as recognized by the board; or 3. At least three years of postlicensure, active practice with evidence of 15 contact hours of continuing education in medical screening or differential diagnosis, including passage of a postcourse examination. The required continuing education shall be offered by a provider or sponsor listed as approved by the board in 18VAC112-20-131 and may be face-to-face or online education courses. 	
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Washington	Limited	1988	<p>RCW 18.74.012</p> <p>Consultation with health care practitioner not required for certain treatments.</p> <p>Notwithstanding the provisions of RCW 18.74.010(3), a consultation and periodic review by an authorized health care practitioner is not required for treatment of neuromuscular or musculoskeletal conditions: PROVIDED, That a physical therapist may only provide treatment utilizing orthoses that support, align, prevent, or correct any structural problems intrinsic to the foot or ankle by referral or consultation from an authorized health care practitioner.</p> <p>RCW 18.74.015.</p> <p>Referral to health care practitioners -- When required.</p> <p>(1) Physical therapists shall refer persons under their care to authorized health care practitioners if they have reasonable cause to believe symptoms or conditions are present which require services beyond the scope of their practice or for which physical therapy is contraindicated.</p> <p>(2) A violation of this section is unprofessional conduct under this chapter and chapter 18.130 RCW.</p>	Chapter 18.74 RCW
West Virginia	Unlimited	1984	No restrictions to access.	

Wisconsin	Limited	1989	<p>Practice requirements.</p> <p>(1) Written referral. Except as provided in this subsection and s. 448.52, a person may practice physical therapy only upon the written referral of a physician, chiropractor, dentist, podiatrist, or advanced practice nurse prescriber certified under s. 441.16 (2). Written referral is not required if a physical therapist provides services in schools to children with disabilities, as defined in s. 115.76 (5), pursuant to rules promulgated by the department of public instruction; provides services as part of a home health care agency; provides services to a patient in a nursing home pursuant to the patient's plan of care; provides services related to athletic activities, conditioning, or injury prevention; or provides services to an individual for a previously diagnosed medical condition after informing the individual's physician, chiropractor, dentist, podiatrist, or advanced practice nurse prescriber certified under s. 441.16 (2) who made the diagnosis. The examining board may promulgate rules establishing additional services that are excepted from the written referral requirements of this subsection.</p> <p>(1m) Duty to refer.</p> <p>(a) A physical therapist shall refer a patient to an appropriate health care practitioner if the physical therapist has reasonable cause to believe that symptoms or conditions are present that require services beyond the scope of the practice of physical therapy.</p> <p>(b) The examining board shall promulgate rules establishing the requirements that a physical therapist must satisfy if a physician, chiropractor, dentist, podiatrist, or advanced practice nurse prescriber makes a written referral under sub. (1). The purpose of the rules shall be to ensure continuity of care between the physical therapist and the health care practitioner.</p> <p>PT 6.01 Referrals. (1) In addition to the services excepted from written referral under s. 448.56, Stats., a written referral is not required to provide the following services, related to the work, home, leisure, recreational and educational environments:</p> <p>(a) Conditioning.</p> <p>(b) Injury prevention and application of biomechanics.</p> <p>(c) Treatment of musculoskeletal injuries with the exception of acute fractures or soft tissue avulsions.</p> <p>(2) A physical therapist providing physical therapy services pursuant to a referral under s. 448.56 (1), Stats., shall communicate with the referring physician, chiropractor, dentist or podiatrist as necessary to ensure continuity of care.</p> <p>(3) A physical therapist providing physical therapy services to a patient shall refer the patient to a physician, chiropractor, dentist, podiatrist or other health care practitioner under s. 448.56 (1m), Stats., to receive required health care services which are beyond the scope of practice of physical therapy.</p>	Wis. Stat. § 448.56 PT 6.01
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Wyoming	Limited	2003; Revised 2009	<p>Practice of physical therapy; license or certificate required; exceptions; false representations.</p> <p>(c) Except as provided in this subsection, a physical therapist with a master's degree, or a bachelor's degree with five (5) years of clinical experience may initiate physical therapy treatment for a new or recurring injury with or without a prescription from a licensed physician including doctor of osteopathy, podiatrist, advanced practitioner of nursing, dentist, chiropractor or physician assistant. Nothing in this subsection shall be construed to preclude a physical therapist from treating a chronic or recurring injury or condition without a prescription, provided that the patient or client was previously diagnosed and prescribed physical therapy treatment within the previous year by a health care provider identified in this subsection and the treatment is directly related to the original prescribed care. Except in an emergency, a physical therapist, without a prescription, is prohibited from initiating physical therapy treatment for children under the age of twelve (12) years, unless the child is to receive physical therapy treatment under an individualized education program or an individualized family services plan. A physical therapist shall refer the patient or client to a licensed physician including doctor of osteopathy, podiatrist, advanced practitioner of nursing, dentist, chiropractor or physician assistant, as appropriate, when:</p> <p>(i) The physical therapist has reasonable cause to believe symptoms or conditions are present that require services beyond the scope of physical therapy practice;</p> <p>(ii) Physical therapy is contraindicated; or</p> <p>(iii) Except for patients or clients participating in general exercise or fitness programs or receiving physical therapy services under an individualized education program or an individualized family services plan, the patient or client has received physical therapy services without a prescription for twelve (12) visits or for a thirty (30) day period, whichever occurs earlier, and further services may be necessary.</p>	Wyo. Stat. § 33-25-102
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Standards of Ethical Conduct for the Physical Therapist Assistant



HOD S06-09-20-18 [Amended HOD S06-00-13-24; HOD 06-91-06-07; Initial HOD 06-82-04-08] [Standard]

Preamble

The Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere. Fundamental to the Standards of Ethical Conduct is the special obligation of physical therapist assistants to enable patients/clients to achieve greater independence, health and wellness, and enhanced quality of life.

No document that delineates ethical standards can address every situation. Physical therapist assistants are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.

Standards

Standard #1: Physical therapist assistants shall respect the inherent dignity, and rights, of all individuals.

- 1A. Physical therapist assistants shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.
- 1B. Physical therapist assistants shall recognize their personal biases and shall not discriminate against others in the provision of physical therapy services.

Standard #2: Physical therapist assistants shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.

- 2A. Physical therapist assistants shall act in the best interests of patients/clients over the interests of the physical therapist assistant.
- 2B. Physical therapist assistants shall provide physical therapy interventions with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/clients.
- 2C. Physical therapist assistants shall provide patients/clients with information regarding the interventions they provide.
- 2D. Physical therapist assistants shall protect confidential patient/client information and, in collaboration with the physical therapist, may disclose confidential information to appropriate authorities only when allowed or as required by law.

Standard #3: Physical therapist assistants shall make sound decisions in collaboration with the physical therapist and within the boundaries established by laws and regulations.

- 3A. Physical therapist assistants shall make objective decisions in the patient's/client's best interest in all practice settings.
- 3B. Physical therapist assistants shall be guided by information about best practice regarding physical therapy interventions.
- 3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient/client values.
- 3D. Physical therapist assistants shall not engage in conflicts of interest that interfere with making sound decisions.
- 3E. Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.

Standard #4: Physical therapist assistants shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, other health care providers, employers, payers, and the public.

- 4A. Physical therapist assistants shall provide truthful, accurate, and relevant information and shall not make misleading representations.
- 4B. Physical therapist assistants shall not exploit persons over whom they have supervisory, evaluative or other authority (eg, patients/clients, students, supervisees, research participants, or employees).
- 4C. Physical therapist assistants shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

- 4D. Physical therapist assistants shall report suspected cases of abuse involving children or vulnerable adults to the supervising physical therapist and the appropriate authority, subject to law.
- 4E. Physical therapist assistants shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.
- 4F. Physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.

Standard #5: Physical therapist assistants shall fulfill their legal and ethical obligations.

- 5A. Physical therapist assistants shall comply with applicable local, state, and federal laws and regulations.
- 5B. Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient/client safety.
- 5C. Physical therapist assistants involved in research shall abide by accepted standards governing protection of research participants.
- 5D. Physical therapist assistants shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.
- 5E. Physical therapist assistants who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

Standard #6: Physical therapist assistants shall enhance their competence through the lifelong acquisition and refinement of knowledge, skills, and abilities.

- 6A. Physical therapist assistants shall achieve and maintain clinical competence.
- 6B. Physical therapist assistants shall engage in lifelong learning consistent with changes in their roles and responsibilities and advances in the practice of physical therapy.
- 6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

Standard #7: Physical therapist assistants shall support organizational behaviors and business practices that benefit patients/clients and society.

- 7A. Physical therapist assistants shall promote work environments that support ethical and accountable decision-making.
- 7B. Physical therapist assistants shall not accept gifts or other considerations that influence or give an appearance of influencing their decisions.
- 7C. Physical therapist assistants shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.
- 7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.
- 7E. Physical therapist assistants shall refrain from employment arrangements, or other arrangements, that prevent physical therapist assistants from fulfilling ethical obligations to patients/clients.

Standard #8: Physical therapist assistants shall participate in efforts to meet the health needs of people locally, nationally, or globally.

- 8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
- 8B. Physical therapist assistants shall advocate for people with impairments, activity limitations, participation restrictions, and disabilities in order to promote their participation in community and society.
- 8C. Physical therapist assistants shall be responsible stewards of health care resources by collaborating with physical therapists in order to avoid overutilization or underutilization of physical therapy services.
- 8D. Physical therapist assistants shall educate members of the public about the benefits of physical therapy.

APPENDIX O

APTA Guide for Conduct of the Physical Therapist Assistant

Purpose

This Guide for Conduct of the Physical Therapist Assistant (Guide) is intended to serve physical therapist assistants in interpreting the Standards of Ethical Conduct for the Physical Therapist Assistant (Standards) of the American Physical Therapy Association (APTA). The APTA House of Delegates in June of 2009 adopted the revised Standards, which became effective on July 1, 2010.

The Guide provides a framework by which physical therapist assistants may determine the propriety of their conduct. It is also intended to guide the development of physical therapist assistant students. The Standards and the Guide apply to all physical therapist assistants. These guidelines are subject to change as the dynamics of the profession change and as new patterns of health care delivery are developed and accepted by the professional community and the public.

Interpreting Ethical Standards

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist assistant in applying general ethical standards to specific situations. They address some but not all topics addressed in the Standards and should not be considered inclusive of all situations that could evolve.

This Guide is subject to change, and the Ethics and Judicial Committee will monitor and timely revise the Guide to address additional topics and Standards when necessary and as needed.

Preamble to the Standards

The Preamble states as follows:

The Standards of Ethical Conduct for the Physical Therapist Assistant (Standards of Ethical Conduct) delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere. Fundamental to the Standards of Ethical Conduct is the special obligation of physical therapist assistants to enable patients/clients to achieve greater independence, health and wellness, and enhanced quality of life.

No document that delineates ethical standards can address every situation. Physical therapist assistants are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.

Interpretation: Upon the Standards of Ethical Conduct for the Physical Therapist Assistant being amended effective July 1, 2010, all the lettered standards contain the word “shall” and are mandatory ethical obligations. The language contained in the Standards is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Standards. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word “shall” serves to reinforce and clarify existing ethical obligations. A significant reason that the Standards were revised was to provide physical therapist assistants with a document that was clear enough such that they can read it standing alone without the need to seek extensive additional interpretation.

The Preamble states that “[n]o document that delineates ethical standards can address every situation.” The Preamble also states that physical therapist assistants “are encouraged to seek additional advice or consultation in instances where the guidance of the Standards of Ethical Conduct may not be definitive.” Potential sources for advice or counsel include third parties and the myriad resources available on the APTA Web site. Inherent in a physical therapist assistant’s ethical decision-making process is the examination of his or her unique set of facts relative to the Standards.

Standards

Respect

Standard 1A states as follows:

1A. Physical therapist assistants shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

Interpretation: Standard 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

Altruism

Standard 2A states as follows:

2A. Physical therapist assistants shall act in the best interests of patients/clients over the interests of the physical therapist assistant.

Interpretation: Standard 2A addresses acting in the best interest of patients/clients over the interests of the physical therapist assistant. Often this is done without thought, but sometimes, especially at the end of the day when the clinician is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist assistant may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

Sound Decisions

Standard 3C states as follows:

3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient/client values.

Interpretation: To fulfill 3C, the physical therapist assistant must be knowledgeable about his or her legal scope of work as well as level of competence. As a physical therapist assistant gains experience and additional knowledge, there may be areas of physical therapy interventions in which he or she displays advanced skills. At the same time, other previously gained knowledge and skill may be lost due to lack of use. To make sound decisions, the physical therapist assistant must be able to self-reflect on his or her current level of competence.

Supervision

Standard 3E states as follows:

3E. Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.

Interpretation: Standard 3E goes beyond simply stating that the physical therapist assistant operates under the supervision of the physical therapist. Although a physical therapist retains responsibility for the patient/client throughout the episode of care, this standard requires the physical therapist assistant to take action by communicating with the supervising physical therapist when changes in the patient/client status indicate that modifications to the plan of care may be needed. Further information on supervision via APTA policies and resources is available on the APTA Web site.

Integrity in Relationships

Standard 4 states as follows:

4. Physical therapist assistants shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, other health care providers, employers, payers, and the public.

Interpretation: Standard 4 addresses the need for integrity in relationships. This is not limited to relationships with patients/clients, but includes everyone physical therapist assistants come into contact with in the normal provision of physical therapy services. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

Standard 4C states as follows:

4C. Physical therapist assistants shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

Interpretation: When considering the application of “when appropriate” under Standard 4C, keep in mind that not all allegedly illegal or unethical acts should be reported immediately to an agency/authority. The determination of when to do so depends upon each situation’s unique set of facts, applicable laws, regulations, and policies.

Depending upon those facts, it might be appropriate to communicate with the individuals involved. Consider whether the action has been corrected, and in that case, not reporting may be the most appropriate action. Note, however, that when an agency/authority does examine a potential ethical issue, fact finding will be its first step. The determination of ethicality requires an understanding of all of the relevant facts, but may still be subject to interpretation.

The EJC Opinion titled: Topic: Preserving Confidences; Physical Therapist’s Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Exploitation

Standard 4E states as follows:

4E. Physical therapist assistants shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.

Interpretation: The statement is fairly clear – sexual relationships with their patients/clients, supervisees or students are prohibited. This component of Standard 4 is consistent with Standard 4B, which states:

4B. Physical therapist assistants shall not exploit persons over whom they have supervisory, evaluative or other authority (eg, patients/clients, students, supervisees, research participants, or employees).

Next, consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients/Former Patients (modified for physical therapist assistants):

A physical therapist [assistant] stands in a relationship of trust to each patient and has an ethical obligation to act in the patient’s best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist [assistant] has natural feelings of attraction toward a patient, he/she must sublimate those feelings in order to avoid sexual exploitation of the patient.

One’s ethical decision making process should focus on whether the patient/client, supervisee or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient/client relationship ends. To this question, the EJC has opined as follows:

The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible.

The Committee imagines that in some cases a romantic/sexual relationship would not offend ... if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

Colleague Impairment

Standard 5D and 5E state as follows:

5D. Physical therapist assistants shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapist assistants who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

Interpretation: The central tenet of Standard 5D and 5E is that inaction is not an option for a physical therapist assistant when faced with the circumstances described. Standard 5D states that a physical therapist assistant shall encourage colleagues to seek assistance or counsel while Standard 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination on the physical therapist assistant's part. This may be challenging in the sense that you might not know or it might be difficult for you to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to determine whether such impairment may be adversely affecting someone's work responsibilities.

Moreover, once you do make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance. However, the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform, whereas 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect his or her professional responsibilities. So, 5D discusses something that may be affecting performance, whereas 5E addresses a situation in which someone is clearly unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom you report; it gives you discretion to determine the appropriate authority.

The EJC Opinion titled Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Clinical Competence

Standard 6A states as follows:

6A. Physical therapist assistants shall achieve and maintain clinical competence.

Interpretation: 6A should cause physical therapist assistants to reflect on their current level of clinical competence, to identify and address gaps in clinical competence, and to commit to the maintenance of clinical competence throughout their career. The supervising physical therapist can be a valuable partner in identifying areas of knowledge and skill that the physical therapist assistant needs for clinical competence and to meet the needs of the individual physical therapist, which may vary according to areas of interest and expertise. Further, the physical therapist assistant may request that the physical therapist serve as a mentor to assist him or her in acquiring the needed knowledge and skills. Additional resources on Continuing Competence are available on the APTA Web site.

Lifelong Learning

Standard 6C states as follows:

6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

Interpretation: 6C points out the physical therapist assistant's obligation to support an environment conducive to career development and learning. The essential idea here is that the physical therapist assistant encourage and contribute to the career development and lifelong learning of himself or herself and others, whether or not the employer provides support.

Organizational and Business Practices

Standard 7 states as follows:

7. Physical therapist assistants shall support organizational behaviors and business practices that benefit patients/clients and society.

Interpretation: Standard 7 reflects a shift in the Standards. One criticism of the former version was that it addressed primarily face-to-face clinical practice settings. Accordingly, Standard 7 addresses ethical obligations in organizational and business practices on a patient/client and societal level.

Documenting Interventions

Standard 7D states as follows:

7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.

Interpretation: 7D addresses the need for physical therapist assistants to make sure that they thoroughly and accurately document the interventions they provide to patients/clients and document related data collected from the patient/client. The focus of this Standard is on ensuring documentation of the services rendered, including the nature and extent of such services.

Support - Health Needs

Standard 8A states as follows:

8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

Interpretation: 8A addresses the issue of support for those least likely to be able to afford physical therapy services. The Standard does not specify the type of support that is required. Physical therapist assistants may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues. When providing such services, including pro bono services, physical therapist assistants must comply with applicable laws, and as such work under the direction and supervision of a physical therapist. Additional resources on pro bono physical therapy services are available on the APTA Web site.

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