AK PT Scope Modernization Work Group - January 28, 2026

Alaska Division of Corporations, Business and Professional Licensing
Zoom
2026-01-28 11:00 - 13:00 AKST

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A. Action Items from Meeting on 01/21/2026:
1. Review input from ASMA; Continue conversation on Primary Care; (9) + 11(d) – healthcare practitioner vs. physical therapy providers.
2. Cross walk between AS 08.84.190(7) and new scope modernization draft 11(a) – (f) definition. Continue conversation of “that may include, but not limited to:” language in 11(b). Discuss option of removing 11(b), keeping AS 08.84.190(7) but including 11(a), (c), (d) and (e) to be more comprehensive.
3. Jonathan Gates - attend Medical Board meeting 02/20/2026 to gather input.
4. Jonathan Gates and select members of work group to schedule and attend APTA-AK leadership meeting(s) to provide education opportunity re: PT Scope Modernization update, language and legislative strategies.

B. Action Items from Meeting on 01/14/2026:
1. Review Conversation around “Primary Care” in preparation for Physician’s board input in upcoming meetings. - WG consensus ondraft language. Need input from medical board and associations.
2. Crosswalk between AS 08.84.190(7) and new scope modernization draft 11 definition. - Incomplete. Tentative WG consensus on draftlanguage. Awaiting APTA-AK input after 01/20 meeting.
3. Artificial Intelligence emerging in the field of physical therapy and possible HIPPA concern, for possible inclusion in draft language. - COMPLETED. Table for regulation in the future.
4. Imaging - no current need for action from this WG.
5. Injections. Injections possibly already covered w/ current language (though would need a script for the medicine).
6. Prescriptive rights for PTs/Prescriptive privileges - Is this something we want to hold off on for this project?

7. Invite medical community to attend remaining work group sessions on 1/21 + 1/28 - AK Primary Care Association; AK Medical Board; AK State Medical Association; Primary Care Collaborative. COMPLETED

C. Action Items from Meeting on 11/26/2025:
1. Review conversation of adjusting term protection for “physiotherapy” to title protection. – COMPLETED
a. Jonthan Gates - attended CHI board meeting on 12/05/25 to gather input. CHI board voices support, and provide formal (written) position statement to the POT/OT board.
2. Review Conversation around “Primary Care” in preparation for Physician’s board input in upcoming meetings.
3. Crosswalk between AS 08.84.190(7) and new scope modernization draft 11 definition.
4. Artificial Intelligence emerging in the field of physical therapy and possible HIPPA concern, for possible inclusion in draft language.

D. Action Items from Meeting on 11/19/25:
1. Invite Alaska Chiropractic Society and Board of Chiropractic Examiners to attend next work group meeting 11/26, gather input, and work on agreeable draft language that provides assurance of title protection only; not term protection for “physiotherapist”. COMPLETED
2. Based on 11/26 discussion, write letter to Board of Chiropractic Examiners for consideration of language to be drafted on 11/26. N/A
3. Ask PHY board to authorize J. Gates to attend 12/5 Board of Chiropractic Examiners meeting to gather stakeholder input at 11/21 PHY Board mtg. - Motion approved by the PT/OT board on 11/21. COMPLETED
4. Crosswalk between AS 08.84.190(7) and new scope modernization draft 11 definition
5. Artificial Intelligence emerging in the field of physical therapy and possible HIPPA concern, for possible inclusion in draft language.

E. Action Items from Meeting on 11/12/25:
1. Eliminating unnecessary definitions – COMPLETED
2. Review conversation of adjusting term protection for “physiotherapy” to title protection. – COMPLETED
3. Accepted suggested changes to terminology as advised by AOTA – completed
4. Board staff contacted APTA-AK representatives in effort to facilitate participation in the workgroup - COMPLETED

4. Purpose and Summary of Workgroup - Review

A. PT Workgroup Objectives - original

Develop a collaborative plan to address modernization of our scope of practice between all stakeholders (including the state licensing board, APTA-AK, national organizations, and licensees) to create statutory change. Identify needs for change/improvement in the current scope of practice language - AS 08.84.190(7) Develop draft language to address any needs that the workgroup identifies. Address the role of PTAs in scope of practice language Develop an updated draft of scope of practice language with future action steps for recommendation to the PHY Board.

B. Objectives - Updated as of 08/07/2025

1. Coordinate with other boards/organizations which may have input and/or concerns (i. e. chiropractic and physician boards)

5. Discussion - Draft Language.....5

Review and edit current draft of AK practice act as presented to the PT/OT board in August of 2025.

Primary discussion to cover the following:

1. Revisit draft language 08.84.190 (9) and (11)(d) - and input from ASMA - primary care discussion.
2. Cross walk between current definition of physical therapy AS 08.84.190(7) and new draft 11(a) - (f) definition. Continue conversation of "that may include, but not limited to" language in 11(b). Discuss option of removing 11(b), keeping AS 08.84.190(7) but including 11(a), (c), (d) and (e) to be more comprehensive.
3. Jonathan Gates - attend Medical Board meeting 02/20/2026 to gather input.
4. Jonathan Gates and select members of work group to schedule and attend APTA-AK leadership

meeting(s) to provide education opportunity re: PT Scope Modernization update, language and legislative strategies.

Resources for discussion of Primary Care:
Title 21. Insurance Chapter
07. Patient Protections Under Health Care Insurance Policies
Sec. 21.07.250. Definitions
AS 21.07.250 (11) “primary care provider” means a health care provider who provides general medical care services and does not specialize in treating a single injury, illness, or condition or who provides obstetrical, gynecological, or pediatric medical care services;

The term “healthcare practitioner” is defined in the Guidebook for the National Practitioner Data Bank as the “individual who is licensed or otherwise authorized by a state to provide healthcare services.” The term “health care provider” has a broader context. At this time, as related to this act, healthcare practitioner refers to a physical therapist, while healthcare provider is more appropriate for the physical therapist assistant.

Abstract - Physical Therapists in Primary Care in the United States: An Overview of Current Practice Models and Implementation Strategies

6. Next Meeting Dates/Times

- Discuss future meeting date(s) to finalize recommendation for the board

7. Next Steps

Objective: Finalize proposed language to be sent to the PT/OT Board for review.

8. Adjourn

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Perspective

Physical Therapists in Primary Care in the United States: An Overview of Current Practice Models and Implementation Strategies

Katie O'Bright, PT, DPT[1,*], Seth Peterson, PT, DPT[2,3]

[1]Redefine Health Education, Chicago, Illinois, USA
[2]Arizona School of Health Sciences, A.T. Still University, Mesa, Arizona, USA
[3]The Motive Physical Therapy Specialists, Oro Valley, Arizona, USA

*Address all correspondence to Dr O'Bright at: info@redefinehealthed.com

Abstract

In the USA, physician shortages and increases in noncommunicable disease burden have resulted in a growing demand for primary care providers (PCPs). Patients with physical and functional impairments have been especially affected by these challenges. However, physical therapists are well suited to meet patient needs in primary care settings by working alongside PCPs and other primary health care team members. When included in a primary care team, physical therapists can improve patient access to care, optimize care navigation, and reduce the overall cost of care. Therefore, the purpose of the current perspective was to (1) provide an overview of established integrated primary care models in the USA that include physical therapists in the care team and (2) outline operational and practice considerations for health care administrators and professionals interested in integrating physical therapists into primary care teams.

Impact Statement. Given physician shortages and increasing burden in primary care in the USA, inclusion of a physical therapist in a primary care team can improve patient access to care, optimize care navigation, and reduce the overall cost of care for patients with physical and functional needs.

Keywords: Advanced Practice Physical Therapy, Extended Scope Physical Therapy, First Contact Physical Therapy, Physical Therapists in Primary Care, Primary Care Physical Therapist, Primary Care Physical Therapy, Primary Care PT, Primary Care Team, Team-Based Primary Care

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Introduction

Primary care is traditionally delivered by a single primary care provider (PCP); however, recent increases in the number of patients presenting to PCPs with multimorbidity, particularly chronic conditions affecting physical function, have burdened primary care management and limited care delivery. [1,2] Given the projected primary care physician shortage in the USA of 17,800 to 48,000 physicians by 2034,[2,3] primary care may benefit from the expansion of the health care team to include a variety of provider types. As suggested by Ubel,[4] this projected shortage is more related to actual primary care rather than a lack of physicians. Therefore, he recommended that "more trained primary care clinicians, of all varieties" are needed to treat patients.[4]

The 2019 Global Burden of Disease Study estimated that 1 in 3 individuals worldwide have health conditions that require rehabilitation services.[5] This estimate included primary neuromusculoskeletal (NMSK) conditions and noncommunicable conditions that affect physical function, such as chronic cardiovascular and pulmonary diseases, cancer-related impairments, and diabetes.[5] This need for rehabilitation services suggests that physical therapists should be integrated at the primary care level to improve patient care.[1,5]

Integration of physical therapists into team-based primary care (TBPC) can be accomplished in a variety of ways, such as through a collaborative warm handoff, defined as a process by which a PCP "hands off" a patient with a physical need to the on-site physical therapist within a primary care clinic[6] (Fig. 1) or direct triage to a physical therapist within a primary care clinic,[7–9] defined as a patient with a physical need being triaged directly to a physical therapist as the first point of contact (Fig. 2). These access-to-care pathways are described in further detail in the "Operational Considerations" section of this paper. Although TBPC is an established model of care,[10] the structure and operational workflows vary from site to site. The most common TBPC staff model in the USA consists of a physician, nurse practitioner or physician assistant, nurse (sometimes serving as a care coordinator), and clerical staff. When other care providers, such as mental health specialists, clinical pharmacists, physical therapists, social workers, and dieticians, are integrated into this primary care team, research suggests that primary care workflow is optimized, lowering total health care expenditures, reducing provider burnout, and improving patient outcomes and satisfaction (Tab. 1). [6,11,12] Internationally, physical therapists are commonly included in both warm handoff and direct triage models (Figs. 1 and 2),[7,8,13,14] but this inclusion is not yet mainstream in most US health care systems.

Integrating a physical therapist into the TBPC staff to address conditions affecting physical function may reduce the current challenges associated with primary care. In addition, research suggests that including physical therapists in the primary care team lowers total health care costs, eliminates delays in care, reduces unnecessary diagnostic tests and treatments, and decreases work-related time off.[6–8,15–17] Therefore, the purpose of the current perspective was to (1) provide an overview of established integrated primary care models in the USA that include physical therapists in the care team and (2) outline operational and practice considerations for health care administrators and professionals interested in integrating physical therapists into primary care teams. For the current perspective, the primary care access models discussed were meant to be distinct from patient-led direct access to a physical therapist outside the primary care clinic (Fig. 3). More specifically, our focus was on models where the first outreach by a patient was toward a primary care clinic—that includes a physical therapist—rather than a physical therapist clinic.

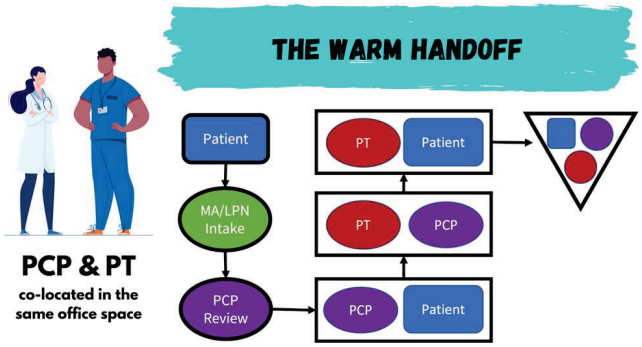


Figure 1. Warm handoff access to care pathway. LPN = licensed practical nurse; MA = medical assistant; PCP = primary care provider; PT = physical therapist.

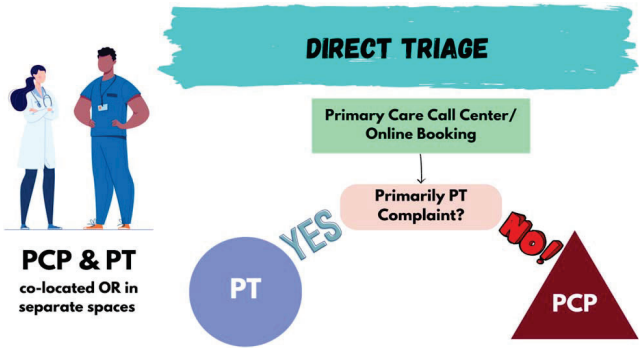


Figure 2. Direct triage access to care pathway. PCP = primary care provider; PT = physical therapist.

Table 1. Outcomes of Physical Therapist Integration Into Primary Care[a]

Outcome	References
Health care cost savings	Szymanek et al[9] Basu et al[34] Bornhöft et al[8]
Reduced wait times	Turner et al[24] McKay et al[16]
Increased utilization of PT	Bodenheimer et al[6] McKay et al[16]
Improved patient satisfaction	Stynes et al[13]
Improved provider satisfaction	Stynes et al[13]
Reduced time off work	Stynes et al[13] Bodenheimer et al[6] Szymanek et al[9]
Reduced unnecessary imaging	Turner et al[24] Bodenheimer et al[6]
Reduced opioid prescriptions	Turner et al[24] Bodenheimer et al[6] 2021
Reduced PCP workload	Stynes et al[13] 2020

[a]PCP = primary care provider; PT = physical therapy.

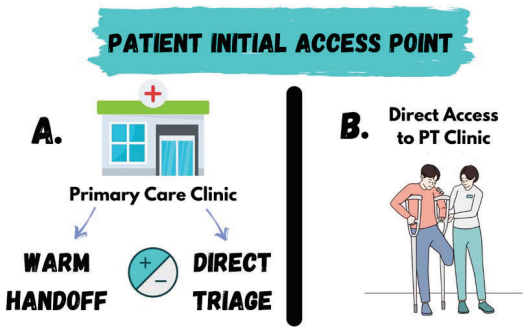


Figure 3. Patient initial access point. (A) Access pathway where the patient's first outreach for care is directed to their primary care clinic. The current perspective focused on this pathway. (B) Patient-led direct access to a physical therapist (PT) outside the primary care clinic. Although similar to the above pathway, this access point has some distinct differences and barriers that are outside the scope of this perspective.

Existing Operating Models

Although integrated primary care teams exist throughout the USA, literature about these teams is scarce. Therefore, in this section, we provided descriptions of known US models and included valuable information from more established international models. To find supporting literature for existing operating models, we conducted a non-systematic, iterative literature search on PubMed for studies published between 2005 and 2023 that described TBPC models that included a physical therapist. Additional insight and resources were based on our collective experience and expertise in the integrated primary care space.

Federal Systems

The USA has a variety of TBPC models at the federal level that integrate physical therapists in primary care teams. Examples include the Military Health System, Veterans Health Administration (VHA), Public Health Service, and Centers for Medicare and Medicaid Services (CMS) programs. In particular, the Military Health System, Public Health Service, and VHA health systems manage a high volume of patients with functional health needs that require physical therapists as part of the primary care team. Despite variability in staffing and workflow operations, these organizations have paved a path for other health systems interested in successfully implementing integrated primary care.

For almost 50 years, physical therapists in the Military Health System have served in first contact roles, particularly for patients with NMSK conditions.[18] In a 2022 study, Szymanek et al[9] reported on an 18-month pilot program that implemented a direct triage model in Soldier Center Medical Homes (ie, primary care clinics) to evaluate patients with acute musculoskeletal complaints. When compared with referral-based physical therapist care, the program resulted in reductions in imaging, number of days with duty restrictions, and referrals to specialty care.[9] It also improved cost savings and decreased long-term disability.[9] The results of this program led to an investigation of the feasibility of physical therapists serving as primary care NMSK experts throughout the Department of Defense.[19] In January 2024, the results of this investigation concluded that system-wide implementation should proceed.[20]

Another TBPC model at the federal level involves the VHA. A 2021 study by McKay et al[16] described embedding a physical therapist in a co-located primary care clinic of the VHA. The authors reported that PCPs increased their inclusion of physical therapists in the care team, leading to reduced discontinuation of physical therapist treatment, cancellation of physical therapist referrals, and wait time to see a physical therapist.[16] The VHA is also involved with an ongoing national effort to integrate physical therapists in each Patient Aligned Care Team by 2025.[21] In addition to improving access to physical therapist services, this integration is intended to optimize health care delivery, improve functional outcomes, and reduce downstream costs through collaborations with the core members of the Patient Aligned Care Team (eg, physician, nurse practitioner, nurse, pharmacist, mental health provider). Importantly, this model can be adapted to meet the needs and resources of each health care facility.[22,23]

In the Public Health Service primary care setting, Turner et al[24] found that a co-located physical therapist reduced delays in access to physical therapist care by more than 80%. Before this integration, there was an estimated 6 month wait time to see a physical therapist.[24] Turner et al[24] also reported that having a physical therapist in the primary care clinic resulted in reduced opioid prescriptions and improved patient satisfaction. In other studies in this setting,[16,18] patients reported that they would not have gone to a physical therapist on a referral basis if the service had not been available on the same day.

Another way physical therapists can be integrated into primary care teams is the Program for All-Inclusive Care of the Elderly (PACE). Developed by CMS in 1997, PACE was designed to promote independence in community-dwelling individuals aged 55 years or older who are at risk of entering a nursing home.[25] Individuals are assessed and cared for by an interdisciplinary team consisting of a center manager, social worker, nurse, PCP, physical therapist, occupational therapist, recreational therapist, dietician, driver, personal care aide, and home care aide.[25] During initial evaluation, the patient typically meets with all members of the care team, and then the team collaboratively prioritizes appropriate care to meet patient needs and ensure the patient remains independent.[25] Examples of PACE services include adult day care, outpatient medical services, dentistry, rehabilitation, counseling, social services, prescription drugs, durable medical equipment, and emergency services.[25] Although PACE programs currently serve many regions in the USA, there remains a need for additional expansion. Individuals and organizations interested in learning more about the PACE program or starting this program should visit the PACE website at https://www.npaonline.org/.

Examples of similar comprehensive care models associated with CMS are rural health clinics and Federally Qualified Health Centers (FQHCs). These health care facilities, usually outpatient clinics, are federally funded and qualify for reimbursement under CMS to address unmet health needs in rural and underserved communities.[26] Typically, these patients have greater health risks and higher rates of noncommunicable diseases.[27,28] Furthermore, difficulties with transportation or limitations of travel time often restrict access to care for this population.[27] Therefore, these facilities represent a major opportunity for including physical therapists in FQHC primary care teams to address general pain and mobility concerns and reduce the physical burden of noncommunicable

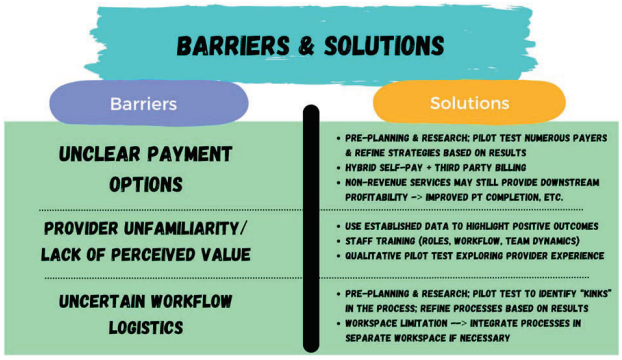
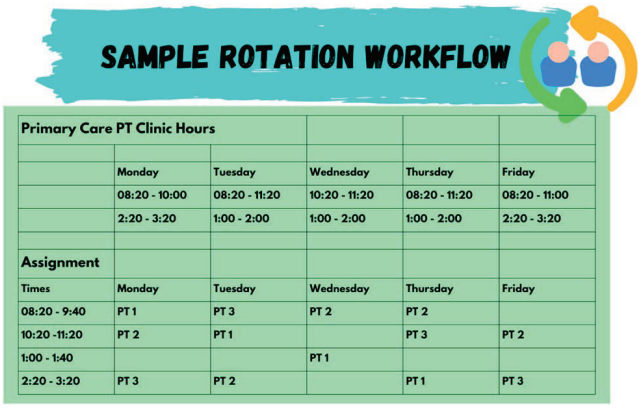


Figure 4. Barriers and solutions for physical therapist integration into primary care. PT = physical therapy.



Primary Care PT Clinic Hours					
	Monday	Tuesday	Wednesday	Thursday	Friday
	08:20 - 10:00	08:20 - 11:20	10:20 - 11:20	08:20 - 11:20	08:20 - 11:00
	2:20 - 3:20	1:00 - 2:00	1:00 - 2:00	1:00 - 2:00	2:20 - 3:20
Assignment					
Times	Monday	Tuesday	Wednesday	Thursday	Friday
08:20 - 9:40	PT 1	PT 3	PT 2	PT 2	
10:20 -11:20	PT 2	PT 1		PT 3	PT 2
1:00 - 1:40			PT 1		
2:20 - 3:20	PT 3	PT 2		PT 1	PT 3

Figure 5. Sample rotation work schedule for a physical therapist (PT) in a consulting role in a primary care clinic.

diseases. Currently, however, there are barriers to payment for physical therapist services in this setting (Fig. 4). In a 2020 update, the Medicare Benefit Policy Manual, which describes requirements and payment policies for FQHCs, indicated that physical therapist services are paid only if provided directly by a physician, nurse practitioner, or physician assistant.[26] The policy also noted that physical therapist services provided by a physical therapist at an FQHC were not billable.[26] However, a current legislative bill includes provisions that would allow physical therapists in FQHCs to bill CMS for services rendered.[29]

Free Clinics

Many university-based and philanthropist-funded free clinics have also used the TBPC model to provide comprehensive care to underserved communities. Coss et al[30] described the planning, implementation, and outcomes of their student-run free clinic that integrated physical therapist and occupational therapy. The strategies and recommendations outlined in the Coss et al paper may benefit organizations interested in establishing the TBPC model in a free clinic.[30]

Regional Health Systems

To our knowledge, most non-federal TBPC clinics with integrated physical therapists are part of regional health systems. Bodenheimer et al[6] described one such clinic in the Bellin Health system in Northeastern Wisconsin. Other hospital systems in the USA have also implemented this model.[31] Bellin Health integrates several physical therapists into primary care on a rotating basis, such that they switch from their usual role in the outpatient physical therapist clinic to primary care in shifts (Fig. 5).[32] They often function as NMSK and vestibular consultants in a warm handoff model (Fig. 1).[32] In this model, the physical therapist is typically introduced to a patient with a functional need after the patient meets with a PCP (same day, same period of time).[32] The physical therapist performs an independent evaluation and then comanages the plan of care for the functional complaint with the PCP. Generally, physical therapists also conduct any follow-up physical therapist care in the outpatient physical therapist clinic; however, there are models where physical therapists conduct follow-up visits in the primary care clinic.[32]

Outpatient Private Practices

Another operating model for integrated primary care teams involves collaborative operations between private practices. In this model, a privately owned physical therapist practice situates a physical therapist in a privately owned family medicine practice. This integration provides easy access to physical therapists for patients with NMSK complaints and other acute or chronic diseases that would benefit from physical activity and exercise (eg, chronic obstructive pulmonary disease, hypertension, diabetes, depression, anxiety, and obesity). Through this collaboration, both practices reap the benefits of team-based care while remaining independent.

Direct-to-Employer Care Models

As the cost of US health care continues to rise, and insurance-covered services decline, employers are seeking cost-effective alternatives to traditional third-party payer health plans.[33,34] One such alternative is direct-to-employer or self-insured care models. With this type of plan, employers contract directly with health care provider organizations to render services to their employees. These emerging care models often include hybrid (in-person and remote) delivery systems to reduce barriers and costs associated with transportation and time off work. Services are generally paid for by the employer on a "per member, per month" basis, or they are partially covered by the employer through a monthly membership that is based on each employee's health plan preferences. There are numerous hybrid digital health organizations offering these models with both direct-to-employer and direct-to-consumer options. A national survey from 2021 reported a third of employers with at least 5000 employees and 38% of employers with 20,000 employees offered direct primary care services.[33] Furthermore, 18% of primary care clinics associated with this model had physical therapists on staff.[33] In another study, Basu et al[34] described a direct-to-employer TBPC clinic for employees and dependents of an engineering and manufacturing firm in southern California. The study compared health care utilization and cost of on-site, near-site, and virtual comprehensive primary care services with traditional community-based primary care.[34] For those who used the direct-to-employer services for at least 50% of their primary care needs, the total cost of health care was lower despite higher primary care spending.[34] Notably, 4 of the 5 most common diagnostic categories reported during the study were musculoskeletal in nature, necessitating inclusion of a physical therapist on the care team.[34] Given the cost savings associated with these care models, it is not surprising that they are attractive to employers.

International Models

Because there are few integrated programs in the USA, there is limited evidence to guide the process of integrating a physical therapist into a primary care team. However, there are well-established international models that can offer valuable supporting data and should be considered during this process.

In the United Kingdom, the Elective Care Transformation Programme initiated a pilot program to collect data on musculoskeletal first contact practitioners (FCPs). These practitioners are defined as physical therapists with enhanced skills who are co-located in primary care clinics. Results from this program indicated that 98% of patients would recommend the FCP service and had confidence in their FCP.[13] Additionally, patients were referred for specialty care less frequently and received fewer blood tests and drug prescriptions.[13] Finally, the integration of physical therapists in this program reduced the workload of general practitioners.[13]

Similarly, Bornhöft et al[7,8] reported that a primary care clinic direct triage model for NMSK complaints in Sweden was found to optimize health outcomes, health care utilization, access to care, work environment, patient satisfaction, and cost efficiency.

In other countries with integrated care models, specific roles have been defined for advanced physical therapist practice (APP) in primary care.[13,14] In 2019, World Physiotherapy adopted its first statement on APP, calling it a more common feature of the profession that is economically and clinically beneficial.[35] Even though APP roles are becoming more common worldwide, a 2018 global survey reported that only 17% of member organizations of World Physiotherapy had defined advanced practice roles in their country.[36] The USA is one of the countries that does not have defined APP roles.[36] Furthermore, although various physical therapist specialty areas exist in the USA, they often do not provide the practitioner with additional privileges. As countries begin to add APP roles for their physical therapists, long-term strategic planning before implementation is recommended to enhance sustainability and should include professional privilege and scope expansion considerations and also clinical and administrative team member training.

Operational Considerations

When integrating a physical therapist into an established primary or specialty care team, several domains must be considered to improve the likelihood of success, and each phase of implementation should be carefully mapped out.[37] In general, these phases include planning, pilot testing, and maintenance.[37] In the current perspective, we focused primarily on the planning phase because a well-executed plan often yields long-term sustainability. This phase is multidimensional, and each domain of the operation—structure, practice, and culture—must be carefully considered.[37]

Structure

The structure of the operation is the most important consideration when implementing a TBPC model (Tab. 2). Building a solid structural foundation for the program is critical for success and sustainability. There are 3 key factors to consider for this domain: access to care pathways, efficiency, and finances.[37]

Access to Care Pathways

This pathway describes how the patient is situated with the physical therapist. In a co-located workspace, the 2 primary pathways for access are the warm handoff and direct triage (Figs. 1 and 2). In a warm handoff (Fig. 1), the PCP identifies a patient issue or complaint that may benefit from a physical therapist consultation. The PCP then huddles with the on-site physical therapist to convey pertinent details of the case before the physical therapist sees the patient. After the physical therapist completes their evaluation, the PCP and physical therapist both meet with the patient to offer options, determine patient preferences, and establish a collaborative care plan.

With direct triage (Fig. 2), a patient presents their primary issue or complaint to a scheduling clerk over the phone or to an online booking system. If the issue or complaint meets preestablished criteria from a primary care physical therapist scope checklist, the patient is directly referred to a physical therapist. A study by Szymanek et al[9] provided an example of this kind of checklist. More importantly, this checklist can be customized to meet the personal scope of individual physical therapists. Furthermore, although all primary care physical therapists should be highly skilled with NMSK complaints, some may feel more comfortable evaluating special populations than others. For example, one physical therapist may excel in pelvic health diagnosis and management, whereas another may prefer to have those with pelvic complaints see either a PCP or pelvic health physical therapist specialist. Similarly, a primary care physical therapist who has exclusively worked with adults in their career may lack the personal scope to meet the needs of pediatric patients. In this circumstance, the practitioner would only accept direct triage patients over a specified age threshold. For this access to care pathway, all these factors must be included in the direct triage primary care physical therapist scope checklist to provide high-quality patient care.

Efficiency

When establishing a TBPC model that integrates physical therapists, time and scheduling aspects of efficiency should be considered. For example, to optimize efficiency and productivity, it is important to determine the volume of potential physical therapist patients at the primary care clinic and the necessary time for such visits. When determining how much time is required for each visit, the clinic's volume and evaluation goals and the type of presenting conditions treated need to be considered.

To determine how many and how often physical therapists are needed in a TBPC clinic, each clinic should evaluate the number of relevant diagnosis codes over a specified period. To start, a clinic administrator could perform data extraction for the number of relevant diagnosis codes over 6 months. However, the number of necessary primary care physical therapists will vary by clinic. For example, if physical therapists assist primarily with isolated consults for musculoskeletal and vestibular needs, fewer may be needed. If physical therapists assist with more comprehensive conditions, such as pelvic health, pulmonary conditions, exercise evaluation for heart disease, hypertension, diabetes, and other noncommunicable diseases, then more may be needed and more often. Ultimately, this information will provide a useful starting point for determining the percentage of full-time staff members needed.

Table 2. Planning Phase Operational Considerations When Integrating a Physical Therapist Into a Primary Care Team

Planning Phase Domain and Considerations	Examples of Specific Considerations
Structure	
Access to care pathways	Warm handoff Direct triage
Efficiency	Assess clinic volume and goals Consider type of conditions treated Assign appropriate staff headcount and schedule
Finances	Insurance Nonrevenue generating services Self-pay
Practice	
Clinical skills	Multisystems clinical reasoning and management skills
Interdisciplinary skills	Strong communication Collaborative care navigation
Clinical privileges	Independent care management Order appropriate diagnostics Provide referrals
Culture	
Clinic team members	Learn about skills, roles, and responsibilities of all team members
Patients	Provide education materials to teach team-based care

Clinics also need to consider how much time is required for each physical therapist visit. This amount can vary by clinic, patient, and presenting condition. If a primary care physical therapist is likely to see 20 patients during an 8-hour day, then the time spent with a patient would be limited to 15–30 minutes. During a typical outpatient physical therapist evaluation, this average time is 45–60 minutes. Similar to the time difference for patient evaluations, the goal of evaluation in primary care clinics may also differ from outpatient physical therapist clinics. In primary care, the goal may involve assisting the primary care team with physical and functional risk stratification, differential diagnosis, and identification of the next best step (ie, care navigation), which may include referral to a traditional outpatient physical therapist. Therefore, in this setting, a physical therapist may mostly educate the primary care team and the patient on the most appropriate next step instead of providing a specific treatment. If the clinic has a lower or highly variable volume, the primary care physical therapist may have a variety of appointment types that accommodate the different patient and clinic needs. For example, during an 8-hour day, the physical therapist may spend 20 minutes on a musculoskeletal consultation, 45 minutes on a diabetes exercise evaluation and education session, 30 minutes on a chronic pain education intervention, and 60 minutes on a pelvic health evaluation.

Finances

The financial factors related to billing and documentation should also be considered when integrating physical therapists into a primary care clinic. When choosing the appropriate billing model, each clinic should also consider contractual obligations and all federal, state, local, and institutional regulations. Examples of billing models to consider include insurance, nonrevenue generating, and self-pay models.

When using the insurance billing model, clinics can choose an incident to PCP or standard physical therapist model. The incident to PCP billing may be used when a physical therapist and PCP are working together with a patient in the same visit. In that case, the physical therapist includes their documentation and Current Procedural Terminology (CPT) codes in the same record as the PCP. This model is especially effective when the physical therapist serves in a consultant role rather than an interventionist or manager role. However, with this billing model, any follow-up care is under the direct management of the PCP instead of the physical therapist. The standard physical therapist (97-series current procedural terminology codes) billing model is the same as billing services in an outpatient physical therapist clinic. For this model, the clinic should also consider third-party payer contractual agreements related to location of care, prior authorizations, and patient copays.

Nonrevenue generating services is another possible billing model. Because there is a high level of variability in billing requirements across multiple third-party payers, some hospital systems have placed physical therapists in primary care as a nonrevenue generating service.[6] In this system, physical therapists rotate to cover primary care in a consulting role, and services are documented in the PCP record. The salary allocation which covers the "borrowed" time of the physical therapist is an important consideration. The value of an integrated physical therapist, as demonstrated in Table 1, may justify purchased care by the primary care clinic. Anecdotally, this method, even without direct billing, has improved downstream outpatient physical therapist attendance, appropriate use of advanced diagnostic testing, and patient satisfaction. Such results seem to justify the "unpaid" staff allocation.[6]

A final possible billing model is self-pay. This feasible model allows a physical therapist to consult as a self-pay add-on to care provided during a standard PCP visit. As third-party payer reimbursement barriers continue to increase, alternative payment options are becoming more mainstream.[34] Paying out of pocket for services may present a challenge to some individuals, but it may be no more expensive, or even more

affordable than services provided under increasingly common high deductible health plans. Importantly, we should not eliminate care options based on preconceived notions that patients will never choose to pay out of pocket. Many patients do and will choose self-pay, especially if it results in expedited care navigation and better outcomes.

Practice

Another domain of the planning phase for implementation of the TBPC model involves consideration of practice patterns (Tab. 2). When compared with traditional outpatient physical therapist care, integration of physical therapists into the primary care team will likely require practice adjustments. For example, a primary care physical therapist will require a high level of multisystems clinical reasoning. The physical therapist's competency and comfort level working in interdisciplinary teams must also be considered. Specifically, they should have demonstrated skills in interdisciplinary communication, medical screening, advanced collaborative care navigation, and interventions across multiple areas of practice (eg, orthopedic, neurologic, pelvic health, and cardiovascular and pulmonary) and across the patient lifespan, while carefully considering individual socioeconomic determinants of health. Therefore, professional development for prospective primary care physical therapists should be included in the strategic planning for program implementation.

Clinical privileges should also be considered as part of the practice domain. A primary care physical therapist can offer the most efficient and effective service when they are able to independently direct and manage care. Ideally, they should be able to order appropriate diagnostic imaging and lab studies, prescribe appropriate medications, and manage referrals to other health care professionals when and where needed. This independence is important because it enhances the timeliness of patient care by reducing the number of approvals needed for basic care. However, barriers may limit physical therapist autonomy. In some US jurisdictions, legislative scope includes such privileges as direct referral for imaging, but clinics or hospital systems may restrict physical therapists from providing these services.[38] This unnecessary barrier contributes to delays in care, increased costs, and confusion among patients and health care providers.[38]

Despite these practice limitations in some US jurisdictions,[36] the outlook for enhanced practice privileges remains positive. Recently, 5 US jurisdictions have added explicit imaging privileges to their state law, and many more changes seem to be on the horizon.[38] Perhaps multiple studies[39–43] reporting that physical therapists possess the requisite skills to independently and safely perform these duties have precipitated these changes. Furthermore, the fear of third-party insurers denying payment for diagnostic imaging ordered by physical therapists has been ameliorated.[44] Jurisdictional scope expansion combined with advanced professional development opportunities for physical therapists will reduce barriers to TBPC integration (Fig. 4).

Cultural

The final domain of the planning phase involves recognizing and addressing the culture of the primary health care team (Tab. 2) (eg, the team dynamics and workflow norms of day-to-day practice). When a new type of health care provider is added to an established care team, all team members need to be educated about the skills, roles, and responsibilities of each member. Such information is necessary to create trust among team members. Ideally, this process would begin before or during the planning phase by establishing positive working relationships between PCPs, physical therapists, nurses, medical assistants, and clerical staff. Several studies have reported that such integration of primary care physical therapists is necessary for success and creates trust and positive rapport among providers.[13,14,35] A qualitative study by Pellekoren et al[35] outlined a variety of themes that created barriers to the successful integration of an APP in a Dutch primary care setting. Examples of barriers included PCPs lacking trust in the APP, PCPs doubting the added value of the APP, and PCPs wanting to maintain authority and control.[35] These cultural barriers may have been mitigated with improved education of the primary care team before integration (Fig. 4).

Patient culture must also be considered since they may not understand the concept of team-based care, especially if they exclusively see their PCP. To prevent patient confusion and optimize utilization, it may be helpful to provide patient education about the TBPC model. Emails and brochures could be used for general information, or patients could be invited to attend meet-and-greet opportunities. Any alteration to an established cultural norm has the potential to create turbulence within a health care team; however, carefully and strategically introducing new team members can alleviate this possibility.

Conclusion

There is a growing need for primary care clinicians who can treat patients with physical and functional impairments. Physical therapists are well equipped to meet these needs in primary care settings by working with PCPs and other team members. Multiple TBPC models exist for integration of physical therapists into primary care teams, and their inclusion has been shown to improve patient access to care, optimize care navigation, and reduce overall costs. To increase the potential for a successful and sustainable outcome for implementation of this TBPC model, primary care clinics should address structure, practice, and cultural considerations during the planning phase.

Author Contributions

Katie O'Bright (Conceptualization, Data curation, Writing—original draft) and Seth Peterson (Writing—review & editing).

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Dr O'Bright is the owner of Redefine Health Education, a physical therapist education services company that also provides continuing

education courses related to primary care physical therapy. Dr O'Bright is also education chair of the Primary Care Special Interest Group of APTA Federal.

Dr Peterson is co-owner of The Movement Brainery, a continuing education company that teaches a course on primary care physical therapy.

The authors completed the ICMJE Form for Disclosure of Potential Conflicts of Interest and reported no other conflicts of interest.

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Perspective

CHAPTER 84.
PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS

Article

1. State Physical Therapy and Occupational Therapy Board (§§ 08.84.010, 08.84.020)
2. Licensing (§§ 08.84.030 – 08.84.120)
3. Unlawful Acts (§§ 08.84.130 – 08.84.180)

ARTICLE 1.
STATE PHYSICAL THERAPY AND OCCUPATIONAL THERAPY BOARD

Section
01. Legislative Intent
10. Creation and membership of board
20. Applicability of Administrative Procedure Act

Sec. 08.84.001. Legislative Intent

This act is enacted for the purpose of protecting the public health, safety, and welfare, and provides for jurisdiction administrative control, supervision, licensure, and regulation of the practice of physical therapy and occupational therapy. It is the legislature's intent that only individuals who meet and maintain prescribed standards of competence and conduct may engage in the practice of physical therapy and occupational therapy as authorized by this act. This act shall be liberally construed to promote the public interest and to accomplish the purpose stated herein.

Sec. 08.84.120. Refusal, revocation, and suspension of license; discipline. (a) The board may refuse to license an applicant, may refuse to renew the license of a person, may discipline a person, and may suspend or revoke the license of a person who

(1) has obtained or attempted to obtain a license by fraud or material misrepresentation;
(2) uses drugs or alcohol in any manner that affects the person's ability to practice physical therapy or occupational therapy competently and safely;
(3) has been convicted of a state or federal felony or other crime that effects the person's ability to practice competently and safely;
(4) is guilty, in the judgement of the board, of gross negligence or malpractice or has engaged in conduct contrary to the recognized standards of ethics of the physical therapy profession or the occupational therapy profession;

BOLD and Underlined = adding language to existing statutory language
Strikethrough = remove language from existing statutory language

(5) has continued to practice physical therapy or occupational therapy after becoming unfit because of physical or mental disability;
(6) has failed to refer a patient to another qualified professional when the patient's condition is beyond the training or ability of the person;
(7) as a physical therapist assistant, has attempted to practice physical therapy that has not been initiated, supervised, and terminated by a licensed physical therapist;
(8) as an occupational therapy assistant, has attempted to practice occupational therapy that has not been supervised by a licensed occupational therapist; or
(9) has failed to comply with this chapter, a regulation adopted under this chapter, or an order of the board.
(10) Practicing or offering to practice beyond the scope of the practice of physical therapy.
(11) Acting in a manner inconsistent with generally accepted standards of physical therapy practice, regardless of whether actual injury to the patient is established.

(b) The refusal or suspension of a license may be modified or rescinded if the person has been rehabilitated to the satisfaction of the board.
(c) The board may not impose disciplinary sanctions on a licensee for the evaluation, diagnosis, or treatment of a person through audio, video, or data communications when physically separated from the person if the licensee

(1) or another licensed health care provider is available to provide follow-up care;
(2) requests that the person consent to sending a copy of all records of the encounter to a primary care provider if the licensee is not the person's primary care provider and, if the person consents, the licensee sends the records to the person's primary care provider; and
(3) meets the requirements established by the board in regulation.

(d) The board shall adopt regulations restricting the evaluation, diagnosis, supervision, and treatment of a person as authorized under (c) of this section by establishing standards of care, including standards for training, confidentiality, supervision, practice, and related issues.

AS 08.84.130 False claim of license prohibited. (a) A person not licensed as a physical therapist, or whose license is suspended or revoked, or has lapsed, who uses in connection with the person's name the words or letters, ***"D.P.T.," "Doctor of Physical Therapy"***, "P.T.," "Physical Therapist," "L.P.T." "Licensed Physical Therapist," "**Physiotherapist**," or other letters, words, or insignia indicating or implying that the

Commented [SR1]: Add to agenda as discussion item for next series; gather information from other states on how they are utilizing language to protect title DPT

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person is a licensed physical therapist, or who, in any way, orally or in writing, directly or by implication, holds out as a licensed physical therapist, is guilty of a class B misdemeanor.

Commented [SR2]: Language added 11/12 per discussion to change strategy from term protection to title protection

(b) Nothing in this section shall be construed to prohibit a person licensed under AS 08.20 from practicing within the scope of practice authorized by that chapter, including the use of physiological therapeutics as an ancillary methodology, provided the person does not use the titles or insignia specified in subsection (a) of this section indicating or implying licensure as a physical therapist.

Commented [SR3]: 11/26 - Potential language to add to assure chiropractic profession use of "physiological therapeutics" and intent of title protection only for physical therapy, not term protection of "physiotherapy".

ARTICLE 5. GENERAL PROVISIONS

Section
190. Definitions
200. Short title

Sec. 08.84.190. Definitions. In this chapter, unless the context otherwise requires,

(1) "board" means the State Physical Therapy and Occupational Therapy Board;
~~(2) "occupational therapist" means a person who practices occupational therapy;~~

~~(3) "occupational therapy" means, for compensation, the use of purposeful activity, evaluation, treatment, and consultation with human beings whose ability to cope with the tasks of daily living are threatened with, or impaired by developmental deficits, learning disabilities, aging, poverty, cultural differences, physical injury or illness, or psychological and social disabilities to maximize independence, prevent disability, and maintain health; "occupational therapy" includes~~

~~(A) developing daily living, play, leisure, social, and developmental skills;~~
~~(B) facilitating perceptual-motor and sensory integrative functioning;~~
~~(C) enhancing functional performance, prevocational skills, and work capabilities using specifically designed exercises, therapeutic activities and measure, manual intervention, and appliances;~~
~~(D) design, fabrication, and application of splints or selective adaptive equipment;~~
~~(E) administering and interpreting standardized and nonstandardized assessments, including sensory, manual muscle, and range of motion assessments, necessary for planning effective treatment; and~~
~~(F) adapting environments for the disabled;~~

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Strikethrough = remove language from existing statutory language

~~(4) "occupational therapy assistant" means a person who assists in the practice of occupational therapy under the supervision of an occupational therapist;~~
~~(5) "physical therapist" means a person who practices physical therapy;~~
~~(6) "physical therapist assistant" means a person who assists in the practice of physical therapy or an aspect of physical therapy as initiated, supervised, and terminated by a licensed physical therapist; the responsibilities of a physical therapist assistant do not include evaluation;~~
~~(7) "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.~~

~~(2)~~ ~~"Competence" is the application of knowledge, skills, and behaviors required to function effectively, safely, ethically and legally within the context of the patient/client's role and environment.~~

(3) ~~"Consultation" means a physical therapist seeking assistance from, or rendering professional or expert opinion or advice to, another physical therapist or professional healthcare provider via electronic communications, telehealth, or in-person.~~)"Consultation" means a therapist seeking assistance from, or rendering professional or expert opinion or advice to, another professional healthcare provider ~~or individual involved in the plan of care~~ via electronic communications, telehealth, or in-person.

~~(4)~~ ~~"Continuing competence" is the lifelong process of maintaining and documenting competence through ongoing self-assessment, development, and implementation of a personal learning plan, and subsequent reassessment.~~

(5) "Electronic Communications" means the science and technology of communication (the process of exchanging information) over any distance by electronic transmission of impulses including activities that involve using electronic communications to store, organize, send, retrieve, and/or convey information.

~~(6)~~ ~~"Nexus to practice" means the criminal act of the applicant or licensee posing a risk to the public's welfare and safety relative to the practice of physical therapy.~~

Commented [SR4]: Remove per discussion 11/19 - does not meet definition criteria as used in existing reference.

Commented [SR5]: Eliminate 11/19 per discussion - not utilized elsewhere in the drafts (PT or OT) or existing statute.

Commented [SR6]: Eliminate per 11/19 discussion as not referenced elsewhere in the existing statute or new draft language.

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(7) "Patient/client" means any individual receiving physical therapy from a licensee, permit, or compact privilege holder under this Act.

(8) "Physical therapist assistant" means a person who assists in the practice of physical therapy or an aspect of physical therapy as initiated, supervised, and terminated by a licensed physical therapist; the responsibilities of a physical therapist assistant do not include evaluation.

(9) "Physical therapist" means a person who is a licensed healthcare practitioner pursuant to this act to practice physical therapy. ~~The terms "physiotherapist" or "physio" shall be synonymous with "physical therapist" pursuant to this act.~~ A Physical Therapist may evaluate, initiate, and provide physical therapy treatment for a client as the first point of contact without a referral from other health service providers.

(10) "Physical therapy" means the care and services provided in-person or via telehealth by or under the direction and supervision of a physical therapist who is licensed pursuant to this act. ~~The term "physiotherapy" shall be synonymous with "physical therapy" pursuant to this act.~~

(11) "Practice of physical therapy" means:

a. Examining, evaluating, and testing patients/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.

b. Alleviating impairments, pain, functional limitations and disabilities; promoting health; and preventing disease by designing, implementing and modifying treatment interventions that may include, but not limited to: therapeutic exercise; needle insertion; patient-related instruction; therapeutic massage; airway clearance techniques; integumentary protection and repair techniques; debridement and wound care; physical agents or modalities; mechanical and electrotherapeutic modalities; manual therapy including soft tissue and joint mobilization/manipulation; functional training related to movement and mobility in self-care and in home, community or work integration or reintegration; as well as prescription application and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic, protective and supportive devices and equipment.

c. Reducing the risk of injury, impairment, functional limitation, and disability, including performance of participation-focused physical examinations and the promotion and maintenance of fitness, health, and wellness in populations of all ages.

Commented [SR7]: Utilized in draft definition for competence (2); physical therapy (11e); draft definition for testing (13).

Patient utilized numerous times in existing statutes
AS 08.84.120(6)Refusal, revocation, and suspension of license; discipline
AS 08.84.188 Compact Enacted - patient/client Definitions (4) Compact privilige

Commented [SR8]: See Model Practice Act for rationale for use of practitioner vs provider

Commented [SR9]: Per 11/12 discussion - remove reference to "physiotherapist" or "physio" in this section and instead go for TITLE protection in AS 08.84.130(a). Term protection is a very broad concept. "Title" protection would clarify for the consumer that only a Physical Therapist or Physiotherapist can provide physical therapy. It is highly doubtful that any other profession (chiropractor) would refer to themselves as a "physiotherapist" when providing physical therapy or "physiotherapeutics."

Commented [SR10]: Discussed 01/14/2026 - no recommended changes regarding primary care

Commented [SR11]: Discussion with chiropractic stakeholders - see addition in AS 08.84.130(b) - remove language here based on discussion from 11/26. Chiropractic advertising utilizes "physiotherapies" - difficult to utilize physiotherapeutics as uncommon term within the public realm.

Commented [SR12]: 11/12 discussion - Language modification per AKOTA and AOTA concerns

BOLD and Underlined = adding language to existing statutory language
Strikethrough = remove language from existing statutory language

~~d. Serving as primary care providers for patients and clients experiencing physical therapy healthcare concerns.~~ **Serving as primary care physical therapy providers.**

e. Referring a patient/client to healthcare providers and facilities for services and testing to inform the physical therapist plan of care.

f. Engaging in administration, consultation, education, and research.

(12) "Teleheath" is the use of electronic communications to provide and deliver a host of health-related information and healthcare services, including, but not limited to physical therapy related information and services, over large and small distances. Telehealth encompasses a variety of healthcare and health promotion activities, including, but not limited to, education, advice, reminders, interventions, and monitoring of interventions.

(13) "Testing" means standard methods and techniques used to gather data about the patient/client, including but not limited to imaging, electrodiagnostic and electrophysiologic tests and measures.

(*Will need to incorporate new occupational therapy definitions in alphabetical order under AS 08.84.190*)

Commented [SR13]: Language change after discussion with ASMA - Pam Ventgen Executive Director.

Commented [SR14]: Discussed 01/14/2026 - no recommended changes regarding primary care

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Work Group Recommendations for associated Regulations Project:

***Telehealth:**
Omit phrase from 12 AAC 54.530(a).
Change Telerehabilitation to Telehealth - 12 AAC 54.530. (regulation project) and omit wording limiting to “geographic constraints or health and safety constraints.” See Centralized Statute 08.02.130

(a) The purpose of this section is to establish standards for the practice of ~~telerehabilitation~~ **telehealth** by means of [an interactive telecommunication system] by a physical therapist licensed under AS 08.84 and this chapter in order to provide physical therapy to patients who are located in this state. ~~and do not have access to a physical therapist in person due to geographic constraints or health and safety constraints.~~

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