STATE OF NEVADA
STEVE SISOLAK
Governor

PHYSICAL THERAPY BOARD
3291 North Buffalo Drive, Suite 100
Las Vegas, NV 89129

BOARD MEETING MINUTES
January 4, 2023

Item 1. Call to Order/Roll Call to determine the presence of a quorum.

Chair Nash called the meeting to order at 9:30 AM. A roll call confirmed a quorum was present.

Board Members in Attendance: Jennifer Nash, Board Chair; Katherine Joines, Vice Chair; Jessie Fisher Board Member; Laura Cerame, PTA, Secretary/Treasurer.

Staff in Attendance: Charles D. Harvey, Executive Director; Debby Dieter Investigator; Muriel Morin Mendes, Licensing Coordinator; April Ramirez, Board Operations Support Specialist. Neena Laxalt, Board Lobbyist.

Board Counsel: Harry Ward, Deputy Attorney General

Item 2. Introduction ***(informational only)***

Chair Nash gave an introduction of this open public hearing on ATI proposed changes to LCB R124-21, After discussions with representatives, some ATI Physical Therapy. The chairman of the Legislative Commission and the Speaker of the House.

Steve Yeager has requested that because of the impact of the ATI proposal and that the Board pull back their regulations, which we have done, and hold a meeting which we are doing now to allow full vetting and discussion on this ATI proposal this will allow hopefully this issue to be Resolved, in this full board meeting, prior to submitting again to the LCB, and to be placed on the Legislative Commission's agenda. Resolved, in this full board meeting, prior to submitting again to the LCB, and to be placed on the Legislative Commission's agenda.

We were advised at the board would pull back the regulation by simply not giving it to the LCB, and that the Board meeting would need a 3-day notice which we have done. We have requested that the representatives from ATI, provide their

proposal to the Association for their distribution to the full membership for review and comments.
So those who would be impacted by this proposal would have sufficient time to provide a position on such proposal to the PT. Board, and as well from the association based on their comments, they received So, with that introduction, now, all knowing why we are here, we are going to move down to the next item, which is public comment on ATI proposed changes.
I will first take representatives from ATI to be able to present their position, and then I will open it up to all public comments.

Item 3. Public Comment:

Erik Kantz: Chief legal officer of ATI

My name is Eric, Kantz, I'm the chief legal officer of ATI

A brief introduction and kind of set the table, and then we have our chief compliance officer. Wade Meyer, and also Mike McKay, both PT's. Here So they'll really talk more to the, to the substance, But I just want to appreciate the opportunity. Revisit the topic with the board.
I know it's being proposed again. ATI proposed changes, but as we said before, we have talked with other organizations, Or not, organizations and some small organizations. Were in more rural areas, And I think there is a broader sense of the need for this, even beyond ATI, which we said before and given the nature of the public's Zoom Meetings and the time limitations on the last. We didn't feel we were really able to, you know, discuss fully our comments around the changes, the regulations with respect to the use of Pt. Techs, and so again Sharon Ash really appreciate you giving us this opportunity to do that from a technical standpoint. I just wanted to walk through, because some of the changes given when we gave comments and some of the language that came back from the Legislative Commission.
There were some differences. So, when we had the discussion, when we first proposed changes in July, that language, it was actually a little different than came back that was under discussion in December so don't know if some of the disconnect there was it wasn't exactly a perfect fit what We tried to do is now modify that language which is what we had sent now to the Board to adopt it more to those appeal.
The exact language to keep back from the Legislative Commission. So hopefully. Now those comments line up a little bit better with the actual language that everyone is looking at. There's one slight fix to the proposed language that we can get into, but there, you know, there were. There are new sections that were added that actually were in tech to be all part of that fourth section. In some of that deal is important because of the references in terms of how it lays out so there's only one there will probably have to talk about that in terms of what those new sections apply to. I just wanted to flag that to be to as well, and really at the end of the day, what we're trying to address is the proper use of Pt. Techs I just want to be really clear, because I don't know if there was, you know, confusion about this before. You know none of these changes are intended to expand the scope of Pt. Techs. Rather, we think it's important to maintain the Pt's ability to

use the Pt. Techs consistent with how they're used, you know. Now in Nevada, and how they have been used for years. The act itself allows a supervision of Pt. Techs very similar to the OT act, and so that's just something that we thought that clarification in the regulations was necessary because we didn't want to give the impression that that it's no longer allowed that the Pt techs are not allowed to act as an extender of the Pts and you know we understand. The Legislative Commission, I think, shares our view in that, in order to maintain that access to care and the role of the Pt. Techs on being better defined under the Regs. Again, Pt. Techs have played a very important role, and we just want them to continue to play that role. We are again not looking for them to expand their scope of care. It did seem, from last discussion, as well, that there was concern about their roles, and we just want to say that we agree that with some of the comments that were made that they should they should not be used inappropriately. If they should not be doing things that Pt's. Should be doing. There are a couple of examples, although it was a little difficult to narrow down, and exactly what the concerns were, because I'm not sure a lot of them were very specific, but we do attend to. We do attempt to address this in the proposed language. You know, we're trying to place garb rails on lists to be very clear that again. We're not looking for them to exercise outside of the scope. They currently do, which, again, is an extension of the Pt. Not acting as a Pt., Themselves. I'd also point out that while there were, there were some Pt. Techs who had said or current therapist. I believe, who were Pt. Techs, before, who said, you know, maybe they were doing some things they shouldn't be doing they also said it was a valuable experience, right? And so that, too, I think, is an important aspect of this. The last thing I'll say is the language that is proposed is actually borrowed from the other statutes. The Arizona statute in particular, and also, we know, is consistent with the OT Regulations Ranks in Nevada, and so in this way we think it's consistent, not only with other States, but also Nevada regulations.

And, as I said, at the top, the statute itself, which clearly envisions a role for the Pt Tech to play under the supervision of a of a Physical Therapist. I guess just to close it in talking with a lot of people. It reminds them a little bit of the of the dry needling, which I think some of you folks have been through before, and that, you know again, just being able to preserve a practice that we think is benefiting the community, and the practice, and so, with that I will, I will stop and let anyone else speak or take this.

However, you want. But again, thank you. Chair Nash for the opportunity.

Mike McKay: ATI

Thank you for this opportunity to just come back. I think you know there's two primary points that I won't belabor, but that Eric had made that I think, is from a physical therapist perspective. Really, critical for us in Nevada is like, as I think about the State as a whole.

One is the access to care piece. I think when I've looked in the past at, you know, just ratios of fiscal therapist per capita, Nevada has had one of the lowest, if not the lowest, ratios, and so that access to care piece, I think, is, we think, about the history of just utilization, of having an extended for care. Delivery, the rehab tech piece is critical and then the other piece, just to kind of emphasize that, I think, he said, was, you know the goal here is not for us to expand the scope of the Rehab tech or expand the change.

The practice in any way, but just to clarify. I make that a point, because, as I think about where our profession has gone over the last 10 to 15 years in terms of

more doctor level graduates, and as we have had more transitional level doctorates as well as entry-level doctorates enter the profession in
The field. There's been a real push from an education standpoint, of becoming more of like a frontline medical provider which in a lot of cases in MD Offices and other places. They have extenders to their own care, and so one of the things that we've seen from an outcome perspective is that we've seen positive outcomes when you rehab techs our used appropriately, and I think that's that becomes the key piece right is
that you know the doctors of physical therapy are the ones to be making clinical decisions, to be providing that skilled intervention piece.
So, I feel that we are very much aligned with the board on that, and that that is a critical piece that we want to continue to maintain, but at the same time, that's why we ask for the clarification around the language, because that was the one area that I didn't feel, at least personally as a therapist comfortable with, because I might walk away from some of the past, meetings or some from the past discussions Without a lot of clarity as to Well, who's interpreting what skilled intervention means?
and is that really defined which becomes a challenge for a lot of the therapists in our community that treat the members of our community? And so, I appreciate the time, and we'll leave it at that.

Wade Meyer-ATI Chief Compliance Officer
I am just reiterating what Eric and Mike have both stated so far, really appreciate the opportunity to collaborate and discuss this further.

We certainly, from our standpoint, as noted by Eric, feel as though that this is not necessarily an ATI specific issue, but something that is seen by not only potentially those practicing currently in the State of Nevada, but those who might be looking to come practice in the State of Nevada, as well as noted, we obviously operate in other States, and as Eric pointed out, you know, really some of the language that we had put into this proposal was in essence taken directly from other practice acts where we operate, and feel like our PTs PTA's and PT Techs field aligned in the practice of physical therapy, and what they are able to do and work on a daily basis, and not have questions and not have concerns around what is appropriate for a PT to delegate to a physical therapist, technician or rehab aid whatever naming convention that's utilized in that particular practice act. I think from my standpoint, as a quick background. I am a physical therapist. I have not operated in Nevada. I've practiced in multiple states currently function in the role of chief compliance officer. And really, on my day-to-day operations, those are the types of questions that I feel consistently and point individuals back to the practice act in their particular state when there is a question that arises around whether it's delegation or what the capacity is for a PT or a PTA Or a rehab tech, because, like we've what we're trying to accomplish here is, give individuals that clarity into what they can do.
The last thing that we want to see as an entity is for our individual therapists to have uncertainty around what their practice is, and how they can function on a day-to-day basis, and we want to be able to point directly to clear statutes that define that those particular items, And I think the overall goal is for you know not only us as stated, but for everyone else to be able to go and reference those points in the Practice act and have the opportunity to get the clarity that we feel as necessary around the delegation piece and what is skilled in intervention and

what might not be. I I think I would also just add to what Mike stated as well. You know the practice of physical therapy clearly has been evolving over the past several years, and you know we see more of that decision making requirement by the physical therapist, and what's involved in that particular skilled piece, and then how they can appropriately delegate tasks, because we know that there is a need for physical therapy.
We're not only seeing that in the State of Nevada, but we're seeing it everywhere else, and so as access to physical therapist is becoming a critical point, we just want to ensure, as pointed out, that the preservation of what a tech can do under the appropriate supervision is there. And there's clarity around that, not only in the state of Nevada, but in every other place where we operate, as well as all the other physical therapists that are out there, certainly we can appreciate as Mike stated, you know that we're Hoping to get more people to come to the state of Nevada, because we know that there's such a demand in that particular region, and so to be able to utilize the appropriate individuals under a physical therapist is a critical piece to the operations, not only in our outpatient setting but we feel everywhere else That you know physical therapists are practicing whether it might be skilled nursing, you know. Acute care. Obviously home health. There's many, many places that Pts are needed. and so, ensuring that that these individuals are being appropriate. Utilized is, is a critical piece to the day to day, for every physical therapist out there. So again. Thank you, Sharon Nash. We do really appreciate this time, and the ability to collaborate on this and ensure we get clarity for everybody out in the field of physical therapy. Thank you.

Jennifer Nash- Board Chair
We all agree that clarity is important.

So, with that, I am just going to, for clarity's sake, read through the language changes that I see we are going to be talking about the addition to proposed definition and NAC 640 in Section 2, which is skilled intervention or treatment intervention means number one. To advise, teach, or instruct a patient concerning the condition or disability of the patient. ATI language ads other than as directed by the physical therapist.
To carry out testing or evaluation procedures. To make any notations in the documents regarding patient care or clinical treatment. With the exception of recording basic data in an exercise log or flow sheet other than as directed by the physical therapist.
Then we switch down to the proposed restatement of NAC 640.595
And we are going to specifically talk where number 5, 6, 7, 8 were added to the language via this Hi proposal, 5 is a physical therapist may determine based on patients' acuity and treatment plan. Whether it is appropriate to use a physical therapy technician to assist in the performance of a selected treatment intervention or physical therapy task for the patient, and, if so, determined document, each intervention or tasks that may be performed by a physical therapist technician including
Recording data recording is in an exercise log or flow sheet number 6 on each date of search a physical therapist shall perform and document each therapeutic intervention that requires the expertise of a physical therapist and determine based upon a patient's acuity and treatment plan whether it is Appropriate to use assistive personnel to assist in the performance of a selected treatment, intervention or physical therapy task for the patient.

Number 7, a physical therapist technician should have received on the job training in those tasks.
Specifically related to the service, comma and direction should specify patient-related tasks, including dosage, magnitude, repetition, setting, length of time, and any other parameters necessary for the performance of the patient-related tasks when the patient related tasks are provided to a patient by a physical therapy technician. The physical therapist shall, during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress.

Laura Cerame-PTA Member
This is Laura Cerame for the record I need to refer to DAG Ward, please. We have a couple of comments in the chat section where people are requesting that you share the language on screen. I don't know due to the open the meeting law If that's allowable or not So, can we have some clarification on that please.

Harry Ward-Deputy Attorney General
Yes, the language can be shared on the screen, so that is not a violation of the open meeting wall

Dr. Andrea Aruskin- Licensed PT in Nevada
I've been a license Pt. For 30 years.
The primary reason for regulations. And for our State Board is to protect the public. The reason for licensure is to assure the public.
The government in third-party payers of the safety and efficacy of physical therapy treatments, allowing anyone else but PTs or PTAs to apply any physical therapy treatment to patients does not keep the public safe nor provide quality the highest quality of care using Pt techs is it
Is a chosen business model, commonly adopted to maximize profits in many cases. Since there is at least one other established and profitable Physical Therapy corporation here in town that does not use Pt. Techs. We know that physical therapy facilities can be successful. Lucrative and ethical without using Pt. Techs Small private clinics that don't use. PT Techs also easily stay financially afloat. Neither desired profit nor quote unquote lack of available PTs or PTAs are really ethical or moral justifications to use PT Techs and patient care In regards to regulatory terminology. The terms treatment, intervention, care, program and therapy all refer to the same thing.
They refer to patient care. All patient care requires skill and licensure, even including therapeutic exercise.
There's really no unskilled intervention or unskilled treatment in a physical therapy facility. One of the reasons for this is constant modification of treatment programs is the norm now. Only licensed PTs and PTAs have the knowledge, training, and experience to apply and modify physical therapy treatments safely and effectively. In further clarification of terminology, there is no quote Unquote scope of practice. For PT Techs scope of practice is a term used for licensed individuals. The proposed revisions from ATI that prompted today's public meeting would not fully protect the public from receiving unsafe care, nor preserve the reputation of physical therapy as a trustable medical profession. Therefore, these proposed revisions go against the PT Boards mission, the APTAs Directive that PTAs are the only personnel qualified to be assisting a PT,

and they also go against physical therapy ethics. I support the PT Board in not allowing anyone who is not licensed as a PT
Or PTA to apply any kind of physical therapy treatment to patients. Again, for the American Physical Therapy Association. Licensed Physical Therapist Assistants are the only person who will qualify to assist a PT. There are some ways to bridge the gap while replacing PT Techs with licensed personnel, and still maximize profit, such as practices could accept PT And PTA students for their clinical rotations. They could start a Residency program for new grad DPT's They could search, search out, and accept contracts from insurance companies that only pay a higher reimbursement rate, and they could even lobby insurance companies to increase their reimbursement rate, assuring them that treatments will only be provided by licensed PTs and PTAs and students from Accredited programs. Thank you for your time.

Lou Hillegass-Licensed PT in Nevada
licensed physical therapist in the State of Nevada since 1994, and it practiced continuously through that time, heading into the last meeting, I was under the assumption that we would be creating some standards of useful for

Technicians, and I fully supported that. However, as the meeting went on, and when we went to the Board Comm or comment section and discussion, it became clear that we were going to stop the use of technicians altogether, and that's the last comment or made that that point
For me and my organization, and we employ 28 therapists in Southern Nevada. This would be a bridge too far access to care will be severely restricted within the community. You know I like to talk straight. You know we're seeing a therapist is seeing 12 patients a day. They're still spending a half hour to 40 min with them Direct care, and we are using therapy technicians to help us move patients along in an exercise program that has been prescribed and taught by a therapist. Things like please. Someone on a cardio device or monitoring and exercise program that is already been established.
These patients are getting top quality care in other states that that I've overseen, and some of my business when things are severely restricted, therapists simply reduce the amount of care receives.
So, in California, very common for patients only have a half hour of care because of reimbursement because of other things.
We're headed down that road. If we completely cut this off, I think that there have been bad actors in the past. I've seen it. I've I know that.
But to completely restrict the use of therapy technicians and a response to that, I think, is again not in the public's best interest.
So, with that, said, I, do support the language that the Legislative Council has brought back to the board, and hope you'll give it its full attention, and I look forward to continuing to give great care to our community and look forward to adopting these guidelines. Thank you.

Debby Dieter- Licensed PT in Nevada, Board Investigator.
Thank you. Chair, Nash. I'm a licensed physical therapist in and practicing physical therapist in Nevada since 1970, and I'm also the investigator for the board.

In a point of clarification from ATI. You describe a PT. Techs as a physical therapy extender. I was wondering what kinds of tasks or duties do you delegate to a PT tech in the course of a patient's practice or patients' program.

Harry Ward-Deputy Attorney General
Madam, chair for the record, Madam Chair for the record, Deputy Attorney General Harry Ward.
My suggestion would be to go through all of the public comments and then go back to them to respond.
This is not a Question, answer, session. This is a public comment, so my recommendation would to go through with everyone that has a hand up, and then go back to them to respond to give them one last response.
But this is not a question-and-answer session. Thank you.

Debby Dieter- Licensed PT in Nevada, Board Investigator.
That was that was primarily my question, my concern as an investigator is that the duties and service that a PT tech is providing is charge for as skilled therapy. In other words, it's billed on the patients Daily Bill, and that was my concern.
Is that unlicensed individuals are providing skilled intervention that is billed for to the patient, and that's pretty much what I had to say. Thank you.

Chelsey Koehler- Licensed PT in Nevada
I'm a license physical therapist. I've been practicing for 11 years now, 8 of which in the State of Nevada, I think one of the concerns is the statement that was made consistent with how they have been used in the past, I feel that this wouldn't be here If we didn't have concerns with how physical therapy technicians have been utilized. A lot of question has been revolved around what skilled care means and CMS Center for Medicare services does define it as it's let's see, quoted skilled care refers to skilled services provided by licensed professionals.
They continue to say custodial care refers to services ordinarily provided by personnel, such as aids.
So just with that definition provided by CMS technician care would not be considered skilled and that wouldn't be billable, I just want to also say that you know what we're trying to do is preserve and progress.
Best practice and patient safety. We're a doctoring profession, and we can't undermine the quality of care that we are able to provide as licensed physical therapist by extending that, to an unlicensed personnel skilled therapy is not intended to be
Provide by anyone other than a license personnel. They say if it's provided by a personal trainer, for example, or a patient's husband and wife, that it's not skilled. So, if it's not provided by a license individual then I don't see how we can call it skilled care.
Thank you.

Sean Ellis- Licensed PT in Nevada
Sean Ellis physical therapist in Nevada. I think this is sort of become sort of a dicey topic on both sides, and I'll keep my comments very, brief, because I think it had been verbalized quite well.

By the last few people who spoke, and there are obviously some challenges, but I think at the end of the day we're really just talking about the fact that we cannot have non license staff providing care that it should be decided by a license professional I mean I think that the end of the day is really what we're discussing here.
We can sort of twist the language a little bit to make it fit certain criteria at the end of the day we only have 2 parts of our profession that are that are authorized to provide care, and that is the physical therapist.

In the physical therapist assistant. And really, it's really just that simple using text to do things like, I think someone that refer to like a position options.

Well, a tech is going to, maybe take you back to my doctor's waiting area or something, and I'm going wait for my position but they're not going to be sitting there drawing blood, or, you know, performing medical interventions on me. Okay, if you want to use that sort of an analogy as far as access is concerned. That is always going to be an issue in the medical profession to some degree, but we can't just say, well, we don't have enough therapist. We'll just let anybody do it. And I think again, those are the kind of really kind of saying that around about a way here and again today, we have a robust in and about a fairly robust physical therapist assistant programs I believe we have 3 in town if I'm in Las Vegas alone. If I'm correct that may be wrong in that. So, we need to look at expanding our skill. Educated folks, and then find appropriate place for technicians.

I mean, I'm not saying that we should not. They should not have it opportunity to sort of be involved in our profession, but not in a way which is basically being allowed to do, which is there, you know, providing care. The exercise is care. I have to use my brain to decide. That's a good thing, or a bad thing, and I think I reiterated last time at the last board meeting, and obviously my comments there. But I just strongly oppose amending. You know these changes, that's what's already been set by the board. Thank you.

Jennifer Nash-Board Chair
So, at this point I don't have any further hands for public comments. I would, you know, definitely like to. Oh, Lou has put his hand up again.

Lou Hillegass- Licensed PT in Nevada
Yeah, just really quick. I think there's been a lot of comment about what's billable And I believe people are applying the CMS standard that which is appropriate with a Medicare patient.
But we're glossing over the fact that commercial payers have different regs for billing. So, I don't think that you can just say billable in a setting like this, and have Everyone understand that same definition because it is. It isn't the same with culinary Union versus Medicare and I'm not sure that billable is what the Board should be supervising.
So, it's just technical, but in terms of that being the standard, then you need to add a whole bunch of definitions here, because every payer has a different definition. So just wanted to make that point. Thank you.

Neena Laxalt-Board Lobbyist

Yeah, I just want to comment, Mr. Perkins has a chat question on the side, and it is questioning whether the Board can preclude questions and answers, and I just want to notify the board and the public members. Chair. If I'm correct, I believe you will be taking time, after all public comment to allow ATI to respond to everything that's been said

Jennifer Nash-Board Chair
Yes, thank you. I will absolutely.

James Mortenson- Licensed PT in Nevada
I've been practicing in Nevada since 2014.I've been involved in physical therapy since 2008. I myself was a technician, and I think that I would like to simply echo the sentiment that's been had regarding the use of technicians here this new proposed verbiage simply writes into law the availability for physical therapy technicians to be able to provide what looked like, or what appear to be skilled services.
The conversation around profitability and the multiple patients being utilized or seen with technicians, is probably in question here. If you look at the Cpt codes themselves, it delineates that they are in their respective increments, and identified as one-on-one care.
If you are observing a technician, and you are seeing multiple patients at the same time, you're unable to provide that care. One-on-one. I would suggest that as we come back to looking at this verbiage, so again, it is an attempt to be able to allow technicians to provide skilled services for which physical therapists are only a physical therapist and physical therapist assistance are only able to provide. Thank you.

Eric, Kantz- Chief legal officer of ATI
I think that you know, Lou's point is a good one.
To your point, madam Chair, the point you made is, it's talking about care. It's talking about safety. To my knowledge, there's been no safety issues raised with respect to techs, as they're currently used in the clinics. Again, this is about extending physical therapy. Care it.
This is not unusual either In Nevada or other States, and so there has been this idea of patient safety and billing. I'm not sure is supposed to be the focus of this. This is, this is about patient care, and it is about safety, and so that that is what I would say to that, and there are events, some concerns about Pt Techs providing professional care. Again, we think the language is fairly clear around this point, which is the Pt Techs will not be engaging in the activities of a Physical Therapist And so I think that's also important. Just to emphasize.

Pamela Smith- Licensed PT in Nevada, Secretary of the NV APTA
Hi! My name's Pamela Smith, Physical Therapist, I'm actually the secretary of the Nevada APTA Association, and it's really important that you know these regulations.
There's more than just this one on the table, and we would like in
I find the additional language more confusing. I do find it possibly allowing more skilled intervention by technicians than the original language that was written. So,

I do oppose the newest language to be added. There are a lot of regulations on the table here, and as an association we are looking to kind of get these regulations. Through sooner than later, because there's important other ones on the board.

Here so. And, by the way, I have been a Nevada Pt. Practicing here for 24 years now. So, I have seen the use of technicians that was not in the most judicious ways, not in the safest ways in the past, and I do think the newest regulations that were originally proposed will avoid that use of technicians and it would be in the public's best interest. So, thank you.

Jennifer Nash-Board Chair
Thank you, Pamela. Does the Association have an official state a position? Is that the position you're supporting? Or is this your personal position?

Pamela Smith- Licensed PT in Nevada, Secretary of the NV APTA
It's my personal position, our formal position is really just to get regulations through.
As for our members, it's really important to know what the definitions are and be able to put everything in place and be following them sooner than later.

Harry Ward- Deputy Attorney General
Madam Chair, before we do close out this comment period, I'd like to once again give ATI and counsel Mr. Eric Kantz, is It cans one final last, I guess.
Pitch to the regarding their comments, to address whether there were rhetorical questions or any other questions, and then just finally make sure there are no more comments before you move on in this matter. Thank you.

Jessie Fisher-PT Board Member, Licensed PT in Nevada
I had one more comment that I wanted to make sure to give ATI a chance to respond to with regards to the language. My concern with the additional language is, that there is a definition of skilled intervention or treatment intervention in section 8.
That appears to open it up, that really anything can be performed by a tech as long as it was directed by the physical therapist, and then later in numbers, some of the following numbers, 5 through 7 mentions the tech being able to perform selected treatment intervention in addition to tasks which with the language changes proposed in section 8. I worry that that opens the Techs up to being able to perform pretty much anything as long as they were directed by the physical therapist. So, I just want to clarify What is intended by that language, because that's the that's a big concern of mine.

Eric, Kantz- Chief legal officer of ATI
Sure, and now I'll also open it up to Wayde and Mike to the extent they do. I can say that in in Number 8 that wasn't the intent, actually the intent of Number 8, I believe, is to ensure that the PT Is involved. And so that really, again, the sectioning got broken out a little bit. Jesse, and it used to be a cohesive paragraph. So, it really was more clarifying. It didn't mean to stand on its own,

and again, I'll just say this to the extent we are not necessarily married to language. We gave our best effort to again ensure that the way the Pt. Techs are being utilized today that they would still be able to be utilized in the future, and so that was the entire intent. So, to the extent we have to work on. Some of the language, together with the board. We're certainly, you know, more than happy to do that, and I would just say it's hard to I think we've covered most of the other comments, but to the extent that we are not advocating for Pt. Techs without training, either. Right? I think what you'll see from our comments is also that again similar to what we do already, these people would be trained and be able to again, as they do in other States.
In addition to currently in Nevada, to again be extensions and be able to provide assistance.

Wade Meyer-ATI Chief Compliance Officer
Yes, thank you. Chair, Nash. I think Eric made the point that I was going to stay there, and that again. There was some potentially issues with how that was laid out. As Jesse noted, and the other key point, I think, was we certainly, as Eric noted, weren't married to the language.
This was a proposal, and this was language that again, I think it's worth noting for all those who've spoken, regardless of your sort of in in favor of the old language or the proposed language is that this language is not anything that's been created by myself, or Eric or Mike, or anyone. This is language that has specifically been drawn from other State practice acts.
I think the other key piece in Lou and some others have noted this as well. Much of my day-to-day also involves the interaction of how do we follow the practice act? how do we follow the payer rules? And I think there is an important part there that there is a delineation, you know.
Certainly, payers have the opportunity to create their own rules that are different from the Practice act, and what the goal here is to address the Practice act Considerations, not each individual payer. Specific rules that they can create on their own. I think that's very important to address, because once again, you know, on my day to day, much of the decision making and the pointing out when you're talking to staff, whether they're in Nevada or other States is okay well, what does the practice act state and we're able
to provide that clear language to them, and then we also have to think about a second layer around. What does the payer say? Because there can be differences?
And so, there's many, many examples out there. I could just point out one very simply. We operate in a number of States that have direct access.
Direct access is something that we're moving towards and hope to get for every single State, because we know that our PTs are trained and have the ability to do those things.
However, we do know that a number of pairs do not recognize that they still require the referral you know.
So, we've been able to clear that hurdle, you know, from a practice at perspective but we do not have that capacity to treat the patient without the referral of the primary care Physician, regardless of the practice act, but I think we want to make sure we're staying clear here that the Practice act is what's being discussed.
The language is a proposed language. We certainly want to collaborate and create the best language that we can, and also just keeping the focus on that

again I think it's been noted many, many times that you know there is a certain capacity that I tech has that does provide safety, and in some ways increased access for patients so that would be my last comment.
And I really again wanted to say, thank you and appreciate your time, Chair Nash

Matthew Leveque- Licensed PT in Nevada
Hi! Thanks, madam. Chair for the record. Matthew Leveque, physical therapist, and stay in Nevada since 2000 just wanted to comment.
I guess I'm coming to the conversation a little late, so I apologize if some of this ground has been covered but some of the new language that has been proposed. I think I agree.
It does open the door for text to be able to perform pretty much anything that the physical therapist teams appropriate, including skilled services which I think everybody who's a clinician understands what skilled services are more to the point there's really no regulation or Stipulation on training the text would be subjected to and receive by the provider. So, I think, saying that they would be trained, they would be able to provide a particular service in a skillful way is, probably a bit of a reach. I think overall. We all know that there's no regulation. There's no consistency and training for technicians.
There's no consistency in education. There's no consistency in skill, and there's no consistency in what they're directed to or supervised, and being allowed to do from one clinic to the next. We recognize that the utilization of technicians does create greater productivity for therapists, which I guess can create better access. But the question, is it? What cost are we providing that access?
Are we allowing skill to reduce? Are we allowing quality to reduce?
Are we allowing the public to be less protected because we want to create greater access? Or are we going to follow the guidelines that we all set forth to follow when we came? Physical therapist and make sure that we're using skilled and licensed individuals to provide care. I think PTA, is the answer to that question. I think, as we talk about Billable versus skilled and all the nuances related to insurance and payers, I think we all recognize that the Medicare rules are being adopted by many other payers out there and that billable services and skilled services. Are going to start to converge as time goes on.
We're seeing discounted services, provided you know it at different levels. It's creating reimbursement challenges. We all know that, and I recognize that that's a business challenge that we all have to address. we're here to address the safety of the public we're here to address what is and is not appropriate. When you talk when you're providing care, and there's, you know, when you use techs and you open up opportunity for techs to be used in any way that the therapist deems appropriate, whether supervised or directly or indirectly you're just opening yourselves up for risk and I think that's something that we all need to recognize and address, and I think the new language just provides an opportunity for that risk to be greater. I think the more restrictive language that was originally preferred proposed, or some version of that is the language to stick with, and I think that most people would agree with that if they sit down and consider the safety and the skill that is needed to provide appropriate care to these patients
Thank you.

Jenelle Lauchman- Licensed PT in Nevada
I am also the teacher for the Nope American Physical Therapy Association, Nevada Chapter, but I'm speaking today as just a PT here in the State, and we're

talking about access to care. They're saying that this new language proposed language will increase access from my understanding. The Pt Still has to be present, so I'm not sure how this will improve access, plus if we're want to talk about increasing access. I believe, one of the proposed changes we could make is increasing. The number of PTAs that a PT can supervise. I believe that was brought up in one of our original meetings.
I have been involved with these changes. I am sad to say for 10 years that we still have not made these changes I was in the meeting that we had, and Carson City many, many, many, many, many years ago, and I agree with Pam that these changes need to be approved. They need to be moved on to LCB. Gotten through LCB and updated one of the things the Board has also discussed is, we don't want to add language. That is lists. We want to keep it to contemporary, and I don't believe this new language completes any of those goals. So not only are we not protecting the public with this new language, we're also again opening up to where we're going to have to come back in a year and make new changes as things change. So, I would be opposed to this new language, and moving it forward, as was to LCB. Thank you.

Eric, Kantz- Chief legal officer of ATI
There's been a lot of talk about safety, and to my knowledge there is no indication that, as the practice is now with the crew, of PT
Techs, that it has been a safety issue. So, I just think we should be careful, as we think about these things, that we not be anecdotal as to the safety aspect.

Mike McKay: ATI
Yeah. The one thing that I would probably add to that is that again, you know, the focus of the clinical reasoning and rationale behind things, you know, an assessing, a patient response to exercise. We continue to agree should be done under the supervision of physical therapist, and so I also anecdotally not having seen a lot of claims.
Data related to, you know, patient safety injuries, other problems.
As a, you know, direct result of exercise, or some other
You know home exercise, review, or setting up on a cardio machine being done by a rehab tech, we there's just not been any evidence for that and so certainly we agree that you know again, not wanting to expand the practice, to continue to protect the community and the Nevada population while recognizing that it in the past, you know the current practice act or the way that we have texts are utilized hasn't at least from an evidence Standpoint caused any regular patient safety issues so just wanted to clarify there.

Matthew Leveque- Licensed PT in Nevada
Thank you, madam, chair Physical therapist. Here, in the State of Nevada, recognizing that we're dealing with, you know, the issue of safety and to Mr. Kantz point earlier. They're there, to his knowledge, and no incidences of safety issues regarding tax, and we should be careful with anecdotal sort of positions. I think ultimately, we need to be very careful with allowing unskilled and unlicensed individuals providing skilled surveys, and I think all of that's what tax are currently doing in many practices.

I think anecdotally. We have several patients coming into our practices that have said that their entire sessions have been started and completed with tax, and I don't say I'm not saying that that's something that's happening across the board but it.
Is something that's happening and I think to ignore the public anecdotal evidence that of the type of service that's going on, and the things that could potentially happen just because you can doesn't mean you should.
And I think ultimately using Techs just because we can use Techs and because it hasn't caused an issue up to this point doesn't mean you should continue to do it in our job as professionals is to make sure that we're providing the best care possible in the best circumstances with
The best staff, and being licensed and regulated is the way to do that, not by using unlicensed, unregulated staff members, and not by doing it with people that have no specific training, honestly, that's been regulated or consistently applied from one practice to the next okay whether or not Anyone practice does a good job of it is irrelevant.
Okay, it's what we can. What can we can apply across the board for the profession as professionals and what are we willing to accept as risk and what are we willing to accept as license professionals and that reflects the care that we're providing?
So, thank you.

Neena Laxalt-Board Lobbyist
Madam chair. So, after listening to this, and just to give you a legislative perspective from my point of view, it sounds to me like I'm not quite sure you're all that far apart is just how to get there.
I think there's some structural problems with the way this draft is set up. I think that there's also language in there, that perhaps ATI did not intend to have the meaning to it, and that's probably based on the structure as well. And I believe the board is sort of caught between the current language, which was perceived by the Speaker and Chair of the Legislative Commission, that your language was too big, and I think that perhaps you, maybe looking at the language proposed, and that that is maybe a little bit off But We can work on this. And I think if ATI can take the concerns back to their group and perhaps rework their wording and submit it. Harry, this is where I'll need you. I believe the Board keeps name a member or 2, and I'm not quite sure, as a working group to work with the team of ATI to try to come up with a consensus.
Somewhere between what the Board has submitted and what ATI has submitted to come up with language that is hopefully satisfying everyone's concerns. Harry, I know there's strange rules for setting up a little subcommittee, or whatever they do, but I'd be happy to work with the ATI team and their lobbyists, but I don't have the technical background to be able to know exactly what techs do or
What techs don't do, and but I think there is a way to work this out, and I'll leave that to Harry to provide instruction on how we can do that so that we can bring something back to the Board prior to the next legislative Commission meeting hopefully that will be on that.

Harry Ward- Deputy Attorney General
For the record Harry, War, Deputy Attorney General.

This is not an official DAGS opinion, but for anything like that to happen, the Board would have to vote on what to do, whether to go ahead and proceed today, of whether to go ahead and adjourn and then set up some sort of meeting and do that and work, with ATI and go back but what's on the agenda today is for us to receive all public comment, to receive all comments on comments, so that the Board will receive the best information possible to render and inform decision on the comments, for then we would go to number 4 close public hearing number 5 the board can then discuss the public comments and at this time the board may properly make a motion. Say, let's adjourn. Let's do with our advisor, etc., etc., and see what we can do. Maybe we can do this to do that old board can say, make a formal motion, whether to approve or disapprove the language.
So, it's going to be up to the board. I cannot do anything more than give suggestions and legal suggestions as to what this Board can do today.
But if you have any questions, just please ask me. Madam, chair once again.
Harry Ward Deputy Attorney General, but before we move on, I would ask, are there any more comments by anyone? Especially ATI concerns, so that the Board can receive the best information possible to render and inform decision today.

Debby Dieter- Licensed PT in Nevada, Board Investigator
Debby Dieter Board Investigator for the record. I do want to speak to Matthew Leveque Comment about Techs role in patient care. I have investigated several cases recently where, as I get down into the detail, the patient actually thought the tech was their physical therapist.
So, it does occur in certain settings where the tech is the primary caregiver day to day and that's the because they don't wear a name Tag.
They're not identified by name or by job, that the patient feels that the tech is actually their primary caregiver and is under the impression that they're a physical therapist.
Thank you.

Richard Perkins-Lobbyist for ATI
Madam Chair, and for the record, Richard Perkins, in this hearing, representing ATI, it just seems to me like we've gotten into this, and I agree complete with what Neena said by the way, and she's been doing this a long time And I really respect her opinion here but it seems to me like we've gotten into this this debate, whether to abolish or expand, instead of using Pt. Text in a fashion that they've been used for years and years putting more guardrails around making sure you know patient care and public safety is important, and if I think it has been pointed out, if ATI's language didn't hit the mark, I'm sure they're not married to that language and would love to, you know, have the opportunity to do that differently.
I'm also completely mindful of the time constraints that you're under in and want to get this done, and it's been, you know, ATI and everybody else on this, on this, in this hearing wants to get this done as quickly as possible. You've been waiting way too long to have your regulations in place with that said, and I'm not your legal counsel, and I very much respect your DAGS legal counsel here.
I think he's spot on, and I know that you also have time constraints with posting for public meetings, and the like, which tends to delay the process rightfully. So, delay the process So the public has access, but with that said, should you

choose to put together a working group again, it sounds to me like you'd need another meeting to approve that.
But have a board approval for that, since it's not on this agenda.
What has happened in the past in very various circles where I've participated is on an official, you know, working group has been put together. That then, you know, gets approved by the board at a later date, and you get you get a jump. Start on that meaning. Somebody from the board can sit down with somebody from ATI
Neena can sit down with somebody from our team, they can at least have a dialogue it's obviously unofficial and meaningless at this point, unless the board approves their participation but just a suggestion in terms of expediting this. You have my ongoing commitment to work with the chairman.
Yeager on the at the legislative Commission to get this included on the next legislative commissions agenda should, we be able to find some ability to get to find the right language, right now the legislative Commission does not have a scheduled meeting in January I'm told it's they're planning on trying to have one in late January. It might get pushed into February, but that's the schedule there. My suggestion on the unofficial working group is just to sort of expedite the process so that we can get it on the next agenda, and everybody can be much more comfortable with the fact that you've got approved regulations on the books.

Dr. Andrea Aruskin- Licensed PT in Nevada
Hi! Yes, just a quick follow up home exercise programs and setting up patients on machines and therapy exercise. They're all skilled therapy as the patient can be hurt by inadequate direction. Instruction and setup. Therapy exercise can heal or hurt, or do nothing, solely depending on how it is taught and modified. On a minute-by-minute basis. Only license Pts and Pts are appropriate or safe to apply any part of a physical therapy treatment. If we're talking about improved access to care for patients in in which some facilities choose to use Pt. Techs the Board could consider increasing the supervision ratio to include more Pts and students. Student Pts and student PTAs, you know. So, upping the supervision ratio, which is currently at one, to 3 to one to 4, or one to 5, as they have in other states, and that would have more licensed or student clinicians available to See patients. Thank you.

Sean Ellis- Licensed PT in Nevada
Just wanted to comment on what one that's going on.
I think Mr. Perkins actually mentioned this, and then discussion of working groups.
I think I am understood. If I'm not understanding this correctly, that's essentially what we are suggesting. We're going to restrict what Techs can do and have done in the State, or are we not? And I think that's really the conversation here. So, if I don't understand what either, we decide to move forward. The bill as written, and allow us, in order to be restrictions on what Techs can do, what is really no need to actually have the bill as written. I don't understand where the where the middle ground really needs to be. There is. we're going to be merit more restrictive. On what Techs we allowed to do in centers or in the Pt. Barn, whatever that is, or we're not going to, and that would just leave my comment. As

I'm not understanding what the compromise would be. Beyond that, those 2 the distinctions there. Thank you.

Jennifer Nash-Board Chair
So, at this time I am seeing no other hands raised. A hand raised indicates someone wanting to give public comment
As I want to ensure that we have sufficient time for ATI to address all public comments as well. Before the board goes into their consistency of all comments. I would encourage you to raise your hand one more time if you would like, before I would close the public comments section

Eric, Kantz- Chief legal officer of ATI

I think I would just echo Richards in and Neena's comments.
I think that is a good path forward, and I guess everything else. We've probably addressed what we can address in in today's session. So, thank you again for your time.

Item 4. Close Public Hearing
Chair Nash closed Public Hearing at this time

Item 5. Consideration of Public Comments ***(For Possible Action).***

Chair Nash informed the public that a discussion will be held amongst the Board members. The Board went through the proposed NAC language that was submitted by ATI. Each Board member participated in the changes. Please see attached document with the Board changes to this proposed NAC 640 language.

Recess 11:44 A.M
Reconvene 12:00 P.M

The Board has created a document with specific changes as well as public comment and Board member comments that will be available to view at our next Board Meeting which will be held on January 13, 2023. This item will be agenized.

Item 6. Consideration of Adoption Regulation ***(For Possible Action).***

Motion: Based on our discussions today. After discussions with representatives from ATI and the public, we have put together a collaborative document that we would like to present and possibly vote on at our next board meeting, which is on January 13, 2023. Jennifer Nash, Board Chair
Second: Kat Joines, Vice Chair

Roll Call Vote: Kat Joines, Vice Chair: Yay, Laura Cerame, PTA Member: Yay, Jessie Fisher, PT member: Yay, Jennifer Nash, Chair: Yay.

Item 7. Public Comment-

Eric, Kantz, I'm the chief legal officer of ATI
We Thank the Board again for their time. I just wanted to say it does seem like there have been substantial changes to the language We propose. So, we'll refrain from commenting any further now, but look forward to seeing the changes on paper

Jenelle Lauchman- Licensed PT in Nevada
I think we've made some good headway. I am just wondering, since it pertains to LCB R124-21 At the next meeting would we be able to also discuss NAC 640.594 Supervision requirements at that same meeting, or will it only be this agenda Item that we can discuss for changes.

Harry Ward- Deputy Attorney General
For the record. Harry Ward, deputy attorney, general, Madam Chair, I can't answer that. That's a question for the LCB. The LCB Sent this back to this Board, based on specific instruction. So, I can't answer that. So, I wish I could be more helpful. I'm here for the open meeting law, and not regarding what LCB Wants.

Item 8. Adjournment
Meeting Adjourned at 12:09 P.M.