

Clinical Exercise Physiologist Compensation Strategies: Recommendations by the Clinical Exercise Physiology Association

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Rationale

Personnel shortages of all types are the single greatest problem facing healthcare organizations according to the American College of Healthcare Executives (ACHE, 2022). Numerous anecdotal experiences from cardiopulmonary rehabilitation programs have reported facing workforce departures, particularly by Clinical Exercise Physiologists (CEPs), as well as having difficulty filling subsequent vacancies. The exit of CEPs from the healthcare workforce, in combination with the looming healthcare staffing shortage, will pose significant challenges for both employers and patients unless meaningful changes can be made to satisfy the contributing causes of these departures.

Since their emergence within cardiac rehabilitation programs in the 1960s, CEPs have applied their expertise in areas where the therapeutic benefit of exercise has been demonstrated to treat or prevent progression of chronic health conditions. Despite the CEPs deep rooted history in delivering and advancing cardiac rehabilitation services, a lack of clarity remains surrounding their skills and roles. This has largely been attributed to an absence of universal standardization of academic preparation and lack of a formal scope of practice (Berry, Neric & Dwyer, 2020). These obstacles have led to a landscape whereby CEPs are commonly not recognized for valuable contributions in not only providing safe exercise interventions but most importantly efficacious services that improve a patient's health, quality of life, and by extension, reduce financial burdens associated with suboptimal management of cardiovascular disease.

The focus of the Clinical Exercise Physiology Association (CEPA) is to advance the profession of clinical exercise physiology through advocacy, education, and career development (CEPA, 2022). As such, CEPA recognizes the challenges facing the CEP as it relates to job opportunities, pay and autonomy within the workplace. This document is meant to be a source of motivation for practicing CEPs and administrators to align professional standards, as well as provide four turn-key strategies or ideas aimed at advancing the profession of clinical exercise physiology and improving the compensation landscape.

1. Alignment of position titles

Position titles for the CEP vary widely throughout the industry (Figure 1) and often misrepresent the CEPs skills and training. Moreover, extensive variability in position title reporting makes compensation assessments for comparable positions exceedingly difficult. More than 19 position titles have been identified to define clinical exercise professionals. This wide diversity of titles being used to describe alike job descriptions impairs the accuracy of market analysis searches within a given geographic area and may lead to the inadvertent comparison of dissimilar positions. As such, it is recommended that position titles be accurate and concise so as to appropriately recognize training and avoid confusion. Exercise Physiologist (EP) and Clinical

Exercise Physiologist are preferred titles depending on the academic preparation, professional certification level, and groups served. It is also recommended that direct reports of these position holders collaborate with regional partners to ensure consensus within their respective markets in order to ensure accurate market analysis for their colleagues.



Figure 1. Position titles vary dramatically for exercise science professionals within Cardiopulmonary Rehabilitation workplaces despite similarity of job duties.

2. Job description review

Job descriptions are a principal resource used by human resource teams to determine pay grade assignments and perform market analysis. Outdated or inaccurate job descriptions impair compensation decisions. Periodic job description reviews should become commonplace procedure to closely monitor the rapidly changing field and an increasingly competitive employment market. Job descriptions should be reviewed annually to ensure accuracy and fair representation of key responsibilities, minimum qualifications, academic preparation, years of service and certification requirements.

CEP duties and abilities are frequently underrepresented and misunderstood throughout many organizations. For this reason, performed duties are often misaligned when vetted against job descriptions. The American College of Sports Medicine (ACSM) has provided associated job definitions for both the ACSM Certified Exercise Physiologist (ACSM-EP) and ACSM Certified Clinical Exercise Physiologist (ACSM-CEP) certification credentials. Inclusion of ACSM certification job definitions provide fundamental minimum standards for the practice of EPs and CEPs within their respective treatment environments and serve as paramount for employers to succinctly align job descriptions with training and capabilities (Table 1).

Table 1. Adapted from American College of Sports Medicine’s (ACSM’s) Certification at-a-Glance (GETP 11)

Certification	Primary Population Served	Eligibility Criteria	Job Definition
ACSM Certified Exercise Physiologist	Apparently healthy individuals and those with medically controlled diseases	<ul style="list-style-type: none"> · Bachelor’s degree in exercise science, exercise physiology, kinesiology, or exercise science-based degree (One is eligible to sit for the examination if the candidate is in the last term of a degree program.) · Current CPR and AED certification (must contain a live skills component such as the AHA or the American Red Cross) - AED not required for those practicing outside of the United States and Canada 	<ul style="list-style-type: none"> · Works with apparently healthy clients and those with medically controlled diseases to establish safe and effective exercise and healthy lifestyle behaviors to optimize both health and quality of life. · Conducts preparticipation health screenings, submaximal graded exercise tests, strength, flexibility, and body composition assessments. · Develops and administers programs designed to enhance cardiorespiratory fitness, muscular fitness, balance, and range of motion. · May be self-employed or employed in commercial, community, studio, worksite health promotion, university, and hospital-based fitness settings.
ACSM Certified Clinical Exercise Physiologist	Apparently healthy individuals and those with cardiovascular, pulmonary, metabolic, orthopedic, musculoskeletal, neuromuscular, neoplastic, immunologic, and hematologic diseases	<ul style="list-style-type: none"> · Master’s degree in clinical exercise physiology or equivalent and 600 h of hands-on clinical experience · OR bachelor’s degree in exercise science, exercise physiology, or equivalent and 1,200 h of hands-on clinical experience · Basic life support provider or CPR for the professional rescuer certification (with hands-on practical skills component); AED not required for those practicing outside of the United states and Canada 	<ul style="list-style-type: none"> · Utilize prescribed exercise, basic health behavior interventions, and promote physical activity for individuals with chronic diseases or conditions; examples include, but are not limited to, individuals with cardiovascular, pulmonary, metabolic, orthopedic, musculoskeletal, neuromuscular, neoplastic, immunologic, and hematologic diseases. · Provides primary and secondary prevention strategies designed to improve, maintain, or attenuate declines in fitness and health in populations ranging from children to older adults. · Provides exercise screening, exercise and fitness testing, exercise prescriptions, exercise and physical activity counseling, exercise supervision, exercise and health education/promotion, and measurement and evaluation of exercise and physical activity-related outcome measures. · Works individually or as part of an interdisciplinary team in a clinical, community, or public health setting. · May receive referrals from a referring practitioner to implement exercise protocols. · Guided by published professional guidelines and standards and applicable state and federal laws and regulations.

3. Consensus on certification

The ACSM offers certification for both CEP and EP professionals. The ACSM and CEPA endorse the ACSM-CEP certification as the industry standard for exercise professionals operating in several different clinical settings including early outpatient (i.e. Phase 2) cardiopulmonary rehabilitation, supervised exercise therapy for patients with peripheral arterial disease, exercise oncology rehabilitation programs, non-invasive stress testing laboratories, and other secondary prevention programs as well as clinical settings where exercise has been shown to be of therapeutic benefit to control chronic health conditions. The ACSM-EP is the recommended certification for those degreed exercise professionals working with apparently healthy populations as well as those with known, medically controlled, diseases (i.e. Phase 3 cardiopulmonary rehab). The associated nomenclature is recommended to distinguish certification holders, encourage professional unity, and coordinate job title and job description consistency throughout the field.

4. Implementing career ladders

Career ladders present a feasible means to improve compensation for EP and CEP professionals in settings where market analysis is absent or resisted. Two effective methods have emerged.

First, some institutions have successfully established job position tiers (i.e. Exercise Physiologist I and Exercise Physiologist II) that provide compensation benefits based on years of service, advanced academic preparation, achievement of professional certification, and the performance of added employment responsibilities. This method can be effective when developed carefully. Leaders should take caution when considering the implementation of new pay grades to preserve position titles consistent with Exercise Physiologist and Clinical Exercise Physiologist verbiage. Distinguishing job title differences should be done through the complement of numeric modifiers (e.g. Exercise Physiologist I and Exercise Physiologist II), not the creation of new position titles. The benefit of this approach is the need to draft new job descriptions, pay grades levels and requirements for the position holder. However, it may fall short if administrators pursuing this method succumb to traditional pitfalls of position design that have plagued the industry including, but not limited to, insufficient job descriptions, ambiguous position titles, and the award of compensation based solely on non-performance-based criteria such as years of experience or academic preparation. **In short, rewarding practitioners for years of service, academic background and/or achievement of certification without meaningful differences in duties performed is a contributing factor to pay inequity that may inhibit the long-term compensation environment for CEPs at the cost of quick gains.** Therefore, special care should be taken in the creation of new positions to ensure that compensation differences are based on position responsibilities and/or meaningful differences in minimum professional requirements to execute essential functions.

A second method is to implement pay incentives and/or differentials for individuals who achieve certain performance markers. This method does not affect base pay rates (e.g. hourly wage), but rather provides incentives for colleagues to receive bonuses or pay differentials based on performance, achievement and maintenance of certification, conducting research, and other professional engagements. This has proven to be an effective strategy wherein motivation is leveraged to improve performance, patient care, and overall department innovation while fulfilling the core goal of improving compensation for CEP professionals. Despite the effectiveness of this strategy, it should be noted that this solution is a highly localized practice that neglects the more collective impacts described above.

A hybrid of these two popularized methods may be the most favorable approach. The creation of position tiers in combination with performance incentives may prove to be the most influential practice to improve the compensation prospects for CEPs. While the creation of position tiers is an attractive option because of its influence on base pay rates for the CEP, resulting market analysis will be limited by comparisons within the immediate geographical region and may not provide as impactful compensation changes as desired. Likewise, pay incentives, though an effective means of providing supplementary compensation, often fail to influence the base rate for their holders and will not have influence on broader market analysis. A result needed to improve national compensation for EPs and CEPs. Therefore, the combination of these strategies may prove to be the winning methodology to enhance compensation and recognition for CEPs within the healthcare setting.

Conclusion

The challenge of inadequate and, at times, inequitable compensation has emerged as the leading issue for most CEPs. Formerly elusive, CEPs now seem to have constructive tools at their disposal to move forward and advance reimbursement opportunities. The occasion to improve compensation for CEPs through professional unification has emerged. While no guarantees of the effectiveness of these strategies can be given, favorable outcomes have been documented and will be outlined in future publications. The CEPA believes that the normalization of position titles, the routine review of job descriptions, adherence to ACSM certification standards, and the considerate implementation of career ladders serve as the most amenable and feasible strategies presently available. These tools will be welcome prospects for a valuable profession and the preservation of its essential clinical exercise personnel.

Available resources:

[CEPA 2020 Clinical Exercise Physiology Practice Survey](#)

[U.S. Bureau of Labor Statistics - Occupational Employment and Wage Statistics - Exercise Physiologists](#)

[Roles & Responsibilities of the CEP - Infographic](#)

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