



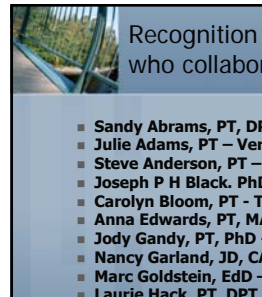



Educational Leadership Conference

October 7, 2006

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Leading the Profession to Autonomous Practice
Transforming Practice through Vision 2020



Recognition and appreciation for all who collaborated for this presentation

- Sandy Abrams, PT, DPT, MED - Philadelphia, PA
- Julie Adams, PT – Vergennes, VT
- Steve Anderson, PT – Seattle, WA
- Joseph P H Black, PhD, MDiv – Bellevue, WA
- Carolyn Bloom, PT - Topeka, KS
- Anna Edwards, PT, MA, MBA - San Diego, CA
- Jody Gandy, PT, PhD - Alexandria, VA
- Nancy Garland, JD, CAE - Columbus, OH
- Marc Goldstein, EdD – Alexandria, VA
- Laurie Hack, PT, DPT, MBA, PhD, FAPTA-Philadelphia, PA
- Roger Herr, PT, MBA, COS-C- Seattle, WA
- Michael P Johnson, PT, MS, OCS - Philadelphia, PA
- Reenie Kavalar, PT - Milwaukee, WI
- Grace Le Fever, PT – Philadelphia, PA


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Recognition and appreciation for all who collaborated for this presentation

- Peter McMenamin, PT, MS, OCS - Chicago, IL
- Sharon E McCallum, PT, DPT – Seattle, WA
- Alma Merians, PT, PhD - Newark, NJ
- Kathy Mairella, PT, DPT, MA – Newark, NJ
- Peggy Newman, PT – Oklahoma City, OK
- Sharon Olson, PT, PhD – Houston, TX
- Janet Peterson, PT, DPT – Shoreline, WA
- Mary Sinnott, PT, DPT, MEd - Philadelphia, PA
- Gwyneth Straker, PT, MS - Lacrosse, WI
- Jennifer Wilson, PT, MBA - Rochester, NY
- Kerry Wood, PT - Colchester, VT
- Stacey L. Zeigler, PT, DPT, MS, GCS – Potsdam, NY


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APTA Vision 2020

- Doctor of Physical Therapy
- Evidence-Based Practice
- Professionalism
- Direct Access
- Autonomous Practice
- Practitioner of Choice

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APTA Vision Sentence

In 2020, physical therapy will be provided by doctors of physical therapy recognized by consumers and other healthcare professionals as practitioner of choice and to whom consumers have direct access for the diagnosis, intervention and prevention of impairments, functional limitations and disabilities related to movement, function and health.

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APTA Vision Sentence for Physical Therapy 2020 (HOD 06-00-24-35)



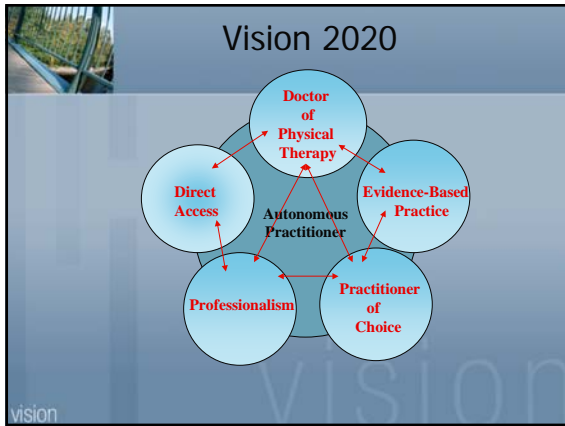
Doctor of Physical Therapy

- **Why is the DPT important?**
- **Educational Framework**
- **Current Challenges**

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Alma Merians, PT, PhD
University of Medicine and Dentistry, NJ

Contributor: Joseph P H Black, PhD, MDiv



Doctor of Physical Therapy

Goal of the DPT is to educate students to be capable of autonomous practice

The educational framework for the DPT is guided by four important documents:

- APTA Guide to Physical Therapist Practice
- APTA Normative Model of Physical Therapist Professional Education
- APTA Professionalism: Core Values
- APTA Guide for Professional Conduct

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Post-Baccalaureate Education

Masters Degree

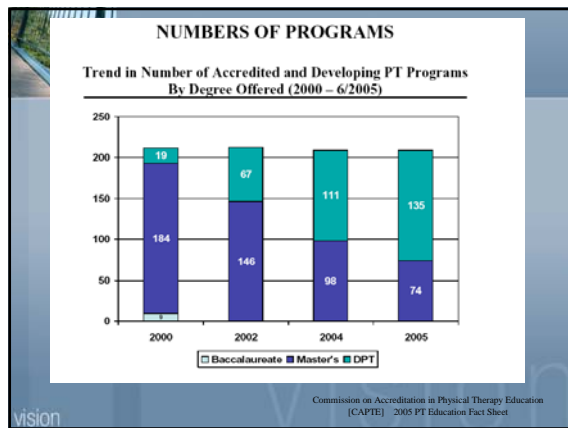
- 22 years for all programs to convert from baccalaureate to masters degree (1979-1/1/02)

DPT Degree

(May 2006)

- 1996 - first DPT graduating class
- 2006 - 158 DPT
54 MPT/MSPT
1 DPT (dev)
- 75% at DPT level

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DPT & The Transition DPT: An Inclusive Transition

DPT Degree

- 2010 - anticipate that 100% of the physical therapist professional education programs will be at the doctoral level

Transitional DPT (t-DPT)

- 2006 - 64 programs award the t-DPT
- Over 10,000 enrolled or graduated
- Cost: \$4,000 - \$20,000
- Either on-site, on-line or a combination

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Doctor of Physical Therapy Curricular Content

- Includes content augmentation in such areas as epidemiology, pharmacology, radiology, ethics, professionalism and core values, practice management, and business and marketing/public relations.
- Cultural awareness, sensitivity, and competence
- Constantly revised to reflect current knowledge

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Doctor of Physical Therapy Educational Outcomes (Selected)

- Recognize when responses to an intervention deviate from the expected; when conditions are outside our scope of practice; and when and how to refer to other practitioners.
- Read, interpret, and evaluate findings from current literature, evidence-based databases, and governmental clinical guidelines.
- Apply relevant findings to patient/client management, including clinical decisions, differential diagnoses, and interventions.
- Document practice outcomes against accepted standards of care.

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Doctor of Physical Therapy

DPT ≠ Doctoring Profession

It is

- A commitment to the other pillars of Vision 2020 - they are all integrated.
- A commitment to evidence-based practice, teaching, and learning.
- A commitment to acquire advanced knowledge, behaviors, and skills.

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Future Challenges

- An inclusive transition to the doctoring profession, including advocacy for the acquisition of the t-DPT.
- Continuously re-align professional education outcomes with the changing needs and expectations of clinical practice
- An increasing need for faculty and academic administrators
- Applicant pool



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Evidence-Based Practice

Sharon Olson, PT, PhD

Contributor: Marc Goldstein, EdD

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Current Practice

- Based on
- Authority 
- Educational Background 
- Tradition 
- Trial and Error 

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Why Not EBP?

- No time for practical use of EBP, contrary to Director's beliefs. (Zeigler and Gaynor, 2006 APTA abstract)
- Recent interviews with clinicians indicated they believe in Evidence Based Practice, but do not believe that most of research evidence can be readily applied to their patients' conditions. (Joe Black, PhD, MDiv,2006)
- Researchers often test one intervention in isolation to minimize the effects of confounding variables. In contrast, clinicians.....may simultaneously change more than one aspect of the intervention strategy and may use more than one intervention at a time.

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Best Research Evidence

- Basic Science
- Clinical Research
 - Diagnosis
 - Prognosis
 - Intervention

How to Begin?

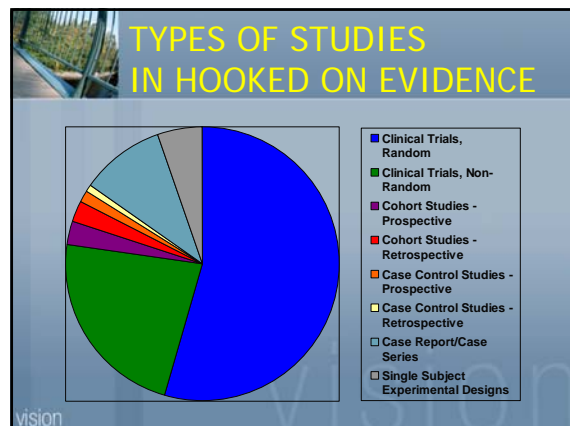
- Focus on Practice Policies
 - Quality Management
 - Reimbursement Issues
 - Marketing/Practice Expansion
 - Continuing Education
 - New Practice Modalities/Approaches


The Quest for Information

- Background information (General Topic)
 - A question root with a verb
 - A diagnosis
- Foreground Question (Specific)
 - Patient/Problem (Diagnosis)
 - Intervention/Assessment
 - Comparison (Alternative assessment or treatment)
 - Outcomes (Results)
- Gather/Assess Information
- Integrate findings into practice/Evaluate results

The Search for Evidence

- Hooked on Evidence
- Open Door/PubMed
- Cochrane Reviews
- PEDro
- Centre for Evidence-Based Medicine (www.cebm.utoronto.ca)
- Evidence in Motion
- StrokEngine
- Evidence-Based Review of Stroke Rehabilitation
- Clinical Evidence
- Best Bets
- Core Journals (Maher et al. Physiotherapy Theory and Practice, 2001)






HOE CLINICAL SCENARIOS

- **Conditions/Clinical Scenarios**
 - Stroke
 - Knee
 - Low back pain
 - Shoulder
 - Cerebral palsy
- Reference Lists
- Outcomes


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Assessing the Evidence

- 3 steps to complete:
 - Screening the articles/reviews
 - Determining level of evidence (I-V)
 - Assigning grade of recommendation (A-C)
- 3 questions to ask:
 - Are the results valid?
 - Are the valid results important?
 - Are these valid, important results applicable to your patients?


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More Suggestions

- Leisurely net-surfing
- Read an HOE extraction
- Read Evidence in Practice in *Physical Therapy*
- Read a Clinical Practice Guideline (www.guideline.gov)
- Read an article from a core journal
- EBP clubs during lunch
- EBP at district meetings
- Clinical/academic partnerships
- Request evidence at continuing education seminars

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PILLAR: PROFESSIONALISM



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DEFINITION OF PROFESSIONALISM IN PHYSICAL THERAPY

A systematic and integrated set of core values that through assessment, critical reflection, and change, guides the judgment, decisions, behaviors, and attitudes of the physical therapist, in relation to patients/clients, other professionals, the public, and the profession.


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HISTORY OF PROFESSIONALISM

- **Code of Ethics**
- **Guide for Professional Conduct**
- **Standards of Practice**
- **Professionalism in Physical Therapy: Core Values**
 - Adopted by the APTA Board of Directors as a core document for physical therapy in August 2003
 - House of Delegates in 2006 adopted Professionalism: Core Values as one of 9 core documents

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CORE VALUES

- Core values require no external justification.
- They have intrinsic value and are of significant importance to those inside the organization (profession).
- They are the soul of the organization (profession) - the values that guide all actions.

Collins J, Porras J. Building your company's vision. Harvard Business Review.


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WHY PROFESSIONALISM AND CORE VALUES?

- Public expectations for a doctoring profession are inextricably linked to core values
- Doctoring profession requires the integration of core values into education, practice, and research, including analysis and application, at higher, more pervasive, and more complex levels


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APTA CORE VALUES

- Accountability
- Altruism
- Compassion/Caring
- Excellence
- Integrity
- Professional Duty
- Social Responsibility


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PROFESSIONALISM CHALLENGES

- Determine methods for teaching professionalism that result in a change in learner behavior
 - Example: Development of a web-based APTA Professionalism Instructional Module
- Measuring (valid and reliable) and assessing core values
 - Example: Use of an instrument that could address core values in the student selection process


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PROFESSIONALISM CHALLENGES

- Integrating core values consistently and pervasively in practice, education, and research
- External stakeholders associate physical therapy as exemplifying core values in their daily interactions
- Changing the culture of physical therapy so that core values are evident

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Direct Access

Kathy Mairella PT, DPT, MA

Contributors: Nancy Garland, JD, CAE
Janet Peterson, PT, DPT, APTA Board of Directors

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What is Direct Access?

“Direct access is the legal right to deliver services to patients without a referral from another health care professional”

Direct Access Task Force - 2000


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What does Direct Access mean to Physical Therapists?

Direct Access includes being paid for services without additional referral requirements

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What does Direct Access mean to patients?

Patients can:

- Obtain PT services without a referral requirement
- Select a PT of choice
- Choose PT services as an option for health care services


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History of Direct Access within APTA

- 1974 – BOD Task Force appointed to study initial evaluation without referral
- 1979 – BOD Policy introduced in HOD which incorporated as part of Code of Ethics – *Practice acceptable without referral where states did not explicitly prohibit*

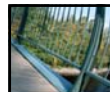
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History of Direct Access within APTA

- 1999 - HOD 06-99-16-210 – HOD passed RC supporting Physician Status and Obtainment of Direct Access
- 2000 – HOD 06-00-24-35 – HOD passed Vision 2020 including the goal of Direct Access at the Federal and State level

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History of Direct Access in State Law

- PT scope of practice defined in state practice acts
- 1957– Nebraska – no mention of referral to access PT
- 1979 - Maryland passed legislation that removed referral requirement
 - Legislation amended insurance statute requiring insurance companies to pay without referral

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History of Direct Access in State Law

- 1980s - 21 states achieve direct access
- 1990's - 9 states achieve DA
- 2000's so far - 10 states: Virginia, Pennsylvania, New Jersey, Wyoming, Louisiana, Ohio, Georgia, Mississippi, Connecticut, New York
- TOTALS: 43 states have some degree of Direct Access, 7 more to go!

Types of Direct Access

- **Unrestricted**
- **Restricted:**
 - Time limits
 - Experience level
 - "wellness" vs. impairments/functional limitations

History of Direct Access in Federal Government

- 1971 – Military – allows Direct Access to PTs with Credentialed Status
- 2001 – APTA has first Medicare Direct Access legislation introduced to eliminate the referral requirement under Medicare of outpatient PT as authorized by state law
- "Medicare Patient Access to Physical Therapist Act"
 - S. 2386 Senate sponsors – Sen Blanche Lincoln (D – Ark), Sen Arlen Specter (R-Pa) 4 cosponsors
 - HR 3633 House sponsors – Rep Phil Crane (R-III), Rep Earl Pomeroy (D-N Dak) 50 cosponsors

History of Direct Access in Federal Government

- 2003 – Re-introduction in March 2003 with same sponsors
 - H.R. 792 - 187 sponsors
 - S. 493 – 18 sponsors
- June, 2003: March on Capital Hill!
 - PTs in every office on Capitol Hill on one day
- March 2005 – Medicare Direct Access bill re-introduced -
 - H.R. 1333 introduced by Rep Pomeroy (D-N Dak) and Rep Hart (R- Pa) 151* co-sponsors (85 democrat, 66 republican)
 - S. 647 introduced by Sen Lincoln (D-Ark and Sen Specter (R-Pa) 15* co-sponsors (10 democrat, 5 republican)

History of Direct Access in Federal Government

- A major revision to the *Medicare Benefit Policy Manual*:
 - Change Request (CR) 3648 - was published by CMS on May 6, 2005, with an effective date of June 6, 2005
 - APTA encouraged and worked extensively with CMS over the last few years for these revisions

Highlights of Manual Changes


Requirement	Before CR 3648	New Policy
Physician Visit	Every 60 days, then 30 days thereafter	No Physician visit requirement, at physician discretion
Physician Orders	Orders required to initiate care	Not required – but prudent Physician required to "certify" each 30 day interval of Rx
Under the Care of a Physician	Patients required to be under the care of a physician	Unchanged
Certification of Care	Physicians	Clarifies (not new policy) physicians (MD, DO, DDS, DPM) and non physician practitioners qualified to certify plan of care if allowed by state law
Date of Certification	Carrier specific but usually with days and must be signed.	As soon as possible – verbal orders accepted if followed by signed certification. PTs have 30 days in which to obtain the signature and delayed signatures on POC



"Public" Opposition to Direct Access

- Patient Safety
- Increased Liability
- Over-utilization

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Putting Direct Access Into Practice

Reimbursement/Payment

- Convincing insurers to pay for physical therapy delivered under direct access
 - At least 20 states have some
- Opportunity to demonstrate value of PT
- Medicare Direct Access

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Putting Direct Access Into Practice

Liability exposure

- Increased responsibility creates perception of increased risk
- No evidence of liability differences in states with and without direct access

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Putting Direct Access Into Practice

" Due to the competent use of primarily noninvasive, nonmedicinal diagnostic and intervention strategies, associated risk to the patient from physical therapy is extraordinarily low while the potential for benefit is substantial"

Gail D Deyle, PT DSc, DPT, OCS, FAAOMPT
 Direct Access Physical Therapy and Diagnostic Responsibility: The Risk-to-Benefit Ratio
 J Ortho Sports Phys Ther 2006; 36(9): 632-634

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Putting Direct Access Into Practice

Marketing

- Opportunities for chapters, sections, hospitals and individual clinics
- APTA's new Moving You to Better Health Ad Campaign Kit: \$45 for APTA members, \$100 with a Beta Tape that is TV-ready
- Ohio Marketing with Direct Access example


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Clinical Education Question

How do we create adequate opportunities for students to learn to practice in a direct access environment?

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Autonomous Practice


Sandy Abrams, PT, DPT, MEd

Contributors: Carolyn Bloom, PT
Steve Anderson, PT



The Evolution of Autonomous Practice:

- The term autonomous practice has created confusion among members especially in relationship to ownership
- Early hesitancy to accept the concept




APTA House of Delegates 2006

RC 13 06:

Autonomous Physical Therapist Practice:

- HOD adopted as a *position*




RC 13 06:

Autonomous Physical Therapist Practice

Purpose:


- To help clarify the characteristics of autonomous practice for our membership
- Clearly delineate that physical therapists (PTs) are expected to practice autonomously in all settings, practice environments, and employment relationships
- An autonomous practitioner is one who accepts the responsibility and risk for professional decision-making



Characteristics of Autonomous Physical Therapist Practice:


- Independent, self-determined professional judgment within one's scope of practice, consistent with the profession's codes and standards, and in the patient's/client's best interest.
- Responsibility and acceptance of risk for all aspects of the physical therapist patient/client management.
- Ability to refer to and collaborate with health care providers and others to enhance PT patient/client management.
- Recognition of circumstances that necessitate a request for consultation and initiation of consultation when in the best interest of the patient/client.
- Clinical decision making that is independent of external financial considerations.
- PT's governance and control of physical therapy practice in all settings.

RC 13-06 Autonomous Physical Therapist Practice



Core Values of Autonomous PT Practice

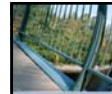
- Independent, self-determined professional judgment and action
- Recognition as a practitioner of choice by public
- Recognition for education, experience, expertise
- Unrestricted direct access
- Professional ability to refer
- Professional ability to refer for diagnostic testing



Need for legislative actions

- Direct Access to remove the referral requirement
- Remove regulations at state level that are barriers to the practice of direct access physical therapy
- Reimbursement for care under D.A.
- Language of change to 'consultation' instead of referral
- Rules and Regulations for PT accountability of actions

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How to 'autonomize' your practice/educational setting

- PTs take individual actions consistent with RC 13 06 in their practice setting, whatever it is
- Alternatives for PT employment:
 - group practice
 - cooperative, partnerships as in other professional fields
- Need to place PT students in non-POPTS settings
- Need to develop model faculty practices

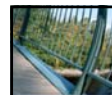
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Where are we going from here?

- Continue the dialogue for further evolution
- Role models needed
- Fear reduction by grassroots PTs
- Instill high levels of professional values
- Continue APTA legislative agenda
- Increase % of PTs donating to PACs
- Encourage grassroots PTs to take actions consistent with autonomous practice in whatever setting they are practicing


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Clinical Education Questions:

- How can we prepare our students and clinical instructors to support autonomous practice?
- What is missing (that we as educators could provide) the presence of which would make a difference?

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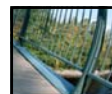


Practitioner of Choice

Jennifer Wilson, PT, MBA
Nazareth College, Rochester, NY

Contributors: Peggy Newman, PT
Sharon E. McCallum, PT, DPT

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Practitioner of Choice

Positioning the physical therapist as...

the "**practitioner of choice** for conditions that affect movement, function, health, and wellness."

- Key word: **positioning**

Vision 2020: "Physical therapists will be **practitioners of choice** in clients' health networks and will hold the privileges of autonomous practice."

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Practitioner of Choice Considerations...

- **Entry-point...**
 - "My PT"
 - Perception of value
...*perception is reality*
- **Market positioning, differentiation & branding**
- **Customer groups – target markets/ "audiences"**
 - **MULTIPLE** stakeholders
 - Internal & external

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Practitioner of Choice:

Autonomous professionals need business savvy.

Question:

Do we understand the (decision-making) role our consumers play in making buying/purchasing (\$\$\$) decisions in health care?

Think like a 'marketer'.

Not what WE want; not what WE value...
It is what our consumers (stakeholders) value.

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Key Terms

Advertising:

- Cut through the clutter;
positioning

Public relations:

- Build awareness & relationships with communities...
- Build (perception) of value

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APTA Strategic Plan for Public Relations & Advertising 2005-2010*

Goal 1:

PTs universally recognized & promoted as **practitioners of choice** for conditions that affect movement, function, and health.

- **Objective A:**
 - Promote PT to consumers and other professionals
- **Objective B:**
 - Support members + autonomous practice

*Part 1

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APTA Strategic Plan for Public Relations & Advertising 2005-2010*

Goal II:

PTs are **autonomous practitioners** who are reimbursed...

- **Objective A:**
 - Advocate federal and state laws & regulations (unrestricted direct access)
- **Objective B:**
 - Improve coverage & reimbursement with payers (public & private)

*Part 1

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Target Audiences (Markets)*

Internal:

1. APTA members
2. Prospective members

External:

1. Consumers
2. Other health care practitioners
3. Legislators & regulators
4. Insurers & payers
5. Employers & injury care coordinators

*Parts 2 & 3

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Think like a Marketer...

We can't forget:

- Relationship selling = sales
 - Ask for the order
- Marketing (market research)
- (Service) Differentiation
 - Value-added

"PT is PT is PT"

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Think like a Marketer...


Key Question:

How do our prospective consumers/members make buying/purchasing (\$\$\$) decisions?

What do they value?

Question: How do we access this information? (market research?)

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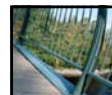


Think like a Marketer...

Response question...

- Then, how do we **position** physical therapy services in the minds of our prospective consumers/members so we are the '**practitioner of choice**'?

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Practitioner of Choice

- Least understood element?
- Difficult to measure success?
- Finite resources (time, \$, people)
- **Question:** How much \$\$ do we invest in PR, advertising, marketing so our consumers "buy from us" (seek out our services; PT = "**entry-point**")

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Thank You!

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