HPA RESOURCE

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Supplement to *HPA Resource*

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Health Services Research: A Review of Domains Relevant to Rehabilitation

Section Special Interest Groups:
• Technology SIG
• Cross-Cultural & International (CCISIG)

Postgraduate Residency Training for Physical Therapists: Its Role in Contemporary Practice

by Greg Hartley, PT, MSPT, GCS

As the physical therapy profession continues to mature and evolve, postgraduate training and education of therapists is becoming even more important. Direct access can be achieved only if we are able to demonstrate that our training and expertise enable us to be a "point of entry" into the healthcare system. Hence, we can expect to become practitioners of choice only if we are prepared educationally for this challenge. Other issues on the horizon, such as pay for performance, will require therapists to be accustomed to using evidence to guide their practices. Moving toward the Doctor of Physical Therapy (DPT) degree is one way our profession is demonstrating educational preparation for independent practice. Another way physical therapists can demonstrate advanced competence is to become Board Certified Specialists.

Postgraduate residency programs are designed to train therapists in a defined specialty area. Curricula in residency programs must reflect an accepted practice analysis if the residency is to be recognized by the American Physical Therapy Association (APTA) as a specialty area.[1] Training received in a credentialed residency program can provide participant therapists with the skills required to become Board certified within a specialty area recognized by the APTA. In addition, these programs are poised to create a "fast track" toward advanced expertise — something that is required for practice to be evidence-based and for physical therapists to be able to treat without referral. This article discusses the credentialing process for residency programs, describes two residency models, gives examples of administrative issues related to these models, and explains the linkage between residency programs and Board specialist certification.

Credentialing Residency Programs

The APTA credentials clinical residency programs to ensure that they reflect current advanced practice in the designated area.[2] To become credentialed, a residency program must provide evidence that the program includes content that addresses all of the areas described in the Description of Advanced Clinical Practice (DACP) or the Description of Specialty Practice (DSP) for a particular specialty area [i.e., the practice analyses].[2] While the curricular content of a residency program typically focuses on clinical practice, some didactic content is required. Residents are mentored by expert faculty within the residency program, the

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hallmark of residency education. Each residency program may arrive at the desired outcome (covering all areas of the DACP/DSP) however it chooses, provided all areas are covered and progression is logical and sequential. The length of a residency is also established by the program itself and can last anywhere from 9 to 36 months. Regardless, a minimum of 1,500 hours is required.[2]

Recall that residents must be licensed physical therapists, not students or student interns. Residency programs offer postgraduate training that is designed to train a generalist, or novice, for specialty practice. Moreover, many programs include objectives that are clearly associated with preparing residents for a Board certification exam. The level of training that occurs in a residency program is always aimed toward advanced clinical practice. It includes one-on-one mentoring, independent treatment, as well as didactic work. Residents are evaluated through written exams and live-patient exams, in addition to other criteria determined by the program itself.[2]

APTA's credentialing program provides a mechanism of ensuring the internal integrity of the residency program and a means of validating the presence of required elements to promote positive outcomes. The credentialing process is similar to the process used by both the Commission on Accreditation in Physical Therapy Education (CAPTE),[3] which accredits just over 200 professional (entry-level) physical therapist programs, and the Accreditation Council for Graduate Medical Education (ACGME)[4], an organization that accredits about 7,800 medical residency programs.

Models for Residency Programs

Residency programs may be organized in a variety of ways. The program might offer all clinical and didactic training on site and in house. It might link with a local university such that clinical training is provided on site, and the university provides didactic education. Or, a university could house the residency program and contract with clinical sites to provide the clinical training and mentoring.

Current APTA credentialed programs represent each of these models, as well as some others, including models using satellite clinics and computer-based instructional methods. Regardless of the organizational structure of the program, the goals are to train postgraduate physical therapists to function as specialists and to untangle the pathway toward expertise without the process taking an unreasonable amount of time. Professional development from novice to specialist to expert should occur as quickly as possible in contemporary practice and into the foreseeable future. Training received in a credentialed program, whether it is university- or clinic-based, offers an attractive option for physical therapists interested in a specialty area and a mentored transition to advanced clinical expertise.

Administration and Management of Residency Programs

Since residents are licensed therapists, most residents enrolled in credentialed programs receive a salary. Typically the salary is reduced to compensate for costs associated with program administration, time invested by mentoring faculty, and tuition (if applicable). How programs handle these arrangements is unique to each program. Here are two examples.

In one clinic-based residency program, participants receive a reduced salary that is 65% to 70% of a typical starting salary. The program has a relationship with a university where the didactic content is provided. Tuition for the courses taught at the university is paid by the clinic-based residency program. The time invested by clinical faculty (expert mentors) that is spent with the resident is offset by the reduction in the resident's salary. During the program, residents are expected to be 75% productive when compared to the typical full time (non-resident) physical therapist. Another incentive in this program is that residents receive university credit for the courses they take as a part of the residency. These credits may be applied to an advanced academic degree. Over the years, this program has broken even on residency finances. More importantly, its staff now consists of four residency graduates, and the facility has not had to spend any additional funds to recruit or retain physical therapists in the program's four-year history.

In a university-based residency program, residents function as teaching assistants (TAs) for the university and receive a small stipend. The resident's responsibilities as a TA include teaching some content in the professional (entry-level) physical therapy program at that university. The didactic content (of the residency program) is provided by the university. The clinical exposure occurs at a facility in the vicinity of the university. Residents are employed by this facility at least half-time and receive a salary commensurate with experience. Clinical mentoring occurs in this facility. The half-time salary plus the university stipend comprise remuneration for the residents.

In both examples, the university and the clinic benefit from having residents. Some additional benefits of having residents on staff include frequent journal clubs or grand rounds as well as more focus on clinical research. Other staff may become invigorated as they observe residents and mentors "up the ante" with regard to evidence-based practice and scientific inquiry.

Residency/Board Certified Specialization Linkage

The American Board of Physical Therapy Specialties (ABPTS) allows graduates of *credentialed* residency programs to count all hours spent in their residency programs

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as hours toward meeting the requirements of eligibility to sit for the board certification examination.[5] This policy permits most residents to apply for and take a Board specialization exam at the completion of a full-time, year-long residency (typical time frame). APTA's credentialing process enables the profession to validate the integrity and outcomes of residency programs. It requires residents to be evaluated in advanced clinical competencies throughout the program.[2] In this way, residency education demands demonstrable measures of advanced clinical knowledge, skills, and abilities that are beyond what the written specialty exam is able to capture. As a result, even novice therapists, upon completion of a credentialed residency training program, are well-suited for clinical specialization.

Currently, APTA has credentialed 11 orthopaedic residencies, five sports residencies, two neurology residencies, and one geriatrics residency.[1] As our profession continues its growth, residency programs are expected to flourish. Specialized knowledge and clinical skills will be required in direct access and pay-for-performance situations. Physical therapists and others who are in a position to facilitate this professional evolution should embrace residency (and/or fellowship) education and consider the benefits these programs and their graduates can offer our profession and our consumers, today and beyond 2020.[6]

For more detailed information on residency programs, fellowship programs, the credentialing process, and benefits of becoming credentialed, check out the APTA website at www.apta.org. In addition, watch for information on the CSM 2007 Pre-Conference Course titled *"Clinical Residency 101: Getting Started and Doing it Well."*

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CCISIG Member Recognized for Volunteer Efforts

by Celia Pechak, PT, MPH

Pennsylvania physical therapist Denise English received a Health Volunteers Overseas' (HVO) 2006 Golden Apple Award in recognition of her dedication to training rehabilitation technicians at Physical Therapy Overseas' former Haiti site. In addition to providing classroom and clinical training for several weeks at a time since 2002, Denise dedicated hundreds, if not thousands, of hours to volunteer recruitment and curriculum revision in her roles as teacher, Program Co-Director, and Curriculum Committee member. She continues to volunteer in Haiti even after HVO was forced to suspend its program due to civil unrest.

Denise is committed to offering care to the disabled of Haiti, the most desperate group in a desperate country. Her compassion for Haiti and its people in need is equaled only by her passion for doing a good job. Denise's dedication should inspire new and experienced therapists alike to follow in her footsteps in making a positive impact in our global community. The CCISIG salutes our fellow member, Denise English, for serving as a role model in our profession.

Celia Pechak is moderator of the listserv for the Cross-Cultural & International Special Interest Group (CCISIG). She may be reached by e-mail at pechak@tyler.net. HPA

HPA Programming for 2007

by Rick Gawenda, PT

The HPA Program Committee is excited to announce its plans for the upcoming preconference course, entitled "Marketing for the Clinician, the Practice, and the Profession: An Interactive Workshop", to be held at the Combined Sections Meeting in Boston on Wednesday, February 14, 2007 from 8am to 5pm. Speakers will be Lynn Steffes, president of a rehab consulting company in New Berlin, WI, that specializes in marketing and advocating for rehab services; Alexis Waters, Department Director of Marketing Services for the APTA; and Steven G. Lesh, chair of the Physical Therapy Department at Southwest Baptist University in Bolivar, MO, and who teaches marketing, administration and management content in that program. This course will focus on the theory and application of marketing strategies across three levels: the individual clinician, the health care organization, and the profession of physical therapy. Marketing theory will be integrated into the real life application of advertising, promotion, and public relations for the physical therapy professional using open, free-flowing discussions. Interactive breakout sessions will enable course participants to evaluate, analyze, and improve upon marketing plans, tools, and strategies that they will be asked to bring to the course. Participants will acquire contemporary examples of effective and efficient marketing strategies to enhance self promotion, clinic visibility, and greater public awareness of the profession that can be taken back to their work settings.

Here is a preview of some *new* HPA programming planned for CSM 2007:

Mary Sinnott and Annette Iglarsh will present the first two parts of a four part series, entitled "Autonomous Professional Practice: Unlocking The Door". This series will focus on leadership. Part I will address leadership for the individual and behaviors within your own practice. Part II will focus on leadership at the point of practice and address ethics of business and actions to take. Parts III and IV will be presented at CSM 2008. Part III will focus on leadership within the profession, and Part IV will focus on leadership within the health care industry.

Dennis Hart, Mark Werneke, and Kathy Scott will present "Pay For Performance: A Model for Future Payment in Physical Therapy". Their presentation will first address the political background behind the current movement in Congress to align financial incentives with outcomes, which is the Institute of Medicine's vision of the future of our health care delivery system. Then they will address how the Medicare Payment Advisory Commission (MedPAC) has (1) advocated an increased role for the Centers for Medicare & Medicaid Services (CMS) in encouraging improved quality outcomes, (2) recommended that CMS conduct demonstrations to evaluate provider payment differentials and structures that reward and improve quality, and (3) recommended that CMS adopt pay-for-performance standards for treatment facilities and managed care plans. In addition, they will describe the development of one pay-for-performance process for outpatient therapy that matched patient self-reported change in function to the number of treatment visits to produce a risk-adjusted algorithm where payment to providers could be based on effectiveness (i.e., did the patient get better) and efficiency (i.e., how many visits were used). Finally, they will share experiences gained by a private insurance plan that is beginning the implementation a pay-for-performance process for physical therapists in a private insurance plan.

Sandra Campbell and Stacey Zeigler will present "Integrating Administrative Skills with Clinical Experiences". This course will bring participants up-to-speed on current CAPTE criteria and the LAMP concept for administrative entry-level skills. The course will include interactions between instructors and participants as they engage in determining specific activities that can be implemented to provide students with the necessary administrative learning experiences while on clinical internships.

Watch for further information regarding HPA-sponsored CSM 2007 sessions in future editions of *HPA Resource*. On behalf of the HPA Program Committee, I invite and encourage every HPA member to attend CSM 2007.

Rick Gawenda, PT is chair of the HPA Program Committee. He may be reached by e-mail at: rgawenda@dmc.org. HPA

SEPTEMBER 17-19, 2006
HILTON MINNEAPOLIS/ST PAUL AIRPORT
MINNEAPOLIS, MN

The list of challenges affecting the physical therapy profession is growing at an alarming rate! You need to know what the challenges are, and you need to participate in the political process to protect the future of the profession and the welfare of the patients and clients we serve.

APTA's State Government Affairs Forum provides a unique learning opportunity—one that focuses on the most pressing issues and teaches you what you can do to make a difference.

SIGN UP NOW! Be there for important issue breakout sessions and presentations on:

- Why Winners Win—How to Recruit, Retain, and Motivate Grassroots Advocates
- The Medicaid Crisis
- Referral for Profit
- How to Build Trusting, Credible Relationships With Your Elected Officials
- Infringement Issues
- Direct Access
- Protecting Electromyography (EMG)
- Featuring Amy Showalter—nationally recognized advocacy expert!
- And much more!

Be sure to attend our salute to the 2006 winner of the State Legislative Leadership Award on Monday night.

WHO SHOULD ATTEND?

Component legislative chairpersons, presidents, chapter lobbyists, executive directors, and government relations personnel, as well as other physical therapists, physical therapist assistants, and students of physical therapy who are interested in the state legislative arena.

REGISTRATION FEES:

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$90 APTA Student Members
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Thursday, August 17, 2006

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For reservations, phone: 800/637-7453
www.MSPairport.Hilton.com

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Please do not make travel arrangements until you have received a confirmation letter from APTA's Service Center.
For registration and further information, contact APTA's Service Center at 800/999-2782, ext 3395. Or visit our Web site at www.apta.org.

Cancellation Policy

Cancellation for the Forum must be received 72 hours before it begins. Requests for refunds must be made to APTA in writing prior to the seminar and will be subject to a 20% service charge per registration. APTA reserves the right to cancel the Forum up to two weeks prior to its start date. In the event of cancellation due to circumstances beyond our control, APTA is at no time responsible for expenses incurred by registrants, including but not limited to costs of airline tickets, other travel, food, or room.

3 EASY WAYS TO REGISTER

PHONE: Call APTA's Service Center at 800/999-2782, ext 3395, 8:30 am–6:00 pm Eastern time, Mon–Fri. Please have your credit card handy.

MAIL the completed registration form to: APTA, 1111 North Fairfax Street, Alexandria, VA 22314-1488.

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❏ Please check here if you have any special needs in order to fully participate in this event. APTA will contact you.

Are you a component designee? ❏ Yes ❏ No

If you are not a component designee, please include your registration fee (payment options below.)

FORUM COST:

APTA Members	$140
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Monday Night reception ticket: Monday, September 18	$10

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HURRY, REGISTRATION ENDS AUGUST 17!

policy watch

MedPAC Urges Congress to Improve Medicare Data

by Dave Mason

Before sweeping changes should be made in Medicare coverage and payment policies, a key advisory group is warning Congress that better data is needed to assess current systems and evaluate alternatives. The Medicare Payment Advisory Commission (MedPAC), an independent 17-member panel created in 1997 to advise Congress on issues affecting the Medicare program, outlined the need for improved information on Medicare spending in its annual June report to Congress. While Capitol Hill is not bound by MedPAC's recommendations and often adopts different approaches, members of both parties rely on the Commission's research to understand emerging issues and identify possible policy options.

Few physical therapists outside the health policy world had heard much about MedPAC prior to 2003, when Congress included a provision in the Medicare Modernization Act requiring the Commission to study the advisability and feasibility of direct access to physical therapists for outpatient physical therapy services. The result of the Commission's one-year analysis was profoundly disappointing – not only did MedPAC conclude that there were "compelling reasons…for retaining Medicare's current requirement that physicians refer beneficiaries to PT services and oversee their care,"[1] but the Commission appeared to have disregarded most of the evidence submitted by APTA demonstrating the safety, cost effectiveness, and improvement in patient choice and quality of life resulting from direct access.

Even before the direct access report was released, MedPAC began to take a more serious look at the substantial growth in Medicare spending for outpatient therapy services. Because these services account for such a small part of overall Medicare spending (2.3% in 2002)[2], MedPAC had never examined outpatient therapy policies in any detail. Although the increased scrutiny involves some risks, it has also improved the awareness of Commission members and staff about some of the problems faced by physical therapists, physical therapist assistants, and the patients they serve. Commissioners have expressed concern about the Medicare therapy cap and the potential impact of referral arrangements involving physician ownership or financial interests. They are also learning first-hand why the Centers for Medicare and Medicaid Services (CMS) have had such difficulty in developing a viable alternative to the current Medicare payment structure.

In "*Increasing the Value of Medicare,*" the report to Congress released this June, the Commission devoted a complete chapter to the challenges in paying for Medicare outpatient therapy care. Entitled "Toward better value in purchasing outpatient therapy services," the chapter offers no specific recommendations but underscores the need for better information on how therapy care benefits Medicare enrollees. "Medicare needs to have a payment system for therapy services that encourages providers to be mindful of the services used while achieving good patient outcomes," the report declares, and then adds "Before CMS considers changing Medicare's method of paying for therapy services, however, it needs more information about therapy users and their outcomes."[3]

The Commission suggested that two types of information are needed to evaluate therapy payment. The first is more complete information about beneficiary impairment, risk factors and rehabilitation potential. The second is measurement of functional status at admission and discharge. MedPAC assessed four current products, including two tools that utilize computer adaptive technology and two that employ a more traditional survey methodology. The Commission concludes that CMS needs to further investigate and research existing tools to validate their reliability for the Medicare population and the varied settings in which care is provided. Although the four products reviewed each offer potential benefits, MedPAC concludes that each is limited in its applicability to be used for all Medicare beneficiaries receiving outpatient therapy.

The Commission's report is likely to set the stage for further pilot projects to design assessment tools that gather risk factor and outcome information, although the agency may have limited funding for such projects. CMS and Congress are also pressed for time as the cost of short-term policy fixes like the therapy cap exceptions process continues to escalate. The clock is running as the pressure on policy makers increases to collect the data needed to improve Medicare payment for outpatient therapy care.

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Dave Mason is Vice President of APTA's Government Affairs Department. He may be reached at davemason@apta.org.

2007 World Confederation for Physical Therapy (WCPT) Congress

The Canadian Physiotherapy Association (CPA) and the Physiotherapy Association of British Columbia (PABC) are pleased to host the 15th International World Confederation for Physical Therapy (WCPT) Congress June 2 - 6 2007, in Vancouver, British Columbia.

Held once every four years, the WCPT Congress promotes contacts and interaction among physical therapists throughout the world, as well as provides a forum for the reporting of research findings and the dissemination of specialist information. The event attracts more than 3,000 international physical therapists, practice managers, students, researchers and academics.

The theme this year is Moving Physical Therapy Forward. It is seen as a unifying theme encompassing global change, challenges and opportunities for the profession of physical therapy and the governments, professionals and populations we work with. There is no better place to move physical therapy forward than at its prestigious international Congress.

“The setting provides a spectacular backdrop to this event and we are confident that the combined expertise and experience of CPA, the International Scientific Committee and WCPT will result in an unforgettable Congress,” explained Brenda J. Myers, Secretary General of WCPT.

Congress 2007 will be structured around five core program tracks including global health, professional issues, professional practice, education and research and development. This year’s event will also welcome four keynote speakers:

Professor Anthony Delitto is Chairman of the Department of Physical Therapy at the University of Pittsburgh. Professor Delitto is a multi-award winning researcher and writer in physical therapy. He has authored or co-authored more than sixty peer-reviewed research papers, and is currently involved in the treatment and research of low back pain.

Professor Mariano Rocabado is Dean of the Rehabilitation Science Faculty at the University Andres Bello, Santiago de Chile. He is an expert on head and neck biomechanics, who has written many books on the subject. Professor Rocabado is a founder member of the academies of head, neck and facial pain in Chile, Brazil and Italy.

Noerine Kaleeba is a physical therapist from Uganda who has played a leading role in establishing AIDS support organizations in Africa, and is currently advising the United Nations AIDS agency in Geneva. She has been awarded several international awards in recognition of her global anti-AIDS efforts and is also currently Chair of ActionAid International.

Judith Heumann, the World Bank’s first Advisor on Disability and Development, is an internationally recognized leader in the disability community and a lifelong civil rights advocate for disadvantaged people. She was previously President Clinton’s Assistant Secretary for Special Education and Rehabilitative Services in the US Department of Education.

About Vancouver, BC

Nestled between the Pacific Ocean and the Coast Mountain Range, Vancouver is a cosmopolitan city perched on nature’s edge and is the perfect location to welcome the world.

A playground for all ages, locals often boast it is possible “to ski, sail and golf all in the same day.” Well, it’s true! Activities range from rainforest walks, ocean kayaking, salmon fishing to skiing, snowshoeing, golfing, roller blading and cycling, all done against awe-inspiring natural backdrops of mountains, wilderness and our spectacular harbor. With several highly rated mountains only minutes from the city, locals enjoy active winters skiing and snowshoeing; and relaxing summers exploring local nature trails along sub-alpine meadows and sparkling mountain-fed lakes.

A vibrant city, the friendly streets are filled with individuals from varied ethnic backgrounds and walks of life. As a result of its culturally diverse population, Vancouver has equally diverse neighborhoods, all of which provide wonderful browsing and shopping opportunities. Vancouver’s exotic setting is also reflected in its array of flavorful offerings. Between its internationally praised fine-dining restaurants and trendy cafes, the city’s many restaurants offer everything from gourmet seafood fare to unique vegetarian dining.

For More Information

For more information about WCPT or CPA, the public can visit the WCPT website at www.wcpt.org, or CPA at www.physiotherapy.ca.

HPA

Dr. Gary Brooks Named HPA Grant Recipient

by Cyndi Scott, PT

The research committee and the HPA Board of Directors extend hearty congratulations to Dr. Gary Brooks, the winner of a $10,000 research grant for his proposal "Physical Therapy Outcomes by Referral Source for Patients with Low Back Dysfunction." Dr. Brooks is Associate Professor at SUNY Upstate Medical University in Syracuse, New York. The grant period begins on August 1, 2006 and ends July 31, 2007.

The research committee received four grant proposals for the 2006-2007 grant cycle. All grant applicants are to be commended for their excellence and innovation in research. Congratulations to all for your fine work and support of this new grant process!

This is the second research grant that the HPA Section has sponsored in recent years, and the first in the competitive grant program that was authorized by the Board of Directors in 2005. In 2004 a grant for $8,100 from the HPA Section was awarded to Drs. Sue Schafer and Rose Lopopolo to support "Perspectives on Administrative and Management Preparation of Physical Therapists Entering Practice in 2020." They presented their findings in February 2006 at APTA's Combined Sections Meeting and have submitted a manuscript to a peer-reviewed journal.

The time is now for health services researchers to begin preparing their proposals for the 2007-2008 grant cycle. Proposals are due on **January 5, 2007**. The request for proposals is available at http://www.aptahpa.org/committees/research/index.cfm or in this and upcoming issues of *HPA Resource*, as well as in upcoming issues of *PT Journal* and *PT Magazine*. The research committee looks forward to a great response and continued excellence in the grant submission process.

Cyndi Scott is chair of the HPA Research Committee. She may be reached by e-mail at cscott@shrp.umsmed.edu.

HPA

CSM2006 Audio Available

Audio recordings from APTA's Combined Sections Meeting (CSM) 2006 are available. For a complete list of recordings, visit APTA's website or go directly to: http://www.siattend.com/Conference.aspx?cid=213&aid=29. **APTA Member Price Per Tape (T) or CD (C): $12** (number of tapes/CDs for each session is indicated in parentheses). **Domestic shipping is $2/unit, max of $10.** HPA-sponsored sessions include the following:

		T	C
CSM06-11176	(1T, 1CD) Skills for Tomorrow's Physical Therapist	☐	☐
CSM06-11179	(1T, 1CD) Introduction to Health Services Research	☐	☐
CSM06-11186	(2T, 2CD) HPA Leadership Forum	☐	☐
CSM06-11189	(1T, 1CD) Developing Future Component Leaders	☐	☐
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Member Services Committee Update

by Tevor Swan, PT

As of June 30, 2006, there were 2149 members of the HPA Section - 2043 physical therapists, 66 PTAs, and 40 students. Membership numbers have been consistently in this range over the last eighteen months.

Three new members of the Member Services Committee have been appointed by the Section Board of Directors. Stacey Zeigler and Terri Simzer from New York and Judy Jenkins from Texas joined the committee effective with the Board meeting at Annual Conference in Orlando in June 2006.

The Member Services Committee is completing work on an online Membership Survey which will be initiated this summer. The survey will be communicated to members of the Section by email, the Section website (www.aptahpa.org), and *HPA Resource*. The Board requests that all members take a few minutes to complete this important survey. The results will be used to help set the future direction and use of resources by the HPA Section.

Planning for CSM07 in Boston from a Member Services perspective is underway. The Section will, once again, sponsor the CSM student mentoring program. A PT student nominee from each of the four Boston area PT programs will be solicited and sponsored by the Section to attend CSM. Students will be supported financially by having the Section pay for their CSM registration fee and PAC luncheon ticket. A mentor from the Section's Board will be identified for each student. Students will attend both the Section Board and Business meetings and assist in staffing the Section booth. This is the 4th year for the mentoring program.

Trevor Swan is chair of the HPA Member Services Committee. He may be reached at swant@healthworksrf.com.

HPA LISTSERV INSTRUCTIONS & DETAILS

Join the Listserv (Subscribe)

There are three ways to subscribe to the listserv:

1 Go to the listserv home page on the internet and follow the directions to subscribe to this group:

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Note that you will be required to register with Yahoo Groups and that your request must be approved by the listserv moderator before it's activated. Be sure to include your full name and APTA member ID in the comment line of your request.

2 Send an e-mail request to the listserv moderator: hpa-list-subscribe@yahoogroups.com. Be sure to include your full name, APTA member ID, and the e-mail address you want to use for the subscription in your message.

3 E-mail a request to office@aptahpa.org to subscribe to the listserv. Be sure to include your full name, APTA member ID, and the e-mail address you want to use for the subscription in your message.

How Do I Use the Listserv?

First of all, you have to be a member of the Section on Health Policy & Administration. Secondly, you have to subscribe to the listserv. Subscribing is easily accomplished through one of the two methods listed above. Keep in mind that you'll be subscribed to the listserv based upon the e-mail address from which you sent the request. Allow 24-48 hours for your subscription to be activated.

Since this is an electronic communication tool, you need to have (or have *access* to) an e-mail system and it's helpful if you have some prior experience using it. Once you are subscribed to the listserv, you'll begin receiving all messages posted to the group through your e-mail. You can reply to the group by hitting the reply button and typing a message. Keep in mind that your reply will be received by the entire group, not just the individual who posted the original message. It's best to only post messages with substance, not simple words of agreement or encouragement, which are perceived by many as unnecessary clutter.

Etiquette

The semi-anonymity of the listserv poses some special problems in relation to communication etiquette. Generally speaking, you should apply the same rules of courtesy to your listserv discourse as you do to teleconference call. Be respectful of others. Don't burden the entire group with arguments or details best shared directly with an individual subscriber.

If you're new to communication by e-mail, the Section has a good resource related to etiquette in electronic communication. Call or e-mail the Section office to request this document or find it on our website: www.aptahpa.org.

Listserv-related E-mail Addresses

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List moderator: Rick Gawenda, rgawenda@dmc.org.

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HEALTH SERVICES RESEARCH: A REVIEW OF DOMAINS RELEVANT TO REHABILITATION

Abstract

Health services research has the potential to shape practice and policy and may contribute as much to the improvement of physical therapy services as does basic science and clinical research. The purposes of this paper are to 1) define health services research, 2) discuss some key research domains, 3) provide examples of health services research relevant to physical therapy, and 4) highlight the importance of and potential for health services research to make meaningful contributions to the profession. This paper presents six key research domains: outcomes, patient satisfaction, expert practice, utilization, health disparities, and workforce. The profession needs health services research in order to answer questions asked by clinicians, administrators, patients, and policy makers. The information we gain could be used to direct meaningful changes in clinical practice, care delivery, and health policy, thus contributing toward the achievement of Vision 2020. [Resnik L, Johnson M. Health services research: A review of domains relevant to rehabilitation. *HPA Resource/HPA Journal* 2006; 6(2): J1 – J8.]

KEY WORDS: *Health Services Research, Health Policy, Physical Therapy, Rehabilitation*

Linda Resnik and Michael Johnson

A Peer-Reviewed Publication of the Section on Health Policy & Administration

Introduction

Since its inception in 2003, the Health Policy and Administration (HPA) Section leadership recognized the need for health services research to evaluate and guide health policies and enhance the way that physical therapy services are delivered. Recently, the American Physical Therapy Association's (APTA) Board of Directors identified the need to focus some of the association's efforts toward this type of research. To that end, the APTA created a task force to develop health policy research questions. The task force met in the Fall of 2005 to begin working on its charge. It is anticipated that this task force, with input from APTA members, will help contribute to the development of a health services research agenda for the profession.

In 2004, the HPA Section established a small grant mechanism to help fund research into health policy and clinical administration in physical therapy. An initial HPA grant proposal was funded in 2004. The first formal HPA Section call for grant proposals was distributed in 2005 with the earliest funding beginning in summer 2006. This small grant program is expected to stimulate development of health service researchers in physical therapy, provide seed money for larger health services related studies, and encourage future funding for this type of research within the Foundation for Physical Therapy's national research agenda.

Because many physical therapists are unfamiliar with this type of research, this paper will 1) define health services research, 2) identify some key domains, 3) provide examples of health services research relevant to physical therapy, and 4) highlight the importance of and potential for health services related research to make meaningful contributions to the profession. As appropriate health services research proposals are developed, we hope that members will seek financial assistance from the HPA Section grant program.

What is health services research?

AcademyHealth is the professional society for health services researchers and health policy analysts and defines health services research as "the multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care, and ultimately our health and well-being. Its research domains are individuals, families, organizations, institutions, communities, and populations."[1] The Agency for Healthcare Research and Quality further explains that health services research "examines how people get access to health care, how much care costs, and what happens to patients as a result of this care. The main goals of health services research are to identify the most effective ways to organize, manage, finance, and deliver high quality care; reduce medical errors; and improve patient safety." [1]

Domains of Health Services Research

While the APTA Task Force and the HPA Section's grant program may be new, and the term health services research unfamiliar, physical therapists have long been interested in health service delivery. Members of the APTA, many of whom are administrators and managers, think about health service delivery every day by asking questions about the impact of service delivery patterns and reimbursement policies. They consistently seek out evidence for best practices at conferences, networking sessions, and through the HPA Section listserv. While limited health services research in physical therapy has been published to date, we believe that a core body of health services literature relevant to physical therapy does exist. This belief is based upon our knowledge of and experience with this topic area, as well as on a recent search on this type of literature in PubMed and CINHAL.

In this paper, we present an overview of six broad domains of relevant literature, provide examples of research pertinent to physical therapy, and suggest areas for future research. We selected the research areas of outcomes, patient satisfaction, expert practice, utilization, health disparities, and workforce because they contain a number of quality published works that are important and relevant to physical therapy.

Outcomes Research

Physical therapists may be most familiar with the large body of work on outcomes measurement development and comparison,[2-17] much of which has been published in journals familiar to physical therapists. Outcomes measurement is a process that describes a systematic method to gauge treatment effectiveness and efficiency in daily clinical practice.[18] Many outcomes research studies focus on development and refinement of measurement instruments, contributing to the creation of useable and uniform measurement systems. In fact, the National Institute for Disability and Rehabilitation Research has already provided millions of dollars of funding for this type of research. Most recently, for example, rehabilitation researchers have advanced the use of item response theory and computerized adaptive testing to refine measures and reduce respondent burden.[19-21]

Outcomes research using reliable, valid, and responsive measures is one important way to learn more about the most effective and efficient means to provide high quality health care. Using these measures, physical therapy researchers have described patterns of health status outcomes in patients with common orthopedic

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diagnoses, spinal impairments, sciatica and knee impairments,[22-24] and stroke.[25] Researchers have examined various factors that effect patient outcome such as exercise history [26] and timely onset of rehabilitation[27] as well as differentiated outcomes and efficiency of therapists with advanced versus entry level training.[28]

Regulatory requirements already mandate the collection of outcomes data in skilled nursing facilities through the Minimum Data Set (MDS)[29] and in home care agencies through the use of the Outcome and Assessment Information Set (OASIS).[30] At this time, outcomes data collection is not required for outpatient settings, this may change in the future. There is a growing interest amongst payers, government, and consumer groups in using outcome measures 1) to evaluate the quality of services provided, creating "report cards" for quality, and 2) to establish pay for performance programs in which the providers who achieve the best outcomes, most efficiently, are rewarded.

We know that efforts to use outcomes data, to measure quality, or to determine payment require complex analyses that adjust for differences between patients, because differences in patient outcomes are associated with type and severity of impairments as well as other factors. Without appropriate adjustment, outcomes cannot be interpreted in a meaningful manner or be attributed to therapeutic interventions. Any reimbursement system or quality ranking system based upon unadjusted outcomes may end up penalizing providers who treat the sickest patients that fail to show enough improvement or require more visits in a treatment episode. At present, this type of research is in its infancy, but the Center for Medicare and Medicaid Services (CMS) has already expressed strong interest in developing pay-for-performance models for rehabilitation. Clearly, further research is needed to identify the best methods of risk adjustment for outcomes within particular patient populations.

Patient Satisfaction Research

Measurement of patient satisfaction is an important aspect related to quality of services and can guide quality improvement initiatives and enhance customer service within physical therapy practice. Several instruments that measure patient satisfaction with physical therapy care have been developed and the measurement properties of these instruments assessed.[31-34] Despite the availability of these instruments, however, few studies have reported on service delivery factors that are associated with patient satisfaction. Potter and Gordon studied patient experiences with physical therapy services delivered in the private practice setting. They found that therapist communication, professional, and organizational skills are positively associated with being considered a "good" therapist.[35] Beattie et al reported that greater continuity of care, ie, receiving care from only one physical therapist, is positively associated with greater likelihood of complete satisfaction with care in outpatient physical therapy.[36] Further research is needed to understand service delivery factors that are both positively and negatively associated with patient satisfaction with physical therapy, so that we can use this information to improve our patients' experiences.

Expert Practice Research

Studies of expert practitioners may be viewed as a type of health services research. Expertise research explores what experts know, how experts think, and how they practice. Findings from these types of studies can guide the development of educational programs as well as the organization and structure of the clinical environment to facilitate the development of expertise.

Research on expert practitioners, much of it conducted by Jensen and colleagues,[37-39] has illuminated practice patterns, philosophies, and ways of caring by expert therapists, as well as offered directions for improving both the training of therapists and delivery of care. In their landmark study, Jensen et al investigated attributes of master and novice physical therapists.[38] Later, they studied 12 experts nominated by officers of the APTA specialty sections for geriatrics, neurology, orthopedics, and pediatrics. [39] They reported that expert clinicians have an inner drive for lifelong learning and a broad knowledge base, share a focus on patient education, and have an understanding about working within the health care system. Experts also understand their own limitations, and their clinical reasoning is based on collaborative problem solving and decision making. Jensen et al also found that experts demonstrate a well-developed ability for self-reflection, with continual reassessment of their own practices, and intertwine intervention and evaluation to fine-tune their patients' treatment programs.

Resnik and Jensen studied expert therapists who were selected because their patients with low back pain had the best outcomes.[40] Practitioners classified as expert in their study had similar years of experience as practitioners classified as average. Experts were distinguished from average therapists by having a patient-centered approach to care. In addition, experts were found to use collaborative problem solving, patient empowerment through education, and cultivation of the patient-practitioner relationship. In general, Resnik and Jensen found that experts provide more of their own direct intervention, limit the nature of delegated tasks more stringently, and supervise their support staff more closely than members of the group classified as average. Further, experts tend to work in teams, with only a single support person. This enables experts to closely direct the care delivered and provides greater continuity of care for the patient.[40] These findings have implications for the organization and delivery of outpatient services for patients with low back pain. However, it is unclear whether these findings can be applied to other settings or other types of patients (besides those with low back pain). Thus, further research is needed to identify and profile expert therapists who treat other types of patients and those who practice in other settings such as inpatient hospitals, nursing homes, and pediatric settings.

Health Service Utilization Research

The study of service utilization is an important area of health services research. Studies of this nature examine patterns of service use and identify facilitators and barriers to 1) access and use of services, 2) variation in service delivery, and 3) the impact of service utilization on patient outcomes. These types of studies

can be used to estimate the optimal frequency, duration, and site of care delivery for specific patient groups, and to examine geographic as well as other variations in the delivery of services.

Several researchers have explored factors related to access to and delivery of physical therapy and other rehabilitation services.[41-43] Freburger and Holmes, for example, examined characteristics of older people who used physical therapy services, along with other factors associated with physical therapy use. They reported that factors other than need are related to the actual use of physical therapy services.[41] Specifically, they found that people with high income are twice as likely to receive physical therapy services than those with low income. In addition, the authors stated that years of education, having supplemental private insurance, geographic region (metropolitan), and supply of physical therapists are all positively associated with the likelihood of receiving physical therapy services.

Wodchis et al, on the other hand, examined the impact of payer incentives on receipt of rehabilitation services and reported that patients with more generous payers, such as Medicare, receive more care than patients with less generous insurance plans.[42] These results suggest that reimbursement impacts the amount of services delivered. However, it is possible that reimbursement may also have influenced the initial referral to physical therapy. Freburger and colleagues examined factors relating to physician referral to physical therapy.[43] They observed differences in referral patterns to physical therapy between orthopaedists and primary care physicians, noting that reimbursement type influenced the likelihood of referral.

Rising Medicare costs for rehabilitation services[44-46] and cost control efforts, such as fixed limits on reimbursement amounts for rehabilitation services (therapy caps), highlight the need for health services research. Due to concerns about the recent therapy cap's impact on Medicare beneficiaries, two large federally-funded studies examined physical therapy utilization under Medicare Part B.[45, 47] In 2002, the Dynacorp Corporation's report for CMS examined outpatient therapy costs and utilization for all Medicare beneficiaries in all settings for the years 1998 to 2000.[45] They concluded that older and minority beneficiaries have the highest therapy costs, in amounts that would exceed the therapy cap, and thus would be disproportionately affected by such limits on payment. In a recently released study, the Government Accountability Office (GAO) examined the 2002 costs of outpatient therapies for Medicare beneficiaries and projected that 14.5% (more than a half million people) would have exceeded the therapy cap had it been in place in 2002.[47] The GAO also concluded that there was insufficient research to help them define the amount and mix of therapy services that were appropriate for Medicare beneficiaries with specific conditions. The lack of research makes it difficult to use scientific evidence to guide Medicare reimbursement policy.

Nevertheless, there is some encouraging, although still sparse, evidence related to the use of rehabilitation services and patient outcomes. Cook et al, for example, determined that receiving occupational and physical therapy services leads to reduced reports of stroke-related problems.[48] Bode et al reported that the amount of therapy provided is positively associated with functional outcomes in patients with stroke.[49] As well, Jette described the relationship between therapy intensity and outcomes of rehabilitation in skilled nursing facilities, reporting that higher therapy intensity is associated with better functional outcomes, shorter lengths of stay,[50, 51] and increased likelihood of discharge into the community.[51] Lastly, the organization of care delivery appears to impact outcomes as well. Langhorne and Duncan, in a study examining patients post stroke, found that organized inpatient multidisciplinary rehabilitation was associated with reduced odds of death and institutionalization in the post-acute period.[52] These types of studies can have strong policy implications because they demonstrate the value of receiving rehabilitation services as well as the costs to society of not meeting the needs for rehabilitation.

Research on the most effective patterns of care delivery may also be used to guide treatment planning and service delivery. Likewise, data on appropriate intensity of therapy visits, duration of treatment, and best site for care delivery may be used to lobby for changes in reimbursement policies of private and public payers. In his editorial on the perils of inadequate evidence, Alan Jette lamented the lack of evidence to support the appropriateness and effectiveness of inpatient rehabilitation services and noted the challenges this created in fighting the 75% rule regarding restrictions on eligibility for inpatient rehabilitation.[53] More health services research to identify the cost-effectiveness of physical therapy services would help to fill these knowledge gaps and guide policy regarding coverage of rehabilitation services.

Health Disparities Research

Much attention has been focused on the large disparities in health status of racial and ethnic minorities in the United States. Discovering the roots of these disparities and confronting them in the delivery of healthcare is a priority for the nation.[54] Several researchers have examined utilization and access to physical therapy services by race and ethnicity. In a study of community dwelling elders, Mayer-Oakes reported that physical therapy use is less prevalent among minority group members than in non-minority members.[55] Two studies reported disparities in the receipt of physical therapy services after hip fracture.[56, 57] Hoenig et al found that black patients are more likely to receive low intensity physical therapy services as compared to non-black patients,[56] while Harada et al found that blacks are 30% more likely to receive no physical therapy services after hip fracture than whites.[57] In contrast, Freburger and Holmes found that in a population of community-based older persons, African American race is associated with increased numbers of physical therapy visits and increased costs, perhaps associated with unmeasured co-morbid medical conditions.[41] Clearly, more research is needed to identify racial and ethnic disparities in receipt of rehabilitation services. Where disparities exist, studies are needed to understand the underlying causes for these disparities, so that actions can be taken to improve access to rehabilitation services for all who need them.

Workforce Research

We need to have an adequate supply of physical therapy personnel to meet the needs of our population and to delivery quality care. Describing the characteristics of the professional workforce, projecting society's future needs for health care workers, and understanding how that workforce is utilized are appropriate health services research topics. In 1995, when health care professionals were in short supply, several authors explored supply, demand, and career patterns of physical therapists.[58-60] In 1998, Chevan and Chevan profiled members of the physical therapy profession by comparing characteristics of therapists from the 1980 census and 1990 census.[61] They noted that the physical therapist population is aging slightly, but remains predominantly female and clustered around the Pacific coast and Northeast. In 1997, the APTA commissioned a study, conducted by Vector Research, that projected future demands for and availability of the physical therapy workforce.[62] Vector projected a decreasing workforce demand for physical therapists (PTs) resulting in a surplus of PTs by the year 2000. They also predicted an increasing demand for physical therapist assistants (PTAs) and an expectation that the ratio of PTAs to PTs in the workforce would increase dramatically, as more PTAs entered the workforce.

Although researchers have described the physical therapy workforce, little research has been published on the utilization of physical therapists and support personnel, or on the impact that utilization patterns and supervisory requirements might have on care quality and costs. Loomis et al reported extensive use of support personnel in Canada.[63] Bashi and Dumholdt examined the use of unlicensed aides in Indiana and reported on common problems associated with lack of supervision.[64] A study conducted by the Urban Institute for CMS analyzed the supervisory requirements for PTAs in each state and compared these requirements to Medicare's supervision definitions.[65] This study provided information to CMS as it reviewed its policies on PTA supervision.

While studies have examined models of successful delegation,[66,67] only one explored the impact of care extenders on patient outcomes in physical therapy. Specifically, Resnik et al examined the impact of state regulation of PTAs on high utilization of PTAs and concluded that the use of care extenders in place of physical therapists is likely to result in less efficient and lower quality care in outpatient rehabilitation.[68]

Studies examining recruitment and retention of health care workers, burnout, and the experience of working in the health professions are also considered health services research. Balogun and colleagues reported that a high prevalence of burnout among physical and occupational therapists in New York City is related, in part, to lack of support from supervisors.[69] Wandling and Smith reported low to moderate levels of burnout among physical therapist members of the Orthopaedic Section of APTA.[70] In addition, they found that the longer therapists were in their current jobs, the greater their self-reported professional accomplishments. Schlenz reported that professional development activities may minimize burnout and enhance retention of physical and occupational therapists who work with head injury patients.[71] Lastly, Blau et al recently examined the impact of the changing health care environment on physical therapists' clinical experiences and found common themes of loss of control, stress, disheartenment and discontent.[72] Despite these negative aspects of the work environment, Blau et al noted that therapists were able to maintain a positive outlook based upon the enjoyment of being a professional, strong interpersonal relationships with their colleagues, and a belief that they were providing high quality patient care.

Additional research on the physical therapy workforce is needed. The most recent comprehensive study projecting workforce needs is now almost a decade old. Much has changed since that time, and we don't have revised estimates of workforce projections. It is entirely possible that we will be facing a severe shortage of physical therapists due to the confluence of demand for physical therapy services associated with an aging population and a protracted decline in the number of applicants, enrollees and graduates of accredited physical therapy educational programs.[73] According to APTA's fact sheet on physical therapy education, there was a 270% decrease in the mean number of applicants per PT school, and a 28% decrease in the number of enrollees per school between 1997 and 2004. Between 2001 and 2004 the total number of US PT graduates decreased by 25%. Further research on staff satisfaction and burnout prevention will be useful for physical therapy managers to enhance staff recruitment and retention, as well as to promote professional development. To achieve the APTA's Vision 2020,[74] a vibrant, accomplished workforce of adequate size will be imperative.

Other research domains of health services

The six domains presented here represent only part of the entire scope of health services research. Discussion of the field in its entirety is a daunting task, far beyond the scope of this paper. Health services research includes areas not covered here, such as health systems, health care financing, health care coverage, health information technology, implementation research, policy analysis, quality measurement and improvement, organizational culture and environment, decision analysis, cost-effectiveness, cost-benefit analysis, gender and health, and patient safety. Much of the literature in these areas, while pertinent to physical therapy, is published in journals unfamiliar to most therapists. In our opinion, future reviews of physical therapy relevant literature in these areas would be welcome contributions to the physical therapy literature.

Importance of and potential for health services research

At the June 2005 meeting of AcademyHealth, physician and writer Atul Gawande delivered the keynote address on the importance of health services research.[75] Dr. Gawande, a surgeon, New Yorker columnist, researcher, and Assistant Professor at Harvard Medical School, asserted that health services research can save more lives in the next decade than can bench science, work on the human genome, stem cell therapy, and cancer research. Dr. Gawande explained that in medicine "there is a gap in what medicine can do and what we actually do" and that health services

researchers try to understand how "to narrow that gap."[76]

Clearly, similar problems exist in allied health and nursing where knowledge (or evidence) about the "right thing" to do is available, yet practitioners fail to use the best evidence in practice for a variety of reasons. Some of these reasons are a matter of individual provider choice, while others are due to failures in the system of care delivery. Dr. Gawande spoke about his investigation into cystic fibrosis centers and his examination of the differences between the "best" and the "worst" centers (as judged by data on pulmonary function of patients).[77] Surprisingly, he found that the best and worst centers offer virtually the same treatments to patients, but there were striking differences in the way that care was delivered within these centers. The best center, for example, had leadership from someone who aggressively pursued consistency of care, while individualizing his approach to each patient, and engaging patients in their own care process.

Dr. Gawande's view of the importance of health services research may surprise some in physical therapy, particularly because many are unfamiliar with the terminology. Yet, as our review has illustrated, members of the physical therapy profession are already engaged in key areas of health services research: measuring health outcomes, performing outcomes research, evaluating patient satisfaction, understanding expert practice, examining the practice environment, and studying utilization.

As a profession, we need to understand the value of health services research and to appreciate the variety of study designs used by health services researchers. As professionals, physical therapists have only recently learned to prize evidence about treatment efficacy and clinical effectiveness. Many have come to understand that in the world of evidence-based medicine, the randomized controlled clinical trial (RCT) is the optimal source of evidence.[78] Consistent with this awareness of the hierarchy of evidence, we have seen how funding agencies prioritize funding of RCTs over other types of studies and how our own association adopted a "clinical" research agenda with little emphasis on health services research. Although the RCT is the gold standard for testing efficacy of treatment, health services research is not conducted, for the most part, using RCTs. RCTs are not feasible or appropriate for most types of health services research, much of which must be descriptive or observational with naturally occurring behaviors followed and measured.

To date, some of the most influential health services research has been conducted by governmental agencies. Given that these studies have broad implications for our profession, physical therapists need to be guiding the research agenda. This type of work can answer many of the questions asked by clinicians, administrators, patients, and policy makers. Furthermore, information from health services research can be used to evaluate and direct changes in clinical practice, care delivery, and health policy.

Based on the important implications of health services research for our profession, we should all ask the question: How do we move forward from here? Clearly, to get the evidence required to support many of our profession's goals, we need to have more physical therapists, clinicians, managers, and academic researchers involved in this type of research. Clinicians and managers who are interested in this type of work can participate in this endeavor by seeking out academic partners with the methodological expertise to help guide them in the research process. To stimulate academic research, we need to have more physical therapist researchers trained in health services research methods, collaborating with health services researchers to direct the agenda, and ultimately, funded to do this work. Lastly, we need to make sure that the APTA and the Foundation for Physical Therapy are taking the necessary steps to stimulate, initiate, and support this type of research. As a profession, the answers available through health services research will be an integral part of our success in achieving Vision 2020.[74]

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ATTENTION RESEARCHERS

The APTA Section on Health Policy and Administration (HPA) Announces a Research Grant Program

Requests for proposals (RFPs) for research grants on health policy and clinical administration topics can be obtained online at:
http://www.aptahpa.org/committees/research

The purpose of the HPA Grant Program is to stimulate, encourage and support research activities that enhance the body of knowledge related to health policy and clinical administration in physical therapy.

The grants are intended to provide funding to assist HPA Section members who are new physical therapist investigators, or established investigators embarking on a new research agenda in health policyh and administration. Through this grant program, the Section hopes to encourage the development of proposals that will seek financial support from external agencies.

1-2 clinical research grant awards of $5000-$10,000 are available to Section members to assist with a 1-year research study that investigates a question or questions of importance to health policy or clinical administration.

Proposals for the 2007-2008 grant cycle are due **January 5, 2007**. Notification of the funding award will be by July 15, 2006. Funding start date will be August 1, 2007. For a paper version of the Request for Proposals, or for further information, please contact the Health Policy Administration office at 877/636-4408 or email at office@aptahpa.org.

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