

A PERSPECTIVE: EXPLORING THE ROLES OF PHYSICAL THERAPISTS ON PRIMARY CARE TEAMS (April 2017)

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This perspective paper is an outgrowth of RC 19-15, a motion adopted by the House of Delegates (House) in 2015 that called on the American Physical Therapy Association (APTA) to investigate the roles of physical therapists in primary care teams, with a preliminary report to the House in 2016 and a final report in 2017. The APTA Board of Directors (Board) approved the preliminary report presented in 2016.

Association staff in June 2016 established a work group made up of United States and international physical therapists with experience in primary care health delivery models.

The work group created a precursor to this perspective, upon which the Board drew in preparing its final report to the 2017 House.

This perspective contains input from the members of the work group and APTA staff members identified above. It reflects an extensive review of the literature relating to primary care.

The APTA Board has not approved this document or any of its recommendations.

APTA is making this document available for informational purposes.

INTRODUCTION

Physical therapists (PTs) provide a unique perspective on purposeful, precise, and efficient movement across the lifespan based upon the synthesis of their distinctive knowledge of the movement system (the collection of systems—cardiovascular, pulmonary, endocrine, integumentary, nervous, and musculoskeletal—that interact to move the body or its component parts) and expertise in mobility and locomotion (<http://www.apta.org/MovementSystem/>). While this expertise positions PTs to address major components of society's primary care needs, the physical therapy profession is challenged to explore futuristic roles in primary care that will allow for better integration in the evolving health care system. Recognizing this need, in 2015 the House of Delegates adopted RC 19-15, directing the association to explore the roles of and opportunities for PTs in primary care, as well as the feasibility of obtaining primary care practitioner status:

That the American Physical Therapy Association investigate and identify:

- The roles of physical therapists in primary care teams;
- Those services of physical therapists that may qualify as components of primary care delivery; and,
- The current and future opportunities for physical therapists to integrate these roles and services into practice, education, and research.

A preliminary report will be provided to the 2016 House of Delegates and a final report will be provided to the 2017 House of Delegates.

Providing Americans with quality, affordable health care, as stated in Title 1 of the Affordable Care Act¹ remains a top priority for the stakeholders within our government and our citizenry. While the United States outpaces all other developed countries in health care costs, we continue to struggle with quality outcomes, especially in the areas of primary care and prevention.² Partly to blame are shortages of primary care practitioners and failure of patients to access the right provider at the right time.^{3,4} In 1994, the National Academies of Sciences, Engineering, and Medicine's Health and Medicine Division, then known as the Institute of Medicine (IOM), defined *primary care* as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing within the context of family and community."⁵ Noncommunicable, chronic diseases are increasing globally, and individuals are living longer with stable health conditions accompanied by disabling activities and participation restrictions. To combat this trend the provision of primary care services is expanding to professionals who have expertise in managing the complex interactions between body structures and functions, and environmental factors.⁵

This perspective paper explores the opportunities, gaps, and readiness of PTs to participate in primary care delivery models by outlining the profession's history and identifying the current status of physical therapist participation on primary care teams and in primary care settings, including an analysis of current practice, education, regulations, and literature associated with this area of practice.

Recommendations are provided to address the current practice limitations and restrictions, and for future advancement of the profession to best serve the public in this role.

BACKGROUND AND HISTORY

The genesis of primary care can be dated back to Europe in World War I, wherein the Dawson report⁶ suggested a need for primary versus the typical secondary care. However, it wasn't until the 1960s that the American Medical Association Ad Hoc Committee on Education for Family Practice and the Millis report stated that every individual needed a primary physician.⁶ Finally, in the 1970s primary care was recognized on the world stage by the World Health Organization:⁶

The definition of primary care was finally realized in 1978 at the World Health Organization (WHO) International Conference on Primary Health Care held in Alma-Ata (now Almaty), Kazakhstan. The resulting 1978 Declaration of Alma-Ata stated: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford. It forms an integral part of both the country's health system, of which it is the central function and main focus, and the overall social economic development of the community. It is the first level of contact of individuals, the family and the community...and constitutes the first element of a continuing health care process."⁶

This paper will refer to the IOM definition of primary care, noting that PTs are not specifically named or indirectly implied.

For years, the United States military health care system has demonstrated our profession's success as first-contact providers, and it illustrates the potential value PTs bring to primary care models. In post-draft 1972, the military was faced with a shortage of orthopedic surgeons and could not keep up with the demands of vast numbers of patients with neuromusculoskeletal (NMS) conditions. Use of military PTs as physician extenders in an entry-point role was 1 solution, a model that was formally implemented in the in the early 1970s.^{7,8,9} In the entry-point role, military PTs performed episodic care, referred patients for imaging and laboratory tests, and prescribed certain medications. Evidence suggests they provided safe and effective care that maximized servicemen's and servicewomen's readiness. In the theater of military operations, this model resulted in reduction of the need for medical evacuation of the injured.^{10,11}

The physical therapy profession, similar to medicine, has evolved, transitioning from secondary to primary care. This transition corresponds to the changes in physical therapist education, scope of practice, and professional autonomy. Initially a technical workforce known as reconstruction aides during World War I and for patient care during the first outbreak of the polio virus in the early 1900s, physical therapists followed physician-generated prescriptions primarily in rehabilitation settings.¹² One hundred years later, PTs are doctoral-level trained, and they practice in many environments, including patient direct-access settings.

Numerous APTA positions (Appendix A) highlight the steps taken by the profession:

- **PHYSICAL THERAPY AS A HEALTH PROFESSION HOD P06-99-19**
- **AUTONOMOUS PHYSICAL THERAPIST PRACTICE HOD P06-06-18-12**
- **DIAGNOSIS BY PHYSICAL THERAPISTS HOD P06-12-10-09**
- **ENTRY POINT INTO HEALTH CARE HOD P06-14-07-11.**

APTA's Guide to Physical Therapist Practice 3.0 (Guide) presents a multidimensional perspective on the role of PTs in primary care and PTs who provide primary care services.¹³ Many of the changes in education and clinical practice have positioned PTs to make major contributions to the delivery of primary care. This is illustrated by the House of Delegates position on the role of the PT in primary care¹⁴:

PRIMARY CARE AND THE ROLE OF THE PHYSICAL THERAPIST HOD P06-06-07-03

Physical therapists participate in and make unique contributions as individuals or members of primary care teams to the provision of primary care.

Physical therapists provide patient/client management in primary care through the processes of screening, examination, evaluation, diagnosis, prognosis, intervention, education, prevention, coordination of care, and referral to other providers to prevent, remediate, decrease, or slow the progression of impairments, activity limitations, and participation restrictions, and lessen the impact of environmental barriers, and optimize cost-effective clinical outcomes.

This has been strengthened with the concept of an annual examination by a physical therapist¹⁵ and, more recently, the profession's positions on health priorities for populations and individuals, and the management of the movement system.¹⁶

Another relevant House motion, RC 23-06 Summit on Physical Therapy and Society (See Appendix A), led to the Physical Therapy and Society Summit (PASS) that convened in 2009. The more than 100 individuals attending PASS developed recommendations for the profession to meet future societal health care needs. The recommendations from PASS are particularly noteworthy, because health care consumers, as well as providers, were integral participants. Recommendations included¹⁷:

- Reorienting practice, education, and research to a health care system that puts consumers of health care at the center and places physical therapists as important partners on a multidisciplinary health care team, a team that also includes close involvement of the consumer within the consumer's community
- Claiming the opportunity that currently exists in the construct of health care reform to use the physical therapist's knowledge and therapies to lead in the area of prevention, health, and wellness

Further, PASS participants unanimously identified a crisis in the primary care physician community that necessitates new models of care, including partnerships with other professionals, and called on physical therapists to reach out and form collaborations with the primary care physician community.

Outside of the passage of direct-access legislation, little of the military practice model has been adopted in public sector practice in the United States. However, examples exist internationally describing physical therapists serving in entry-point and primary care roles.¹⁸ Countries such as Canada,¹⁹ Great Britain,^{20,21} and Australia²² are among those that have adopted models with physical therapists/physiotherapists providing primary care services, including serving on primary care teams, developing models of primary care for physical therapy/physiotherapy, and identifying roles for physical therapist/physiotherapists tied to the delivery of primary care services discussed later in this paper.

Through the House of Delegates' positions and APTA's core documents, the physical therapy profession has articulated a role for PTs in primary care: serving as an integral part of primary care teams and providing primary care services. However, APTA has not adopted a position stating that PTs are primary care providers. In addition, the association has neither articulated specific primary care roles, services, or models for PTs beyond the general statements outlined in APTA policies and the Guide; nor has it identified the prerequisite steps or authorities that PTs would need to achieve to fully realize the profession's role in providing primary care services or participating on primary care teams. Last, APTA has not prioritized external recognition (through legislation, regulation, or identification by other primary care provider organizations) for physical therapists achieving primary care roles, services, or participation on teams.

EDUCATION

History of Professional Physical Therapist Education in the United States

Following World War II, the education of physical therapists in the United States began moving from postbaccalaureate certificate programs housed at military bases for nurses and physical educators to baccalaureate programs housed in academic institutions.²³ As outpatient physical therapy practices increased in the 1970s and 1980s, the House of Delegates adopted a policy that supported physical therapist practice independent of practitioner referral as ethical if included in state practices acts. Concomitantly, the House adopted a resolution calling for PT education to rise to a postbaccalaureate degree level.²³ In 2000, the House endorsed Vision 2020, which called for physical therapists' entry-level education to be at the doctoral level and identified 5 elements necessary to transition to a doctoring profession.²⁴ Some of these elements, including autonomous practice, direct access, and professionalism buttressed the role of PTs in primary care. Subsequently, the House adopted a new vision statement, whose guiding principles include collaboration, including education models that facilitate interprofessional values; and access/equity, which includes PTs serving as a point of entry to the health care system and in doing so strengthening our role as contributors to health care teams (See Appendix A).²⁵

Professional Physical Therapist Education: Physical Therapists and Primary Care

Supportive and driving documents and organizational bodies of physical therapist education include the *Guide to Physical Therapist Practice, A Normative Model of Physical Therapist Professional Education*, the Federation of State Boards of Physical Therapy model practice act, and Commission on Accreditation in Physical Therapy Education (CAPTE) evaluative criteria. The Guide, initially published in 1995 and last updated in 2013, serves as a description of practice for all stakeholders and provides a framework for PTs to contribute to and participate in primary care models. Chapter 1 in Guide 3.0¹³ is devoted to roles of PTs as primary care team members for individuals with both acute and chronic conditions. For individuals with acute musculoskeletal and neuromuscular conditions, physical therapists are described as providing triage and developing plans of care based on initial examinations and diagnoses. For patients with chronic conditions, physical therapists are described as principal providers of care and coordinators of care within a collaborative care team. Specific settings where physical therapists might currently serve in primary care roles include industrial and workplace settings, community-based agencies, and school systems.

In the 1990s, APTA began developing a consensus document to describe the essential components of physical therapist education and in 1997 published the inaugural *A Normative Model of Physical Therapist Professional Education*, with subsequent revisions published in 2000 and 2004. Although primary care is not mentioned, practice management expectations in the most recent edition include "Management of Care Delivery" defined as "... planning, organizing, and implementing a plan of care for

a patient/client that includes first-contact care, care in other settings, care provided in tertiary setting by the physical therapist and care that involves other practitioners.”²⁶

CAPTE is recognized by the US Department of Education and the Council for Higher Education Accreditation as the accrediting body for professional physical therapist and physical therapist assistant education programs (See Appendix B). While CAPTE’s evaluative criteria do not include specific reference to primary care, some of the required curricular components include elements that prepare physical therapists for participation in the delivery of primary care services. This is true not only within the criteria that describe the scientific background in body structures and functions, but also within the criteria that are designed to achieve the outcomes required for entry-level practice (Appendix C).²⁷ Beyond the didactic portion of the curriculum, there is no specific reference to primary care in clinical education.

Although not explicitly stated in the profession’s seminal education documents, elements of the US Army-Baylor University Doctoral Program in Physical Therapy provide an example of what “might be.” The program prepares its graduates as generalists during a 1-year internship.^{7,11} The students have several opportunities to practice in primary care settings, developing skills of triaging and providing primary management of patients with NMS conditions.

Postprofessional Physical Therapist Education: Roles of Physical Therapists in Primary Care

In response to the need to provide a workforce with the necessary skills to meet the needs of individuals, communities, and the demands of an ever-evolving health care system, the physical therapy profession has developed various venues for postprofessional development, including clinical residency and fellowship programs. Clinical residency programs are designed to advance a physical therapist’s management of a patient within a given specialty area of clinical practice. Clinical residencies are a minimum of 9 months and 1,500 hours and are a path for new graduates to become board-certified clinical specialists.¹² Fellowship programs are a minimum of 6 months and 1,000 hours and are designed to allow a more experienced physical therapist to gain a deeper expertise in a specialty or sub-specialty.¹² Currently there are no residencies in primary care.

The military also has a rich history of postprofessional education that prepares physical therapists for entry-point and physician extender roles.^{7,11} The Army developed a postprofessional continuing education course to support primary care and direct-access PT services. This 9-day course, the COL Douglas A. Kersey Advanced Clinical & Operational Practice Course, provides advanced training and education for military PTs (both active duty and reserve) who practice in a primary care role evaluating and treating patients with NMS conditions.^{7,11} The US Air Force offers a 9-day course identical in content to the Army NMS screening course. At present, military and civilian PTs from all 3 medical branches of uniformed services—Army, Navy, and Air Force—may attend these courses. Military PTs are not required to complete these courses to begin practice in a direct access setting, as all PTs are trained in differential diagnosis and medical screening during their professional PT education program. For a military PT to become a direct access or physician extender, the key is the credentialing process—of which specific education (didactic and clinical) is a part of the credentialing. Military PTs function as physician extenders in a direct access environment—there are not 2 separate credentialing processes. Military PTs who are not Army-Baylor DPT graduates typically have additional educational and clinical experience requirements before becoming credentialed as direct access providers.

Knowledge of managing musculoskeletal conditions is essential whether or not a PT is acting as an entry point to health care. Childs et al^{28,29} found that military PTs who were board certified in orthopedic or

sports physical therapy performed better than colleagues who were not board certified and also better than all physicians (military and civilian) except orthopedic surgeons on an assessment of musculoskeletal knowledge. The study also found that military PTs, as many attend the Army or Air Force courses,⁷ responded equivalently to those who were board certified. This study was recently replicated by Rundle et al,³⁰ comparing the knowledge of civilian PTs to military PTs. The study concluded that civilian PTs scored lower than military PTs on knowledge of managing musculoskeletal conditions, speculating that the difference is the expanded privilege set for military physical therapists.

PRIMARY CARE MODELS (Roles and Services)

Many areas of physical therapist practice could be considered relevant to the provision of primary care services and complementary to care provided by other practitioners. In addition, PTs are well positioned to provide a larger portion of ongoing primary care services versus solely episodic care or entry-point encounter. The following models, although perhaps not exhaustive, describe how PTs currently contribute to primary care and how they may function as designated primary care providers in an evolving health care system.

United States of America

Military: Peacetime Health Care

During peacetime, PTs in the military health care system primarily provide evaluation and treatment to patients who are referred for PT care. Primary care direct-access PT services have typically been facility- and provider-dependent, as well as currency-based to maintain critical deployment skillsets. With constrained medical resources and an increasing prevalence of musculoskeletal injuries within the active duty military force,³¹ the need for PTs to support medical providers as physician extenders is increasing. The Air Force, for example, instituted a policy in 2015 mandating direct-access physical therapy at every medical treatment facility to directly supplement Air Force medical home clinics in managing NMS conditions. Additional PT service expansions across the armed services have included placing PTs in military medical home clinics as well as embedding PTs into combat units as primary care, direct-access providers.

Important yet limited research exists supporting the role of military PTs performing as direct-access providers. A practice analysis by Donato et al³² reported that PTs who performed in a primary contact role, either military or civilian, rated the ability to establish physical therapy diagnosis as extremely important compared with non-primary contact PTs. Rated somewhat lower among all groups was the knowledge and responsibility to identify nonmusculoskeletal conditions. As expected, military PTs rated responsibility and skills for diagnostic imaging, medication prescription, and laboratory study ordering higher than did civilian PTs, likely due to their ability to be credentialed to perform these procedures.

Diagnostic accuracy of military physical therapists has been assessed for use of ankle imaging rules³³ and in clinical diagnostic accuracy in patients referred for magnetic resonance imaging.³⁴ In both studies, military PTs performed at levels similar to orthopedic surgeons, emphasizing both the knowledge and skill to appropriately manage patients with musculoskeletal injuries. Additionally, the use of advanced imaging in a military direct-access sports physical therapy clinic was deemed appropriate in over 80% of cases when compared with current clinical guidelines.³⁵ The safety of physical therapist management was reported by Moore et al³⁶ after analyzing more than 112,000 new physical therapy patients, with 45.1% being seen without a referral over a 40-month period. No adverse events were reported, providing evidence of the ability to safely screen and manage patients regardless of the mechanisms of access.

Kaiser Permanente

Kaiser Permanente in Northern California was founded in 1945 and as of 2016 has nearly 4,000,000 members. Kaiser Permanente comprises 3 main entities:

- Kaiser Foundation Hospital
- Kaiser Foundation Health Plan Inc
- The Permanente Medical Group

Northern California Kaiser has 21 hospitals, 238 medical offices, over 7,600 physicians, and in excess of 700 PTs in total (current as of third quarter 2016).

The Permanente Medical Group provides care for the Kaiser members, and since the mid-1990s PTs have been practicing within primary care at Kaiser. Initially embedded in family medicine departments,⁹ more recently the PT's role in primary care has been more consultative than rehabilitative. As of the beginning of 2016, most primary care PTs at Kaiser no longer have their own dedicated treatment rooms in the medicine departments. This transition was largely driven by a growing membership and the need for more exam room space to accommodate more physicians in primary care.

Prior to 2016, PTs in primary care had dedicated treatment rooms in the medicine departments and would see patients in the primary care department for evaluation, treatment, and occasional consultation with the physician. Any follow-up beyond the first day would largely occur in the physical therapy department. In this setting patients were seen upon referral as well as without a prior office visit with the physician. Over the years, with the necessary collaboration between PTs and physicians forging closer proximity to each other, familiarity between the 2 disciplines grew immensely. The growing familiarity also helped with increasing general consultation of PTs. In other words, in addition to requests for evaluation and treatment, physicians knocked on the door for specific questions (eg, whether or not a patient presentation was likely a neck problem versus a shoulder problem; whether or not it indicated referral to the PT department, the spine clinic, or neurosurgery). Common communication barriers were lowered, and the general comfort level between the professions was heightened. This was likely an important factor in establishing some of the early service agreements surrounding imaging requisitions, medication recommendations, and work activity status forms.

In the PT's consultative role in primary care at Kaiser Permanente, requests are made by telephone to what is called a "roving PT." These visits take place following a phone call by the physician while their patient is still in the exam room. The physician presents the case to the roving PT over the phone and, among other things, articulates the problem, question, or other circumstance that warrants a request for a PT's 10- 15-minute consult during the same office visit with the physician in their exam room. The PT helps the physician answer many different questions during these visits. The physician may call and request the consult to find out whether a presenting arm complaint is arising from a shoulder impingement or a cervical radiculopathy, or, on occasion, to specifically add to the physician's decision making in regards to further workup for cardiac, neoplastic, or other nonmusculoskeletal disease. More common questions are whether or not imaging, physical therapy, or other specialty referral is indicated. Often these clinical questions are explored and answered in the presence of both the physician and the patient. This is uncommon in most outpatient settings, and, inevitably, learning in these teams takes place by both clinicians. Immediately and over time the understanding of each other's recommendations and practice are more clear and efficient. Besides the improved quality of care for the patient, collaboration between the physician and the PT has been cited as critical in program implementation.^{37,38}

Despite the APTA positions, the Guide 3.0 description of physical therapy roles in primary care, and the literature—where physical therapist practice and primary care has been cited and is often advocated for^{32,37,39}—there do not appear to be examples of its integration on any other large scale.

INTERNATIONAL

Publications have provided examples of PTs practicing in some type of primary care environment in other countries.⁴⁰ Physiotherapy (physical therapy) scope of practice descriptions that relate to primary care include:

- autonomous, work within wider health team (New Zealand)⁴¹
- advanced scope of practice and extended scope (Australia)²²
- practicing in settings beyond traditional hospital setting (Ireland)⁴²
- essential participants in health care delivery system, para-professionals (Singapore)⁴³
- primary health care providers (Canada)¹⁹
- independent practitioners, members of health service provider teams (WCPT)⁴⁴

The United Kingdom, Australia, Spain, Brazil, and the Netherlands have advocated for integration of PTs in various models of primary care.^{18,45-49} PTs obtain vital signs, perform range of motion (ROM) tests, take a lead role in falls prevention, and instruct women’s health group exercises. They also can perform “self-referral/direct access” in a primary care setting^{18,49} and assess the receptiveness and support of other primary care team members to the PTs in that setting.³⁸

Canada

In Canadian doctrine, the role of physiotherapy in primary health care includes working as part of a “team to maximize mobility in response to the needs of patients across the lifespan.”⁵⁰ Physiotherapists are cited to be equipped with the ability to diagnose, treat, and manage acute and chronic conditions, which can then have a positive impact on quality of life, population health, and lowering of health care costs. One of the most comprehensive publications on primary care specifically for physical therapy is *Primary Health Care: A Resource Guide for Physical Therapists*, published in 2007 by the College of Physical Therapists of Alberta, Canadian Physiotherapy Association.⁵¹ Physiotherapists in Canada who practice in primary care do so in publicly funded hospital settings. Physiotherapists function as part of primary care teams including health promotion and disease prevention. Their focus as part of these teams is to “maximize mobility in response to the needs of patients across the lifespan. Physiotherapists help ensure continuity of care for patients and their families...”⁵⁰

United Kingdom (UK)

In the UK the consultative role of PT has been well-established. Physiotherapists in the UK have the jurisdictional scope of practice to make medicine recommendations, prescribe medication with a doctor’s countersignature (supplementary prescriber), and perform injection therapy.⁵² Physiotherapists who work in primary care are called general practice (GP) physiotherapists and manage musculoskeletal caseload in primary care “reducing the pressure on GPs ... and ... improves the patient experience”.⁵³ In 2013, the UK physiotherapist profession moved to independent prescribing.⁵² The British Medical Association and the Royal College of General Practitioners put together guidance literature for GPs and commissioners to understand the benefits of implementing general practice physiotherapy roles via⁵⁴:

- Contracting, by which the physiotherapist is paid at an hourly rate for services
- Directly employing a physiotherapist and paying a salary
- Inviting a physiotherapist to join the practice as a partner

In a systematic review, there were 34 articles examining therapist performance in triaging lists of referred patients.⁴⁶ The review, which included assessments from focus groups of experts and patients, found that PTs were accurate in the diagnosis and management of musculoskeletal cases. They also concluded that PT consultant triaging decreased wait times and costs, and increased referral and diagnostic agreement with noted high patient and GP (physician) satisfaction. The review concluded that PT's were among the most suitable of clinicians to triage patients with musculoskeletal conditions.

Physical therapists are defining themselves among their health professional colleagues in the telehealth sphere. Telephone consults (Tcons), video consultations (Vcons), PT pools, and roving PTs are all meaningful PT encounters that eliminate transportation needs and expedite specialty care. Decreasing inappropriate specialty referrals, providing PT consults during the same visit with the physician, and bringing services to the patient's home via Vcons and Tcons all decrease transportation needs and thus facilitate access to care. Tcons by PTs have also been examined in the UK^{55,56} with both positive and negative impressions by both patients and providers. One finding was clear: patients were more concerned about being seen sooner and not as concerned with who saw them.

Ireland

Ireland showed clinically significant improvement in exercise tolerance when trialing joint partnership for community-based pulmonary rehabilitation between acute hospital and primary care physiotherapy services.⁵⁷ Ireland also reported the use of physiotherapists as part of a diabetes prevention team consisting of community physiotherapist, community nurse, and public health nurse.⁵⁸

New Zealand

New Zealand's publically funded health care, for the most part, delivers physiotherapy services in secondary care facilities. New Zealand had a Primary Health Care Strategy vision for multidisciplinary teams of primary health care professionals. Funding allowed for employment of a physiotherapist in a primary health center in a low socioeconomic area. Following a 6-month pilot access to physiotherapy services improved as well as job satisfaction for the health professionals.⁵⁹

Sweden

In Sweden's primary care triage patient sorting system, patients with musculoskeletal disorders (MSD) are triaged directly to physiotherapist. A study examined the utilization effects of medical services when patients sought primary health care clinics (PHCC) for MSD and looked at how the effects of the triaging system vary for different sub-groups of patients retrospectively.⁶⁰ Out of 1,673 patients with MSD, 656 patients were assessed by general practitioners.⁶⁰ Significantly fewer patients triaged to physiotherapists required multiple general practitioner visits for the MSD or received MSD-related referrals to specialists/external examinations, sick leave recommendations, or prescriptions during the following year compared with the general practitioner-assessed group.⁶⁰

Brazil

Brazil's physiotherapists, similarly to the US, continue to define their role in primary care but are establishing themselves as part of the primary care health team, specifically in the areas of "promotion, prevention, rehabilitation individually and collectively."⁶¹

PAYMENT AND REGULATION

Federal programs, such as Medicare, do not define physical therapists as primary care providers, but they do recognize nurse practitioners, clinical nurse specialists, physician assistants, and family, internal, and geriatric medicine physicians.⁶² Financially, including physical therapists as part of the primary care

model may lead to increased access and quality of care while reducing costs and unnecessary utilization of services and interventions. Therefore, in congruence with “triple aim” developed by the Institute for Healthcare Improvement (IHI)—improved population health, improved individual patient experiences, and reduced cost per capita for the services provided—federal, state, and private payers could benefit from expanding the definition of primary care providers to include physical therapists. However, with changing payment models it is not clear how being considered a primary care provider will affect payment for physical therapists. Conversely, there potentially are increased malpractice and liability costs as well as greater responsibilities and expectations. Evidence in the literature is limited, and more data, particularly under the value-based current payment systems, are needed to show that physical therapy is a driver in reducing health care costs in primary care settings.

While it appears that physical therapists have background, education, and practice expertise to contribute to and participate in the delivery of primary care, a primary care practitioner is traditionally considered to be a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or is a nurse practitioner, clinical nurse specialist, or physician assistant, from the payment perspective of the Center of Medicare and Medicaid Services (CMS). Therefore, in most cases, physical therapists are financially excluded from operating as primary care clinicians despite the relevance to the personal health care needs of patients.

When physical therapists operate as physician extenders or entry-point providers as members of the primary care team, the financial model is primarily in a cost-containment system, where provider organizations operate in a single-payer, managed care, or capitated system. Managed care is a generic term for various health care payment systems that attempt to contain costs by controlling the type and level of services provided. Providers are discouraged from performing procedures, because they are not paid anything extra for performing them.⁶³ However, most health care providers operate in a traditional fee-for-service (FFS) model, in which services are unbundled and paid for separately, giving an incentive for clinicians to provide more medical interventions (eg, diagnostic procedures and treatments), because payment is dependent on the quantity of care, rather than quality of care.⁶⁴ Both models have significant financial implications for the utilization of physical therapist services and whether physical therapists should be considered primary care providers. In cost containment systems, such as the Army and Kaiser models, physical therapists are granted a degree of autonomy due to their ability to provide entry-point and extender services at lower cost with increased quality, resulting in reductions in unnecessary utilization and cost, shorter wait times for referrals to specialists, improved patient education, and decreased invasive interventions.⁶⁵⁻⁶⁷ Therefore, in a FFS system, where physicians are incentivized to increase utilization of diagnostics, invasive procedures, and medication, they could be less inclined to include physical therapists as part of the care model. And, some PTs may prefer to have less autonomy in exchange for larger payments within a FFS system. Recognizing this moral hazard and the shortfalls of both managed care and FFS payment systems, CMS has been steadily increasing the number of value-based programs (VBPs) that reward health care providers with incentive payments for the quality of care that they provide to Medicare beneficiaries. Additionally, Health Care Cost Institute (HCCI) along with America’s Health Insurance Plans (AHIP) announced their initiative as well. The goal of VBPs is to provide better quality care for individuals, improve health for populations, and lower growth of expenditures.⁶⁸

To take advantage of the payment reform environment, Accountable Care Organizations (ACOs) have emerged. ACOs are organizations of groups of physicians, hospitals, and other health care providers who come together voluntarily to give coordinated quality care to Medicare patients.⁶⁸ The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right

time, while avoiding unnecessary duplication of services and preventing medical errors.⁶⁸ When an ACO succeeds both in delivering high-quality care and spending health care dollars more efficiently, it will share in the savings it achieves for the Medicare program.⁶⁸ ACOs' incentive payments are determined by comparing the organization's annual costs with CMS-established benchmarks. ACOs must achieve or exceed a minimum savings rate (MSR) of 2% to qualify for shared savings. These benchmarks are based on an estimation of the total FFS expenditures associated with management of a beneficiary.⁶⁹

To facilitate shared savings, CMS introduced bundles, which estimated total cost of all of the services a patient would receive per episode over a set time period for a specific DRG (like for knee and hip replacement). The goal of bundled payments is to drive comprehensive and coordinated care. Due to the cost and the frequency of joint replacements, Comprehensive Care for Joint Replacement (CJR) is the first mandatory payment model being tested. Bundled payments are perceived as a compromise between FFS and capitation, where the payments can either be retrospective or prospective.⁷⁰ In the retrospective model, providers continue to bill the payer under existing FFS payment based on a set budget. If the providers exceed the episode budget, they owe the payer, and vice versa if the providers come in under budget.⁷⁰ However, in the prospective payment model, the payer sends one payment to the providers, who then must decide how to distribute the funds.⁷⁰ Physical therapists play an important role in managing costs in a bundled payment; however, in the prospective model, there is greater uncertainty in the equity of payment distribution to physical therapists in a physician-centric care delivery model. As payment models evolve, even for pre- and postoperative management, PTs will have to be cognizant of the equity in funding distribution as services and payments become bundled.

The degree to which physical therapists will be able to effectively influence value-based payment models will vary based on each state's regulatory environment. The scope of practice for physical therapists is dynamic, evolving with evidence, education, and societal needs, and has 3 components: personal, professional, and jurisdictional.⁷¹ The personal scope of practice consists of activities undertaken by an individual physical therapist that are situated within a physical therapist's unique body of knowledge for which the individual is educated, trained, and competent to perform that activity.⁷¹ The professional scope is rooted in the profession's unique body of knowledge and evidence in the movement system; whereas, the jurisdiction scope of practice is established by a state's practice act governing the specific physical therapist's license and the rules adopted pursuant to that act.⁷¹ The jurisdictional scope does not always align with physical therapists' full scope of knowledge and, at times, limits the professional scope of practice. Even though there may be circumstances in which the professional and personal scope of practice may support the utilization of physical therapy in entry-point or primary care settings, the jurisdictional scope of practice could place restrictions on physical therapists from participating in those care models.

A widely recognized inefficiency in medicine is the high frequency of what have been deemed to be inappropriate referrals from primary care.^{45,72,73} In the US and elsewhere, FFS models do not have the same inherent drivers as do capitated reimbursement or value-based or outcome-based models. The latter values efficiency and is penalized by inefficiency.

It appears one commonality abroad is the absence of a FFS structure, which is also true for the military, the VA, and Kaiser Permanente. The fee structure may have a significant role in why physical therapy in primary care has not been as developed in the US outside of the military and Kaiser Permanente.⁷⁴

This may change soon. A National Academies of Science, Engineering, and Medicine publication states: "The cost reimbursement structure has been shifting over time, partly due to the Affordable Care Act,

from a fee-for-service model, to a value based payment model. Providers will have to work differently to achieve good outcomes as well as assume the risk of suboptimal outcomes.”⁷⁵

BENEFITS TO SOCIETY

The potential benefits to society from the practice of physical therapists in primary care are many, but they are dependent on the continuing evolution of the definition of primary care, as well as on the continued development of health care policy and payment. One could organize the potential benefits to society from the practice of physical therapists in primary care around the IHI triple aim: improved population health, improved individual patient experiences, and reduced cost per capita for the services provided.⁷⁶ Layered within these areas outlined by the IHI are the factors that perhaps allow for the achievement of these broad aims, such as access for a greater percentage of the population to the right health care provider at the right time to allow for the most appropriate management strategy, regardless of previous limitations related to jurisdictional scope of practice or the structural limitations of health care organizations and payers.

Improved population health

Multiple examples exist, despite a historically narrow role, for the improvement of population health from physical therapist practice in a primary care role. The majority of these historic examples (described in detail throughout this perspective paper) are as physical therapists serving primarily as extenders and entry-point providers, and they most often involve care of patients with musculoskeletal conditions. Despite this narrower role, care by physical therapists has consistently demonstrated improved and quality outcomes that provide numerous benefits to society.⁶⁷ From improved individual patient outcomes to reduced episodes of care and reduced time away from participation in life, physical therapist care in these roles has demonstrated benefits not only directly to individuals but indirectly to a population affected by the health of individuals receiving care from a physical therapist.⁶⁷

Patient Experience of Care

The experiences for patients in physical therapy, in the form of self-reported satisfaction, have traditionally been positive and a strength of clinical practice for physical therapists.⁷⁷ In a primary care role, patients would have increased and earlier access to the care from a physical therapist. This, too, has been shown to have high ratings of satisfaction from patients when care models that increase access, such as same-day services, are implemented.⁷⁸ Access to a physical therapist in a primary care role that allows patients earlier accessibility to the most appropriate care may continue to improve the patient experience to a greater percentage of our society.

Per Capita Cost of Health Care

When physical therapist care is accessed through entry-point or primary care roles, there are examples of reduced cost with similar or superior outcomes to historically, typical pathways for primary care intervention, such as seeing a physician or nurse practitioner first.^{4,65} Coupled with these findings are the consistent findings of no increases in adverse events.^{4,65} Often these reductions in cost are demonstrated by reductions in unnecessary procedures directly related to patient care.⁷⁹ However, additional reductions in cost have been demonstrated indirectly through quicker returns to participation in life activities.⁶⁷

Additional Benefits Beyond Direct Patient Care

Additional benefits to society may come from primary care designations for physical therapists within contexts beyond those described within direct patient care situations. Primary care status would allow physical therapists to be included in programs that place primary care providers in practice settings and

geographical areas of high need in exchange for loan forgiveness or repayment. This will improve access to the care of a physical therapist in some of the areas of our society that have the most need, while reducing the chance of physical therapists restricting their practice choices secondary to their student debt.⁸⁰ Additionally, with a reduced debt burden the profession can attract more future physical therapists from diverse backgrounds that can better care for a society with changing demographics.

Primary care status may also allow researchers who investigate physical therapist practices and services access to additional research funding to continue to add to a body of knowledge that improves the health of the members of our society. These benefits beyond direct patient care provide for more upstream benefits to society in the areas of prevention and are important considerations in the role of physical therapists in primary care and how this role will be defined.

FEASIBILITY (Opportunities in practice, research, and education)

Considering current practice by the physical therapist at entry-level, it appears that the physical therapist could provide multiple services as contributions to a primary care team. In the absence of jurisdictional restrictions on the legal scope of physical therapist practice or restrictions on payment for services from insurance companies and Medicare, some physical therapists are able to practice to the full extent of their education and contribute to primary care teams as physician extenders. The federal sector does not dictate jurisdictional restrictions. It should be noted that the majority of examples in which physical therapists provide services that could be considered contributory to primary care are traditionally episodic and not necessarily part of a sustained partnership addressing a large majority of personal health needs. There are growing needs in primary care beyond traditional medicine that are specific to the expertise of the physical therapist related to the movement system and how individuals interact with their environment.

The opportunities and feasibility for physical therapists in primary care will depend somewhat on the profession's decision either to continue emphasis on providing triage and extender services within medicine or to widen the consideration of primary care to include the services that are needed to manage the movement system across the lifespan. These directions would not necessarily need to be divergent, but they would potentially require different long-term actions by the profession. Under current models, the addition of physical therapists to existing lists for primary care providers would require significant action by the association in regard to the naming of physical therapists as primary care clinicians, but it would not necessarily require significant changes in practice, education, or research. However, if the profession were to take a broader role in primary care, it is likely that more changes in practice, education, and research would be necessary. Any action to achieve primary care status related to regulatory and payment strategies would require significant planning, financial investment, and resources; and the short- and long-term effects are unknown at this time and would need to be explored.

SUMMARY

APTA does not have specific language or positions on the roles and services of physical therapists in primary care beyond stating that PTs have a role on a primary care team. No actions or plan have been devised or adopted to define physical therapists in this realm, to achieve recognition inter- or intraprofessionally as primary care physical therapists, to develop the steps needed to achieve such status, or to explore the areas of expansion in the PT scope of practice that would represent the necessary skillset and education. Given the resources that would need to be dedicated, any such effort would need to be considered in broader context with APTA's Strategic Plan, as well as with other initiatives approved by the House of Delegates that are under way.

While physical therapists provide unique and important contributions to primary care, there are multiple avenues in which this occurs and additional opportunities that have yet to be realized.

CHALLENGES

1. **Definition/Terminology.** Consistent use of primary care-related terminology is needed. Current definitions and descriptions, outside of the 1994 IOM definition, of primary care are not consistent from state to state, let alone from country to country.
2. **Education.** In the United States there are no formal (entry-level or postprofessional) education opportunities or built-in curricula for students specific to practice in primary care.
3. **Regulation.** To date no practice acts designate or list physical therapists as primary care providers, nor do any prohibit it. Direct access exists in all 50 US states but is not regulated consistently from state to state, and in most cases requires not only coordination with other patient providers but oversight by a primary care physician or nurse practitioner following the initial evaluation or 30 days of treatment. Work in this area needs to include adding regulatory language about the physical therapist's ability to order and interpret specific imaging and lab tests, and to prescribe medications. If we are going to adopt the military system or that of another country we have a lot of work to do in this arena.
4. **Payment.** Medicare does not name physical therapists as practitioners who can be referred to as a primary care provider. In the US health care system physical therapy is a "service." In hospital settings (acute care and intensive care units) physical therapy is billed as part of a group of services, not as an independent provider consultation. In outpatient, physical therapy is a specialty, and patients must pay a copay for every visit. Many insurance companies will not pay for physical therapy beyond the initial evaluation if there is not a referral from a physician or other primary care provider, or beyond 30 days of physical therapy treatment without a referral from a physician or other medical care provider.
5. **Public Perception/Population Health.** The population at large does not view physical therapists as their "primary care" physical therapist. Annual check-ups by a physical therapist are not widely known or commonly provided. APTA supports promoting the health of the community and society (Appendix A), but it has not determined whether physical therapist roles in primary care will remain in the frame of the individual or evolve to include the health of communities.
6. **Professional.** APTA has not taken a stance or clearly defined the roles of physical therapists in primary care, the services that they would provide, or a discrete plan to advance the profession under the primary care umbrella.

UNANSWERED QUESTIONS AND ITEMS TO CONSIDER

The considerations listed below are based on the history of the profession, the current states of practice, review of the literature, clinical practice, and business experience of the members of the work group:

- Promote innovative involvement of physical therapists in primary care settings through an Innovation Summit 3.0;
- Determine the degree and context that primary care practice by the physical therapist is included in current professional physical therapist education programs;
- Consider partnerships in interprofessional education for teaching primary care in a team environment;

- Promote the establishment of primary care as an ABPTS clinical specialty in the physical therapy profession;
- Determine legislative activities, existing and needed, related to practice act restrictions and limitations;
- Establish partnerships with other primary care stakeholders, associations, and organizations;
- Model and predict payment and the value of physical therapy in current roles and in primary care roles;
- Advocate for physical therapists to be added to loan reimbursement and scholarship programs related to primary care roles; and
- Advocate for physical therapists to be added lists that provide funding for research in primary care.

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GLOSSARY

Advanced physical therapist. A licensed, graduate of a physiotherapy program who has received postprofessional training and is certified to perform procedures or practice areas that are otherwise out of the general, professional scope of current practice of physical therapy, such as prescribing medicine.

Civilian physical therapist. A board-licensed physical therapist whose initial professional training and degree are not that of a military school such as Baylor's Physical Therapy Doctoral Program.

Direct access. Direct access means the removal of the physician referral mandated by state law to access physical therapists' services for evaluation and treatment.

Entry-point provider. First-contact clinician.

Jurisdictional scope of practice. The jurisdictional (ie, legal) scope of practice is established by a state's practice act governing the specific physical therapist's license, and the rules adopted pursuant to that act. (APTA, last updated 2015)

Model. Chosen design of practice professionals related to patient care.

Personal scope of practice. The personal scope of practice consists of activities undertaken by an individual physical therapist that are situated within a physical therapist's unique body of knowledge where the individual is educated, trained, and competent to perform that activity. (APTA, last updated 2015)

Physician extenders. Clinicians who are trained to perform some of the privileges usually refrained for a medically trained physician, such as PTs in the military or physician assistants or nurse practitioners in primary care settings.

Primary care. Provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and a practicing in the context of family and community. (IOM, 1994)

- a. **Primary care provider.** Clinicians who render primary care service as defined in "primary care" above; Medicare defines primary care provider as a physician, nurse practitioner or physician's assistant.
- b. **Primary care team.** Collaborative group of clinicians who provide various primary care patient-centered services.
- c. **Primary care environment.** Setting or circumstances under which primary care services are rendered by skilled physicians for the majority of personal health care needs.

Professional scope of practice. The professional scope of practice of physical therapy is defined as practice that is grounded in the profession's unique body of knowledge, supported by educational preparation, based on a body of evidence, and linked to existing or emerging practice frameworks. (APTA, last updated 2015)

APPENDIX A

APTA House of Delegates and Board of Directors Positions (as of September 9, 2015)

PRIMARY CARE AND THE ROLE OF THE PHYSICAL THERAPIST HOD (P06-06-07-03)

Physical therapists participate in and make unique contributions as individuals or members of primary care teams to the provision of primary care.

Physical therapists provide patient/client management in primary care through the processes of screening, examination, evaluation, diagnosis, prognosis, intervention, education, prevention, coordination of care, and referral to other providers to prevent, remediate, decrease, or slow the progression of impairments, activity limitations, and participation restrictions, and lessen the impact of environmental barriers, and optimize cost-effective clinical outcomes.

CONTINUITY OF CARE RECORD HOD (P06-08-12-10)

Whereas, A Continuity of Care Record (CCR) contains relevant information for authorized professionals, and is prepared when a patient/client: is discharged from a hospital; is referred by a primary care provider to any specialist; or is transferred from one provider to another¹;

Whereas, A CCR may include clinical, demographic, medication, procedure, treatment, health/well-being, and background information²;

Whereas, The goal for a CCR is to enable a provider to easily access the information from a previous encounter and to update the information when the patient/client goes to another provider in order to support the safety, quality and continuity of care;

Whereas, The CCR may be carried by the patient/client, sent by the referring provider, or accessed by the subsequent provider;

Whereas, The CCR may be in any Health Insurance Portability and Accountability Act compliant format;

Whereas, The CCR improves intraprofessional and interprofessional communication for continuity of patient/client care through all episodes and all settings of care; and

Whereas, Physical therapy is an integral part of health care delivery;

Resolved, That the American Physical Therapy Association supports the inclusion of elements of physical therapist patient/client management as a component of Continuity of Care Records.

Resolved, That the American Physical Therapy Association advocates for inclusion of elements of physical therapist patient/client management to key groups including: organizations that are creating CCR specifications and implementation guides; and standards development organizations that are creating terminology codes to be used in the CCR.

1. CCR FAQs Webpage. Medical Records Institute Web site. Available at: www.medrecinst.com/librarticles.asp?id=43. Accessed March 24, 2008
2. Federal Register. Vol 72. No 188/ Friday, September 28, 2007/Notices. Available at www.Cms.gov. Accessed June 7, 2008.

PRINCIPLES AND OBJECTIVES FOR THE UNITED STATES HEALTH CARE SYSTEM (HOD P06-13-20-18)

The American Physical Therapy Association (APTA) supports a health care system that provides all individuals within the United States access to and provision of high-quality health care that meets the needs of individuals, patient populations, and communities. The system must include provision of coordinated, collaborative, comprehensive, effective (cost, quality, and value) care, including physical therapist services. Physical therapists are integral to health care and health care teams and make unique contributions that are essential for comprehensive health care regardless of the model of health care delivery.

APTA endorses the following guiding principles for the United States health care system:

PRINCIPLE I: ACCESS TO CARE

The health care system provides access to care for all persons of all ages inclusive of:

- Respect for individual autonomy to select providers who are qualified and authorized by state and other jurisdictional law to provide health care services, including physical therapists.
- Provision of health care services within the full scope of providers' practice as supported by their education, training, and professional standards, including direct access to physical therapist services.
- Health care service delivery models that facilitate high-quality patient-centered care. These health care service delivery models may necessitate changes in law, regulation, payment policy, and institutional bylaws to optimize outcomes, efficiency, and cost effectiveness.
- The ability for individuals to choose high-quality, affordable health care coverage based on transparent and complete information regardless of type of plan (government, employer, private). These plans should allow for pre-tax accounts that can be used for long-term care and other patient-defined health care needs.
- Coverage that cannot be denied due to preexisting or congenital health conditions.
- Education and training of sufficient numbers and types of health care professionals.
- Coverage for programs and incentives that prevent injury, impairments, activity limitations, participation restrictions, and illness; and that promote wellness and aid in maintenance of functional independence for individuals with chronic disease and long-term disability.
- Coverage for medically necessary assistive technology, including but not limited to durable medical equipment.

PRINCIPLE II: QUALITY OF CARE

The health care system must be patient-centered and focus on quality, inclusive of safety, effectiveness, efficiency, and timeliness, and be equitable.¹ Quality is the measure against which individuals and communities achieve desired health outcomes, including functional outcomes.

- Care is delivered based on clinical evidence.¹
- Care is delivered competently, including technical and cultural competence.¹
- Delivery of care is patient-centered, inclusive of patient goals and desired outcomes.
- Care is delivered using appropriate measures, including examination, evaluation, diagnosis, prognosis, intervention, and outcomes.²
- Positive indicators of high-quality care as defined by physical therapists should include measures of outcome, including functional outcomes; individual achievement for maximizing independent living; individual establishment of a healthy lifestyle; optimal symptom management of pain, impairment, activity limitations, participation restrictions, and disability; and patient/provider satisfaction.

- Physical therapists will hold themselves accountable to the public and to payers through peer review, and physical therapists are the only appropriate professionals to review the delivery and utilization of physical therapist services.

PRINCIPLE III: VALUE-BASED PAYMENT

The health care system must provide equitable payment based on value of care and must be reasonable based on cost over value.³ This core principle of payment, including payment for physical therapist services, must be universal, irrespective of payer or health care system.

- Mechanisms to control costs must include models that provide innovative care delivery, including the use of and payment for telemedicine and virtual visits.⁴
- Models of health care delivery that improve efficiency, decrease cost, improve patient satisfaction, and result in positive health outcomes will include physical therapists as care entry points for individuals who can and should be safely and effectively managed by physical therapists.
- Value-based payment must include wellness and prevention services that result in higher health status, less cost, and fewer hospitalizations and procedures, with payment or sharing of savings to the practitioners involved.
- Practitioner referral arrangements that result in profit back to the referring practitioner must be prohibited by law.
- Value-based payment must include sensitive and refined measures that consider the severity of individual condition and intensity of services provided and that result in positive health outcomes.⁵

PRINCIPLE IV: TEAM-BASED CARE

Team-based health care must be delivered in an integrated manner that results in the coordination of health services to individuals, families, and/or their communities. The team must function around the needs of the patient, with identification of the team leader based on the needs of the patient. This team leader should change with the changing needs of the patient.¹ Team-based care must identify, establish, and measure the basic principles and expectations that result in improved care to the individual or patient population.

- Team-based care must be purposeful and organized, with appropriate “handoffs” of responsibility and information.¹
- Team-based care models must measure outcomes of care provided to the individual or patient populations, to ensure the most efficient and highest-quality care.
- Team-based care is broad, including all health care settings, such as primary and acute care, chronic care, rehabilitation, and hospice.¹
- Patient and patient-defined family members are part of the health care team who, at the patient’s request, are included in the identification of care goals, the coordination of care across settings, and the health care team’s established lines of communication.¹
- Team-based care must include defined roles, functions, responsibilities,¹ including the concepts of new models of care that allow all providers to exercise their professional judgment within their full scope of practice.
- The health care team is dynamic, with the needs of the patient determining who best can lead the team at any given point of care.
- The patient is the center of the health care team. The team does not belong to a single provider, system, or discipline.¹

1. Mitchell PM, Wynia R, Golden B, et al. Core principles and values of effective team-based health care. Discussion Paper. Washington, DC: Institute of Medicine, 2012.
2. Guide to Physical Therapist Practice. 2nd ed. *Phys Ther.* 2001;81:9-744.
3. Porter M, Teisberg E. Redefining health care. Harvard Business School Press; 2006.
4. Baker LC, Johnson SC, Macaulay D, et al. Integrated telehealth and care management program for Medicare beneficiaries with chronic disease linked to savings. *Health Affairs.* 2011;30(9). <http://content.healthaffairs.org/content/30/9/1689.abstract>.
5. American Physical Therapy Association Guiding Principles, Alternative Payment System Task Force.

PHYSICAL THERAPISTS' ROLE IN PREVENTION, WELLNESS, FITNESS, AND DISEASE MANAGEMENT (BOD P02-14-02-01)

Physical therapists play a unique role in society in prevention, wellness, health promotion, and disease management by serving as a dynamic bridge between health and health care for both individuals and broader populations. Although physical therapists are experts in rehabilitation and habilitation, they also have both the knowledge and the opportunity to help individuals and populations improve overall health and prevent the need for avoidable health care services.

Physical therapists' roles may include education, direct intervention, research, and collaborative consultation. These roles are essential to the profession's vision for transforming society by optimizing movement to improve the human experience.

Physical therapists, like most health professionals, are educated to provide services in the health care environment. Unlike many health professionals, physical therapists are also uniquely trained to adapt health recommendations to the community environment where individuals live, work, learn and play. This knowledge and ability to work effectively in both environments enables physical therapists to adapt medical recommendations to specific environments, to interpret health recommendations in a meaningful way, and to facilitate modification of health behaviors by individuals.

Physical therapists are uniquely qualified to serve in this role in the following ways:

PREVENTION, WELLNESS, FITNESS, AND HEALTH PROMOTION

- Integration of decision-making skills across all dimensions and contextual factors of the International Classification of Function (ICF)
- Ability to incorporate personal factors of medical and health history into a comprehensive plan of care that includes data related to body structures and functions, activities and participation, and relevant environmental factors
- Interaction with individuals and populations in the environment where they live, work, learn and play
- Application of best available evidence in the development and use of intervention and measurement strategies in program planning for individuals and communities
- Highly skilled at adapting tasks and the environment to promote healthy behaviors and improved health outcomes for individuals with complex medical and functional needs
- Integration of scientific principles of movement, function, and exercise progression to promote physical activity and improve health outcomes
- Integration and interpretation of the elements of medical/biopsychosocial/health promotion models

DISEASE AND DISABILITY MANAGEMENT

- Recognition of the risk factors for and the course of chronic diseases and their potential impact on quality of life and on activities and participation
- Ability to establish and facilitate collaborative, client-centric relationships that empower patients/clients in self-care initiatives across the lifespan and through the health continuum with an emphasis on movement and function
- Application of best available evidence in the development and use of intervention and measurement strategies to educate individuals and facilitate the prevention of primary, secondary and tertiary conditions or the restoration of functional mobility
- Provision of non-surgical and non-pharmacological care as a hallmark of physical therapist practice
- Ability to interpret and prognosticate health outcomes and functional needs where people live, work, learn, and play

DYNAMIC LINK BETWEEN HEALTH AND HEALTH CARE

- Ability to maximize collaboration with a variety of providers in health care and in health, wellness and fitness to help individuals both with and without health conditions reduce their disease risk and improve their health and quality of life
- Ability to have a significant impact on society through engagement by physical therapists both in the medical environment and in the community. Physical therapists are a dynamic bridge from the clinic to the community where individuals live, work, learn and play
- Ability to adapt health recommendations to the individual's environment
- Ability to communicate and collaborate with relevant health care professionals to help individuals receive appropriate health care

Proviso: This position has been adopted by the APTA Board of Directors with the understanding that this position and all other positions on this topic be incorporated into the policy review project with a comprehensive policy forwarded to the 2015 House of Delegates.

PHYSICAL THERAPY AS A HEALTH PROFESSION HOD P06-99-19-23

Physical therapy is a health profession whose primary purpose is the promotion of optimal health and function. This purpose is accomplished through the application of evidence-based principles to the processes of examination, evaluation, diagnosis, prognosis, and intervention to prevent or remediate impairments in body structures and function, activity limitations, participation restrictions or environmental barriers as related to movement and health.

Physical therapy encompasses areas of specialized competence and includes the development of new principles and applications to meet existing and emerging health needs. Other professional activities that serve the purpose of physical therapy are research, education, consultation, and administration.

AUTONOMOUS PHYSICAL THERAPIST PRACTICE HOD P06-06-18-12

Physical therapists have the responsibility to practice autonomously in all settings, practice environments, and employment relationships. Autonomous physical therapist practice is characterized by:

- 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 the physical therapist patient/client management
- Recognition of circumstances that necessitate a request for consultation and initiation of such consultation when in the best interest of the patient/client
- Clinical decision making that is independent of external financial considerations
- Physical therapist governance and control of physical therapy practice in all settings

DIAGNOSIS BY PHYSICAL THERAPISTS HOD P06-12-10-09

Physical therapists shall establish a diagnosis for each patient/client.

Prior to making a patient/client management decision, physical therapists shall utilize the diagnostic process in order to establish a diagnosis for the specific conditions in need of the physical therapist's attention.

A diagnosis is a label encompassing a cluster of signs and symptoms commonly associated with a disorder or syndrome or category of impairments in body structures and function, activity limitations, or participation restrictions. It is the decision reached as a result of the diagnostic process, which is the evaluation of information obtained from the patient/client examination. The purpose of the diagnosis is to guide the physical therapist in determining the most appropriate intervention strategy for each patient/client. In the event the diagnostic process does not yield an identifiable cluster, disorder, syndrome, or category, intervention may be directed toward the alleviation of symptoms and remediation of impairments in body structures and function, activity limitations, or participation restrictions.

The physical therapist's responsibility in the diagnostic process is to organize and interpret all relevant information collected. The diagnostic process includes obtaining relevant history, performing systems review, and selecting and administering specific tests and measures.

When indicated, physical therapists order appropriate tests, including but not limited to imaging and other studies, that are performed and interpreted by other health professionals. Physical therapists may also perform or interpret selected imaging or other studies.

In performing the diagnostic process, physical therapists may need to obtain additional information (including diagnostic labels) from other health professionals. In addition, as the diagnostic process continues, physical therapists may identify findings that should be shared with other health professionals, including referral sources, to ensure optimal patient/client care. When the patient/client is referred with a previously established diagnosis, the physical therapist should determine that the clinical findings are consistent with that diagnosis. If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise, the physical therapist should then refer the patient/client to an appropriate practitioner.

ANNUAL VISIT WITH A PHYSICAL THERAPIST HOD (P05-07-19-20)

The American Physical Therapy Association recommends that all individuals visit a physical therapist at least annually to promote optimal health, wellness, and fitness, as well as to slow the progression of impairments, functional limitations, and disabilities.

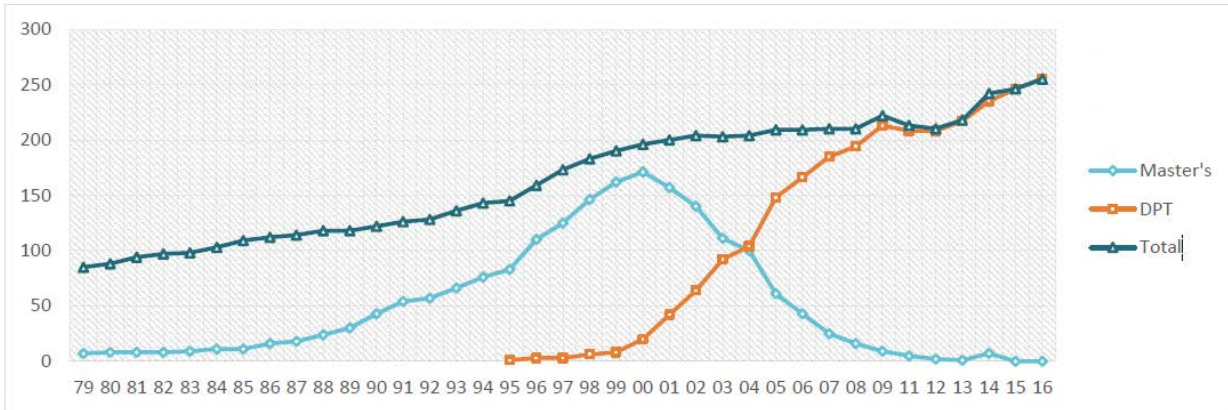
RC 23-06 Summit on Physical Therapy and Society: file:///C:/Users/anitabemis-dougherty/Downloads/2006%20House%20of%20Delegates%20Minutes.pdf (page 23)

That the American Physical Therapy Association (APTA) convene a summit in or by 2010 with annual reports to the House of Delegates that shall focus on how physical therapists can meet current, evolving, and future societal health care needs. The consideration of innovative process, technology, or practice models by this Summit on Physical Therapy and Society shall not be constrained by existing law, regulation, education, or reimbursement policy. Summit participants shall include but not be limited to leaders within: Physical therapy, Health policy, Public policy, Academia, Engineering, Bioscience, Theology, and Information technology.

Background on PASS: <http://www.apta.org/PASS/Background/>

APPENDIX B

Figure 2 Number of accredited programs by degree offered 1979 – 2016



http://www.capteonline.org/uploadedFiles/CAPTEorg/About_CAPTE/Resources/Aggregate_Program_Data/AggregateProgramData_PTPrograms.pdf

APPENDIX C

CAPTE Standards and Required Elements for Accreditation of Physical Therapist Education Programs (1: 7A, 7C, 7D:16, 17, 18, 19, 21, 22, 24, 28, 34, 35, 36)

Standard 7

The curriculum includes content, learning experiences, and student testing and evaluation processes designed to prepare students to achieve educational outcomes required for initial practice in physical therapy and for lifelong learning necessary for functioning within an ever-changing health care environment.

REQUIRED ELEMENTS:

- 7A** The physical therapist professional curriculum includes content and learning experiences in the biological, physical, behavioral and movement sciences necessary for entry level practice. Topics covered include anatomy, physiology, genetics, exercise science, biomechanics, kinesiology, neuroscience, pathology, pharmacology, diagnostic imaging, histology, nutrition, and psychosocial aspects of health and disability.

Evidence of Compliance:

Narrative:

- Describe where and how each of the delineated biological and physical sciences content areas is included in the professional curriculum. Do not include prerequisite courses.

Appendices & On-site Material: See SSR Instructions & Forms

- 7C** The physical therapist professional curriculum includes content and learning experiences about the cardiovascular, endocrine and metabolic, gastrointestinal, genital and reproductive, hematologic, hepatic and biliary, immune, integumentary, lymphatic, musculoskeletal, nervous, respiratory, and renal and urologic systems; system interactions; differential diagnosis; and the medical and surgical conditions across the lifespan commonly seen in physical therapy practice.

Evidence of Compliance:

Narrative:

- Describe where and how each of the delineated clinical sciences content areas is included in the professional curriculum.

Appendices & On-site Material: See SSR Instructions & Forms

- 7D** The physical therapist professional curriculum includes content and learning experiences designed to prepare students to achieve educational outcomes required for initial practice of physical therapy. Courses within the curriculum include content designed to prepare program students to:

Evidence of Compliance:

Narrative:

- For each of the following elements:
 - Describe where the content is presented in the curriculum and provide example(s)/description(s) of the learning experiences that are designed to meet the practice expectations (i.e., describe where and how the content is taught throughout the curriculum);
 - Provide a maximum of 5 examples of course objectives that demonstrate the highest expected level of student performance, include course **prefix and number, course name, objective number and the full wording of the objective**. Include objectives from clinical education courses, if applicable. If the expectation is a curricular theme,

examples of course objectives from multiple courses are required, up to a maximum of 10 objectives; and

- Describe outcome data, where available, that demonstrates the level of actual student achievement. **For Initial Accreditation ONLY**, describe how the program will determine the actual level of student achievement, including planned outcome data.
- **For Initial Accreditation ONLY**: if curricular changes have occurred since the program started, provide the requested information based on the curriculum experienced by the charter class. Contact Accreditation Staff to discuss what additional information should be provided for the current curriculum.
- If the program teaches content beyond what is addressed in Elements 7D1-7D43, identify the content, where and how it is taught and the highest expected performance level. If being taught to competency, identify how and where competency is tested.

Appendices & On-site Material: See SSR Instructions & Forms

Patient/Client Management Screening

7D16 Determine when patients/clients need further examination or consultation by a physical therapist or referral to another health care professional.

Examination, Evaluation and Diagnosis

7D18 Perform systems review.¹

7D19 Select, and competently administer tests and measures² appropriate to the patient's age, diagnosis and health status including, but not limited to, those that assess:

- a. Aerobic Capacity/Endurance
- b. Anthropometric Characteristics
- c. Assistive Technology
- d. Balance
- e. Circulation (Arterial, Venous, Lymphatic)
- f. Self-Care and Civic, Community, Domestic, Education, Social and Work Life
- g. Cranial and Peripheral Nerve Integrity
- h. Environmental Factors
- i. Gait
- j. Integumentary Integrity
- k. Joint Integrity and Mobility
- l. Mental Functions
- m. Mobility (including Locomotion)
- n. Motor Function
- o. Muscle Performance (including Strength, Power, Endurance, and Length)
- p. Neuromotor Development and Sensory Processing
- q. Pain

¹ **Systems Review:** Including the cardiovascular/pulmonary system through the assessment of blood pressure, heart rate, respiration rate, and edema; the integumentary system through the gross assessment of skin color, turgor, integrity, and the presence of scar; the musculoskeletal system through the gross assessment of range of motion, strength, symmetry, height, and weight; the neuromuscular system through the general assessment of gross coordinated movement and motor function; and the gross assessment of communication ability, affect, cognition, language, and learning style, consciousness, orientation, and expected behavioral/emotional responses.

² **Test and Measures:** The list is adapted from the *Guide to Physical Therapist Practice (2014)*.

- r. Posture
 - s. Range of Motion
 - t. Reflex Integrity
 - u. Sensory Integrity
 - v. Skeletal Integrity
- Ventilation and Respiration or Gas Exchange

7D21 Use the International Classification of Function (ICF) to describe a patient's/client's impairments, activity and participation limitations.

7D22 Determine a diagnosis that guides future patient/client management.

7D24 Establish a safe and effective plan of care in collaboration with appropriate stakeholders, including patients/clients, family members, payors, other professionals and other appropriate individuals.

Management of Care Delivery

7D28 Manage the delivery of the plan of care that is consistent with professional obligations, interprofessional collaborations, and administrative policies and procedures of the practice environment.

7D34 Provide physical therapy services that address primary, secondary and tertiary prevention, health promotion, and wellness to individuals, groups, and communities.

7D35 Provide care through direct access.

7D36 Participate in the case management process.