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WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

JAN - 2 2024

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Department's response to House Report 117–397, pages 191-192, accompanying H.R. 7900, the National Defense Authorization Act for Fiscal Year 2023, "Improving Military Readiness through Physical Therapists Serving in Primary Care Roles," is enclosed.

House Report 117–397, pages 191-192, requests an analysis of the feasibility of allowing physical therapists to serve in a primary care neuromusculoskeletal expert (NMSE) role throughout the Department of Defense (DoD) as well as a review of associated patient outcomes, military readiness, preservation of the force, and cost. One way DoD physical therapists can function as primary care NMSEs is through the Direct Access to Physical Therapy (PT) Program. Direct Access to PT is defined as the ability to obtain PT evaluation and treatment without a referral from a physician or other health care provider.

Also enclosed is the Joint Base Lewis-McChord published results of an 18-month Direct Access to PT initiative. This demonstrated a reduction in imaging studies being performed, number of days on profile, cost of care, number of referrals to specialty care, and long-term disability for the patients that accessed PT directly versus the traditional referral-based model. Due to the success of this initiative, Direct Access to PT will be piloted in 13 additional Defense Health Agency Markets over the next 18 months and across the enterprise no later than December 2025.

Thank you for your continued strong support for the health and well-being of our Service members.

Sincerely,

Ashish S. Vazirani
Acting

Enclosures:
As stated

cc: The Honorable Adam Smith
Ranking Member

Report to the Committee on Armed Services of the House of Representatives

Improving Military Readiness through Physical Therapists Serving in Primary Care Roles

December 2023

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $8,400.
This includes $3,700 in expenses and $4,700 in DoD labor.
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PURPOSE

This report is in response to House Report 117–397, pages 191-192, accompanying H.R. 7900, the National Defense Authorization Act for Fiscal Year (FY) 2023, on Improving Military Readiness through Physical Therapists Serving in Primary Care Roles. The report addresses whether a Primary Care Neuromusculoskeletal Expert (NMSE) role for physical therapists will improve patient outcomes, military readiness, preservation of the force, and reduce costs. The report also describes current efforts by the Defense Health Agency (DHA) to increase the utilization of physical therapists in primary care roles through enterprise-wide implementation of the DHA Direct Access to Physical Therapy program.

INTRODUCTION

All credentialed and privileged physical therapists employed by the Department of Defense (DoD) may see patients without a referral. This allows physical therapists to serve in a Primary Care NMSE role for the evaluation and treatment of musculoskeletal (MSK) injuries. One way DoD physical therapists can function as Primary Care NMSEs is by providing Direct Access to Physical Therapy (PT).

Direct Access to PT is defined as the ability to obtain physical therapy evaluation and treatment without a referral from a physician or other healthcare provider. Research on Direct Access to PT has demonstrated that physical therapists providing primary care for MSK injuries is both safe and effective. Further, research shows a reduction in imaging, medications prescribed, number of PT visits, overall reduction in health care utilization, and substantial cost savings with no documented adverse events, adverse State licensure actions or litigation.[3,4,5,6,7,8,9] Recently, the PT service line at Joint Base Lewis-McChord (JBLM), Washington, published results of an 18-month Direct Access to PT research study. Their findings demonstrate a reduction in imaging studies being performed, number of days on profile, cost of care, number of referrals to specialty care, and long-term disability for the patients that accessed PT directly versus the traditional referral-based model.[10] Those results are consistent with Direct Access to PT literature.

Based off the successful research conducted at JBLM, the DHA identified Direct Access to PT as a leading practice in FY 2021. It is an approved Enterprise Solution and is included in the DHA FY 2023-2027 Campaign Plan under "Improve Patient Outcomes." The goal of the DHA Direct Access to PT program is to develop a sustainable and scalable process for implementing Direct Access to PT across the Military Health System (MHS). This consists of a high-level phased implementation approach led by the DHA Neuromusculoskeletal Clinical Community in collaboration with a variety of stakeholders from DHA and the Services.

BACKGROUND

MSK injuries are one of the leading factors negatively affecting military readiness. MSK injuries account for over 2 million health care visits a year, 25 million lost duty days a year, and health care costs exceeding $700 million a year.[1] Physical therapists serve as Primary Care NMSEs and as the experts in nonsurgical management of MSK injuries. As a specialty service,

PT often operates in a referral-based system. This requires Service members with MSK injuries to schedule an appointment with a Primary Care provider first to obtain a referral prior to being able to access PT services. This may extend the time to access PT care by up to 28 days,[2] which can be detrimental to the short- and long-term outcomes of acute MSK injuries and negatively impacts unit readiness.[1,3,4]

DISCUSSION

During the initial stages of the DHA Direct Access to PT program, the program organizers sent a Request for Information (RFI) to explore what other Direct Access to PT programs already existed within the MHS, and to gain insight on any other best practices or challenges to implementation. The RFI was distributed to DHA Direct Reporting Markets and military medical treatment facilities (MTFs) through the DHA Market Execution Office in October 2021 and received 85 total responses. Of the 85 responses, 72 (84.7 percent) reported practicing some level of Direct Access to PT within their Market/MTF. The responses provide evidence that 19 of DHA's 20 Large Markets have at least one facility delivering Direct Access to PT. Among the 17 Small Markets, 11 stated they had at least one facility practicing Direct Access to PT. Among the Stand-Alone MTFs, 29 were reported to practice Direct Access to PT. Of those already offering Direct Access to PT, there was a wide variety of access channels for Service members to obtain PT directly, to include: walk-in appointments, embedded PT within Primary Care, embedded PT within their unit, centralized call-in booking for templated appointments, and front desk/clinic booking for templated appointments.

The most frequent category describing barriers to applying Direct Access to PT practice concerned capacity issues in staffing to support its execution. Approximately 43 percent of respondents reported barriers in this category. The overwhelming specifics described within this category revolved around limited PTs, PT support, administrative, and/or booking staff to handle the increase in patient volume in PT as a result of Direct Access application. The second most frequent concern was for the category of Direct Access booking, where barriers in lack of training, aligned appointment concepts, booking algorithms, self-appointing, and policy requirements were described – representing approximately 10-20 percent of shared barriers depending on respondents' Market alignment. Organizational cultural issues in implementing Direct Access were also prevalent. Respondents shared a lack of awareness among clinical management, providers, and patients that Direct Access options are available. They also reported a lack of change management efforts for the adoption of Direct Access in MTFs currently operating with the traditional practice of managed care and referral-based access. Other emergent barrier categories included limitations in physical facilities (inadequate space and equipment) and the evolving patient electronic health record.

Respondents to the RFI also shared best practices that facilitated implementation of Direct Access to PT within their MTFs. Among those reported, the most frequent themes were within the organizational culture category. These themes included effective marketing strategies to facilitate Direct Access practice and consisted of applying marketing strategies to actively spread its awareness, formalized coordination across PT, Primary Care, booking, and other key stakeholders, and attitudinal prioritization for Direct Access, acute MSK injuries, and readiness. Simplified booking standards were the second most shared best practice cited in the RFI. This

included establishing aligned appointment processes and screening algorithms. Implementing Direct Access education, training standards (e.g., train-the-trainer, mentorship programs), and staffing resources to support increased MSK patient volume expected in PT consequent to Direct Access application were also prevalent responses.

Focusing on optimizing the best practices identified and mitigating the barriers as reported in the RFI, the DHA chartered a Direct Access to PT work group who developed a variety of standardized processes, resources, and tools to expand the delivery of Direct Access to PT across the MHS. These enterprise-wide solutions include a standardized booking protocol, centralized appointing process, standardized appointment type, and a variety of dissemination and implementation materials (e.g., infographics, Frequently Asked Questions, email templates, implementation checklists, and training slide decks) that are currently available electronically to all users with a Common Access Card on the DHA SharePoint site. The DHA Direct Access to PT work group is currently assessing the effectiveness of these processes through a three-phased implementation pilot program. Phase A of the pilot program started in June 2022 in the Puget Sound Market. Phase B consists of six additional Markets divided into two cohorts. Three of the Phase B Direct Reporting Markets (Central North Carolina, Sacramento, and El Paso) implemented DHA Direct Access to PT in January 2023, and an additional three Direct Reporting Markets (San Diego, San Antonio, and Tidewater) implemented in August 2023. Phase C will consist of select Small Markets and Stand-Alone Clinics and is scheduled to conclude in December 2025.

Throughout the phased pilot implementation, the DHA Direct Access to PT work group will be measuring the performance and effectiveness of the program. These measures include the volume and utilization of Direct Access to PT, number of days to PT care for both Direct Access and traditional referral-based model, the percentage of MSK evaluations performed in PT versus Primary Care, the number of Private Sector Care PT initial evaluations performed in the catchment area, and the percent of active duty Service Members on temporary profiles for MSK conditions greater than or equal to 90 days.

CONCLUSION

In conclusion, it is entirely feasible for physical therapists to serve in a Primary Care NMSE role throughout the DoD. Physical therapists employed in the DoD already have the credentialing and privileging to perform this role. There is research to suggest that Direct Access to PT is safe, effective, and will improve patient outcomes, military readiness, preservation of the force, and reduce costs.

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Implementation of Direct Access Physical Therapy Within the Military Medical System

MAJ Eliza Szymanek, PT, DSc; Dr Megan Jones, PT, DPT;
CPT Casey Shutt-Hoblet, PT, DPT; MAJ Robert Halle, PT, DSc

ABSTRACT

Introduction:
Readiness is the Army's number one priority. Physical therapists (PTs) are musculoskeletal (MSK) experts and have been serving as physician extenders in a direct access role in the military since Vietnam. Utilizing a PT in the direct access role has demonstrated a reduction in imaging, medication prescribed, number of physical therapy visits, and overall reduction in healthcare utilization.

Materials and Methods:
The Joint Base Lewis-McChord physical therapy service line initiated a readiness-focused direct access initiative in May 2018. A simple algorithm was developed to help screen and identify appropriate service members for direct access physical therapy sick call. Physical therapy sick call hours were established at seven Joint Base Lewis-McChord Physical Therapy clinics.

Results:
During the initial 18 months of this direct access PT initiative, a total of 3,653 initial physical therapy evaluations were completed. Injury location included 26% (953) knee, 26% (945) ankle, 16% (585) low back, 15% (551) shoulder, 9% (316) hip, and 8% (303) leg.

Conclusion:
In the military, where readiness is the number one priority, it is essential that we optimize the medical resources available to our service members in order to minimize lost duty days and overall long-term disability. This project demonstrates a way to optimize the military healthcare system in order to reduce cost and healthcare utilization and minimize duty days lost to MSK injuries. Utilizing a conservative estimate, $3.6 million was potentially saved in military healthcare utilization costs. The subanalysis performed at one clinic comparing referral-based care with the direct access model demonstrated a reduction in imaging, days on profile, cost savings, reduction in referral to specialty care, and decreased long-term disability. In the military healthcare system, where our primary care team resources are limited, it is important to consider the PT as part of the acute MSK injury management team.

INTRODUCTION

Readiness is the Army's number one priority.[1] The definition of readiness is the nation's ability to have the right forces, in the right place, at the right time, to fight the right war.[2,3] Musculoskeletal (MSK) injuries are one of the leading factors negatively affecting military readiness. Musculoskeletal injuries account for over 2 million healthcare visits a year, 25 million lost duty days a year, and healthcare costs exceeding $700 million a year.[4] Military physical therapists (PTs) serve as physician extenders and as the experts in nonsurgical management of MSK injuries. Military PTs have served in this role since the Vietnam War, and as a result, their practice pattern differs from their civilian counterparts in a number of ways.[4,5] Physical therapists have the education and credentialing to perform appropriate medical screening, prescribe medications based on a limited formulary, order diagnostic imaging, order appropriate laboratory testing, and provide limited duty restrictions (physical profile, Supplementary appendix A) to soldiers and airmen when needed.[5–10] Common imaging ordered during the course of a safe and thorough neuromusculoskeletaI examination may include radiology, magnetic resonance imaging, ultrasound (both MSK and vascular), and nuclear medicine or bone scan. An example of the aforementioned limited medication formulary can be found in Supplementary Appendix B, and examples of laboratory testing ordered by the PT can be found in Supplementary Appendix C.[6–8]

Incorporating PTs in the direct access role has demonstrated a reduction in imaging, medications prescribed, number of physical therapy visits, and overall reduction in healthcare utilization.[11–13] Denninger et al. also reported substantial cost savings, reporting in acute neck and low back pain patients cost savings of $1,543 per patient who were initially treated by PT versus the traditional medical model.[14] The cost

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savings associated with utilizing a PT in the direct access model have been echoed in several systematic reviews.[12,13]

Although armed with the education and capability, not all military medical systems integrate the PT into the acute MSK injury management team. As a specialty service, physical therapy often operates in a referral-based system. A referral-based system is the one in which a patient is seen first by their primary care manager (PCM) and then referred to specialty care providers as deemed appropriate. In a referral-based system, a referral to a specialty care provider can take up to 28 days until the initial evaluation is performed.[15] Waiting 28 days to see a PT can be detrimental to the short- and long-term outcomes of MSK injuries,[4,13,14] especially in our active duty population where their absence affects the readiness of their unit.

This article describes a physical therapy direct access initiative, which was implemented throughout seven physical therapy clinics on Joint Base Lewis-McChord (JBLM), a large military base serving over 35,000 active duty service members. The aim of this initiative was to enhance access to physical therapy for the service members assigned to JBLM in order to reduce overall healthcare utilization for acute MSK injuries.

MATERIALS AND METHODS

In order to improve access to expert MSK care for Soldiers and Airmen, JBLM physical therapy service line initiated a readiness-focused direct access initiative in May 2018. All clinics included in this initiative provide care to active duty soldiers and airmen, aged 18-50 years. To streamline the roll-out of direct access across seven PT clinics, a physical therapy working group was initiated in February 2018. This group developed a simple algorithm (Fig. 1), modified from the Air Force Direct Access Physical Therapy Care Memorandum for Record published in 2015.[16,17] The algorithm was developed with the purpose of helping sick call screening personnel and primary care providers identify appropriate service members for direct access physical therapy sick call. The working group developed physical therapy sick call hours which were in line with each clinic's primary care sick call hours to more efficiently perform sick call screening and improve access to physical therapy care. Each clinic officer in charge (OIC) then educated the primary care teams at his/her respective clinic on the direct access physical therapy plan of action and availability. In May 2018, four of the seven JBLM PT clinics implemented direct access, followed by the two Brigade Combat Teams by September 2018 and finally the main Madigan Army Medical Center clinic in February 2019. All PT clinics in this initiative are physically located within the footprint of either a Soldier Centered Medical Home or an Army Medical Center. Physical therapists participating in this initiative were active duty service members or General Schedule employees, ranging from 1 to 25 years of clinical experience. For the initial 18 months of implementation, records maintained by each PT clinic OIC tracked monthly initial direct access encounters, location of initial direct access encounters, follow-up, and treatment encounters performed during sick call hours.

Descriptive statistics were collected and analyzed using Microsoft Excel 2016 and SPSS version 22. The total number of encounters and location of injuries were summated. A retrospective analysis of ankle injuries was completed from one Soldier Centered Medical Home PT Clinic. This subanalysis included a convenience sample of 86 ankle injuries. For the subanalysis, outcome measures compared between the two groups included seven variables, three of which used parametric data and four variables used yes/no (binomial responses). The parametric variables are as follows: 1, days between injury and care provided (time to PT referral); 2, number of days spent on physical profile (days on profile); and 3, number of medical visits utilized throughout this course of care (number of PT visits). The binomial "yes/no" responses dealt with the variables as follows: 4, referral to specialty care (specialty care referral); 5, return to duty (RTD); 6, permanent profile assigned (permanent profile); and 7, imaging ordered. Outcome measure number six, permanent profile assigned, was operationally defined in this case as the service member being placed on a permanent profile or undergoing a medical board.

RESULTS

During the initial 18 months of this direct access PT initiative, a total of 3,653 initial physical therapy evaluations were completed. Injury location included 26% (953) knee, 26% (945) ankle, 16% (585) low back, 15% (551) shoulder, 9% (316) hip, and 8% (303) leg (Supplementary Appendix D). Including follow-ups and PT treatments, a total of 5,066 encounters were completed during this time. A retrospective subanalysis comparing referral-based and physical therapy direct access ankle injuries in the initial 18 months of implementation at one Soldier Centered Medical Home was performed.

A total of 86 patients with ankle injuries (age range 18-47 years) were included in this subanalysis, 47 ankle injuries were included in the direct access group and 39 in the referral-based group. Ankle diagnoses included were ankle sprains, stress injuries, plantar fasciitis, Achilles tendinopathy, and calf strains. In regard to days to obtain a PT initial evaluation, in the referral-based group, it took an average of 57 versus 6 days in the direct access PT group. The average length of profile in the referral-based group was 75 versus 27 days in the direct access PT group. A cost-saving estimation was performed utilizing regional-based healthcare costs.[18–22] A cost per episode of care estimate was performed using an estimate of 1.8 relative value units per visit and a 2019 fee schedule indicating $36.03 per relative value unit. The direct access PT group utilized, on average, three visits versus the referral-based PT group utilized five visits, leading to estimated cost savings of $129 per ankle pain patient. Utilization of imaging in the referral-based group was 82%, compared to 43% in the direct access PT group. Specialty care referrals to orthopedics, physical medicine, and podiatry were 36%

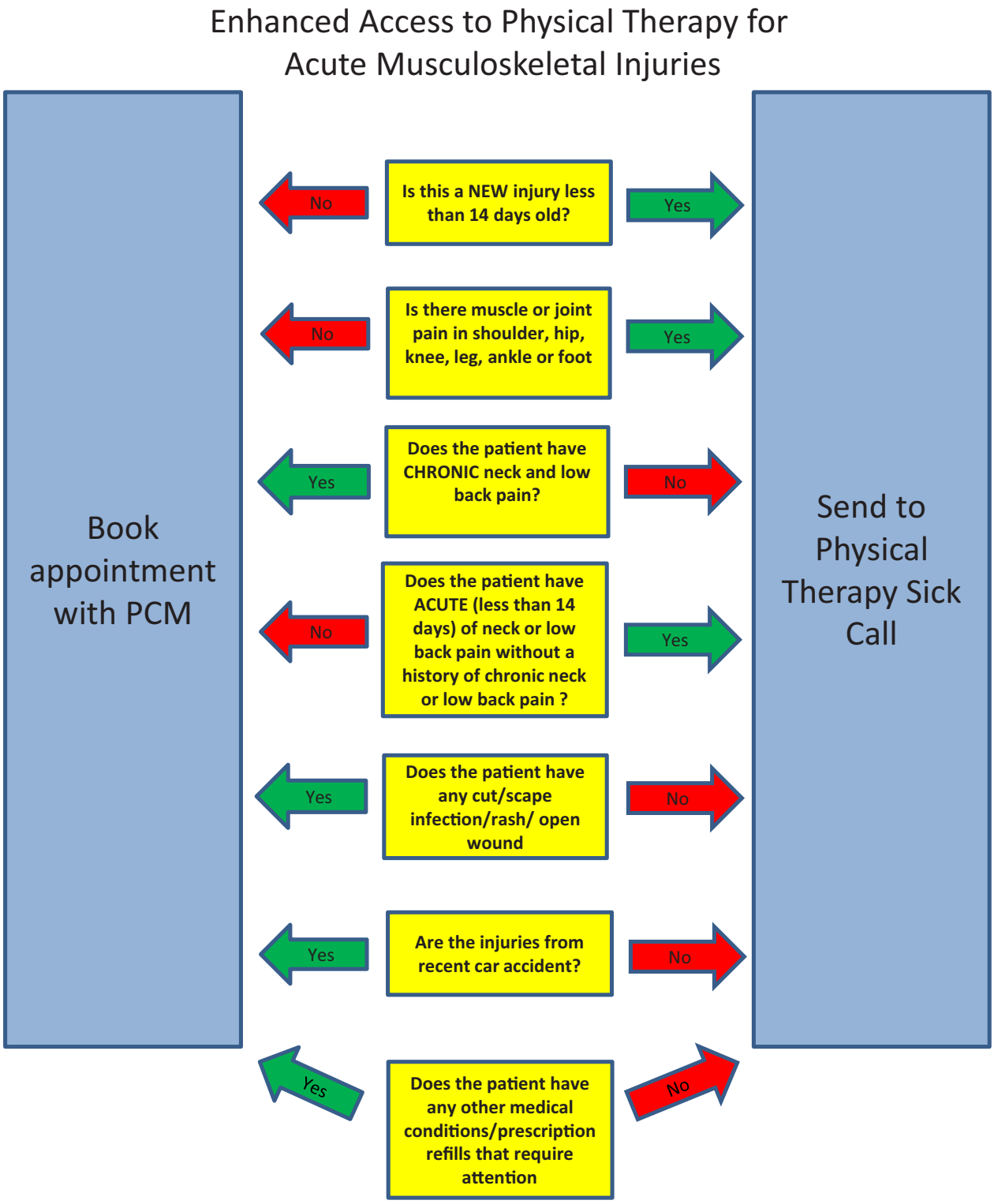

FIGURE 1. Enhanced access to physical therapy for acute MSK injuries. Algorithm developed to screen and identify appropriate patients for direct access physical therapy.

in the referral-based group versus 9% in the direct access PT group. Finally, long-term limitations including permanent profiles were 36% in the referral-based group and 9% in the direct access PT group.

TABLE I. Descriptive Statistics and Statistical Analysis for Parametric Variables Analyzed[a]

Independent variable	Provider type	*n*	Mean	SE and mean	Statistical probability (*P*)
1. Time to PT referral					<.001
	PCM	39	56.69 ± 47.07	7.53	
	PT	47	5.57 ± 7.89	1.15	
2. Days on profile					<.001
	PCM	39	74.51 ± 69.31	11.10	
	PT	47	27.32 ± 26.08	3.80	
3. Number of PT visits					.021
	PCM	39	4.77 ± 3.95	0.63	
	PT	47	3.11 ± 2.06	0.30	

Descriptive statistics and statistical analysis for the parametric variables analyzed.

[a]Values are mean ± SD unless otherwise indicated. Time to PT referral = number of days from point of injury to time patient had an initial evaluation with physical therapy. Days on profile = number of days patient spent on profile during the course of care for the treated injury. Number of PT visits = number of visits utilized during the course of care for the treated injury. Statistical probability (*P*) = results of independent *T*-test comparing means between primary care manager (PCM) and physical therapist (PT) provider types.

Seven variables were examined using SPSS version 22, three of which used parametric data and four variables used yes/no (binomial responses). The parametric variables are as follows: 1, days between injury and care provided (time to PT referral); 2, number of days spent on physical profile (days on profile); and 3, number of medical visits utilized throughout this course of care (number of PT visits). The binomial "yes/no" responses dealt with the variables as follows: 4, referral to specialty care (specialty care referral); 5, RTD; 6, permanent profile assigned (permanent profile); and 7, imaging ordered.

For the three parametric variables (time to PT referral, days on profile, and number of PT visits), an independent *t*-test comparison was made between these two groups, utilizing the dependent variable of days for variables time to PT referral and days on profile, and number of visits for number of PT visits. Levene's test was used to assess the homogeneity of variance for each of these variables, and the null hypothesis was rejected in each case. Therefore, a corrected independent *t*-test analysis was used. For each of the three comparisons, a significant difference was observed between the groups. Descriptive statistics and independent *T*-test analysis are provided in Table I.

The binomial "yes/no" data were examined utilizing a chi-square contingency table that assessed observed compared to expected frequencies. The cells were framed by outcome (yes/no responses) for the two columns and the type of provider (primary care provider/PT) across the two rows. For three of the four variables, a significant Pearson's chi-square value was observed (variables 4, 6, and 7), with the only nonsignificant contingency table examining RTD status (variable 5). For specific Pearson's chi-square values including standardized residuals, see Table II.

DISCUSSION

Over an 18-month period, 3,653 initial physical therapy evaluations were seen in a direct access setting. Based on Denninger et al.'s findings that reported in acute neck and low back pain patients cost savings of $1,543 per patient who were initially treated by PT versus the traditional medical model and given that 3,653 initial PT evaluations were completed during this initiative, $3.6 million was potentially saved in military healthcare costs.[14] Including follow-up appointments and physical therapy treatments, a total of 5,066 encounters were seen during direct access physical therapy hours. By utilizing physical therapy, a large number of encounters were potentially made available to PCMs for non-MSK pathologies. Before this initiative, all 3,653 patients would have initially been evaluated by a primary care provider before seeing PT.

All but one of the participating PT clinics already existed within the footprint of a Soldier Centered Medical Home. The only change that occurred within the PT clinics was time allotted for direct access care, which on average was 90-120 minutes per day. By providing allocated time for physical therapy direct access, it allowed for streamlined care for acute MSK injuries presenting to the SCMH daily sick call to readily be seen the same day by a PT.

A strength of this initiative is that it captured the types of MSK injuries that present to direct access physical therapy. Ankle injuries are a common MSK injury and represented 24% of all injuries seen within the direct access setting during this period of time. In the subanalysis performed at one clinic comparing referral-based care with the direct access model, the authors observed a reduction in imaging, days on profile, cost of care, referral to specialty care, and patient long-term disability. These results are consistent with current direct access literature.[13,14] Direct access physical therapy research highlights reduced healthcare utilization and costs primarily with low back and neck pain[13,14] this subanalysis sheds light on the potential optimization in care of additional MSK injuries. In the military, where readiness is the number one priority, it is essential that we optimize the medical resources

TABLE II. Statistical Analysis for Binomial "Yes/No" Variables Analyzed

Independent variable	Provider type	Outcome decision (yes/no)		Pearson (probability/*P*)
4. Specialty care referral		Yes (std. resid.)	No (std. resid.)	
	PCM	14 (1.6)	25 (−0.9)	
	PT	6 (−1.5)	41 (0.8)	
				$\chi^2 = 6.39$ (.011)
5. RTD		Yes (std. resid.)	No (std. resid.)	
	PCM	35 (−0.3)	4 (1.2)	
	PT	46(0.3)	1 (−1.0)	
				$\chi^2 = 2.57$ (.109)
6. Permanent profile		Yes (std. resid.)	No (std. resid.)	
	PCM	14 (2.0)	25 (−1.1)	
	PT	4 (−1.9)	43 (1.0)	
				$\chi^2 = 9.66$ (.002)
7. Imaging ordered		Yes (std. resid.)	No (std. resid.)	
	PCM	32 (1.7)	7 (−2.1)	
	PT	20 (−1.6)	27 (2.0)	
				$\chi^2 = 13.9$ (<.001)

Statistical analysis for binomial "yes/no" variables analyzed. std. resid. = standardized residual. Specialty care referral = number of patients eventually referred to specialty care during the course of treatment for the treated injury. RTD = number of patients eventually returned to full duty during the course of treatment for the treated injury. Permanent profile = number of patients eventually given permanent profile or were otherwise limited from performing full military duty long term. Imaging ordered = number of patients who received imaging during the course of treatment for the treated injury.

available to our soldiers and airmen in order to minimize lost duty days and overall long-term disability.

The subanalysis data indicate that for each of the three parametric variables assessed, there was a significant difference in the dependent variables between PCM referral and PTs. Specifically, patients were able to obtain care with less delay than when being seen initially by a PCM (time to PT care). For the variable of the number of days spent on profile (days on profile), patients spent significantly fewer days on profile when treated by a PT compared to a PCM. For the variable reflecting the number of medical visits used (number of PT visits), there was a significant difference observed, with fewer visits utilized when seeing a PT as compared to a PCM. For specific *t*-test values and levels of significance, see Table I.

For the nonparametric "yes/no" comparisons, a similar pattern was reported with less utilization when a patient was seen by a PT compared to a PCM for three of the four studied variables. Specifically, patients had significantly fewer referrals for specialty care when seen initially by a PT compared to a PCM (specialty care referral). Patients seen by PT first were also assigned significantly fewer permanent profiles than those patients initially seen in a PCM setting (days on profile). Third to also, significantly fewer imaging studies were requested for those patients initially seen by a PT as compared to those seen by a PCM (imaging). The only chi-square contingency table that did not show a significant difference dealt with the eventual RTD. For specific Pearson's chi-square values and the impact of standardized residuals, see Table II.

CONCLUSION

This is an example of the implementation of direct access PT across a large military installation. This readiness initiative demonstrates a method to screen and manage acute MSK injuries in a physical therapy direct access setting. It demonstrates a way to optimize the military healthcare system in order to potentially reduce cost and healthcare utilization and minimize duty days lost to MSK injuries. In the military healthcare system, where our primary care team resources are limited, it is important to consider the PT as part of the acute MSK injury management team. In future studies, a prospective analysis of cost savings, healthcare utilization, and impact on limited duty days would be beneficial in order to best capture the overall impact of early access to physical therapy for acute MSK injuries within the military healthcare system.

Study Limitations

The primary goal of this initiative was to enhance physical therapy access to care for the service members assigned to JBLM with acute MSK injuries. To our knowledge, this is the first physical therapy direct access initiative implemented across a large military installation. This initiative highlights a way to implement direct access physical therapy; however, there are several limitations. Although the total number of encounters and location of injuries were captured, a robust prospective analysis in regard to the impact of direct access physical therapy to cost savings, healthcare utilization, and impact on limited duty days was not performed.

Although our retrospective subanalysis of ankle injuries provides some additional insight, it also has limitations. This subgroup was a convenience sample of ankle injuries either referred to physical therapy from a PCM or seen in a direct access setting. There could have been confounding factors not analyzed within this subanalysis. The data from our subanalysis did not allow us to stratify the effects of age, gender, or service affiliation. In future studies, additional information may be concluded in considering these additional demographics.

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SUPPLEMENTARY MATERIAL

Supplementary material is available at *Military Medicine* online.

FUNDING

The authors certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

CONFLICT OF INTEREST STATEMENT

None of the authors have any relationship that could reasonably be viewed as creating a conflict of interest, or the appearance of a conflict of interest, that might bias the content of the manuscript.

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