Implementing Direct Access at Hospital-Based Outpatient Clinics

Combined Sections Meeting 2015

Speaker(s): Aaron Keil, PT, DPT, OCS
Session Type: Educational Sessions
Session Level: Intermediate

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HPA The Catalyst is the Section on Health Policy & Administration of the American Physical Therapy Association
Pursuit and Implementation of Hospital-Based Direct Access: Highlighting Direct Referral for Radiology and Reimbursement Data

Aaron Keil PT, DPT, OCS

Disclosure

No relevant financial relationship
Session Learning Objectives

1. Understand which key stakeholders may be involved in this process and how to effectively dialogue with each.

2. Identify and prepare for potential barriers that may arise in the process of incorporating direct access.

Session Learning Objectives

3. Cite key research that supports the use of physical therapists in Direct Access roles including direct referral for imaging.

4. Create a compelling Executive Summary for incorporating direct access at your institution.

5. Effectively develop clinical competencies for physical therapists functioning in direct access roles.
Session Outline:

• Intro / Quiz
• Support for DA
• Support for Imaging
• Clinical Decision Making and Imaging
• Barriers to Implementation (perceived and real)
• Developing a strategic plan
• What success looks like
• Q&A

Direct Access: Legislative Success

• 50 States and the District of Columbia allow patients to be examined without a referral

• 44 Include provisions for treatment
Why the lack of Implementation?

• APTA survey 2009 (~1,700 therapists)

• Top reasons for lack of implementation:
  
  #1 ‘A requirement by my facility that all patients have a referral’
  
  #2 ‘Concerns over reimbursement’

Direct Access at Georgetown

• Practice Act updated in 2007

• Late 2009 asked ‘Why not’?

Common responses:
  • “Hospital policy won’t allow it.”
  • “CMS doesn’t allow it”
  • “Insurance companies don’t pay for it”
Fact Finding:

• Practice Act Language?

• Hospital policy language?

• Reimbursement?

• Has it been done before at a similar institution?

Boissonnault et al 2010 (PTJ)

• “Pursuit and Implementation of Hospital-Based Outpatient Direct Access to Physical Therapy Services: An Administrative Case Report”
The Plan:

• Local Staff & Leadership Support

• Executive Summary:
  • Highlighting Consumer Choice

• Referral for Radiology??

Radiology:

• PT Board Query:
  • Goal: Compliance with the referral mandate
  • “Does section 6710.13 prohibit physical therapists from referring patients directly for diagnostic imaging studies?”
PT Board Opinion:

• “Based on the foregoing language, the Board believes that a physical therapist may refer a patient for diagnostic imaging to a health care provider who is qualified to perform such testing, provided the other conditions as set forth in the regulation are met.”

Strategic Planning:

• Preparing for questions:
  – ‘Will insurance pay for it?’
  – ‘Will it be over-utilized?’
  – ‘Is it safe?’
  – ‘What does ortho think?’
  – ‘Are you really adequately trained?’
Clinical Competencies:

- Coursework:
  - Medical Screening (Bill Boissonnault)
  - Radiology (Michael Ross)
- Shadow time in Radiology
- Follow ACR guidelines
- Clinical Vignettes Discussion
- Selected articles
- Patient tracking, on-going discussion

The Chain of Command:

- Director of Rehab
- Medical Director
- Chief of Orthopedics
- Vice President of Medical Affairs
- Chief Operations Officer
- Bylaw Review Committee
Updating Hospital Policy Language: Policy #109 Section 9

• “Per District of Columbia regulations (Direct Access Physical Therapy), out patients may be seen by a physical therapist without the prescription of or referral by…”

• “Only Physical Therapists who have received appropriate training…”

• ‘Per the District of Columbia…Physical Therapists can directly refer outpatients to a radiologist for imaging studies which may include but are not limited to x-rays, magnetic resonance imaging, bone scans and Doppler ultrasound studies’.

Case Study: First DA patient at Georgetown

• Clinical Presentation
  – 50 y/o male
  – DM, s/p mid-foot fusion ~2 months
  – Prior PT. ‘not great’

• CC knee pain...
  – NWB (Rollator walker)
  – Insidious onset
  – Grossly swollen
  – Warm to touch
  – Severe loss of ROM
GUH • MRN : 6573053 • Account : 324795350
KNEE 4V OR MORE, LEFT
1/24/2012
Obsv: Jan 24 2012 8:05AM
Result: Jan 24 2012 10:54AM
by
FINAL
PROCEDURE: DIA 0137 - KNEE 4V OR MORE, LEFT

CLINICAL HISTORY:
Arthritis.

FINDINGS:
Standing AP, oblique, and lateral views of the left knee. No comparison
Moderate suprapatellar left knee effusion. Calcifications within the
hyaline cartilage may represent chondrocalcinosis. No significant joint
space narrowing or osteophytosis.
As we discussed there is an unusual vertical type fracture through the
lateral femoral condyle and distal femoral metaphysis consistent with a
subacute fracture. Articular surface appears congruent. Callus formation
seen. No other fractures seen.

IMPRESSION:
Distal femoral fracture.

ICD-9: ( 715.26 )

Dictated By: MATTHEW MINN M.D.
This Imaging Study Was Reviewed and Its Interpretation Verified by:
EDWARD PIEN M.D.on Jan 24 2012 10:51AM

Distribution:
Ordering Dr: KEIL, AARON PAUL
Ordering Attending: KEIL, AARON
Attending Dr: KEIL, AARON

“As we discussed there is an unusual vertical type fracture through the lateral femoral condyle...”
Outcomes:

<table>
<thead>
<tr>
<th></th>
<th>1st year (2012)</th>
<th>2nd year (2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total DA pts seen:</td>
<td>85</td>
<td>109</td>
</tr>
<tr>
<td>Plain films ordered:</td>
<td>10 (12%)</td>
<td>10 (9%)</td>
</tr>
<tr>
<td>Advanced imaging:</td>
<td>8 (10%)</td>
<td>6 (5%)</td>
</tr>
<tr>
<td>Reimbursement:</td>
<td>100%</td>
<td>&gt;95%*</td>
</tr>
</tbody>
</table>

Summary:

• Direct Access CAN be implemented...even at a Hospital

• Insurance DOES pay

• Strongly consider including radiology privileges
Thank you

References


26. Dept. of Payment, Policy and Advocacy, American Physical Therapy Association, 2010

