Transfer of Learning: Engaging Patients through New Methods of PT-Directed Patient Education

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Thank You
HPA Grace Knott, PT, GCS
Announcements
Housekeeping

HPA Mission
transform the culture of physical therapy through initiatives that enhance professionalism, leadership, management, and advocacy to foster excellence in autonomous practice for the benefit of members and society.
Objectives:

1. Apply new strategies to capitalize on teaching-learning processes to streamline care and communication.
2. Engage in effective transfer of learning techniques in multi-disciplinary clinical scenarios.
3. Recognize emerging models of transferring information that assists members of the care coordination team to improve quality while containing healthcare costs.
4. Discuss models of care that are truly revolutionizing the patient care management arena.
Future of Healthcare: Integrating Interprofessional Competencies

1. **Interprofessional teamwork:** The levels of cooperation, coordination and collaboration characterizing the relationships between professions in delivering patient-centered care

2. **Interprofessional team-based care:** Care delivered by intentionally created, usually relatively small work groups, which are recognized as having a collective identity and shared responsibility for a patient or group of patients, e.g., rapid response team, palliative care team, primary care team, operating room team
Integrating Interprofessional Competencies into PT Practice

Different Roles

Professional competencies in health care:
Integrated enactment of knowledge, skills, and values/attitudes that define the domains of work of a particular health profession applied in specific care contexts
Integrating Interprofessional Competencies into PT Practice

Also

Interprofessional competencies in healthcare:
Integrated enactment of knowledge, skills, and values/attitudes that define working together across the professions, with other health care workers, and with patients, along with families and communities, as appropriate to improve health outcomes in specific care contexts.
Integrating Interprofessional Competencies into PT Practice

**Interprofessional teaching:**
“When practitioners from two or more professions learn with each other to enable effective collaboration and improve health outcomes”

**Interprofessional collaborative teaching:**
“When multiple health workers from different professional backgrounds work together with patients, families, and communities to deliver the highest quality of care”

(WHO, 2010)
Freedom to Think  ➔  Freedom to Teach
Professional Advocacy

‘My physio keeps me moving.’

You don't need to see a doctor to see a physio.

Find a Physio →
Physical Therapy Advocacy Criteria

Please use the following criteria to conduct Physical Therapy advocacy activities:

1. Qualify your professional introduction as a “Physical Therapist”, except when advocating with a friend who already knows who/what you are.
2. Clarify your professional authority over biomechanical (macro-biological) movement sciences, and distinguish the benefits of not being a specialist of macro-biological pathology.
3. Clarify that Physical Therapists first start by “Examining” patients to determine a “Differential Diagnosis”. The first differential process is a medical screening and Review of Systems to determine if the patient has co-morbid medical conditions that necessitate medical referral. Second, the physical therapist determines a non patho-anatomic “Movement Impairment Diagnosis” that directs the planned physical therapy interventions. Physical Therapists’ role as “Diagnosticsian” must be reinforced to consumers and referral sources. There is no better way to project Physical Therapy’s unique body of knowledge than through “Diagnosis”. This shapes the behavioral understanding of consumers and referral sources to not only associate PT with technical interventions, but with clinical decision making.
4. Clarify the benefits of PT practice philosophy that utilizes movement science to identify and treat etiological variables, e.g. “Physical Therapists treat the cause, not the symptoms”
5. Clarify that in 49 states you can directly consult with a physical therapist prior to physician intervention. The fact that insurance may or may not reimburse the patient for this visit doesn’t affect the fact that the patient has a movement related disorder that only a physical therapist can diagnose and offer intervention for.
Forging Links to Moral Action: Reaching Beyond Boundaries

Jensen reports, “A Limitation of PT codes of ethics is the implicit assumption that physical therapists have the required professional autonomy to implement the ethical obligations derived from the codes.”

.: Physical therapists are required to balance competing values and interests and make ethical decisions about appropriate treatments in situations where they do not have full responsibility or authority to decide a course of action.

.: DuVall says this hinders Professional Actualization.
Core Elements of Clinical Practice

- Examination
- Evaluation
- Diagnosis
- Prognosis
- Interventions/
- Outcomes
Differential Diagnosis of Movement Impairments
Reference

Diagnosis and Treatment of Movement Impairment Syndromes
Shirley A. Sahrmann
Sahrmann asks

“Are Physical Therapists Fulfilling their Responsibilities as Diagnosticians?”

JOSPT Editorial Sept 2005

Perhaps more collective harm is done by PTs failing to establish a Movement Impairment Diagnosis, than failure to Medically Screen
The Treatment Diagnosis
*Drives the POC*

Per Highmark Medicare Guidelines November 2010:

1. Dx should be specific
2. Dx should be relevant to problem to be treated as possible
3. Both a medical diagnosis (from physician/NPP) and *impairment based treatment diagnosis* are relevant
Is it ethical for physical therapists to “evaluate” physical therapy patients?

In 1974, Johnson hypothesized that the role of the physical therapist as it was currently known, would disappear to be replaced by an expanded role which would include evaluation, assessment, and initiation of treatment programs.

Historical Perspectives

- Prior to this evolutionary debate, physical therapists were primarily responsible for the provision of expert treatment, not evaluation.

- Evaluation, diagnostic processes and associated clinical judgements considered functions of referring physician.

- PT primarily required to possess technical competence with treatments ordered by a referring physician.
In 1975 two Army medical doctors researched the feasibility of using physical therapists as primary “screeners” for patients presenting with the complaint of low back pain. The investigation concluded that patients primarily cared for by physical therapists received more expeditious care, and was acceptable and satisfactory to the patient.

James JJ, Stuart RB: Expanded Role for the Physical Therapist: Screening Musculoskeletal Disorders. Phys Ther 55. 121-132, 1975
Likewise, circa 1970’s, similar professional evolution of physiotherapists was occurring in Australia and New Zealand.

The driving forces behind the Australian and New Zealand physiotherapists were their motivation to treat not only patients’ symptoms, but to assume the responsibility for identifying the pathokinesiological etiology of their patients’ movement impairments and functional limitations.

Clinical Decision Making:
Orthopaedic Physical Therapy

- Orthopaedic physical therapy embraces the broadest field within our profession.
- May be the *most* basic science of all our practice.
- We are seeking to enhance the movement of the musculoskeletal system as clinical physical therapists.
1983 APTA identifies “Movement” as the focus of Practice

Nagi Model of Classification

Pathology <> Impairment <> Functional Limitation <> Disability

Saad Z. Nagi Sociologist 1965

- Organized a construct to identify, label and classify the consequences of disease
- Adopted in the Disability in America Report to The Institute of Medicine in 1991

“Disability is not viewed as inherent in the person, but rather as a function of the interaction of the individual with the environment”

**Acquired Disease:** etiology Micro Organisms and Impairments

**Acquired Impairments:** etiology Disease or Repetitive Movements and Sustained Postures
ICF Model: International Classification of Functioning, Disability & Health

“Enablement Model“

ICF is the World Health Organization’s (WHO) framework for measuring health and disability....

Adopted in 2001
Nagi Model vrs ICF Model

- Each model mentioned can be used to generate hypotheses about the interrelationships of different components included in the model.

- The key to successful rehabilitation management is understanding the relationship between target problems and the components (impairments, functional limitations, and psychosocial and environmental factors) that affect them and addressing those (ie, the target mediators) with the most potential for improvement.
Diagnosis Based Physical Therapy Practice

- Do physical therapists diagnose?
- This was the question put before the APTA’s House of Delegates in 1984. (APTA, House of Delegates 06-84-1978, 1984.)

- After surprisingly little debate, the APTA’s House of Delegates established that “physical therapists may establish a diagnosis within the scope of their knowledge, experience and expertise”.
Diagnosis Based Physical Therapy Practice

- Rose was first to contend the need to define the role and function of diagnosis in physical therapy practice stemmed from the importance of distinguishing physical therapy diagnoses from those made by other health care practitioners.

- Rose proposed that this diagnostic distinction would reflect and expose physical therapists movement-science based unique body of knowledge.

Sahrmann also saw that diagnosis placed an emphases on the identification of key-specific movement impairments by labeling the cluster of signs and symptoms that would best establish effective interventions and reliable prognoses.

(Sahrmann S. A challenge to diagnosis in physical therapy: tradition. APTA. CSM Opening lecture;1997.)
Sahrmann defined PHYSICAL THERAPY DIAGNOSIS: the term that names the primary dysfunction toward which the physical therapist directs treatment; whereby, the purpose of diagnosis was to guide treatment and is therefore a necessary prerequisite for intervention.

(Sahrmann S. A challenge to diagnosis in physical therapy: tradition. APTA. CSM Opening lecture;1997.)
Diagnosis Based Physical Therapy Practice

- In 1995, the APTA’s House of Delegates mandated that physical therapists are required to provide diagnoses to all patients under their care.

(APTA House of Delegates. 06-97-06-19, 1995.)
Diagnostic Delimma

2. Norton BJ. 2004: Focus on Diagnosis
3. Sahrmann S. 2005: Are Physical Therapists Fulfilling Their Responsibilities as Diagnosticians?
4. Davenport TE. 2006: Diagnosing Pathology to Decide the Appropriateness of Physical Therapy: What’s Our Role?
5. Boissonault B. 2006: Drawling the Line on Dx Pathology
Critical Thinking in Modern Practice: Policy on Differential Diagnosis

1. **DSM**: Direction Susceptible Movement defines the Movement Impairment, distinguishes the uniqueness of PT’s Body of Knowledge.

2. Patho-anatomical labels merely describe symptoms, these are ICD-9 Codes.

3. Etiological variables are identified to focus the POC onto the problems causative factors.
Critical Thinking in Modern Practice: Medical Screening

- Review of Systems Tool
- DVT Algorithm Tool
- PE Algorithm Tool
Cognitively Organizing Data: Policy on Differential Diagnosis and Assessment

Policy on Differential Diagnosis, Medical Screening and Assessment

Patients/Clients coming to our facility are either direct access (self referral) or referral from an outside professional source. Direct access patients are initially seeking a “diagnosis” in search of what is the source of their presenting symptoms. Referral patients have already been provided a patho-anatomical diagnosis and are seeking intervention to treat their symptoms. With either patient it is our policy to form diagnoses for Physical Therapy that are movement impairment based. It is the intent of this policy to clarify the Physical Therapist’s role in also identifying variables of etiology in relation to the movement impairment based diagnosis. Affectively, the Physical Therapist must emphasize the patho-anatomical diagnosis as only a primary symptom that is plausibly caused by a summation of movement impairments. Forming an assessment in this manner will properly direct the skilled intervention to appropriately attend to the cause of the presenting patho-anatomical symptoms.

Effective medical screening by the physical therapist is performed on all patients to ascertain that the patients’ symptoms are not of pathological origin that fall outside of the physical therapists’ scope of practice. Medical screening is conducted at the “systems level” and by identifying “red flag” symptoms and signs which necessitate medical referral. This medical screening process is a function of both subjective and objective examinations that culminate with evaluation of the collected data and clinical reasoning that results in the final decision to treat, refer or treat and refer. The evaluation and clinical reasoning involved with medical screening data do not culminate in the establishment of labeling (diagnosing) of pathology.

Initial Consultation Assessment Documentation Organization:

1. Medical Screening Hypothesis stated at the Systems level and supported by examined symptoms and signs
2. Movement Impairment Diagnosis (Hypo or Hypermobility, Offensive Motion, Direction Susceptible Movement)
3. Patho-anatomical Symptoms (ICD 9 Diagnoses)
4. Functional Limitations
5. Plausible Etiology (Sustained Postures, Repetitive Motions, Momentum Trauma)
6. Prognosis for Physical Therapy: Physical therapy Goals and anticipated time/length of care, frequency, and duration

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Policy on Differential Diagnosis, Medical Screening and Assessment

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Cervical      Shoulder      Elbow      Hand      Thoracic
Lumbar       Hip           Knee       Ankle      Foot

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Teaching Responsibility: Policy on Prognosis

“New Consults” routinely need “Prognostication Processes” in place to ascertain that our patients’ needs are met both affectively and physiologically. This policy is often not emphasized enough in clinical practice. Also, delivering “Prognosis” at the end of an initial Consult is where PTs can effectively apply our Teaching-Learning actualizing “Advocacy Criteria”.
Critical Thinking in Modern Practice: Policy on Prognosis

When you introspect back upon your Initial Consult to the question, “Did I verbally state the patient’s “Prognosis” to the patient?” You may answer, “Yes, I always discuss the POC with the patient and make sure they are on board”; but, are you presenting not only an explanation of the POC, but **ALL** of the following important prognostication elements:
1. **Anticipated outcome level**, i.e. “given your compliance, you should be able to ______ function”. Here we need to integrate our medical screening exam’s data to clinically reason on all identified medical co-morbidity’s (e.g. age, diabetes, Beighton Score etc) influences on anticipated outcome and all importantly, (independent of the referring physician) discern if this patient has the potential to achieve a measurable change in function that is worthwhile to their quality of life and worthy of 3rd party payment.
2. **The ideal frequency and duration:** To assure a measurable change in function, the patient’s ideal frequency and duration is ______, (despite what the referring physician might have suggested or the insurance company allows). We, as Physical Therapists, are obligated to advocate for our patients what the sciences that govern our clinical practice.
Critical Thinking in Modern Practice
Policy on Prognosis

This is an opportunity to autonomously Teach Physical Therapy’s unique body of knowledge, as a doctoring profession, to effectively advocate for:

1. The patient (as a whole)
2. The patient’s specific body parts that are found in your exam to be impaired.
3. The PT profession, and
4. Your place of employment, i.e. your practice.
Critical Thinking: Cognitive Processes
Developing The Thinker

Assessment Documentation Organization:

1. Medical Screening Hypothesis stated at the Systems level and supported by examined symptoms and signs
2. Movement Impairment Diagnosis (Hypo or Hypermobility, Offensive Motion, Direction Susceptible Movement); prevent Mvt to Path
3. Pathoanatomic Systems (IDC – 9 Diagnoses)
4. Functional Limitations
5. Plausible Etiology (Sustained Postures, Repetitive Motions, Momentum Trauma)
6. Prognosis
Introspective Evaluation of Initial Consultation

1) Rate your subjective medical screening examination processes:

2) Rate your subjective movement based examination processes:

3) Rate your objective medical screening examination processes:

4) Rate your objective movement based examination processes:

5) How fluid was your gathering of the “Biomechanical Vital Signs”?

6) Rate your evaluation of medical screening data

7) Rate your evaluation of movement based data:

8) Rate your ability to formulate a diagnosis of the movement impairment syndrome(s):

9) Did you verbally state the “Diagnosis” to the patient?

10) Rate your explanation to the patient as to their patho-anatomic (ICD-9) symptoms?

11) Rate your discussion of the patient’s Impairment to Functional Limitation connection via diagnosing and treating “The Cause” (etiological variables) to the patient?

12) Rate your ability to formulate the movement based prognosis(s):

13) Did you verbally state the patient’s “Prognosis” to the patient?

14) What particularly do you want to work on for your next new patient consultation?
Meta-Cognitive Processes

- Repeating Narrative Introspection Tools
- Developing highest levels of Critical Thinking

- Developing the *Modern Physical Therapist*
Decision Making Algorithm

Clinical Decision Making Model for the Modern Manual Therapist

- Medical Screening

First Order Clinical Decision Making
- Rule Out Lumbar Spine
- Rule Out Neurodynamics
- Rule In Peripheral Joint

Second Order Clinical Decision Making
- Normal Mobility
- Hypomobility
- Hypermobility

Third Order Clinical Decision Making
- Prioritize Regional Interdependence

Treatment
Teaching the Clinical Scientist: Assessment Note Writing

Progress Note Assessment

Patient: _____________________________ Date: ________________

A: Patient presents with (Impairments):
  - Pain
  - Swelling
  - Stiffness
  - Decreased ROM
  - Muscular/Capsular Length
  - Weakness
  - Patterns of Recruitment
  - Other

  impairment(s) of the __________ area/joint(s),
  resulting in the movement impairment of ____________________________________________,
  which causes the Functional Limitations of:

  Posture
  Sleeping
  Bed Mobility
  Sit
  Transfer
  Stand
  Balance
  ADL
  Gait
  Lifting
  Traveling
  Vocational
  Repetitive Motion
  Recreational
  Social Activities
  Sexual Activities

  Functional Limitation(s) Patient needs physical therapy for treatment of the primary impairment of ________ to enhance the patient’s functional capacity and rehabilitation potential. Given the patient’s positive/negative response to intervention, the movement impairment diagnosis of ________________________ is confirmed/refuted and the rehabilitation prognosis is excellent/good/fair/poor.

Signed:

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Introspective Evaluation of Physical Therapy Visit

1. Rate your pre-visit chart review, (understanding of anticipated medical and movement-based hypotheses):

2. Rate your patient greeting and treatment environmental preparation:

3. Rate your re-evaluation for new medical co-morbidities:

4. Rate your review of patient journey (Pain, ROM, Strength, Function):

5. Rate your presentation of patient “Affective Interventions”:

6. Rate your determination of patient’s primary Functional Limitations:

7. Rate your identification of primary impairments limiting patient function:

8. Rate your psychomotor execution of practice philosophy (Joint mobility, NMR, ADL, Therapeutic Exercise):

9. Rate your evaluation of intervention effectiveness:

10. Did you cite any references to support any of your patient-practitioner interactions?

11. Rate your therapeutic presence:

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Physical Therapy Professional Evolution as Related to Differential Diagnostics

- The 2020 Vision Statement’s goals include physical therapists as the practitioners of choice, physical therapists as autonomous practitioners, physical therapists practitioners as doctors of physical therapy, and patient/client direct access to physical therapists.

- Providing patients direct access to physical therapists remains a professional priority.
Pillars of Vision 2020

- practitioners of choice
- autonomous practitioners
- doctors of physical therapy
- direct access
Physical Therapy Professional Evolution as Related to Differential Diagnostics

“Autonomous practice is practice characterized by independent, self-determined professional judgement and action.”

“An autonomous physical therapist practitioner, within the scope of practice defined by the Guide to Physical Therapist Practice, provides physical therapy services to patients/clients who have direct and unrestricted access to their services, and may refer as appropriate to other health care providers and other professionals and for diagnostic tests.”
Grassroots Demand Is High

- Jette and Jette have reported that musculoskeletal impairments account for a large percentage of conditions for which medical care is sought in the United States, and a large portion of the cost associated with this care is related to the disability caused by these impairments.*

Evolving Consumer Demand

- By 2030, the number of US citizens over age 65 will exceed 70 million.*
- Due to advents in cardiovascular technology, the majority of the populous will live longer.
  - There will be the challenge for physical therapy professionals to meet an increasing patient demand of physical therapy to improve function, health, quality of life and independence.

* US Census Bureau
Affective Domain

Interviewing Skills as Related to Teaching Patients

- Appropriate attitude is considered the healing attitude that fosters a healthy collegial relationship. (Davis CM. Patient practitioner interaction: an experiential manual for developing the art of health care. 3rd Edition, Slack, INC. Thorofare, NJ.)

- Good timing is regarded as providing the necessary and uninterrupted time to listen to the patient very carefully as he or she tells the interviewer the story of the problem.
Artful phrasing skill that involves using the right kind of question at the right time, avoiding unnecessary jargon, slang and dialect.

Likewise, artful phrasing reassures the patient that he or she is being attended to at a serious and thoughtful level. (Davis CM. Patient practitioner interaction: an experiential manual for developing the art of health care. 3rd Edition, Slack, INC. Thorofare, NJ.)
Affectively Communicating With Physicians

- Boissonnault and Bass noted that screening for medical disease includes communicating with a physician regarding a list or pattern of signs and symptoms that have caused concern, not suggesting the presence of a specific disease.

(Boissonnault WG, Bass C. Medical screening examination: not optional for physical therapists. JOSPT. 14:241-242.)
Koopmeiners suggests physical therapists assume the role of collaborative practitioner. (Goodman CC, Boissonnault WG. Pathology: implications for the physical therapist. Philadelphia: WB Saunders; 1998: xiii)

Likewise, Hulme et al. recommended that physical therapists should take the initiative in developing good rapport and maintaining a viable relationship with physicians. (Hulme JB, Bach BW, Lewis J. Communication between physicians and physical therapists. Phys Ther. 1988;68:26-31.)
In their study, Hulme et al. found that many physical therapists accept the physician’s prerogatives of issuing orders for treatment but want to be involved in the evaluation and decision-making that lead to these orders.

Affective Interventions

1. Identify the learning level of the patient.
2. Review “Journey” on each visit clarifying Goals and Prognoses.
3. Clarify that pain is not the sole goal, but ROM, Strength, and uncompensated Function is the focus of our interventions.
4. Remind the patient they may “feel” better before they are structurally better
5. Execute start of visit with organization, confidence, and on time
6. Time Efficiency is important: Stay within 1 hour visit time limit or less
7. Use scientific references to support your patient dialogue and professional correspondences.
Organizing The Teaching Learning Process

- As a Teacher, your ability to engage your clinical students (Patients, Physicians, Colleagues, Interns, Residents, Fellows) in the following 7 step-by-step activities will prove to be the most effective means for you to both teach and account that new learning has been achieved.

- This Teaching Learning Process (TLP) will be particularly applicable for the teaching of new psycho-motor skills/activities.

Catlin, PL Emory University School of Medicine 1983
Organizing The Teaching Learning Process

1. **Identify the level of the learner**: Here the teacher/mentor determines appropriate language and complexity levels to communicate verbally and non-verbally with the learner.

2. **State the behavior to be learned**: Here, the teacher states verbally the name of the activity/skill to be taught/learned. This element gives the new activity a “cognitive handle” from which the new skill can be recognized.

3. **Demonstrate the behavior**: Here, the teacher actually performs/demonstrates the step-by-step psycho-motor execution of the new skill. The learner visually observes the teacher’s demonstration and connotes subtle and global aspects of the skill.
4. **Provide examples:** Here the teacher provides the learner with examples of similar skills. Via the concept of “psychological association”, this step will enhance the learners understanding of the new elements by associating it with a familiar behavior that the learner already knows.

5. **Solicit examples:** Here the teacher asks the learner what this behavior is like to them. The learner is challenged to drawl from their past/familiar experiences to now link their newly learned behavior to a familiar behavior. Via “psychological association”, the learner now links and makes connections to a familiar behavior which enhances acquisition of the new behavior.
Organizing
The Teaching Learning Process

6. Allow Practice: Here the teacher permits adequate time for the learner to repetitiously practice the new behavior or component pieces to the new behavior. Due to the repetitious nature of the practice, the teacher must ascertain that all practiced components are performed satisfactorily.

7. Evaluation of performance: Here the teacher evaluates the component step-by-step pieces of the global behavior/skill. The teacher depicts which piece or pieces need further development so to satisfactorily perform the global behavior. Offering the learner step-by-step “procedural criteria” adds to the objectivity of the evaluative process.

Catlin, PL Emory University School of Medicine 1983
Holistic Practice Philosophies

- In light of physical therapists gaining greater amounts of practice autonomy as they assume a role as primary contact providers, I believe that physical therapists WILL view their patients holistically and not consider their patients simply as a “knee” or “back problem”.
Evidenced Based Practice Issues

- If physical therapists are to move more toward evidence-based practice, further study is necessary to significantly identify which factors in a patient’s history are of most value to the differential diagnostic process for specific clinical conditions.
Evidence Based Practice Issues

- Physical therapists must determine the sensitivity, specificity and likelihood ratios of not only our tests and measures, but of our patient’s subjective data.
Health Policy and Reimbursement Issues

- Current USA Medical Payment Systems
  1. Promote over-utilization via fee-for-service
  2. Inhibit disease prevention and wellness
  3. Procedure based reimbursement.
  4. Conflicts of interest where illness profitable and wellness means less business.
So, What is Wrong with Insurance?

1. *First, it's temporary.* This may work for auto policies, but not for human health.
2. *Second, health insurance is mostly contingent on where you live and whom you work for.* It's easy to transfer car insurance, but not health insurance.
3. *Finally, insurance companies make more money by minimizing pay-outs than by keeping people healthy.*
Foreshadowing

CMS: Quality Measure Reporting

- Value Based Purchasing Initiatives Supported by Legislation
  - 2006 Tax Relief and Health Care Act
  - 2007 Medicare, Medicaid, and SCHIP Extension Act
  - 2008 Medicare Improvements for Patients and Providers Act
  - 2010 Affordable Care Act
  - MPFS Final Rule (Nov 2010, pgs 1053-1208)
Foreshadowing

Why Quality Reporting?

• Attempt to close the gap between best practice and current practice
• Provide the public information on providers and facilities to enhance use of “quality providers”
• Eliminate waste in the Medicare program
Pay-for-Performance Initiatives and Non-Pay for Non-Performance Initiatives to Improve Healthcare and Reduce Costs

Pitfalls

- **Pitfall #1: 'Performing to the test.'** Time-stretched PTs may focus on only one or two measures.

- **Pitfall #2: The reporting burden.** Participating means spending administrative time gathering data—time not spent with patients

- **Pitfall #3: Poor time-money balance.** Some measures may appear to be easy to achieve, but may not provide enough financial incentives to see them through.
Pay-for-Performance Initiatives and Non-Pay for Non-Performance Initiatives to Improve HealthCare and Reduce Costs

Pitfalls

- Pitfall #4: Measures not based on evidence. Selected measures must be carefully chosen as well as evidence-based.
- Pitfall #5: Misaligned incentives. Some incentives target helping patients change their behavior—but insurers don't go far enough to help with that modification.
- Pitfall #6. Aiming at the wrong target. Too many programs measure only individual physicians with their relatively small patient populations, not medical groups or even larger community systems.
As CMS Goes, They all go!

- Medicare Cap’s temporary solution may be replaced by Pay for Performance initiatives
- Possible plans for non-voluntary mandate to report Outcomes measured against pre-set performance benchmarks
- 2010 discussions about development of a consensus-based provider registries and penalties for providers who don’t meet pre-set performance benchmarks

Jonathan Basset
Senior Associate Editor
ADVANCE FOR DIRECTORS IN REHAB
May 2010
PQRS

“Physician Quality Reporting System”

• 2011: Program has changed name from “PQRI” to “Physician Quality Reporting System” (PQRS)
  – Reflects that the program is now permanent
Incentives for Eligible Providers (EPs)

• 2007-2014
  – Voluntary program with bonus payments based on allowable charges for the reporting period
    • 2011: 1%
    • 2012–2014: .5%
• 2015 –
  – **Negative payment update for unsuccessful reporting**
    • 2015: -1.5%
    • 2016 and thereafter: -2%
Transparency:

Public Reporting

- CMS is now required to post names of Eligible Providers who successfully report in PQRS
- [www.medicare.gov](http://www.medicare.gov) - existing Physician Directory will be the platform for this reporting
- Full implementation of public reporting by 1/1/13
What are measures?

- Mechanism for clinicians to report specific activities and clinical problem solving
  - CMS wants to identify, promote, and reward the use of measures that reflect good ‘evidence-based’ patient care in areas where gaps in practice have been identified.
  - CMS is capturing information on provider behavior and processes
Bundling Payments
An alternative to today’s reimbursement models

Health care reform debates often focus on provider reimbursement.

Two most common reimbursement models—
1. fee-for-service and
2. capitation—
both have their critics>><>
Fee-for-service Payments

- **Fee-for-service**: each service provided is priced, paid for separately
- Blamed for contributing to the lack of coordination of care across providers and settings and the provision of services that have little or no health benefits

Capitation Payments

Capitation:
- allocates to an entity a lump sum, usually prospectively, all the needed care for an individual.
- Incentive to provide fewer services than a patient might need.
- Difficult to adjust the lump sum amount to account for varying levels of illness.
Bundling Payments

Bundling

1. “bundled payment systems,”
2. “case rates,” or
3. “episode-based payment”

- Single payment for all services related to a treatment or condition
- Spanning multiple providers, multiple settings
Bundling Payments

Bundling

- already has been tested with:
  1. cataract treatment,
  2. knee and shoulder arthroscopic surgery,
  3. hip replacement surgery

But does bundling combine the best elements of fee-for-service and capitation…or the worst?
Bundling

- Part of health care reform concerted effort to create a post acute care bundling payment system.
- Concerned that patient outcomes can be vulnerable if early patient discharge is promoted.
Bundling Payments

1. Okay being grouped with other providers working toward excellence
2. Only want to be grouped with other high-caliber providers
3. Bundling has the potential to be effective if bundled providers use verifiable evidence to justify their interventions and outcomes.
4. Must be like-minded, with similar clinical values and philosophies.
5. Reimbursement must focus on meeting and maintaining targeted health care outcomes.
Bundling Payments

Challenges of bundling:
Is the fair and appropriate distribution of reimbursement $ among all providers involved in the care????

- Surgery may require 2 hours of the physician’s time with periodic 15-minute follow-up office visits,
- Rehabilitation provider may work with the patient 10-15 hours over the course of treatment and follow-up appointments.
Bundling

- Patient may benefit from an additional service, but the facility will not be reimbursed for providing it.
- What incentive does the facility have to provide this service?
- May omit this service if it is beneficial, but not necessary.
Bundling Payments

- Linking payment to quality care and patient outcomes within an episode of care delivery and allowing clinicians to share in the potential savings (and financial risk) will encourage care coordination, increase quality and efficiency, and refocus health care on the patient...

*Development of bundles should be an interim step to accountable payments.*
APTA’s Policy on Bundling

- Edmond Cleeman, MD, an assistant clinical professor of sports medicine at Mount Sinai Hospital in New York believes that bundling poses a dire threat to physical therapists.
APTA’s Policy on Bundling

■ “It will destroy physical therapy private practices”

■ “Bundling will favor hospitals or medical/orthopedic practices that have physical therapy in-house. The private PT practices will suffer huge financial losses. Many will be forced to close.”
APTA’s Policy on Bundling

- Cleeman explains, “they will have to wait to get paid because the insurance will pay [the physician] the bundled fee.
Bundled Payments

If government or private insurance bundles reimbursement, what happens in a difficult case that requires more physical therapy sessions?

- You can’t pigeon hole patients and say they all need 8 sessions. Some may need 16
- PTs will have two choices: provide treatment for free or cut the patient off, that can not be good for the patient.”
MASLOW'S
Hierarchy of Needs

Physiological Needs

Safety Needs

Belongingness & Love Needs

Esteem Needs

Need to Know & Understand

Aesthetic Needs

Self-Actualization

Transcendence
Questions

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