



Unrestricted patient/client access to physical therapy has long been a goal for the profession. Actions on the state level, trends in the health care environment, and a strong APTA vision are generating the momentum to make direct access a reality in this decade.

Vision in Action Direct Access

by Justin Moore, PT

Direct access is more than just a legislative trend affecting physical therapists. Lack of direct access to physical therapy is a significant problem for the people we serve. As PTs and PTAs, we address patient/client problems on a daily basis. We provide care that results in improved function and quality of life for thousands of people.

Isn't being able to access a physical therapist's expertise as much of an impairment to a patient/client as limited glenohumeral joint mobility? We should address this problem aggressively, with the same vigor and dedication with which we address our patients' and clients' problems.

To take an in-depth look at the issue of direct patient/client access, it may be beneficial to frame the issue in terms of the patient/client management model of the *Guide to Physical Therapist Practice*¹ (the Guide). The elements of this model are examination, evaluation, diagnosis, prognosis, and intervention.

History on Our Side

The Guide states that *examination* is required prior to any intervention. Direct access is an integral part of physical therapy's future. Achieving that vision requires that we know the history of direct access and obtain all relevant and necessary data.

APTA's Board of Directors adopted the following definition of direct access in November 2000: "Direct access is the legal right to seek and receive the examination, evaluation, and intervention of the physical therapist without the requirement of a physician referral."

The sidebar on page 78 gives some background on the profession's steady advancement toward greater autonomy, culminating in direct access. Direct access was first

obtained in Nebraska in 1957, when that state passed a licensure and scope of practice law that did not mandate a physician referral for a PT to initiate care. Since that time, 32 additional states have enacted or changed physical therapy practice acts to eliminate physician referral as a prerequisite to physical therapy care.

Currently, there are 19 states that allow direct access through state practice act provisions stating conditions when a referral is not required. These conditions range from care over a certain number of calendar days, to a certain number of visits, to initiation of specific interventions. There are 14 states that have direct access "by omission"; that is, their practice acts do not include language requiring a physician referral to initiate care, and thus no barrier to access exists. Practice acts in an additional 13 states do not require a referral for physical therapy examination and evaluation but do require a referral for the PT to begin treatment. Only 4 states do not have any form of direct patient/client access to physical therapy examination and evaluation: Alabama, Indiana, Ohio, and Virginia.

Myths and Facts

The examination gives us core facts and measures; in the evaluation process, the PT uses these to make a judgment. The examination reveals a strong case for direct access to PTs. The evaluation, however, reveals that, although the policy and facts of direct access are on our side, the politics or environment have not been on the side of physical therapists. The environment still is not ideal, owing to many factors, from other health care providers who have a self-interest in limiting patient/client access to PTs, to some of

our own colleagues who may be apprehensive about practicing without a referral. Some of the politics of direct access are exemplified in the following myths and have been used by these opponents.

Direct access will lead to the overutilization of physical therapy services and higher health care costs. False! In January 1997, a landmark study was published in *Physical Therapy* demonstrating that episodes of physical therapy care initiated by another health care provider resulted in 60% more office visits, and that total paid claims were 123% or 2.2 times higher than for episodes of care initiated by PTs. This study further indicated that episodes of physical therapy care initiated by other health care providers were longer in duration than PT-initiated episodes of care.² Direct access is cost-effective, and it increases consumer choice in health care.

Direct access is an expansion of the scope of physical therapy practice. False! Direct access has been a part of physical therapy practice since 1957, meaning the citizens of Nebraska have had access to physical therapy care without unwarranted restrictions for more than 40 years. Thirty-three states currently have some form of direct access to PTs. To frame direct access as an expansion of practice has no merit, because PTs in the majority of states already practice within this scope.

Direct access will put the public's health, safety, and welfare at risk. False! Communications to APTA from the Federation of State Boards of Physical Therapy and leading liability carriers such as CNA confirm that PTs' liability rates and the incidence of complaints against PTs from the public are extremely low and do not differ between states in which

patients/clients have direct access to PTs and those in which they do not.

Direct access is unimportant, because Medicare and third-party payers still require a physician referral. False! Although it's true that elimination of the referral requirement in state practice acts does not guarantee payment, direct access is anything but unimportant. For one thing, direct access sets the foundation for PTs to work with payers to demonstrate the cost-effective benefits of early intervention and physical therapy care. In addition, many important clinical roles for PTs fall outside of the traditional third-party-payment-based systems; for example, the school-based pediatric physical therapist. Direct access supports two trends in reimbursement, direct contracting and first-party payment. There are entreprenuring PTs who would like

access to some of the many health care dollars spent outside the traditional medical model, but they cannot capitalize on these opportunities without direct access.

The Diagnosis Is Simple

When a label is given to a cluster of signs and symptoms, it is called a diagno-

sis. Physical therapists use examinations and evaluations to make a diagnosis for every patient/client. One purpose of diagnosis is to guide the practitioner in selecting an appropriate intervention.

The diagnosis regarding direct access is simple: Patients/clients are limited in their access to physical therapy care, and this

Ultimate Professional Control

The debate over direct access can be traced back to the profession's initial struggles for professional autonomy. For many years, APTA pushed for professional sovereignty and emancipation from the American Medical Association's American Registry of Physical Therapists (ARPT) in areas such as licensure, accreditation, and standards of education. Each battle that was won accumulated to the issue of direct access, where the PT fought for ultimate professional control.

Although direct access at the state level got its start in 1957, in most states, direct access would not become a realistic goal for more than a decade (or even decades) after that. At APTA, the initial House of Delegates action on direct access was taken in 1973, when the Maryland Chapter suggested that APTA endorse the principle of initial evaluation without practitioner referral. The house referred the suggestion to the Board of Directors for further development. In 1974, the House directed the Board to establish a task force that would be charged with developing a 5-year plan for implementing guidelines for "initial evaluation" (what today is referred to as direct access). Two years later, however, the House rescinded the original 1973 endorsement.

"I think the feeling in the profession was that we weren't ready yet," says Robert Bartlett, PT, MA, FAPTA, who was APTA president at the time.

In some practice arenas beyond the state level, the issue of direct access was simply a matter of practicality. In 1974, the US Army was facing a severe shortage of physicians and a concurrently high level of musculoskeletal injuries resulting from military training. The Army sought to relieve the problem by allowing PTs and OTs within its ranks to assume responsibility for musculoskeletal evaluations without physician supervision.

At APTA, however, the issue lay largely dormant until 1978, when the Maryland chapter came through with another motion on practice without practitioner referral, which was defeated in the House. However, the House *did* initiate a direction to the Board asking it to develop a policy statement, which came to pass in 1979. Consequently, the APTA *Code of Ethics* was revised to allow PTs to practice without referral wherever state law did not expressly prohibit it. Essentially, what that Board of Directors motion did was turn the issue over to the state level, where chapter members continued to lobby for the right to practice without practitioner referral.

In reflecting back on the period, Bartlett theorizes that it is the profession's devotion to quality control that suppressed initial House attempts on direct access. "The major concern that dominated the discussion was that physical therapists in 1973 did not have appropriate training to stand alone. As the years passed, and the educational curricula improved, more people became comfortable with the idea. In retrospect, I think our conservatism, although it is part of what governs the quality of our care, is ultimately what held us back. Other related professions have had no such concern for quality control, and have been aggressive and successful in their pursuit of accreditation and direct access. But because of physical therapy's self-awareness of its ethics and limitations, we moved more slowly."

—L. Caitlin Smith

limitation poses a significant public health problem, with the potential of higher health care costs and fewer positive clinical outcomes due to delays in care. As physical therapy advocates, we can use this diagnosis as a guide to increase our chances of a successful outcome through our legislative interventions.

Policy and the Real World

Prognosis is the determination of the predicted optimal level of improvement and amount of time needed to reach that level.

The prognosis for direct access in all 50 states is good. It starts with APTA leadership. At the June 2000 APTA House of Delegates meeting, the House set a road map, *Vision 2020*. In 20 years, the vision for physical therapy includes patient/client access to PTs without unwarranted restrictions, and that means direct access in all 50 states.

In addition, in March 2000, the APTA Board of Directors appointed a Direct Access Task Force to develop a strategic plan to achieve direct access in all 50 states. This plan includes elimination of referral mandates and reducing the unnecessary restrictions or provisions on direct access. The initial stage of the strategic plan, which involves assisting APTA chapters in the areas of legislation, public relations, education, and research, was approved by APTA's Board of Directors in November 2000.

Most important, APTA state chapters also have taken giant strides in preparing their intervention to correct the impairment of limited patient/client access to physical therapy. They have created consensus support, strong grass-roots networks, and excellent leaders to make direct access a reality in their states. From Alabama to Wyoming, 18 states will introduce legislation in 2001 to remediate the problem of restricted patient/client access to physical therapy. These states are more prepared and better equipped than ever before. [Editor's note: For a word on this topic from the state level, see this month's "Letters," page 8.]

But what about the "real world," the communities in which PTs and PTAs must practice, and its effect on the prognosis? The time for direct access is right. The external environment moves our prognosis from good to excellent. During the recent election, health care—and, specifically, *access* to care—were a top policy priority. Direct access is consistent with the trend toward giving consumers greater choice in their health care decisions.

Passion and Duty

An intervention is the purposeful interaction with the patient/client and, when appropriate, with other individuals involved in patient/client care, to produce changes in a condition. Intervention in this case can be writing a letter to a legislator, asking a patient/client to communicate with legislators, donating to your state's political action committee (PAC), or volunteering to assist at a fitness clinic in your state capitol.

APTA is here to help you intervene and make a difference. The State Legislative Advocacy Center (congress.nw.dc.us/amerpta/states.html) is one tool at your disposal through APTA's Web site. Your state chapters can also guide your actions in advocacy. Thomas Jefferson once said, "Science is my passion, legislative advocacy my duty." Those words are essential to the physical therapy profession.

A Vision in Focus

Outcomes are the results of the patient/client management process. With direct access, the successful outcome for patients/clients is greater access to physical therapy and more choice in their health care decisions. This outcome has many positive attributes for patients/clients, from prevention and wellness to innovative new care and services.

The vision of PTs practicing in an autonomous, independent nature is a goal within reach. We encourage you to act, become involved, and bring *Vision 2020* into clear focus. **PT**

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