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McKenzie practitioners have a unique perspective on the topic of autonomous practice because the "thinking" of MDT fits in to the Direct Access paradigm. It is important that MDT be at the forefront of this discussion and we have dedicated this issue to this topic to encourage your dialogue and action.

GUEST COMMENTARY 1

Direct Access and the McKenzie Practitioner

Erik van Doorne, PT, DPT, Cert. MDT

Direct access is not a new topic for our profession. It has been an important part of the Vision Statement of the American Physical Therapy Association (APTA), who has been fighting for the rights of patients to see Physical Therapists without having to obtain a physician's referral for almost 30 years. It has been a battle fought and won on the state level, resulting in 48 states and the District of Columbia who have eliminated the physician referral requirement for patients to access Physical Therapists for an ***evaluation***, while 44 of those states and DC also allow access to some form of Physical Therapy ***treatment*** without referral.

The battle continues at the state level, but has now gone to the federal level to achieve direct access under Medicare. The APTA introduced the Medicare Patient Access to Physical Therapy Act (HR1829) on March 31, 2009 and will soon follow with its senate companion bill. This is a very important goal for our profession and a big step in lowering the barriers for patients to receive our care. This direct access bill would allow Medicare payment for the services Physical Therapists provide without a physician's referral or signing of the plan of care.

"Just as we empower our patients, we must do so with ourselves and our profession."

But is it safe? The answer is a resounding yes. Clearly, a growing number of states have achieved direct access, and the evidence from the federation of State Boards of Physical Therapy and Health Providers Service Organization (HPSO), a leading liability carrier, shows no increased risk to patients in states who have direct access. HPSO does not rate a Physical Therapist as a higher risk because they practice without a referral.

Another problem is that patients normally have to wait to get an appointment for a referral to go to Physical Therapy, leading to an unnecessary delay in care. A study by Dr. Jean Mitchell and Dr. Greg de Lissovoy of Georgetown University and Johns Hopkins University, respectively, found that reimbursement under direct access will realize cost savings of approximately $1200 per patient episode of care. So, not only does it provide quicker access to our services, it also saves money.

Furthermore, a study published in April 2002 in the Journal of Bone and Joint Surgery (JBJS) by Kevin Freedman, MD, MSCE and Joseph Bernstein, MD, MS showed clearly that there is inadequate musculoskeletal training in medical schools. Our profession is more than ready for direct access in every setting with every patient in every state.

Now, I can hear you thinking, "What does all of this have to do with me, the McKenzie MDT practitioner?"

We should be <u>**leading**</u> this battle for direct access. I cannot think of a better trained practitioner to be that entry point for musculoskeletal injuries. Certified McKenzie practitioners – that is, credentialed and diplomaed – have received, in addition to their regular Physical Therapy education, unique advanced assessment and treatment skills. The McKenzie Method has provided us with a structured, evidence based, logical and safe method to assess patients with musculoskeletal injuries. Therefore, MDT clinicians are very well trained to look for the pathology and the red and yellow flags. We know when the assessment doesn't make sense, or when red flags come up and when we need to refer a patient to their physician for additional medical care or diagnostic testing.

How many times do you still look at the referral when a patient comes in? Or do you grab your McKenzie assessment form and start from scratch and at the end come to a conclusion and treatment plan?

The McKenzie Method is proven to be a safe and valid, well researched method of assessing and treating patients. We have passed the test as Credentialed MDT practitioners and even more extensive and grueling training in the McKenzie Method for Diploma holders. I think we are the Physical Therapists who should feel most comfortable with direct access because of our advanced training and skills.

Just as we empower our patients, we must do so with ourselves and our profession. So, this is my challenge to you: If we consider ourselves professionals, we should at least be a member of our professional organizations and get involved to help create change. Become a member of The McKenzie Institute because they give us the method, the continuing MDT education, and the ongoing support to provide the best care for our patients; and also become a member of your professional association (APTA, CPA) who fight for the PT profession to make sure our patients can come to us without unnecessary hurdles. I think we owe such a modest investment to our patients. ■

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The Evolution of Direct Access: Our Time Is Here

By Susan Bamberger, MPT, Cert. MDT

Oregon Physical Therapists have been providing direct access services since 1993. MDT is exquisitely designed to provide results in a direct access environment, as its design allows for safe, accurate diagnosis and continuous confirmation of need for services.

In 2007, the time to treat without a referral expanded from 30 to 60 days. I will breathe a sigh of relief when Oregon finally has unlimited direct access. However, as an MDT clinician, I find that 60 days is normally plenty of time to make a classification and manage accordingly.

I recently completed the clinical component of the Diploma program in Austin, TX, where direct access is limited to evaluation only. This different practice environment gave me a new appreciation for how direct access improves our autonomy as Physical Therapists. In Texas, because direct access is limited to the evaluation only, insurance companies will not reimburse for services without a referral. So, even though there is some direct access in Texas, it is not currently used by many Physical Therapists in that state.

Many PTs I speak with express their frustration at not being able to work to their potential. We all see referrals for shoulder pain when it is really the neck. We all see people who should have been in therapy a long time before, as well as those that have no business in therapy at all. Until we achieve autonomous practice, we will not have a chance to demonstrate our full value in health care.

When a consumer has to go to their physician to get a Physical Therapy referral, the ultimate power lies in the hands of the physician, thus perpetuating the belief that the physician needs to be "in charge" of allowing consumers to receive Physical Therapy. This is, of course, the impetus for including direct access in APTA's Vision 2020: To reach our vision, we must be seen as the practitioners of choice in the consumer's mind.

Opponents to direct access are concerned that we cannot diagnose disease processes, and these need to be ruled out before starting Physical Therapy. Any MDT clinician should feel comfortable treating in a direct access environment. Since MDT is an investigative process aimed at classifying mechanical syndromes, this sophisticated system leads you to decide if PT services are appropriate.

Many Physical Therapists believe insurance companies will not reimburse for direct access services, thus making it impractical. Whenever a state first implements direct access, payment is a challenge. As we gain more access to consumers directly, insurance companies learn they save money and improve outcomes when consumers choose to go directly to a Physical Therapist.

Since Oregon has had direct access for over 15 years, insurance companies have had time to see the positive effects of going directly to PT, and today many insurance carriers in Oregon cover direct access Physical Therapy care. This process has been a steady evolution, as it will be in all states, as Physical Therapists gain direct access nationwide.

From a business perspective, having direct access has allowed MDT therapists in Oregon to reach out to the community. Luncheons for physician's offices and their staffs are being supplemented by community events and having a presence in local events and schools. Noel Tenoso, a private practice Cert. MDT in Oregon, reports that he relies far more on his community contacts and word of mouth than he used to.

Working in a direct access environment supports autonomous practice that MDT therapists are more than qualified to provide. Achieving unlimited direct access is essential to practice in the manner appropriate for our level of expertise and training. ■

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The Benefits of Versatility

Capt. Gilbert Magne, BMR(PT)

As physiotherapists, we find ourselves in a variety of clinical situations and challenges. In August 2007, I was en route to Kandahar, Afghanistan in support of the Canadian Forces Task Force. As the sole physiotherapist for the Role 3 Multinational Medical Unit (R3 MMU), I was responsible for providing care to the NATO forces and supporting civilian personnel in both the inpatient and outpatient settings. The base was the size of a small city with a very transient population, resulting in a situation of limited resources, the most significant of which was time. There were only so many hours and days that I could work, and the clientele were limited in how often they could see me. Therefore, I relied heavily on self management strategies that are the backbone of MDT.

Although I worked mostly in a tent and had access to most modalities, braces and equipment, my strongest asset was my MDT clinical skills, which allowed me to screen and assess patients quickly to determine responders and non-responders. Relying on my MDT skills for assessment made the most of my time and that of the patient. Frequently, I was presented with someone who was only available for one to two days on the base before transferring to a different location where there were no services available. This direct access to me allowed for faster care, and because of my MDT training, I had the confidence to proceed with treatment, or refer red/yellow flags to an MD for further investigations.

Another benefit of my MDT training was also determining prognosis. It is a high tempo situation, and the commanders need to know if their troops will recover quickly enough to return to the field or need to be replaced. My ability to estimate how quickly someone will respond to treatment and may be ready to return to the field, assisted in making the appropriate decision. An example was a member who presented with an irreducible derangement, who needed to be sent home for more extensive medical care, being unable to continue with his duties on deployment.

Because the only resource needed for MDT is your thinking cap, this makes it a very versatile method for treating patients in a variety of situations. A tent, a living room, or even an office cubicle can become your assessment room and that kind of flexibility is priceless. ■

GUEST COMMENTARY 4

Certified McKenzie Clinic with Direct Access

Kari Lambden, BScPT, Cert. MDT and Audrey Long, BScPT, Dip. MDT

Four years ago, Bonavista Physical Therapy in Calgary, became the only Certified McKenzie Clinic in Alberta. Working in our clinic is one credentialed therapist, two therapists that are in the process of completing the MDT course series, and Audrey Long, a McKenzie instructor.

As a Certified McKenzie Clinic, we are *unique* in our area because just about every physiotherapy clinic offers manual therapy, IMS, acupuncture, orthotics, pilates, massage and exercise therapy. *Only our clinic* consistently offers MDT by all of our therapists who are committed to using the MDT assessment and treatment principles.

The good news is that we are fortunate to have direct access in Alberta, which means that clients do not require a physician's referral to access our services and are able to choose the practitioner they wish to see. Physiotherapy visits for "soft tissue injury" are not funded provincially, which means that most clients are paying out of pocket for their treatment. Even better news is that MDT saves clients money. Using MDT, significant progress can usually be made within three sessions and, if not, we can provide a reasonable treatment plan and timeline for the client if their problem is irreducible, non-mechanical or other.

When we teach clients how to effectively self treat, they need fewer visits and can often successfully manage themselves if they have a future episode. The beauty and strength of MDT is that it is evaluative, diagnostic and prophylactic, and we are uniquely positioned to provide this type of care and education. Despite fewer treatments per patient, our schedules continue to fill up! Word of mouth is a powerful advertising tool.

By the time clients see a physiotherapist for their injury, many of them have "googled" their injury and symptoms. Not only is MDT well supported by the literature, many clients find us directly off the Institute's website (www.mckenziemdt.org). While having a McKenzie instructor and researcher on staff is certainly a bonus, all therapists on staff benefit from repeat and increased clientele based on their reputation of good results.

Although clients can access us directly, we still get many referrals from the Worker's Compensation Board (WCB), insurance companies, non-MDT physiotherapists and physicians. We have educated them about the MDT approach and use this as one of our primary marketing tools. Of particular note, the WCB respects our reputation. We either achieve good results or give honest and helpful case management advice. We regularly receive requests from the WCB to assess patients who have failed therapy elsewhere. Furthermore, the WCB will often approve doubling the regular treatment rate for compensation cases assessed and treated at our clinic.

We have had direct access for a long time and have been a Certified McKenzie Clinic for four years. With the abundant literature behind the approach, being able to offer MDT has been an excellent marketing tool. More importantly, our results and reputation have never been better. ■

GUEST COMMENTARY 5

MDT in a Deployed Military Environment

Maj. Troy McGill, BSC, PT, Dip. MDT

As a military Physical Therapist, I have been fortunate to practice in a direct access capacity for the past nine years. As a MDT trained therapist, I am also very well suited for this responsibility.

Military PTs are normally the "gate-keepers" for musculoskeletal complaints. Initially, we have to complete an Advanced Clinical Orthopedic Practice course, which includes information on prescribing medication, ordering laboratory tests and general interpretation of imaging studies. With additional training, further credentialing is possible to conduct and interpret EMG or nerve conduction studies as well. Upon completion of the required training, PTs are mentored by an MD for the first year. The MD reviews the appropriateness of prescribed medication, lab tests, imaging studies, and referral patterns. Feedback is given on a quarterly basis to ensure continuity of services offered. After this year of mentoring PTs are allowed full independent practice.

In studies by Greathouse et al (1994) and Childs et al (2005), it was shown that PTs have the knowledge base to manage musculoskeletal conditions and that PTs are able to work more efficiently and effectively, reducing patient visits, medicine utilization and use of imaging studies. PTs are now utilized in hospital emergency rooms, offering several advantages for patients, in that; early mobilizations of musculoskeletal injuries have shown greater functional outcomes in less time (Lebec and Jogodka 2009). The military PT model has been effective in getting the patients the right care at the right time. As MDT trained therapists, we must actively support the APTA in pushing for direct access in all environments for PTs.

I will soon be deploying to a location in the Middle East where I will be working directly with two orthopedic surgeons. I'll be the first point of contact for patients in the acute setting, performing the initial assessment, then if needed, refer to the orthopedic surgeons. During my deployment, I'll have the chance to: 1) Demonstrate the value of MDT clinicians as primary care providers for acute and non-acute musculoskeletal conditions, 2) Assess how MDT is viewed/what value it offers in assessing patients through the eyes of the orthopedic providers, and 3) use FOTO to track outcomes when applicable.

This will be a remarkable opportunity to educate the staff physicians about MDT. More importantly, because a large percentage of soldiers are in the area for only a day or two and then sent back into the field, the ability to teach self-treatment strategies to patients with such limited access to medical care will be extremely important. ■

Troy McGill, a Major in the United States Air Force based at Elmendorf AFB, AK, was named 2008 Air Force Field Grade Physical Therapist of the Year. He is also completing a PhD in Orthopedic Physical Therapy and is working with Mark Werneke's team in collecting MDT outcomes data using the FOTO system. www.fotoinc.com/MDT.htm

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There's still time to rendezvous in... **Rio de Janiero • August 28-30, 2009** for the 11th International Conference in MDT
Challenging the Structures in Musculoskeletal Medicine • www.mckenziemdt.org/conf2009.cfm

McKenzie Practitioner and Patient Advocacy

Allan Besselink, PT, Dip. MDT

Direct access to Physical Therapy still faces many barriers in the United States. Many of these barriers are simply not in the best interest of the patient, in that the current regulatory practice of a "referral" process to get to the appropriate provider creates greater costs for the patient and the right to immediate and effective care, a fact that patients simply do not understand.

As a physical therapist in Texas, I have watched the continued struggle with direct access to Physical Therapy. Texans can see a Physical Therapist for an initial evaluation, but cannot subsequently receive treatment without a physician referral. As a McKenzie practitioner, not having direct access is an enormous barrier to caring for our patients. With an assessment process that naturally shifts to treatment, we are faced with a dilemma. If the assessment reveals a directional preference, then instead of simply taking the next step and educating the patient regarding the importance of this, we must then interject "you need to see a physician for a referral."

In an era of "evidence", there is plenty to indicate that direct access to Physical Therapy would increase a patient's access to appropriate and necessary health care, decrease their cost of care and restore the patient's right to choose. Studies have shown that there is a direct cost benefit to the consumer by seeing a Physical Therapist as the first line of assessment, with some estimates as high as a savings of 55%! This cost extends not only to the individual, but to the state's Medicare system as well. In a state like Texas where one out of four people are uninsured, this is critical.

Moreover, according to the Texas Medical Association[1], there is a significant shortage of physicians in the state, which only underscores the need for additional qualified first line practitioners.

In order for our health care system to move forward, it is time for all of us to put our best foot forward and foster a medical system that is *truly* patient-centered. A Physical Therapist's training is focused on the use of therapeutic exercise in the treatment of disorders of the musculoskeletal and neurological systems. We possess the knowledge and skills for autonomous practice - to evaluate, to make functional and mechanical diagnoses, and to establish a plan of care for our patients. APTA Vision 2020 alludes to this as a future goal when *this is already a part of our current scope of practice.*

When I was trained in Canada, I was taught to think as an autonomous professional. It wasn't questioned. I was considered the "expert" in what I did by everyone in the system (doctors included).

But none of this matters unless the consumer knows what we do, why we do it, and how it improves their quality of life and health care. We need to speak to the consumer effectively and in the end, provide a good consumer-centered experience.

Ultimately, consumers are faced with a clear reality:

- Choice of health care is limited by regulatory practice.
- Legislators define regulatory practice.
- Consumers vote for legislators.

It is really quite a simple process. This is where the consumer can speak up and be heard.

As McKenzie practitioners, we are intimately aware of our role as diagnosticians and as mentors in the process of self care. We have the training to do so, and we know that MDT outcomes save money for the patient and for the payer. There is no question that in the long term, McKenzie practitioners must lead the way in the pursuit of direct access.

Perhaps this reveals the true benefit of the McKenzie practitioner – as one of patient advocacy in an era of evolving health care and future reform. ■

[1] TMA reference can be found under "Ensure High Quality Health Care for All Texans" at http://www.texmed.org/Template.aspx?id=7326

Dialogue about your Direct Access experiences (successes and struggles) with your colleagues:
http://www.smartsport.info/

To access direct links to the articles or sources for all references in this issue and those below, visit our online MDT Bulletin:

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More Resources of Interest:

- **The International Policy Summit on Direct Access and Advanced Scope of Practice in Physical Therapy (hosted by WCPT, CPA, and APTA) in Washington, D.C. 22-24 October 2009 http://www.directaccesssummit.com/**
- **Medicare Direct Access: What You and Your Patients Can Do (APTA)**
- **An APTA source for consumers: What is PT and what can it do for you?**
- **APTA Vision 2020**
- **CPA on Direct Access**
- **CPA Vision 2020**