PREVENTION AND WELLNESS ARE THE FUTURE OF THE PROFESSION

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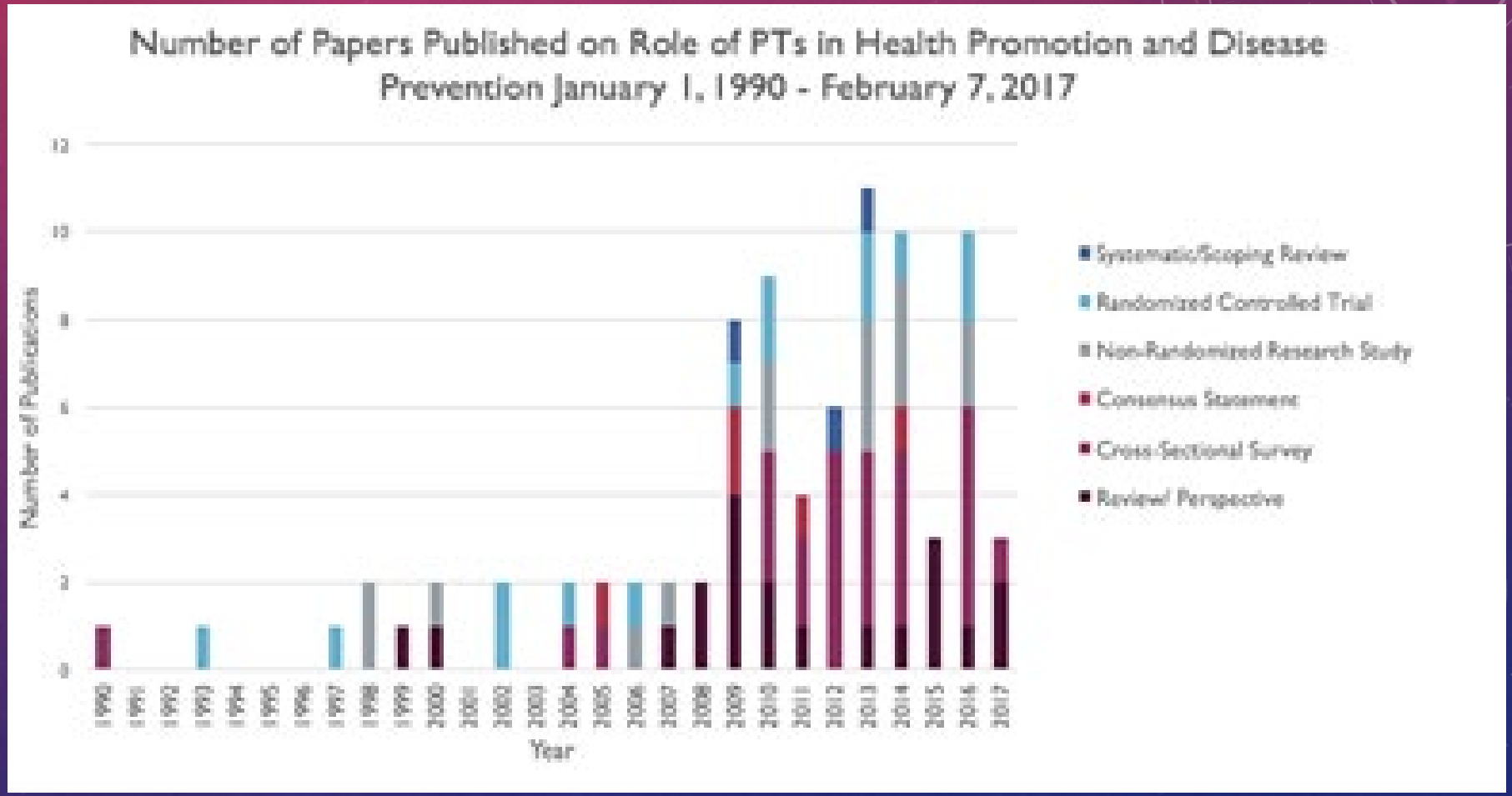
OBJECTIVES

- 1) Discuss the role of prevention, wellness, and health promotion for older adults in physical therapy practice;
- 2) Describe the key gaps in knowledge and skills of entry level physical therapists to be able to implement prevention and wellness practices; and
- 3) Contribute to the development of a “white paper” on the practice/business, advocacy, regulatory,and education concerns in implementing prevention and wellness practices.

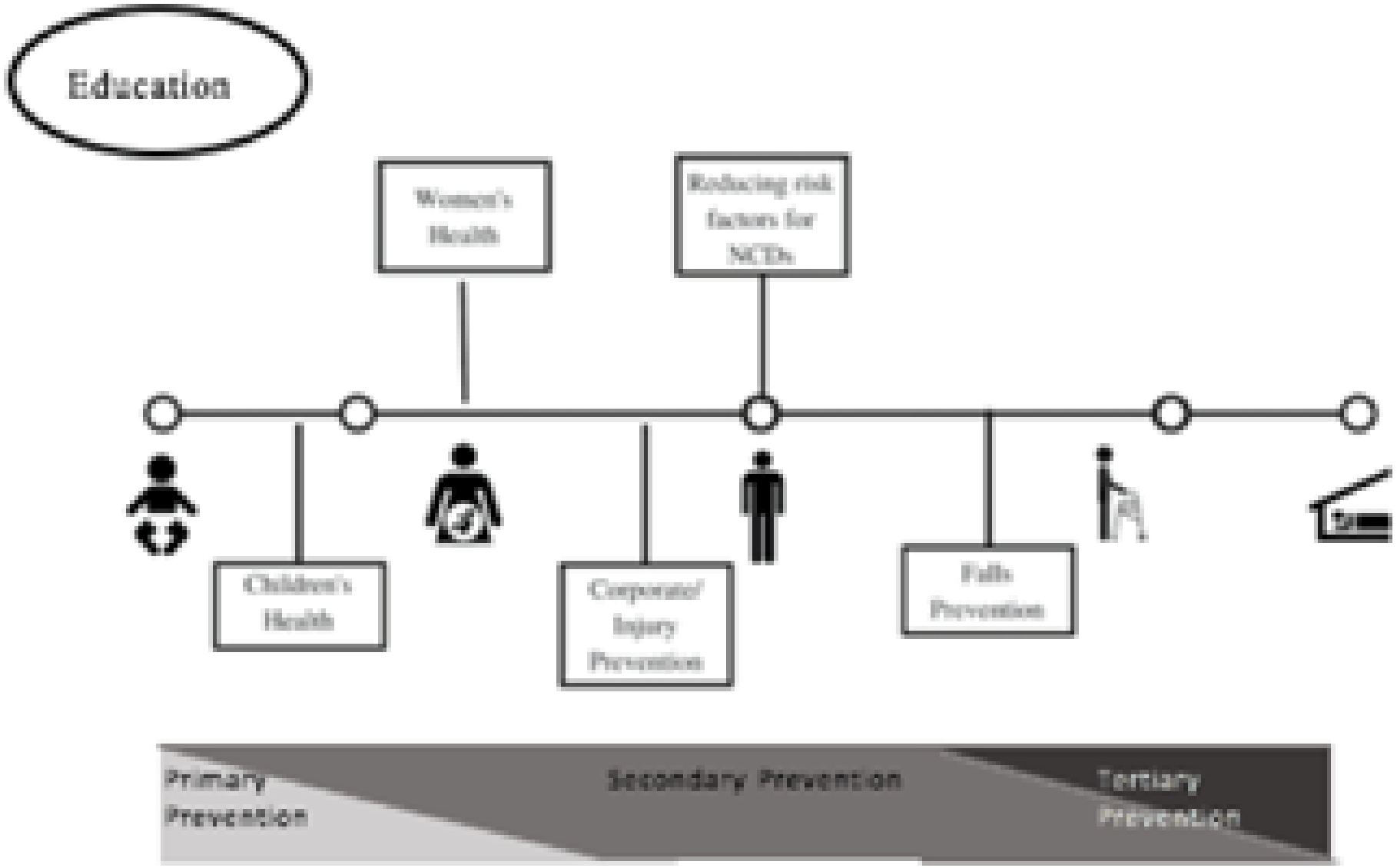
CPA DEFINITION AND SCOPE OF PRACTICE

- According to the CPA document *A Description of Practice: 2000 and Beyond*, Physiotherapy is a ‘first contact, autonomous, client-centered profession dedicated to:
  - Improving and maintaining functional independence and physical performance;
  - Preventing and managing pain, physical impairments, disabilities and limits to participation: and
  - Promoting fitness, health and wellness.

SCOPING REVIEW



Physical Therapists Ability & Willingness to Counsel



School-Based Programs

Sports Injury Prevention

Pre-Post Natal Health

Corporate Wellness Programs

Workplace Injury Prevention Programs

Falls Prevention Initiatives

Health Promotion Counselling (eg. physical activity, proper sleep hygiene)

REGULATION

(BILLING PRACTICES, SCOPE OF PRACTICE CONSIDERATIONS, RISK OF GOING TOO FAR OR DOING WHAT IS NOT CONSIDERED OKAY THROUGH THE COLLEGE)

WHAT CAN BE BILLED UNDER THE PHYSIOTHERAPY SCOPE OF PRACTICE AND WHAT IS INAPPROPRIATE?

- Scope of practice issues but also insurance reimbursement issues
- QC: make sure heath promotion maintains in SoP = MSK systems
- Inform/educate – need to have a way to objectively state improvements with positive predictive values. Insurance providers may or may not reimburse.
- Professional Code: 39.4 Describing exactly what is expected by professionals including health promotion
- College about what you can do safely and what you can bill for.
- 2 provinces: NB ON – NB SoP can bill for wellness groups with assessment in advanced. Ex programs have clear expectations. ON billing around more episodic care. Insurance companies expect to see beginning and end of treatment. How can we think of the dentist model – in prevention and have articulated role and can bbill in prevention?
- Barrier may not be the College but more the provider eg insurance for yoga for individuals with x,y,z
- More helpful that the work we are doing is supported by the evidence
- SoP and Billing *key theme* - being able to order blood work eg glucose and interpret that – prevention aim to increase SoP; MB can't bill for exercise classes that are wellness based.
- **NEED: Regulatory bodies across provinces being uniform in ideas
- In a group, if there are changes that need to happen in terms of exercise prescription, the PHYSIO needs to maek those change. When the PTA makes the change, it is not physio?
- LTC homes: heavily reulated in terms of what is what in terms of physio – PT vs wellness; get audited regularly and publicly
- Insurance companies complaining around what we are billing on rather than our patients issuing complaints.
- On the Alliance website there is a document "is it physiotherapy"

WHERE DOES PREVENTION START AND END?

- Birth and death
- Childrens hospital: address parents as well as child; education around how can be involved in programs across different ages; start incorporating pain education in childhood so don't have the same chronic pain issues later in life. Establishing foundations
- 6 month check ups/ annual check ups – PPE (physiotherapy preventative exam). Can we access them when they're asymptomatic so we have a baseline measure to see where they are at from MSK health perspective.
- Multidisciplinary team focus on prevention – on par because we are also primary care so can see with direct access.
- Fit for Life Check up – talk about current physical and social activities and what your goals are for the upcoming months; what might be barriers for achieving those goals. Screening measures to create a plan of any issues that have come up .
- Needto be putting in the skills so individuals can be self-reliant, able to cope and manage their issues. Aim for discharge once have acquired those skills.
- If there is a risk of developing something, should manage it more closely – if see people preventatively may be able to flag this earlier.
- Depends on the lens looking through
- Goal specific end to treatment. When talking about olderadults, this becomes more complex because their health it more complex. If asking, preventing transition to LTC… never ends. How do we justify this cost?
- If we're better at primary prevention, don't need to be as nececsasry in secondary and tertiary prevention
- Cautionary note: Maybe we don't need to FIX; when get older, mortality is OKAY. Preventing distress for people as they reach the end of their lives.
- Womens Health: Prevention for pelvic health – pregnancy prehabilitation; postpartum

HOW MUCH HEALTH AND WELLNESS SERVICES CAN BE BILLED UNDER PHYSIOTHERAPY?

WHAT ARE THE GUIDELINES INCLUDING DOCUMENTATION NEEDED TO PROVIDE GROUP-BASED EXERCISE PROGRAMS IN A HEALTH AND WELLNESS CAPACITY FOR PERSONS AT RISK FOR OR WITH DIFFERENT CHRONIC HEALTH CONDITIONS?

EDUCATION

(NOT FEELING CONFIDENT IN EDUCATION, NO CONTINUING EDUCATION OPPORTUNITIES)

ARE STUDENTS GIVEN ENOUGH EDUCATION TO COUNSEL ON HEALTH PROMOTION SUCH AS PHYSICAL INACTIVITY, REDUCING SEDENTARY TIME, SMOKING CESSATION AND BASIC NUTRITIONAL COUNSELLING?

- Not a lot entry level education around health promotion counselling – but time is often the limiting factor
- Health promotion may not key education priority during masters – con ed post graduation?
- Baseline education there – practical implementation of this not there
- Not enough of us in practice who are doing HP counselling – clinical practicums may be area to gain these skills for those taking students
- Current student: Feels ARE getting good education around physical inactivity and sedentary time; nutrition: referral to dietician. PERFORMING these skills less time – time barrier for having to learn so many things
- Don't have enough time to be educated on all aspects on health promotion – now students are getting better at getting that information on their own in order to provide these services to their clients. Bachelors degree can be mitigating factor for comfort in this area. Less didactic time spent in this area.
- Hard skills that should be done up front – should be done very early on in the process of starting your education.
- Varies depending on school curriculum; need to get REPS IN

IS THERE ENOUGH EMPHASIS ON THE HEALTH PROMOTION ASPECT OF PHYSIOTHERAPY CARE VERSUS SPECIFIC TREATMENT OF ORTHOPEDIC/CARDIAC/ NEUROLOGICAL CONDITIONS AND SYMPTOMS?

ADVOCACY

(COMPETITION FROM OTHER HEALTHCARE PROVIDERS, PERCEPTION OF CLIENT THAT PHYSIOTHERAPY IS A REACTIVE SERVICE VS. PROACTIVE)

HOW DO PHYSIOTHERAPISTS ADVOCATE FOR THEIR ROLE IN HEALTH AND WELLNESS ESPECIALLY WITH COMPETITION FROM OTHER PROFESSIONALS SUCH AS PERSONAL TRAINERS AND KINESIOLOGISTS?

HOW DO WE ADVOCATE FOR THE ROLE OF PHYSIOTHERAPISTS FOR PREVENTION OF INJURY AND CHRONIC CONDITIONS VERSUS REACTIONS TO THESE CONDITIONS ONCE THEY HAVE MANIFESTED?

“Follow the Money” – advocacy vs lobbying. Advocacy – talking to key decision makers to see how we can allocate resources more effectively to optimize health. Where are the inefficiencies in spending and how is physio going to contribute to reducing spending. Make the business case: GLA:D program example. 25000 cost of joint replacement, 9000 for further revision. If we can reduce 3 replacements – for a therapist seeing couple hundred people, justifies paying for a FTE of physio. Redistribution of funds that makes business sense.

- Added physios to primary care to reduce ER – use examples from your local area
- Make an argument to the government
- Physicians on our side. Still in a medical model. Surgeons may not be willing to have physios in their clinics to do screens. May be less money for them in the end.
- Developing RELATIONSHIPS with other healthcare providers to advocate for us working together to optimize outcomes.
- Role can evolve – working independently as well as side by side with surgeons as appropriate
- Patients are partners in advocacy – if they realize the value, they have a STRONG voice in the clinical realm
- Clinical practice guideline – we have to develop them and treat USING them.

BUSINESS

(INSURANCE BUSINESS PRACTICES, PRIVATE BILLING)

IN PRIVATE PRACTICE, WHAT HEALTH PROMOTION SERVICES AND PRACTICES CAN BE BILLED TO INSURANCE COMPANIES?