COVER STORY

Collaboration is Key: The Evolving Role of PTs and OTs in O&P

Clinics and hospitals have sought to house physical and occupational therapists under the same roof as O&P practitioners. Experts discuss why the collaboration model will expand.

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A decade ago, when a patient required the services of either a physical or occupational therapist in addition to orthotic or prosthetic care, the results were often more reminiscent of a tennis match than anything else, according to **Tiffany Ryan, MOT, OTR/L,** national director of therapeutic services for Advanced Arm Dynamics.

Patients would be forced to "bounce around," she said, between their physical therapist (PT) or occupational therapist (OT) and their O&P practitioner, passing notes of information between them and acting more akin to a go-between rather than a patient receiving comprehensive care. As a result, those tasked with providing care were rarely on the same page.

"We have six OTs and one PT, together with our seven prosthetists, and we're specialists in upper limb prosthetic rehabilitation – that's all we do. Our full-time job is working alongside the prosthetist, and this is an evolution that was not part of the therapy world 10 years ago," Ryan told *O&P News.* "The complex nature of the upper limb requires someone who is knowledgeable about all types of prostheses and components, and that technology changes rapidly, so it's important to have someone who is immersed in it and doing it all the time to meet the needs of this specific patient population."

A 'siloed system' and the ankle-joint battleground

According to Ryan, this multidisciplinary approach to care stands in stark contrast to what she called the “siloed system,” which she said was the norm as recently as 10 years ago. Under that system, PTs and OTs would practice separately from O&P practitioners. The resultant care could often grow “disjointed” and force the patient to spend additional time and energy making sure one health care provider knew what the other was doing.

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“Previously, and still in some settings, it has been the siloed approach to care, where the patient sees the prosthetist and then sees the therapist separately, going back and forth,” she said. “An OT would come in for a portion of a patient’s prosthetic rehabilitation in the prosthetist’s setting, or the patient would be sent over to the therapist. However, it would not be a collaborative, concerted effort, with more than one discipline working together to get patients fitted and trained.”

According to Ryan, the problem arose from health care providers who had tied themselves to the standard outpatient care model, and then applied it to specialized care.

“The evolution for us was realizing that model doesn’t work for our patients,” Ryan said. “If you want to provide care that patients are satisfied with, minimizing their burden is the first and easiest step you could take. In addition, patient population care is a focus in medicine now, rather than a generalist point of view. Patients have better outcomes. This became obvious to us over the years.”

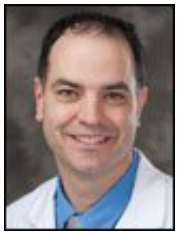
Another issue under the siloed system was that when PTs and OTs did work with O&P clinicians, they could encroach on each other’s responsibilities, according to **Matthew Parente, MS, PT, CPO, FAAOP,** program director, department of rehabilitation sciences at the University of Hartford in Connecticut and clinical education specialist for Hanger Clinic.

“When PTs and P&O clinicians would work hand-in-hand, in some areas they would work great together,” Parente told *O&P News.* “However, in other areas, PTs may deliver custom orthotic devices, such as knee braces or ankle gauntlets, or there might be devices that the PT will deliver instead of an orthotist which, as you can imagine, may cause some confusion, but also blurring the lines regarding scope of practice, which could also have financial implications.”

Traditionally, it appeared the blurry line was across the ankle joint, Parente said. This “battleground” was created due to minimal insurance coverage and reimbursement of devices below the ankle joint, including foot orthoses.

“The orthotist usually would not be terribly concerned if a PT delivers a custom-fit foot orthosis or even a knee brace, but there would be much greater resistance to them delivering custom fabricated orthoses,” Parente said. “Does it happen? I’m sure there are unique situations everywhere. It depends on the relationship between the therapist and the prosthetist.”

Communication and collaboration



Matthew Parente

According to Parente, better communication is the most important aspect when considering the recent model of collaboration between therapists and O&P clinicians. Increased and better communication, often as a result of housing the PT or OT in the O&P clinic, allows the patient to be seen and evaluated with “both sets of eyes,” and receive unique viewpoints from all involved, he added.

“This can produce better outcomes, and maximizes the benefits of the patient,” Parente said. “That is being explored in several communities and practice models right now where they work together more with the patient as opposed to the PT saying, ‘I’ll call your prosthetist,’ or ‘Would you ask the prosthetist to do this next time?’ The patient is no longer the person in the middle, relaying messages.”

Instead, under the collaborative model, the therapist and the O&P clinician are in the room together and observe what everyone is doing and saying.

“It is an evolving practice model, and I think several companies now see the benefit of that,” Parente said. “You have to look at it as a shared responsibility between the therapist and the prosthetist.”

According to Parente, it is important to not “paint with a broad brush” with regard to practices and which models they choose to implement. In some practices, the collaboration model is nothing new.

Patricia Rogel, CO, LO, OTR/L, who is starting a new practice to offer orthotics and OT/PT under one roof in Illinois after working at the Ann & Robert H. Lurie Children’s Hospital of Chicago for 20 years, said she has been lucky enough to work under the collaborative model for most of her career.

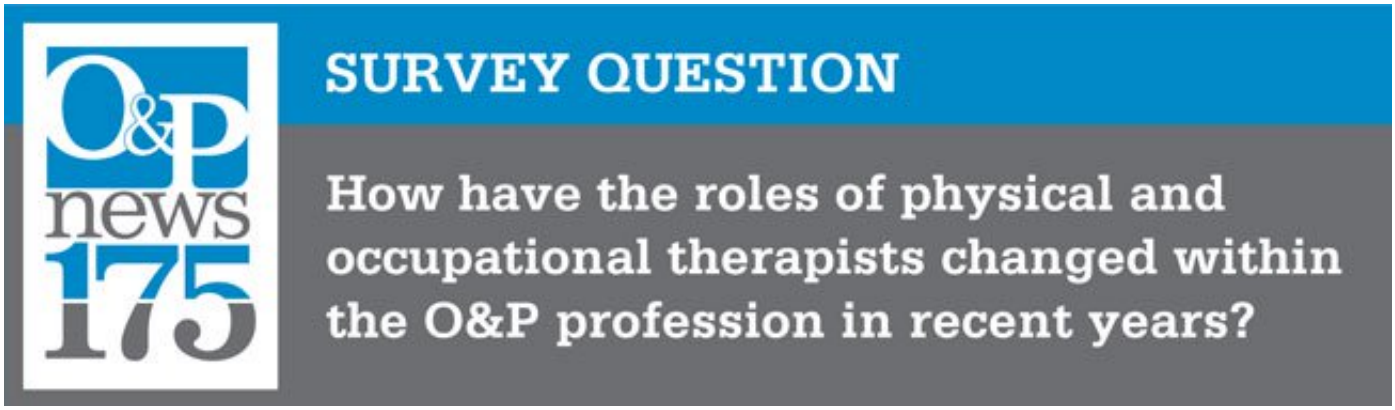
“I find working with the PTs and OTs is better because you will have two great minds looking at things as opposed to just one,” she said. “A therapist who is working with a patient on a weekly or biweekly basis can provide a lot of valuable information in regard to the function of an orthosis when the patient is fatigued or following prolonged use of an orthotic device.”

However, that experience is far from universal, Ryan said. Rather, hospitals and clinics began to change in favor of a more collaborative approach during the past 10 years partially in thanks to new technologies, but also due to a need to improve communication, she added.

“There were developments in technology and not just in electric, body-powered and passive devices,” Ryan said. “There are more options for upper limb patients and if we have more to offer, obviously that means there are more people involved in prosthetic rehabilitation. Also, in health care in general, there is an approach toward a more collaborative system, and care providers are increasingly seeing it has a good model of care.”

> According to Ryan, having a therapist in the room when the patient is seeing a prosthetist or orthotist, increases the patient’s proficiency with the device. It also increases patient satisfaction and gives patients a greater chance at regaining function in less time.
>
> **Tiffany Ryan**

“Also, modifications can be made during the appointment, as needed, immediately,” Ryan said. “This prevents the patient from having to travel around with a prosthesis that doesn’t fit well or isn’t properly programed. With collaborative multidisciplinary care, we can have a functional prosthesis on a patient by the second or third day, which allows the therapy team to quickly initiate training with that patient.”



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Higher education, changing certification

According to Parente, the shift toward more collaborative approaches directly followed another change in both the therapy and O&P professions — the increased importance and presence of advanced degrees.

PTs have gone from a profession of bachelor's degrees to one of master's degrees and doctorates, while O&P education has similarly graduated from the bachelor's degree and post-graduate certificates to the master's level, he said.

"These changes came about with the academic revolution, which was pushed by the professional organizations," Parente said. "It's not just throwing more responsibility on their plate, but an increase in the quality of the education, and that has helped establish the roles of both the therapists and O&P. We're coming out with a better educated clinician who is a better consumer of research."

Another, more recent change came about due new regulations announced this year by CMS, according to Rogel. In January 2017, CMS released a proposed rule that would implement requirements and specify the qualifications needed for O&P practitioners and suppliers. The proposed rule also would enact provisions in the Social Security Act, which "requires that no Medicare payment shall be made for an item of custom-fabricated orthotics or for an item of prosthetics unless furnished by a qualified practitioner and fabricated by a qualified practitioner or a qualified supplier at a facility that meets criteria the Secretary determines appropriate."

The proposed rule would define a qualified practitioner as someone who is "licensed by the state, or in absence of licensure requirements is certified by the [ABC] or by the [BOC], or is credentialed and approved by a program that the Secretary determines, in

consultation with appropriate experts in orthotics and prosthetics, has training and education standards that are necessary to provide such prosthetics and orthotics."

Patricia Rogel

"Medicare has been working on revising some of the protocols so that facility accreditation is required to provide custom orthotics and prosthetics," Rogel added. "Previously, it was in the scope of practice of PTs and OTs to provide these services. It is now required they have proper facility accreditation and supervision by a certified O&P practitioner."

Measuring outcomes

In addition to changing the way patients interact with their health care providers, the new collaboration model also promises to alter the way PTs, OTs and O&P practitioners measure outcomes, according to Ryan.

At Advanced Arm Dynamics, therapists are measuring outcomes throughout the fitting process, and continue to do so at predetermined intervals after patients leave their facility, Ryan said.

"We keep in contact and we follow up frequently and do objective measures," she said. "This helps us keep track of how people are progressing and it alerts us of any issues we need to address. In the siloed model, information can get lost in translation if no one is coordinating the patient's care and follow-up. Services are also repeated because they've failed previously. If services were initially provided in a more concerted way, they probably would not need to be repeated later."

Thinking about the future

According to Ryan, the future of O&P and therapy will see the expansion of the collaborative care model to more hospitals and practice. That, in turn, will lead to better recorded, outcome measures and documentation.

"Health care changes quickly. From everything I read, this model of care, with specialists working together, is proving to be beneficial to patients and to payer sources," Ryan said. "If we and others in our industry continue to measure our outcomes and objectively demonstrate the value of the intervention, I think that trend will continue."

Rogel agreed, adding that patients will continue to benefit from therapists and O&P clinicians working together.

“I think it will continue to be team management as the norm for the care of patients,” she said. “I always rely on the PTs and OTs to give me their input or suggestions for the best orthoses for patients we both follow. Face-to-face communication is always the best, because people have a tendency to misinterpret some electronic transactions. People can easily misunderstand each other over email.”

Looking ahead, Parente said communication will continue to be key for PTs, OTs and O&P practitioners who collaborate in patient care. He added that education will be an important factor in making sure future clinicians understand the importance of fostering a healthy relationship not only with patients, but also with their partners in patient care.

“I teach both, in PT programs and in P&O, and the thing I tell people on both sides is that you are looking to build a relationship, the cornerstone to any good relationship is communication,” he said. “When you have faulty communication, you leave doubt, questions, concerns and anxieties, which are not good for the patient, are not good for the prosthetist-orthotist and are not good for the therapist. Most of the time, these complaints fall on the physician’s ears. They hear, “I can’t get these two on the same page.” That is something they shouldn’t have to worry about or even hear. These problems can be averted through improved communication, and then the patient benefits.” – *by Jason Laday*

Reference:

CMS. Available at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-11.html. Accessed: Sept. 21, 2017.

Disclosures: Parente reports employment with Hanger Clinic and the University of Hartford. Ryan reports employment with Advanced Arm Dynamics. Rogel reports employment with PROrthotics & OT LLC.