

Integrating Physical Therapists Into Primary Care Within A Large Health Care System

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Background: Bellin Health in Wisconsin has pioneered the colocation and integration of physical therapists into primary care pods.

Methods: This is an observational study based on one in-person visit and several interviews.

Results: For patients with musculoskeletal complaints, providers make warm handoffs to the physical therapist, who is a few steps away. The physical therapist performs most of the visit, providing diagnosis, treatment, and patient education. Research studies show that—compared with physician management—appropriate patients managed by physical therapists have better outcomes, lower costs, and higher patient satisfaction. In a fee-for-service environment, the business case for this innovation requires an increased number of follow-up referrals to the physical therapy department. In the Coronavirus disease 2019 (COVID-19) era, physical therapists can provide video visits with equal quality compared with in-person visits.

Conclusion: The Bellin Health program is a blueprint for other primary care practices to integrate physical therapists into primary care teams. (J Am Board Fam Med 2021;34:866–870.)

Keywords: Patient Care Team, Physical Therapists, Physical Therapy, Primary Health Care, Wisconsin

Teams in primary care often consist of core teams that are supported by extended care teams. Core teams, or “teamlets,” involve a provider and medical assistant responsible for a panel of patients. Extended care teams, including registered nurses (RNs), pharmacists, behaviorists, social workers, physical therapists, and others, support several core teams for patients who require more intensive services.¹ Physical therapists, who have a Doctor of Physical Therapy degree, are seldom considered primary care team members.

This article explores how physical therapists in multispecialty groups can help rescue primary care providers (eg, physicians, nurse practitioners, or physician

assistants) from the overwork and burnout that has affected ambulatory medicine. Following a general discussion, the article describes a pioneering example of physical therapy integrated into primary care.

The Troubles of Primary Care

Primary care is challenged. A Merritt Hawkins “secret shopper” survey found that wait times for primary care patients grew by 30% from 2014 to 2017.² With poor access, patients are going elsewhere. Acute primary care visits per capita dropped by 30% from 2002 to 2015, while urgent care, retail clinic, and emergency department visits grew.³

For providers, primary care is barely “do-able.” According to Yarnall et al, it would take 21.7 hours per day to provide excellent care for a standard panel of 2500.⁴ Family medicine burnout rates exceed 50%, leading providers to reduce their hours, further restricting patient access.⁵ In many practices, primary care teams provide little help.⁶

Physical Therapists in Extended Care Teams

Extended care teams can address many of these challenges. Research studies show that RNs and

This article was externally peer reviewed.
Submitted 16 August 2020; revised 24 September 2020;
accepted 28 September 2020.

From the University of California, San Francisco (TB);
Bellin Health, Green Bay, WI (JK, AT, JJ).

Funding: None.

Conflict of interest: None.

Prior presentation: No prior presentation.

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pharmacists can independently care for a large proportion of patients with diabetes and hypertension with excellent quality, requiring little if any provider time.¹ This would add capacity to see more patients, thereby improving access without worsening burnout.

Physical therapists can similarly add capacity while reducing provider work. A 2014 systematic review found that patients directly accessing physical therapists, compared with those referred by a physician, had better outcomes (more fully achieved goals, less average pain, and fewer missed days from work), lower costs, higher patient satisfaction, decreased imaging, fewer medications, and no increased risk of harm. The number of physician visits decreased with direct access, showing that physical therapists were offloading work from physicians.⁷ According to the American Physical Therapy Association, all 50 states allow direct access to physical therapist services, though details vary among jurisdictions.⁸

Let us do a thought experiment based on pre-COVID-19 face-to-face visits. Assume a typical provider works 200 days per year and sees 20 patients each day; capacity is 4000 visits per year. Let us say the provider has a panel of 2000 patients who, on average, want 3 visits per year. Thus, the demand for that provider's appointment slots is 6000 visits per year. The demand-capacity gap is $6000 - 4000 = 2000$, which leads to poor access for patients.

Consider how physical therapists can help. Musculoskeletal complaints are 1 of the most common reasons why patients seek care.^{9,10} Research studies estimate that patients with musculoskeletal conditions account for 10–27% of visits to primary care physicians.^{11–15} Let us suggest that 15% of visits are for musculoskeletal conditions which physical therapists can handle independently. Fifteen percent of the 4000 visits offered by our provider is 600 visits provided by the physical therapist. The demand-capacity gap drops from 2000 to 1400. Adding visits that nurses, pharmacists, and behaviorists can provide independently, the extended care team can close the demand-capacity gap, improving patient access without increased provider burnout.

Case Report of Physical Therapists Integrated Into Primary Care

Bellin Health in Northeastern Wisconsin has created powerful core teams in which 2 clinical

assistants (“care team coordinators”) work with each provider, offering team visits with their patients.¹⁶ Currently, Bellin is pioneering a program in which physical therapists—co-located and integrated into primary care—provide support during patient visits that reduce provider visit time.

The concept of integration in primary care includes (1) the coordination of services between the primary care home and other entities in the medical neighborhood, and (2) bringing new services into the primary care home.¹⁷ The co-location and coordination of primary care and physical therapy services at Bellin exemplify the second form of integration. Most studies examining the addition of services into primary care feature behavioral health. For example, a recent study found that patients with depression treated in an integrated setting had a greater reduction in PHQ-9 scores than patients treated in a co-located environment without primary care-behavioral health coordination.¹⁸ While publications on physical therapy integration into primary care are sparse, 1 review does categorize modes of integration of rehabilitation services (including physical therapy) into primary care.¹⁹

The Bellin integration program began in 2018 within 1 primary care pod. Each weekday, 1 physical therapist is co-located to the pod to be available for any musculoskeletal complaint coming to 1 of the pod's physicians. The physical therapists, who generally see patients in a separate physical therapy department within the same clinical site, rotate to become the co-located and integrated physical therapist. This structure allows a physical therapist to be dedicated to primary care patients, providers, and teams daily. As of February 2020, Bellin offered integrated physical therapy support for 32 primary care providers at 3 sites.

Physical therapists can provide treatment and support for various conditions, including education and exercise in addressing musculoskeletal pain affecting neck, back, shoulder, hip, knee, ankle, and foot. They can treat vertigo, address falls and balance, and do exercise education for persons with diabetes, depression, and chronic pain. Physical therapists aid physicians in making a diagnosis and creating a plan of care.^{20,21}

At Bellin Health, patients briefly see their provider first, followed by a visit with the co-located physical therapist for appropriate patients. Seeing the provider first makes sense because many visits include musculoskeletal problems plus other issues.

Thus far, Bellin has not made direct appointments with the co-located physical therapist. Providers can turn patients over to the physical therapist in warm handoffs or co-visit with the physical therapist. Co-visits educate providers who become more comfortable with musculoskeletal issues. Primary care physical therapy visits can be a one-time affair with education and exercises taught, or patients can receive follow-up in the physical therapy department. Co-location is crucial to the success of the program. If the physical therapist were down the hall or upstairs, they would not be consulted, “out of sight, out of mind.”

Physical therapists did not need additional training for the primary care role. Because providers see musculoskeletal patients first, they identify who is appropriate for warm handoffs. After the consultation, therapists share their recommendations with the provider and the patient.

The integrated physical therapy program has not been subjected to a robust evaluation, but initial assessments have been made. In a small survey of providers for the year 2018, all respondents felt strongly that integrated physical therapy adds value to their practice and their patients. Many have reflected on the skill of physical therapists in assessing orthopedic conditions. Anecdotal evidence supports that integrated physical therapy reduces provider stress; physical therapists spend additional time with patients, allowing providers to move quickly to their next patient.

Patient satisfaction with the program has been 98.6%, in part because they do not have to wait and return for a physical therapy referral but receive the service right away. Using the Focus on Therapeutic Outcomes metric, patients who received integrated physical therapy had highly positive patient-reported outcomes.²²

Physical therapists appreciate the program as a change of pace from their traditional schedule of seeing 1 patient after another. The therapists enjoy the engagement with providers. They especially like that they influence patients early versus later, help improve outcomes and use less imaging which reduces spending.

Does the co-location program increase primary care capacity and reduce the work of providers? On average, the integrated physical therapist sees about 8 patients per day. The impression of Bellin’s leaders is that primary care capacity does increase, though exact numbers are not available. Providers

relate that their workday is more efficient with co-located physical therapy since having therapists readily available saves time in assessing and treating musculoskeletal conditions. Providers may double-book patients with musculoskeletal issues, knowing that a physical therapist can handle most of the visit.

The Business Case

Wisconsin, like most states, allows direct access to physical therapy without a referral. However, Bellin has opted to have providers initiate co-located physical therapy visits. Initiating the visit, providers bill in the usual manner, receiving payment higher than that paid for physical therapy-only visits. Bellin has considered direct access to physical therapy, which would be financially achievable under value-based contracts but challenging under fee-for-service.

On the positive side, having physical therapists in the primary care space increases referrals to the physical therapy department, where visits are billed. At 1 Bellin site, referrals increased by 34% in the year following integration. After the integrated program started, 1 in 33 primary care visits resulted in a physical therapy department referral compared with 1 in 42 visits before the program, indicating an increase in referrals. A benefit of this program will be the decreased cost of care as value-based payments continue to increase. In summary, the business case for integrated physical therapy is still a work in progress.

Spreading Physical Therapy in Primary Care

Many primary care practices could use and integrate physical therapists as part of their extended care team, allowing increased capacity, improved access for patients, and possibly reduced burnout.

One challenge is the business case for physical therapy integration in primary care; clinical leaders need to engage their chief financial officer early in the planning. Bellin Health has concluded that integrating physical therapists in small clinics is not viable due to the insufficient volume of appropriate patients. To justify the cost of dedicating a physical therapist to primary care in a fee-for-service setting, the therapist needs to see enough patients to generate additional referrals to the physical therapy department.

Another barrier may be physicians, who traditionally have difficulty giving up clinical control and engaging physical therapists. At Bellin, provider acceptance has grown as they experience the quality provided by the therapists, the offloading of clinical work to a well-trained team member, and the clinical skills they learn from physical therapists.

Physical Therapy and the COVID-19 Pandemic

The co-location of physical therapists into primary care began before the pandemic. In fact, primary care physical therapy is possible using video visits. Several systematic reviews have found that physical therapy via telehealth can improve pain and physical function similar to that of in-person care for such conditions as osteoarthritis, low back pain, or following total knee arthroplasty. Physical therapists can assess pain, swelling, range of motion, muscle strength, balance, gait, and overall function by video visits. In studies, the diagnostic agreement between telehealth and in-person assessment ranges from 60% to 93%; agreement for clinical management decisions reaches 83%. Patient satisfaction with telehealth physical therapy can be as high or higher than for in-person visits.²³

Conclusion

Without a team, overworked primary care providers cannot offer prompt access for their patients without working harder. Highly skilled physical therapists can independently care for many patients with musculoskeletal conditions, thereby adding the capacity to see more patients without increasing provider work. The case report described here—integrating physical therapists into primary care—provides 1 blueprint for such a primary care innovation.

To see this article online, please go to: <http://jabfm.org/content/34/4/866.full>.

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