

PPS DICUS AWARD ACCEPTANCE SPEECH

Marilyn Moffat

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President Andersen, members of the PPS Board of Directors and Awards Committee, fellow private practitioners, and friends. I am truly humbled in being selected as the 22nd recipient of the Robert G. Dicus Award – the highest honor that is bestowed upon a member of the Private Practice Section. I join an incredible list of true leaders in the profession, and it is fitting to give each and every one of them due recognition for the paths that they have traversed and the roads that they have paved for all of us – Charles Magistro, Ben Johnson, Jim McKillip, Jay Goodfarb, Royce Noland, Clem Eischen, Lucy Buckley, Tom Carlson, Frances Guglielmo, Peter Lord, Al

Amato, Jack Close, Chuck Hall, Robert Doctor, Ernie Burch, Jim Gould, Peter Towne, Helene Fearon, Florence Kendall, Michael Weinper, and Jayne Snyder. I also am in the enviable position of having personally known and interacted with each and every one of these individuals during my practice lifetime.

My physical therapy educational program started the very year that Bob Dicus was diagnosed with amyotrophic lateral sclerosis. After graduation and already immersed in professional activities, I had the good fortune of meeting and getting to know Bob, and I also will never forget the memorable 1975 House of Delegates when Bob was made an honorary member of the association.

Private practice has a long tradition and a rich history within our association. We often equate the beginnings of private practice as we

know it with the “radical movement” in the 1950’s started by Dicus, Magistro, McKillip, Kendall, and a handful of others to convene a meeting of self-employed physical therapists with the possibility of forming a section. While those initiatives did indeed lead to the formation of the Self-Employed Section, one of the earliest private practitioners was a reconstruction aide by the name of Marguerite Irvine who served as the 15th President of the APTA. Thus, private practice developed concomitantly with the evolution of the profession in the United States.

While statistics are not available from our earliest history, over the years of data collection we can see the dramatic change that has been occurring with increasing private practice. Hospital based practice 20 years ago accounted for approximately 42% of physical therapist practice and had dropped to 13% in 2001. On the

other hand, 20 years ago, only 15% of our practitioners were in private practice as opposed to almost 30% in 2001.

CHANGE IN PRACTICE VENUES

Facility	1983	2001
Hospital	41.9	
Acute Care Hospital		13.1
Private Physical Therapy Office	14.7	
Private Out-Patient Office or Group Practice		29.4

I started preparing for this acceptance speech with the question of: “Why me?” Most in the profession think of me as a full time academician and a political figure who has served in multiple capacities within the APTA. And then I decided, it was important for you to fully understand the other side of my practice life. I am the embodiment of the solo entrepreneurial private practitioner, and I have been so, for the almost 40 years of my practice life time.

I started my private practice in 1965, as many of us did, doing home visits after my full day of work in a hospital and rehabilitation facility. I had the good fortune of having more patients than I could ever handle referred to me by the Chair of the Department of Orthopedic Surgery at the hospital (Dr. Walter Thompson). Walter was one

of those wonderful, extremely skilled surgeons who only operated when it was absolutely necessary, who recognized and valued physical therapy services, and who was delighted to have someone that he could just call up and say I would like you to see Mr. Jones or Mrs. Brown and knew that the patient would be taken care of to the best of my ability. Our professional relationship lasted 11 years when he finally retired from his position at the medical center. My referral base by this time had increased many fold and word of mouth from patient to patient brought increasing numbers of patients to me. During that time I had also set up a small practice office on Long Island in addition to my practice in New York City.

I searched around to find another conservative orthopedist to whom I could now refer many of my patients. Once again I found a

truly compassionate human being and excellent surgeon (Dr. Peter Rizzo) with whom I eventually shared office space. You will note that I said shared office space. I paid my share of the expenses, and I did all of my own billing – my income was mine and his was his. We referred to each other when appropriate and referred to others also when appropriate. The thought of his owning me or my being owned by him never entered either one of our minds. We were truly professional equals each in our own area of specialty – mine physical therapy and his medicine.

Peter had been doing consultant work with both the NYC Police and Fire Departments. At one point he asked me to become involved with the New York City Police Department since they were looking for someone to help them to see if they could cut down their disability payments for

back and neck related problems. This consultant position wound up as almost another full time job (on top of my academic responsibilities and my solo private practice). I not only treated patients who had been injured on the job in the department's health services unit, but also attempted to analyze the training and further requirements of being a NYC cop. I loved the challenge but could not endure the frustration of inertia and lack of desire to make changes, especially on the part of the union. NYPD had a very interesting retirement policy in their union contract. If they retired after 20 or 25 or 30 years, they went out on 1/2 pay that was taxable income. If they went out on disability retirement, they went out on 3/4 pay non-taxable. Needless to say there was great incentive to retire on disability. I tried to suggest major changes including: instituting continuing fitness

requirements for each member of the force with fitness tests being administered each year, lightening up the gear that they carried around their waists, getting more out from desk jobs and back walking the streets, changing the footwear to greater impact absorbing soles, starting weight control programs, getting earlier high quality services in times of injury so that they didn't become lost in the shuffle of the bureaucracy and therefore became increasingly prone to prolonged disability, and so on. After 5 years of constantly trying to make changes, I finally decided it was not worth hitting my head against a wall. However, I came away from the department with an incredibly healthy respect and admiration for many of those who try to protect us on a daily basis. Interestingly, all of those changes were eventually implemented with a new police commissioner and a mayor

who insisted upon reform within the department – but that was many years later.

My 12-year relationship with Peter Rizzo abruptly ended when he was fatally shot in the head by a member of the NYC Fire Department who had been trying to get disability pay for 8 years. In spite of the emotional trauma of losing a best friend and esteemed colleague, my practice continued.

I have, as a private practitioner, lived through all the ups and downs, all of the trials and tribulations of attempting to provide high quality physical therapy services in ever changing health delivery environments. My practice started with the idyllic fee for service model with no reimbursement forms, no copious regulations by the government and insurance companies, and no attitude on the part of patients that someone had to pay for their health care. They

willingly paid and if they could not afford it, a reduced fee or no fee were the modus operandi since an office staff was not needed to keep up with the burdensome paper work and hassling with insurance companies. And over the years I gradually watched and became immersed in the ever-increasing reimbursement changes, the codes that did not reflect the caliber of our services, and the increasing attitude of patients that someone should pay for their health care.

There is also the political side of my activities within the entire specter of private practice. From my earliest days I have staunchly supported and fought for the needs of the private practitioner. I was on APTA's first Governmental Affairs Committee (with Clem Eischen, Archie Moore, and Jim Finch). All of our efforts were with issues that directly or indirectly affected private practice. As a committee we

enhanced the support for the association's APT-CAC. As President of the NY Chapter, I hired a well-respected lobbyist and along with Stan Arno helped set up the first chapter PAC so that we would begin to have needed influence in the halls of Albany. Again our issues were predominantly those that affected private practice. Even a change in our practice act in 1980 gave us evaluation and prevention without practitioner referral.

I have testified on behalf of private practice issues more times than I can remember. When I was APTA president we set up the first insurer's summit to try to make insurance companies aware of the needs of those of us in private practice. Also during that time, we were able to get Helene Fearon and Steve Levine appointed to the AMA coding panel so that we finally began to get codes reflective of our practice.

We were able to achieve significant changes in the RVU's during my Presidency between 1992 to 1995. To review just a little history, many of you will remember that physical therapist practice was looked upon as a modality pushing practice in the late 1980's. In reality, the Medicare payment system in place at that time reimbursed a physical therapist in private practice almost as much for a hot pack as it did for therapeutic exercise or functional training. Galvanized into action to straighten the situation out, we were able to achieve a downgrading of the fee for unattended modalities and an upgrading of the fees for therapeutic exercise, functional training, and manual therapy. It is interesting to look at these changes between 92 and 95 and even to today.

YEAR	MODALITY	TIME	RVU
1992	Hot Pack		.47
1992	Therapeutic Exercise	30 min	.54
1995	Hot Pack		.34
1995	Therapeutic Exercise	15 min 30 min	.60 1.20
2003	Hot Pack – no longer reimbursed by Medicare		.12
2003	Therapeutic Exercise	15 min 30 min	0.76 1.52

I lived through the entire fiasco of the Clinton health care reform being done behind closed doors and closing so many of us as practitioners out of the process. We had the alphabet soup of regulations [the BBA (balanced budget act), PPS (Medicare prospective payment system), MDS (minimum data set), RUGS III (the third version of the resource utilization groups), and OBRA (omnibus reconciliation act)] imposed on many facets of our practices. We had the alphabet soup of insurance plans from HMOs to PPOs to POS.

But I also lived through spearheading the development of the “Guide to Physical Therapist Practice.” When I reflect on the hours that hundreds of physical therapist volunteers provided into the compilation of that document, I am still in awe of what we accomplished in 5

years. The ramifications of finally putting forth a complete and consistent description of who we are, what we do in practice, how we do it, the tools we use, and the parameters in which we do it have been far reaching for all of us. The Guide has been invaluable for individual therapists having to confront reimbursement agencies, invaluable for chapters in legislative arenas, and invaluable for our negotiating therapists at the CPT/RBRVS table in getting the manual therapy codes.

I lived through the times when the small practice professional like myself was almost written off as the mega practices, especially corporate owned, became the vogue. And in spite of all the changes, my practice as I know many, many other smaller, tightly held practices continued to flourish. We flourished because people knew the value of what they were

receiving in our practices. We had relationships established that stood the test of time. Word of mouth became as big a referral source as anything and as big a marketing tool as we ever could have hoped for. I even went the for pay method five years ago with a little fear and trepidation, but am so happy I did, and I still have as many patients as I wish to handle. My patients come from all walks of life – artists, maids, high powered business persons, hair dressers, heads of government, actors, teachers, secretaries, and even some persons whose real names I never knew. They have all crossed the threshold of my office expecting to receive the highest caliber of services possible. And I hope that I have not disappointed any of them.

Consultative activities continue to be a part of my practice life. I was asked at the end of the spring baseball training season to go to Florida

by the owner of the New York Mets to take a long hard look at their training program and a follow-up visit to the new exercise facility that was going to be build at Shea Stadium. Hopefully next year suggestions agreed upon by their owner, their new trainer, and new associate trainer, who is also a physical therapist, will raise their standings from the bottom of the barrel. My practice also led to consultative work with DePuy, one of the manufacturers of joint replacements. I wrote APTA's Book of Body Maintenance and Repair for the lay audience and have just completed another book with Carole Lewis that we are probably going to title "Age Defying Fitness." A national program in the osteoporosis arena has asked me to consult for them.

My practice today is still between 15 and 18 hours a week on top of my academic and other

responsibilities, and I will never trade the private practice part of my professional life for anything in the world. Even though it often means that I see patients and clients on Long Island on Saturdays and sometimes on Sundays. The sense of accomplishment and professional satisfaction derived from this type of practice has little equal.

Never one to leave without some words of challenge, I will do so now. You, and I obviously am including myself in these challenges, as private practitioners have at times, but not always, been the leaders of the profession. Now is the time when you must be leaders and exemplary role models for the ideals of practice.

You must serve as the master clinicians for our students, for we know your practices and behaviors are most likely to be adopted by our students. Just as an aside, we have incorporated

into our educational program at New York University a one day a week observation during each of four semesters with a master clinician. These carefully selected clinicians all have at least 5 years of experience (in musculoskeletal, neuromuscular, cardiovascular/pulmonary, and other systems areas). They each allow two to three students to come to their practices to observe those “best,” high quality services. The clinicians love it and the students love it because there is no pressure on either part of grading the student and the student doesn’t interfere with the day-by-day operations of the practice.

You must also set the standards for practice. Being master clinicians in all of your practices means that patients and clients must see you for more than 10 minutes of your undivided attention, and they must be aware of the

cognitive and physical skill required of you in your practice. Why does a physician assume that she or he can provide physical therapy in their office and make a great deal of money from it. Because the assumption is made that physical therapy services are routine activities capable of being done in 10 to 15 minutes of time by multiple levels of personnel. How many of these physicians know what differentiates the physical therapist master clinician's practice from run-of-the-mill work? And if they do not, then it is about time that we teach them. I have been blessed in my professional life with the physicians with whom I have practiced, but I have also cultivated those relationships. I have known the internists, the rheumatologists, the gynecologists, and the dentists. And yet, I am dismayed when one of my very good orthopedic surgeon friends (one who started his orthopedic residency when I started

my fledgling career) says to me – and I quote – “that I would have no problem with you practicing without referral in New York State because you are different. When you treated my back, I had never had such a thorough examination prior to determining what needed to be done to get rid of my back pain. Your treatment program left no stone unturned” – end of quote. This kind of statement made my back hair stand up, and yet I had to evaluate it in light of what he had obviously experienced with the services provided by other physical therapists. We must be sure that we are the consummate practitioners of our métier, so that we are not only sought out by patients and clients, but also by physicians, dentists, podiatrists, and even nurse practitioners and physician’s assistants because we are the best that there is.

The value and worth of our services is reflected daily and hourly by what we do and how we do it. Mastery is not difficult to achieve, but it does require an expectation of excellence and an assurance that it is maintained. Standing around chatting with colleagues while patients do their own thing, looking at the clock, expecting to leave by 4:00, not being involved outside of practice in association activities, not supporting legislative efforts, etc, etc, etc are not examples of the master clinician. All of you as private practitioners must expose your patients, your clients, your referring sources, and our students to these “best” practices – no short cuts, no compromising of quality services, no delegation of services to inappropriate personnel, no yielding of ethical principles.

Now more than ever as physician owned physical therapy services have once again

reared their contemptible heads, we must continue to pursue all possible legal ways to preclude physician owned physical therapy services, and we must press the government for redress. In this case it means all consumers must have direct access to physical therapy services, whether it be on the state or the federal level. Our time, effort, financial resources, and whatever else it takes must see this goal reached as quickly as possible. We cannot sit back and expect the Section's or APTA's government affairs staffs to do the work for us. While they provide unbelievable support in this arena on a constant basis, we too must be willing to go that extra mile. Rallies in Washington and at state capitols must be regular occurrences. Donations to PACs must no longer be token contributions. Visits to legislators in their home offices, hosting fund raising parties for them, and contributing to

their individual campaigns all the way from dollar contributions to ringing doorbells to get out the votes must be ongoing activities of each of us. Wouldn't it be fantastic if at the end of 2004, all individuals would have direct access to physical therapy services provided only by or under the supervision of the physical therapist.

One last challenge, you must also lead the charge to a doctoring profession and if you are not already enrolled in a transitional DPT program, you should be. Being on equal footing with others in health services delivery is essential to achieving the professional status to which we have aspired. And it becomes even more so as we become points of first contact in health services delivery.

This Section that has recognized me today has meant a great deal to me. It has provided a forum for me and for all of us as practitioners

and support staffs to come together, to meet with our peers, to become ever aware of the challenges confronting us, to learn what might work in promoting and operating a practice, and to glean the knowledge and wisdom from our colleagues. I have been truly blessed with the most incredible array of patients, clients, professional colleagues, and friends who have been a part of my life. I thank you from the bottom of my heart for this honor and I wish you all God speed.