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Research Report

Direct Consumer Access to Physical Therapy in Michigan: Challenges to Policy Adoption

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Background. Despite the ability of consumers to receive treatment from a physical therapist without a physician referral or prescription in 45 states, Michigan continues to require a physician prescription. Given the impending primary care provider shortage, direct access should be considered as a potential solution to barriers that prevent patients from accessing timely musculoskeletal care.

Objective. The purpose of the present policy analysis was to analyze why an attempt in 2006 to remove the prescription requirement in Michigan was not adopted.

Methods. The Policy Analysis Triangle approach, which considers the relevant actors, processes, and context in which a policy must be considered, was used to analyze why Michigan House Bill 5618 was not passed. Data sources included position statements from relevant stakeholders, state government documents, stakeholder analysis, and a systematic review of the literature.

Results. Multiple data sources, including a systematic review of the literature, revealed that direct access does not pose a risk to public safety and may result in better outcomes with regard to cost and quality of care. Failure of Michigan to adopt direct access in 2006 was due to scope of practice conflicts and various political contexts and processes.

Conclusions. Direct consumer access to physical therapy services appears to be sound health policy that should be reconsidered by Michigan's legislature to alleviate the primary care provider shortage for those with musculoskeletal disorders.

The projected shortage of at least 44,000 primary care providers[1] and the 32 million newly insured individuals resulting from the federal Patient Protection and Affordable Care Act of 2010 (PL 111-148)[2] will require that the United States closely examine the deployment of the nation's health care providers. A diverse and highly specialized workforce provides opportunities for a variety of disciplines to function in primary care roles to improve access and reduce cost by eliminating unnecessary provider visits. However, redeployment of a discipline may be limited in some states due to restricted scopes of practice. "Direct access" is the term describing the ability of a patient to go directly to a physical therapist without a prescription or referral from a physician. Physical therapists are trained to function as primary care providers for musculoskeletal problems, have the potential to help mitigate the substantial projected primary care provider shortage, and are able to currently function in this role in 46 states.[3,4] Michigan is 1 of 4 states that continue to require physician prescription or referral, which prevents the public from directly accessing the care of a physical therapist.

The purpose of the present analysis is to examine why the most recent attempts to pass direct access legislation in Michigan failed, in order to direct future legislative efforts. The Policy Analysis Triangle approach, developed by Walt and Gilson,[5,6] was selected as the policy analysis framework because it is comprehensive in its consideration of the many other factors beyond the merits of a policy that influence its development and adoption. Walt and Gilson based the framework on their observations that policy adoption and implementation failure occurs because most policy analyses focus on content of the proposed policy rather than on the context, processes, and actors involved in policy adoption and development. This analysis, therefore, also will consider those additional factors.

Background

History of Direct Access in the United States

In 1973, the House of Delegates (HOD), as the decision-making body of the American Physical Therapy Association (APTA), resolved to establish the necessary "guidelines which stipulate the professional and ethical implications and responsibilities of [physical therapist] evaluation [of patients] without practitioner referral."[7] The HOD revised this resolution in 1978 to "devise a plan for the development of physical therapy practice [evaluation and treatment] independent of practitioner referral."[8] At that time, only 2 states did not require practitioner/physician referral. Subsequently, APTA began a direct access initiative to eliminate the physician referral requirement in all jurisdictions in the United States.[9] There also were progressive changes in professional education standards to better prepare entry-level clinicians to be able to screen for the presence of medical disease and to function in a direct access environment as a point of entry into the health care system. These efforts have resulted in 46 states and the District of Columbia now permitting some degree of direct consumer access to physical therapy treatment. Seventeen states have unrestricted direct access, and the other 29 states and the District of Columbia have a variety of provisions or restrictions on how a consumer can access and receive physical therapy treatment.[9] Examples of these provisions or restrictions include: (1) time limits that require a referral within a specified period of time from the beginning of care, (2) referral to a physician if progress is not made within a specified time frame or if the patient exhibits signs or symptoms of a problem outside of the physical therapist's scope of practice, (3) experience or continuing education requirements, and (4) established diagnoses or prior referral for physical therapy for the same problem.

History of the Michigan Public Health Code and Physical Therapist Scope of Practice

Physical therapists in Michigan have been licensed since 1965 as a result of Michigan Public Act (PA) 164. The initial scope of practice of physical therapy was restricted to being "under the prescription and direction of a physician," defined as a doctor of medicine, osteopathy, or podiatry. The requirement for practice under the "direction" of a physician was removed as a result of Michigan PA 368 of 1978. Doctors of dentistry were permitted to prescribe physical therapy by Michigan PA 178 of 1982, but those with a subfield license (eg, physician's assistant who is licensed as a subfield of medicine) were prohibited from doing so. In 1987, Michigan PA 213 permitted physical therapists to evaluate, educate, and consult without a prescription, but retained the requirement for treatment upon physician prescription. Attempts to remove the physician prescription requirement during several legislative sessions were not successful (Michigan House Bill [HB] 5014/Senate Bill [SB] 620 of 2001–2002, HB 4176/SB 1174 of 2003–2004, and HB 5618 of 2005–2006).

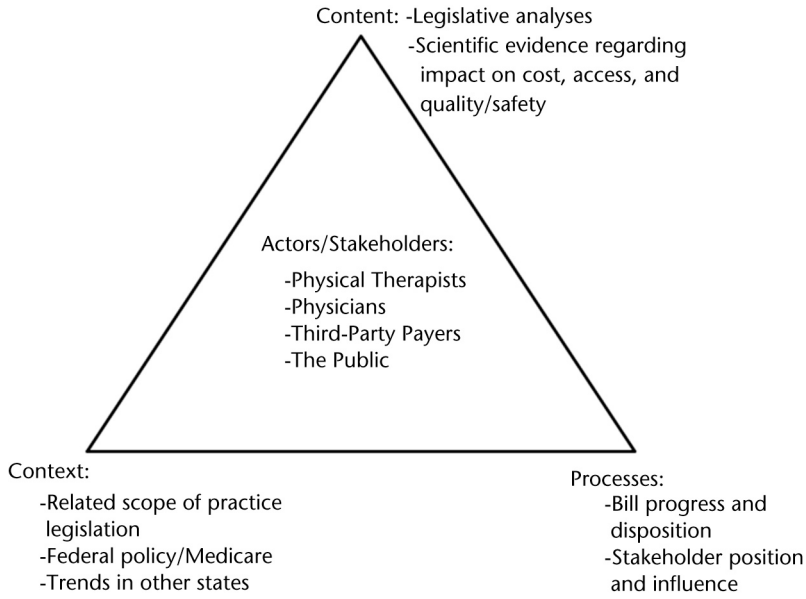

Figure.
The Health Policy Triangle.[5,6]

Regulatory Policymaking and Policy Analysis

The purpose of regulatory policymaking is to provide the necessary constraints on a group of individuals "to produce outcomes consistent with citizens' preferences manifested by democratically accountable representatives."[10(p411)] In the context of health professional scope of practice under a state's public health code, regulatory policymaking seeks to provide protection to health care consumers receiving services in that state.[11] Lawmakers developing and modifying policies within the public health code, therefore, are acting as moral agents who must understand how the public will be affected by such policies.[12] However, the philosophical underpinnings of policymaking in a democratic society are rooted in rationality and pragmatic philosophy, which seek to achieve a "working harmony between diverse values, desires, and their anticipated consequences."[13(p265)] Indeed, modern regulatory policymaking is not free of special interest influence, nor can the scientific evidence used in policymaking be apolitical.[14]

Policy analysis can be a retrospective or prospective endeavor. Either can provide insight into the complex process of policy development, adoption, and implementation.[5,6] Retrospective analysis can provide insight into why a policy was or was not adopted and, if adopted, how effectively a policy was implemented, whereas prospective analysis can provide concurrent and predictive understanding and guidance in the policymaking process.[5] Best practices in policy analysis utilize frameworks to ensure that the conclusions of an analysis are "clear and testable propositions."[6] Furthermore, policy analysis can foster both the development and utilization of theories that explain the policymaking process.[6] The present analysis is retrospective.

Methods of Review and Analysis

Walt and Gilson's Policy Analysis Triangle[15,16] (Figure) accounts for additional factors beyond policy content that affect policy development, adoption, and implementation, including social and political contexts, political processes, and primary stakeholders or actors. The Policy Triangle framework, therefore, can help explain why, in a social and political system of competing interests, policy adoption and implementation attempts have failed and may help direct future policymaking strategies. The present analysis utilized the Policy Analysis Triangle approach to establish the content, context, processes, and actors relevant to direct access legislation in Michigan during the 2001–2002, 2003–2004, and 2005–2006 legislative sessions.

Analysis of policy content includes not only a description of the policy's intent and provisions, but also an assembling and examination of the evidence regarding the anticipated impact of the policy.[17] Therefore, in addition to describing the proposed changes to the Michigan Public Health Code introduced during 3 different legislative sessions, the present analysis of policy content sought to describe the potential impact of the direct access using the available research evidence and its effect on access, cost, and quality of physical therapy services.

The analysis of the policy content of direct access legislation introduced during each Michigan legislative session included examination of the provisions in each bill. This was supplemented by use of House and Senate legislative analyses when available. Michigan House and Senate legislative analyses are written by nonpartisan House or Senate staff for use in legislative deliberations and provide a summary of the intent, provisions, and arguments provided by supporters and opponents of a bill. Each bill and the associated analyses

are available on the Michigan Legislature Web site.[18]

Given that analysis of policy content includes examination of the potential impact of a proposed policy,[16] the present analysis also included examination of the evidence regarding the potential impact of direct access that might have been available to legislators in their decision making during a given legislative session. This examination included a literature search of CINAHL and PubMed databases using the following key words: "physical therapist," or "physical therapy" and "medical screening," "medical referral," "decision-making," or "direct access." Reference lists from articles found by these searches were utilized to discover additional articles. Articles were included if they specifically addressed some element of direct access or medical screening (identification of disease outside of the physical therapist scope of practice) by physical therapists. There were no exclusion criteria. Articles were considered to be "available" for consideration by legislators if they were published by the midpoint of the legislative session in which the legislation had been introduced (eg, for legislation introduced during the 2005–2006 legislative session, articles were considered to be "available" if published by 2005).

Analysis of the context of the proposed legislation included examination of situational and cultural factors that provide a better understanding of how direct access legislation may have been perceived by legislators and possible reasons why the proposed legislation failed to be adopted. *Situational factors* were defined as other specific legislative events or legislative precedents related to the practice of physical therapy, as well as a description of the legislature in terms of political party control. *Cultural factors* were defined as general perceptions of physical therapy that may have existed at the time that each bill was being considered. Therefore, analysis of context included:

- Consideration of the prevalence of direct access in other states using data from APTA about the number of states that permitted direct access during each legislative session.
- Consideration of federal legislation known to the author that sought to remove the physician prescription requirement for physical therapy services provided under Medicare.
- A search on the Michigan Legislature Web site for other legislation during each of the 3 legislative sessions that amended or proposed to amend the physical therapy practice act. The search term used was "physical therapy."
- Description of the legislature with regard to party control using historical data from the Michigan Legislature Web site.[18]

The analysis of processes included a description of each bill's progress and final disposition in the legislature, analysis of legislator voting record on direct access, identification of relevant stakeholders, a description of stakeholders' position on direct access, and an estimation of stakeholder influence. Bill progress, disposition, and legislator voting record were obtained using the Michigan Legislature Web site. Relevant stakeholders and their positions were identified using the Michigan House and Senate legislative analyses, which identify supporters and opponents of the bill and describe each group's rationale for their position. An attempt also was made to examine committee hearing attendance and written testimony; however, Michigan law does not require this information to be retained following the conclusion of the legislative session. Thus, this information was not available for analysis. Therefore, stakeholder position also was determined using position statements from representative organizations when available. Stakeholder influence was estimated by political action committee (PAC) contributions obtained from the Michigan Campaign Finance Reporting Searchable Database.

Additional sources of data were utilized to support the aforementioned analysis strategies. First, a search for media stories about direct consumer access in Michigan was conducted using the MLive online news outlet for Michigan and the NewsBank database with the Michigan filter selected. Search terms were "physical therapy" or "physical therapist" and "direct access," "scope of practice," "referral," or "prescription."

The second additional source of data to support the planned analysis was consultation with 2 lobbyists from a large, multiclient lobbying firm (Bret Marr and Terry Vanderveen from Muchmore, Harrington and Smalley Associates, Lansing, Michigan; personal communication; February 14, 2011). The lobbyists were selected based on author convenience. Both lobbyists currently represent the Michigan Physical Therapy Association (MPTA), although neither were involved in the direct access efforts described in this article. Multiclient lobbying firms represent a wide variety of special interest groups and have expertise in many different industries. Both lobbyists were very familiar with direct access legislation, as one represented the Michigan Occupational Therapy Association and the other represented the Michigan College of Emergency Physicians (neither organization had a position on any of the bills analyzed in this article). The purpose of the lobbyist consultation was to provide unbiased, expert insight into and confir-

mation of those elements in the political process that are not documented. Both lobbyists were provided a draft of the article containing background, collected data, and provisional analysis in advance of a 1-hour conference call. The discussion during the consultation was unscripted, unrecorded, and focused on the influence of stakeholder PAC contributions on political processes and possible reasons that direct access legislation failed to progress (Appendix).

Results

Content

The intent of and provisions in each bill were obtained from the bills and the associated legislative analyses, which provided the following content-related information (briefly outlined in Tab. 1). The primary objective of each bill was to remove the prescription requirement for physical therapy intervention. Each bill had additional provisions stating that patients must be referred to a physician if they have problems outside of the physical therapist scope of practice or do not make reasonable progress. Other proposed changes to the Michigan physical therapy practice act included the addition of a continuing education requirement for license renewal, definition of the physical therapist assistant, endorsement of APTA's professional *Standards of Practice* and *Code of Ethics*, and a requirement that applicants for initial licensure possess the Doctor of Physical Therapy degree by 2009. A final provision in each bill stated that changes in the physical therapist scope of practice would not require nor preclude third-party payer reimbursement for services provided under direct access. It should be noted that HB 5618 of 2005 included considerably more restrictions on providing interventions under direct access (Tab. 1).

With regard to the potential impact of direct access in Michigan, a literature search sought to determine what research evidence was potentially available to legislators during their deliberations in each legislative session. The articles that were available during each legislative session are summarized in Table 1. During the 2001–2002 session, 11 articles were available. All articles supported direct access and suggested that direct access may increase access[19–22] and reduce cost.[23] The articles also provided some evidence that direct access would not compromise clinical outcomes[24–26] and that physical therapists are able to screen for medical disease.[27–29] During the 2003–2004 legislative session, only an additional case report about the medical screening ability of physical therapists became available.[30] However, by the 2005–2006 session, there was a substantial increase in the number of published articles that were available to legislators. Fourteen new articles provided further support of direct access: 1 article demonstrated that physician prescription specificity was not related to outcome or number of visits,[31] 1 article demonstrated no adverse events or episodes of litigation under direct access,[32] 2 articles demonstrated adequate physical therapist performance on case-based tests and scenarios,[33,34] and 10 additional case reports demonstrated physical therapists' ability to screen for medical disease.[35–44] One article raised concern about physical therapists' ability to screen for medical disease by demonstrating that physical therapists underestimated the probability of deep vein thrombosis in several case vignettes.[45] Table 2 briefly summarizes all articles about direct access that were available during the Michigan 2005–2006 legislative session.

Context

A strength of the Policy Analysis Triangle approach is that it includes an analysis of the context in which proposed changes in health policy must be adopted. The analysis revealed several situational and cultural factors that may have contributed to the failure of direct access legislation during the three separate legislative attempts (Tab. 1).

Situational factors. Several situational factors may have negatively influenced legislators' perceptions about direct access. Despite the increase from 36 to 43 states that permitted direct access to physical therapist intervention during the 2001–2006 period, federal (Medicare) policy continued to require physician referral for physical therapy provided to Medicare beneficiaries. Federal legislation to repeal this requirement introduced in each congressional session failed to pass.

With regard to other legislation attempting to amend the physical therapy practice act in Michigan, several bills were found during the Michigan 2005–2006 legislative session that highlighted issues related to autonomous physical therapist practice. Michigan PA 281 of 2005 allowed physician assistants to prescribe physical therapy. This legislation was unanimously adopted, with supporters stating that because of physician oversight, physician assistants prescribing physical therapy posed no risk to patient safety. However, Michigan HB 5288 of 2005, a bill to allow nurse practitioners to autonomously prescribe physical therapy, was only introduced into the House and did not progress further. No legislative analyses were available for review, but according to lobbyists from a large, multiclient lobbying firm (Bret Marr, Terry Vanderveen; personal communication; February 14, 2011), the bill was not addressed by the legislature

Table 1.
Summary of Results[a]

Content	Legislative Session		
	2001–2002 HB 5014/SB 620	2003–2004 HB 4176/SB 1174	2005–2006 HB 5618
Key provisions	The same provisions were included in 2000–2001 and 2003–2004: -Removal of prescription requirement -Requirement for referral to physician if signs or symptoms of problem outside scope of practice or no reasonable improvement -Establishment of continuing education requirement with commensurate increase in licensing fee -Endorsement of professional Standards of Practice and Code of Ethics -Definition of the PTA -Exemption of third-party payers from any requirement to pay for services under DA -Requirement for the DPT for eligibility for initial licensure after 2009		Same provisions as previous years, with additional restrictions on practice under direct access: -Allowed if service is for same diagnosis as previously treated within previous year and one of the following: 1. Possesses the DPT 2. Has 2 years of experience 3. A physician is readily available in the facility -Must inform primary health care provider -Must have additional continuing education in differential diagnosis -Must be CPR certified -Must refer to physician for care exceeding 45 days or 20 visits
No. of published articles	11	12	27
Context			
No. of states with DA	35	39	43
Relevant factors -Cultural	-Societal perspective of the need for physician oversight and direction of care -Failure of federal legislation seeking to permit DA under Medicare		
-Situational	-No other legislation related to physical therapy	-No other legislation related to physical therapy	-Physician assistants allowed to prescribe physical therapy under physician oversight -Failed attempt to allow nurse practitioners to prescribe physical therapy because it would be without physician oversight -Physical therapists prohibited from performing needle electromyography
	Republican House, Senate, and governor	Republican House and Senate; Democratic governor	Republican House and Senate; Democratic governor
Processes			
Legislative disposition	-Introduced to House and Senate July 2001 -Referred to respective health policy committees -Passed House Policy Committee and House; vote 65–33, with bipartisan support -Senate Health Policy Committee did not hold a hearing; senator sponsor/physician/Health Policy Committee member did not advocate for a hearing	-Introduced to the House February 2003, Senate April 2004 -Referred to respective health policy committees -House Health Policy Committee hearing September 2004; no vote taken that day, nor during the remainder of the session despite repeated requests by the House sponsor -Senate Health Policy Committee did not hold a hearing	-Introduced to House -Referred to Health Policy Committee -No hearing was held -Senator/physician on Health Policy Committee strongly opposed
Stakeholder influence -Position -No. of licensees -Political action committee contributions for respective session	Supporting: -Michigan Physical Therapy Association, 6,765 licensees, $6,928 Opposed: -Michigan State Medical Society, 32,554 licensees, $473,679 -Michigan Orthopedic Society, 6,660 Licensees, $10,600 -Michigan Association of Chiropractors, 2,756 licensees, $59,725	Supporting: -Michigan Physical Therapy Association, 7,011 licensees, $12,190 Opposed: -Michigan State Medical Society, 29,784 licensees, $169,815 -Michigan Orthopedic Society, 6,260 licensees, $13,850 -Michigan Association of Chiropractors, 2,817 licensees, $66,620	Supporting: -Michigan Physical Therapy Association, 7,616 licensees, $11,995 Opposed: -Michigan State Medical Society, 30,687 licensees, $199,748 -Michigan Orthopedic Society, 6,409 licensees, $21,884 -Michigan Association of Chiropractors, 2,921 licensees, $70,120

[a] HB=Michigan House Bill, SB=Michigan Senate Bill, DPT=Doctor of Physical Therapy, PTA=physical therapist assistant, DA=direct access, CPR=cardiopulmonary resuscitation.

Table 2.

Available Articles About Direct Access During the 2005–2006 Legislative Session

Author/Year	Key Findings
Access	
Durant et al, 1989[20]	83% of patients attending 1 of 25 outpatient clinics in Indiana were supportive of direct access
Domholdt and Durcholz, 1992[22]	Up to 10.3% of patients accessed physical therapy without physician referral in North Carolina, Utah, and Nevada
Crout et al, 1998[21]	Up to 8.8% of patients accessed physical therapy without physician referral in Massachusetts
Snow et al, 2001[19]	73% of South Floridians would go directly to a physical therapist
Cost	
Mitchell and de Lissovoy 1997[23]	Compiled claim data from Maryland Blue Cross Blue Shield showed 123% lower costs and 60% fewer visits under direct access
Quality	
Davenport et al, 2005[31]	Physician prescription lacked sufficient specificity to guide treatment and was not related to clinical outcome
Moore et al, 2005[32]	Retrospective review of 50,799 patients seen under direct access showed no adverse events or episodes of litigation
James and Stuart, 1975[24]	Demonstrated feasibility and quality of care by a physical therapist in a musculoskeletal primary care provider role in the US Army
James and Abshier, 1981[25]	Documented the proliferation of physical therapists as musculoskeletal primary care providers in the US Army and found that care provided was "consistent with accepted standards of medical care"
Daker-White et al, 1999[26]	Randomized controlled trial of consultation and management by orthopedic surgeons and physical therapists showed no differences in patient-reported outcomes, satisfaction, and cost
Riddle et al, 2004[45]	Physical therapists underestimated the probability of the presence of deep vein thrombosis 49%–86% of the time
Moore et al, 2005[33]	Physical therapist diagnoses were highly consistent with magnetic resonance imaging results
Childs et al, 2005[34]	Physical therapists outperformed all physician specialty groups except orthopedic surgeons on a standardized knowledge test for management of musculoskeletal conditions
Robert and Stevens, 1997[29]	Case reports demonstrating the ability of the physical therapists to screen for and identify the presence of medical disease requiring referral to the physician for further medical evaluation and management
Greenwood et al, 1998[28]	
Gray 1999[27]	
Cleland and Venzke, 2003[30]	
Weishaar et al, 2005[35]	
Thien-Nissenbaum and Boissonnault, 2005[36]	
Sasaki, 2005[37]	
Ross and Bayer, 2005[38]	
Garber, 2005[39]	
Asavasopon et al, 2005[40]	
Browder and Erhard, 2005[41]	
Johnson and Abrams, 2005[42]	
Mamula et al, 2005[44]	
Stowell et al, 2005[43]	

due to pressure from the Michigan State Medical Society (MSMS), which had aggressively opposed previous attempts at increased independence of nurse practitioners on the premise that only the physician is able to independently diagnose health conditions and develop an appropriate plan of care. The assertion that there must be physician oversight of all health care providers and the acceptance of this premise by legislators also was evidenced in PA 264 of 2005, which resulted in Michigan becoming 1 of only 2 states that prohibited physical therapists from independently performing needle electromyography. The legislation readily passed with over a two-thirds majority vote in both chambers and was opposed only by the MPTA.

With regard to political party control during the Michigan 2001–2002 legislative session, Republicans dominated the House and Senate under a Republican governor. Both legislative sessions during the 2003–2006 period were presided over by a Republican majority House and Senate under a Democratic governor.

Cultural factors. A general societal perception exists of the physician as the health care provider who oversees and directs health care,[46] and nearly all members of society associate the physician with diagnosis and treatment of disease, illness, and injury. Physical therapy is not well known to the public. To my knowledge, there has not been any movement by the general public either for or against direct access to treatment by a physical therapist.

Processes

The analysis of processes sought to identify to what extent stakeholder position and level of influence impacted the progress and disposition of direct access legislation between 2001 and 2006. The results of these analyses are briefly outlined in Table 1 and are discussed below.

Bill progress and disposition. In each of the legislative sessions in which direct access was attempted, the bills were introduced and referred to each chamber's respective health policy committee. During the 2001–2002 session, HB 5014 passed the House with a two-thirds majority vote, but then did not progress any further. Analysis of the only voting record on direct access in Michigan revealed that that Democrats and Republicans supported the bill in similar proportions. During the 2003–2004 session, a hearing for HB 4176 was held in the House Health Policy Committee, but no vote was taken despite requests by the sponsor of the bill, who was a member of the committee. Two of 16 Health Policy Committee members in the House and 3 of 7 members in the Senate had voted against direct access in 2002. Then, during the 2005–2006 session, no hearing in either chamber was even scheduled for HB 5618. Two of 17 Health Policy Committee members in the House and 3 of 5 members in the Senate had voted against direct access in 2002. Consideration of the stakeholders' positions and their respective levels of influence was conducted to provide insight into the reasons why direct access legislation failed to progress during each legislative session. Stakeholder position is considered first, followed by an analysis of stakeholder influence.

Relevant stakeholders and stakeholder position. Based on the legislative analyses, the MPTA was the only stakeholder in support of direct access legislation during each of the 3 legislative sessions. The MPTA asserted that the physical therapist is adequately trained to perform medical screening and identify medical disease requiring physician referral and that despite a physician prescription, the physical therapist is responsible for ensuring that the patient's problem is one that is appropriate for physical therapy. Furthermore, the MPTA stated that the physical therapist must examine the patient and determine the nature of the patient's problem to develop an appropriate treatment plan regardless of whether a referral is received. Therefore, they argued, the physician visit results in increased cost and delay of treatment. The MPTA cited research and other sources that demonstrated the cost benefits of direct access and the fact that there was no increase in malpractice claims[47] or variations in liability insurance premiums between states with and without direct access[48] and that the majority of other states permit direct access. Regarding the requirement that applicants for initial licensure have the Doctor of Physical Therapy degree starting in 2009, the MPTA expressed preference that the date be changed to 2019, but there was no indication of opposition to this provision by physical therapists' or physical therapy practices in the legislative analyses.

The MSMS and the Michigan Orthopedic Society offered 3 core arguments: threat to the physician–physical therapist relationship within the health care team, increased utilization and cost, and public safety. They argued that without the ability to diagnose medical disease, physical therapists are unable to safely decide on the nature or cause of the problem to be treated and that there is a risk that serious underlying medical disease will not be appropriately recognized and managed. The MSMS rejected the assertion that physical therapists are sufficiently trained to identify and manage musculoskeletal problems amenable to physical therapy treatment and that physical therapists can effectively screen for conditions

not appropriate for physical therapy and make appropriate referrals. The MSMS speculated that the reason there was no difference in liability claims in states with direct access was that patient harm was not reported, but they offered no data to substantiate this conclusion. The Michigan Chiropractic Society also was opposed to direct access, but no specific arguments could be attributed to their organization based on the legislative analyses.

Although third-party payers were not identified as having taken a position on direct access, the legislative analyses identified concerns about increased health care cost and its impact on employers offering health coverage to their employees. Therefore, additional information was sought to determine how third-party payers may have perceived direct access. Blue Cross Blue Shield of Michigan (BCBSM) Provider Class Plan Summaries (biennial summaries of enrollment and cost data for rehabilitation providers) reflect the organization's position on direct access by stating that the requirement for physician prescription and approval of treatment plans for physical therapy services provided an effective mechanism for controlling "costs associated with unnecessary utilization."[49] No data were presented in the summaries to substantiate that conclusion. Additionally, the position of numerous third-party payers, including BCBSM, is represented by the Economic Alliance for Michigan (EAM), whose members believe that scope of practice expansions, including direct access to physical therapy services, results in decreased quality of care and increased costs.[50] Although BCBSM and the EAM did not go on record in opposition to direct access legislation, it was commonly understood that these organizations informally expressed concern about changes in scope of practice and the associated fiscal impact (Bret Marr, Terry Vanderveen; personal communication; February 14, 2011).

Stakeholder influence. For the purposes of this analysis, stakeholder influence was measured in terms of PAC contributions. Table 1 outlines the financial political campaign contributions by the primary stakeholders. The opponents of direct access were in a position of considerably greater influence than the MPTA, which was the sole advocate for direct access.

During the analysis of processes, additional possible methods of stakeholder influence were noted. Two legislators, both of whom were physicians, may have played key roles in the ultimate disposition of each legislative effort. During the 2001–2002 session, the senate companion bill (SB 620) was sponsored by a senator who was also a physician and member of the Senate Health Policy Committee. The second physician legislator served on the House Health Policy Committee during 2001–2002, then on the Senate Health Policy committee 2003–2006, and had expressed strong opposition to direct access in a 2008 interview.[51] This interview was the only news media article found related to direct access in Michigan.

Discussion

The present analysis of several legislative attempts to allow direct consumer access to treatment by physical therapists in Michigan considered the proposed policy content, context, and legislative processes that may have resulted in its failure to be adopted. Such an analysis might inform future attempts to implement direct access in Michigan.

The 2 primary issues debated by the supporters (the MPTA) and opponents (physician groups) of direct access were cost and safety. Physician opponents argued that direct access would jeopardize cost and safety, but offered no evidence to support their position. Although not on record as opposed, the opposition of third-party payer groups to direct access is without supporting data as well. In contrast, the MPTA argued that research evidence supports direct access with regard to both cost and safety. Indeed, during the 2001–2006 time period, there was a progressive increase in the research evidence supporting the safety of direct access and an increase in the number of states permitting direct access. However, the progress of direct access legislation in each legislative session was progressively less. Compared with the nearly successful initial attempt during 2001–2002, the 2005–2006 attempt (HB 5618) did not even receive a hearing. This failure is ironic because HB 5618 was much more conservative and placed numerous limitations on the circumstances in which a physical therapist could treat a patient under direct access. In addition to these compromises with opponents, there were 27 published articles refuting claims that direct access results in increased cost and risk to patients, and direct access was the prevalent pattern of practice in the United States. The reason why direct access legislation made no progress in 2005–2006 is unclear. However, the use of a comprehensive policy analysis framework provides insight into the other factors that may have resulted in repeated failures in direct access policy adoption.

Several prominent contextual and process-related barriers to policy adoption became apparent after conducting this analysis: (1) a limited constituency supporting direct access with regard to number of individuals and their political influence, (2) a perception that only the physi-

cian can independently diagnose and treat patient problems, and (3) legislators in positions of power who oppose a bill.

First, with regard to a limited constituency, it would have been difficult for legislators to see the potential benefit of direct access for Michigan's citizens when only a relatively small group of individuals with limited exposure (as measured by PAC contributions) were in support of direct access. Although PAC contributions may not directly influence legislator activity or voting, financial contributions, especially for attending fund-raising events, do provide a greater amount of exposure to the legislator during which the stakeholder's views can be communicated (Bret Marr, Terry Vanderveen; personal communication; February 14, 2011). This exposure is especially important in states such Michigan that have term limits. Michigan legislators are limited to 6 years in the House and 8 years in the Senate. These term limits result in a heavy reliance by political parties and their candidates on constant fund-raising due to the frequent turnover in each district, with significantly fewer elections that have well-established, long-term incumbents. Thus, this constant fund-raising increases the influence of lobbyists and their associated PACs. Furthermore, there is a shift of corporate, institutional knowledge from legislators with relatively short tenures to relatively long-term lobbyists (Bret Marr, Terry Vanderveen; personal communication; February 14, 2011).

Although the present analysis did not allow for quantification of grassroots member mobilization and activity, it is clear that consumer groups, third-party payers, policy experts, and other health care professionals were notably absent in the efforts to promote the adoption of direct access. It is tempting to speculate that the provision requiring the Doctor of Physical Therapy degree for initial licensure may have been controversial within the physical therapy community and, therefore, may have limited grassroots support and mobilization. However, all programs in Michigan were expected to graduate students with the doctoral degree by 2009, and there was not any indication in the legislative analyses that there was dissent within the physical therapy community. Furthermore, this provision was included in the proposed legislation during each of the 3 attempts and, therefore, does not account for the disparate progress made in 2001–2002 compared with 2005–2006.

With regard to the perception that the physician must direct and oversee all other health care providers, it is difficult to overcome physician arguments that warn of patient harm if other health care providers were to function autonomously. The intent of the public health code is to ensure the protection of the public, and the burden of proof is on the proponents of change to demonstrate that patient safety would not be jeopardized. There was a considerable increase in the research evidence against the opponents' claims during the 2001–2006 period, but it appears that the research evidence available at the time was insufficient or was not adequately communicated to legislators to overcome the opponents' arguments. Although it is not possible to know which articles, if any, were considered by legislators, the Michigan House and Senate legislative analyses noted that the proponents of direct access cited literature supporting the impact of direct access on cost, access, and quality. It also is not known how effectively the MPTA's grassroots efforts were in communicating this research evidence.

Additional barriers that prevented a limited constituency's ability to overcome physician opposition included the failure of federal legislation seeking to allow direct access under Medicare and other state-level legislation reinforcing the perception that the physician should direct and oversee physical therapy treatment. Given that federal legislators chose to not permit direct access to physical therapy for Medicare beneficiaries, state legislators may have been more reluctant to adopt a similar policy at a state level. It should be noted, however, that several other states over that time period adopted direct access despite this federal precedent. Alternately, state-level legislative precedents may have had a greater impact during the 2005–2006 Michigan legislative session. Legislators' perceived need for physician oversight of physical therapy services may have been reinforced by permitting physician assistants to prescribe physical therapy under a physician's supervision, eliminating the ability of physical therapists to perform needle electromyography, and not adopting legislation that would permit nurse practitioners to independently prescribe physical therapy. Although these bills were not considered during the 2001–2004 period, they may be reflective of many legislators' perception of the need for physician oversight.

Although the aforementioned explanations are plausible, the failure of HB 5014 during the 2001–2002 legislative session to continue its progress and receive a hearing in the Senate Health Policy Committee after having passed the House with a two-thirds majority vote is interesting because it suggests that there may have been other factors unrelated to the merits of the bill that impeded its progress. Possibilities include partisan conflicts, conflicts among sponsors or other legislators from different chambers, and indi-

vidual biases or preferences exerted by those in leadership positions.

With regard to partisan conflicts, the voting record in the House revealed that it received bipartisan support, and both chambers and the governor's office were all Republican controlled. Thus, it is not likely that partisanship played a role in the failure of HB 5014 to progress.

Regarding conflicts among sponsors or legislators from different chambers, there would not be any written record of such conflicts. However, no such conflicts were recalled by lobbyists familiar with the bill (Bret Marr, Terry Vanderveen; personal communication; February 14, 2011). The fact that the sponsor of the Senate companion bill to HB 5014 was a physician and member of the Senate Health Policy Committee should have increased the likelihood that the bill would progress in the Senate. However, the fact that no hearing was ever held despite requests of the House sponsor may indicate that he was ultimately persuaded by the MSMS to not permit continued deliberation about direct access (Bret Marr, Terry Vanderveen; personal communication; February 14, 2011).

During the 2003–2004 and 2005–2006 attempts, another physician senator on the Senate Health Policy Committee and who was strongly opposed to direct access[51] may have significantly influenced decisions to not to allow deliberation on SB 1174 in 2004 and may have influenced House leadership in 2003–2004 to not spend time passing a bill that would not progress in the Senate (Bret Marr, Terry Vanderveen; personal communication; February 14, 2011). It should be noted that during 2005–2006, 3 of the 5 Senate Health Policy Committee members, including the physician legislator, had previously voted against direct access in the House in 2002. With a majority of the committee either being overtly opposed to direct access or having a history of being opposed to direct access, the House Health Policy committee may have decided to not allow a hearing on an ill-fated bill.

In summary, there are a variety of explanations that could account for the failure of direct access legislation in Michigan to be adopted during the 2001–2006 period. Although it is desirable to reach a definitive conclusion, the cause of this failure is likely multifactorial. Furthermore, the purpose of the present analysis was to direct future legislative efforts by identifying the most likely barriers to direct access policy adoption. Future attempts to remove the physician prescription requirement in Michigan should consider the conclusions provided by the present analysis. Grassroots efforts that effectively mobilize physical therapists and physical therapist assistants to educate their legislators about the profession and direct access have been the mainstay of legislative advocacy in the physical therapy profession dating back to the 1980s. The advent of online and electronic resources to identify physical therapists who are constituents of key legislators allows for more targeted methods of communicating the merits of direct access. However, additional strategies should be considered. Advocates of direct access should develop a broader, more effective constituency of support for direct access, directly address the roles of the physical therapist and physician in diagnosis and patient management and how they fit into health care reform, and consider political tactics and strategies for overcoming legislators in positions of power who oppose direct access.

First, with regard to developing a broader constituency of support, a number of strategies can be utilized, such as facilitating a letter-writing campaign by patients and by seeking support from other professionals, such as nurse practitioners and chiropractors, who may want to be able to refer patients for physical therapy. Additionally, increasing the effectiveness of this constituency can be accomplished through aggressive PAC fundraising and utilizing those monies to increase exposure to legislators through more active engagement in legislators' fund-raising campaigns. Increased exposure to legislators allows for a greater opportunity to educate them about the growing body of supporting research evidence[52–66] and provide reassurance that direct access does not endanger the public. Perhaps the most influential constituency are legislators themselves. Finding legislators with prior positive experiences with physical therapy who are willing to advocate for direct access peer-to-peer is another way to help build a broader, supportive constituency within the legislature itself.

A second strategy that could be used by states seeking direct access is to directly confront the issue of diagnosis by physical therapists and to reinforce their intent to continue collaboration with physicians in patient care. It should be made clear that physical therapists do not intend to diagnose and manage medical conditions that fall outside of their scope of practice and that physical therapists will continue to collaborate with physicians and the health care team in the care of patients. However, confronting the issue of diagnosis by physical therapists and the possible need for compromise must be considered carefully. For example, 3 states currently require that a physician establish a diagnosis prior to consumer accessing physical therapy directly, and another 7 states require that the

diagnosis to be treated had been previously referred to physical therapy by a physician. When Texas first gained direct access in 1991, physician opposition was removed when a provision requiring previous physician referral to physical therapy was included[67] (although it should be noted that Texas is currently seeking to remove this restriction). Other common compromises include experience requirements and time limits for patient treatment under direct access before a physician referral is required. Rhode Island obtained direct access with these provisions in 1992 despite continued physician opposition.[68] However, compromises may not result in bill passage when there are influential legislators who pose formidable barriers as evidenced by Michigan's direct access bill in 2005–2006, which contained both of these compromises.

Therefore, although it is not likely that any one constituency can directly influence which legislators assume positions of power, it is important to consider other strategies that allow a bill to circumvent individual barriers. For example, it may have been appropriate for direct access legislation to be referred to an economic development–related committee, because there are financial and business-related implications inherent in direct access. This strategy was effectively utilized by the Michigan Association of Chiropractors in 2009 (PA 221) to revise their scope of practice to include the treatment of peripheral joints after 30 years trying to overcome physician opposition (Bret Marr, Terry Vanderveen; personal communication; February 14, 2011).[69] Another strategy utilized by this organization was to include language that amended various parts of Michigan's insurance code that legally shielded third-party payers from any requirements to pay for services that fell within the expanded chiropractic scope. Although a similar intent was included in Michigan's previous direct access attempts, the language was apparently insufficient to legally achieve its intent. Thus, legal counsel or other expert consultation may be necessary to develop language that will achieve the intended effect.

There are several limitations to the present analysis. First, it is a retrospective analysis that relied upon publicly available documents. Other documents were not available that may have provided insight into other stakeholders' positions and a more detailed description of the legislative deliberations such as records of attendance, verbal testimony, and written testimony from committee hearings.

Second, the reasons for whether legislation is heard and brought forward for a vote are not documented and are likely mutlifactorial. Given that this analysis did not include interviews with representatives of other stakeholder groups such as the MPTA, MSMS, BCBSM, and the EAM, there may be other important explanatory variables that were not considered. Therefore, the present analysis required some speculation based upon circumstantial evidence and expert opinion from lobbyists who were selected by the author based on convenience and who were provided a draft of the collected data and preliminary analyses, which may have influenced their responses.

The third limitation of the present analysis is the method for determining the role that research evidence played in supporting the safety and cost benefits of direct access is difficult, and this analysis can only offer speculation as to what evidence legislators used in their deliberations.

Fourth, stakeholder influence was determined by overall PAC contributions for each legislative session and did not account for the recipients of such funding (eg, health policy committee members), nor did the data analyzed allow for an estimate of grassroots activity. Unfortunately, electronic records of contributions to individuals are difficult to search and were incomplete for the period prior to 2004, and many contributions from special interest groups come from individual contributions facilitated by the organization. Thus, accounting for all contributions from a given special interest is very difficult and time consuming.

The fifth and most significant limitation is the potential for author bias.[5] However, multiple sources of data were used in the present analysis.

Conclusions

Despite an increasing number of states allowing direct access, several states continue to have provisions that restrict a consumer's ability to directly access physical therapy treatment. Removing these provisions may be considerably difficult. Analysis of 3 recent attempts at removing the physician prescription requirement in Michigan between 2001 and 2006 with regard to content, political and social context, legislative processes, and key stakeholders revealed that the success or failure of direct access policy adoption is complex and multifactorial. Effectively articulating how diagnosis is used by physical therapists and communicating the evidence that direct access does not result in increased costs or decreased safety for the public may require: (1) a larger constituency of direct access supporters, including other professions, consumer groups, and legislators; (2) a more influential constituency that effectively uses PAC resources to gain exposure to legislators to communicate this evidence;

and (3) the creative use of legislative processes and mechanisms to circumvent legislators in positions of power who oppose direct access legislation.

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Appendix.

Lobbyist Consultation Topics

Recollection of direct access legislation

General impression of stakeholders' positions:

—Physician groups (Michigan State Medical Society, Michigan Orthopedic Society)
—Chiropractors
—Blue Cross Blue Shield of Michigan
—Economic Alliance for Michigan
—Michigan Physical Therapy Association

General impression of legislators' views on direct access and apparent loyalties to health care special interest groups

Potential factors that impeded the progress of direct access legislation:

—Stakeholder influence and the interaction of political action committee contributions and term limits
—Legislative processes, including:
  —Party control
  —Coordination of legislation (or conflicts) between chambers
  —Insights regarding health policy committee chair position on direct access, as well as potential external influences or pressure
  —Health policy committee composition
  —Bill sponsorship

Direct Consumer Access to Physical Therapy in Michigan: Challenges to Policy Adoption

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