



This article is based on a presentation by Michele Thorman, PT, DPT, MBA, Chair of the FSBPT Continuing Competence Committee and Heidi Herbst Paakkonen, MPA, Continuing Competence Programs Manager for FSBPT, at the 2018 FSBPT Annual Meeting.

Risks, Supports, and Engagement

Continuing Competence is Making a Shift

The Federation of State Boards of Physical Therapy's (FSBPT's) Continuing Competence initiative is eleven years old. In the early years of the initiative, our research led us to the development of the Continuing Competence Model. The model itself is a valuable tool, but associated with that model are three guiding principles that will likely be enduring:

- continuing competence should be self-directed;
- evaluation and periodic re-assessment of one's knowledge, skills, and abilities is essential to provide focus to ongoing development; and
- there is no one-size-fits-all or single right way to pursue continuing competence.

There should be multiple paths, strategies, and methods for licensees to demonstrate that they have maintained and sustained their competence.

Over the past decade the majority of states have adopted the spirit or the essence of the model and most of all of its elements — a significant accomplishment. However, inspired by emerging information and research, at the direction of the FSBPT Board of Directors, the FSBPT Continuing Competence Committee is revisiting the state of continuing competence and the model. FSBPT has explored these topics with the membership at the Leadership Issues Forums for the last three years, asking whether the existing approaches are effective and evidence-based. The responses were that there really isn't any evidence, and we can't state with confidence that our requirements are ensuring that licensees maintain competence. Physical therapy regulators have a hunch that if licensees are staying engaged, they are probably maintaining their competence, at least to some degree. But the disengaged licensees — those are the ones we're concerned about as regulators.

Physical Therapy Regulators' View is Evolving

Physical therapy licensing boards are in agreement with a shift from a punitive approach to a more supportive and proactive approach. Boards must also decide how to describe the state of less-than-competent. It isn't "incompetent," as any licensee can flow between a state of competence and a state of not competent as a result of certain temporal factors. What regulators are starting to embrace is the idea

of risk-based regulation: focus on harm prevention and promotion of outcomes. Regulators are also accepting that the evidence does not support that the existing “tick-a-box” regulatory requirements ensures competence.

Preliminary research into disciplinary actions against licensed PTs and PTAs indicates the number one category of disciplinary actions taken by boards is failure to complete continuing competence requirements. This means boards are spending the majority of their resources on infractions presenting a very low public risk. Is that the best use of the board’s limited resources? The committee is advocating a shift to focusing on the risks that might lead to a loss of competence, and at the same time exploring what supports mitigate those risks. It is important to note, however, that having a high number of risks doesn’t equate to incompetence, and access to and use of a lot of supports doesn’t ensure competence. Much of the committee’s upcoming work is to identify and be aware of what risks can impact competence, and also identify and/or build appropriate supports to mitigate those risks.

The Fork in the Road

Yogi Berra advised that when you come to a fork in the road, take it. Change isn’t a very attractive proposition — even if it is evolutionary versus revolutionary. The FSBPT Board of Directors charged the Continuing Competence Committee to research development of a new model using best evidence. There isn’t a lot of evidence, but the developing model is the best effort to take the fork in the road we think may lead us somewhere productive.

The committee’s initial work involves shifting from the tick-a-box approach — in which the licensee is “competent” if they completed the required number of continuing education credits — to an approach that focuses on helping licensees be engaged in their practice and helping employers create an environment that motivates employees to engage.

Simply said, our duty as regulators is to make sure that practice is safe and effective and ethical. Initial licensure, at that point in time, may equal competence to the newest graduate. What happens next? Requiring a specific number of continuing education units to demonstrate competence is, at best, arbitrary. And, even if it wasn’t arbitrary, there’s no evidence to establish this has any impact on ensuring competence or preventing harm. It just feeds into the “I gotta do it” mentality of renewing a license, which doesn’t assure physical therapy patients have access to safe and effective care. It only prescribes how low the floor is. Consumer groups remind us that we’re not in the business as regulators to find the bad apple. We’re in the business to ensure care provided by a physical therapist or a physical therapist assistant is effective and ethical.

Revisiting and “Reimagineering” the Model

The committee is recommending a shift from a static and prescriptive model to one that is dynamic and allows licensees to continue developing over a lifetime. Educators need to instill a fire in their students before they walk across the commencement stage to help them understand that there is no static state of being after they leave the classroom. Regulators will need to find that standard that determines how low is the floor and what the minimal acceptable standard is and determine if they have the right rules guiding them. Maybe our practice acts are written for the 1 percent. We all work with someone who only wants to be a minimal competent practitioner, but the majority of licensees aspire to grow and do better. Are our regulations designed to encourage engagement and motivate licensees? Is that really the regulator’s role?

Research shows that a significant percentage of the patient outcomes have very little to do with what regulators did; they have much more to do with the individual practitioner, how they related and connected, and how they motivated and brought that patient along to a more healthy place. So, when we talk about compassion, confidence, getting consent, and communication, do we have the right rules as it

relates to soft skills? And what are those soft skills?

In your practice acts as they exist today, do you have the right rules to touch any of these realms? One of the members of the committee described the depressing, un-motivating, uninspiring effect the tick-the-box approach had on his dietitian spouse. We know other professions that have a similar approach to self-assessment. The research shows it's not effective and we're not good at it.

Earlier this year, some FSBPT leaders met with our regulatory colleagues from Canada and Australia, as well as representatives from Canada's malpractice insurer to examine if regulatory efforts should focus more on identifying and managing risk? Can regulators look at something more proactively in a preventative mindset by identifying the risk to see if we can get ahead of it before it becomes a real harm? The group agreed that risks were both internal and external conditions or factors that might influence the PT or PTA's judgment. But what are those factors?

Harms are risks that actually have a negative consequence. Said differently, harms are risks that have been realized. We know that when licensees touch people, there is an inherent risk that goes along with that. What level of risk is acceptable if we're going to practice physical therapy in a progressive, ethical, and effective way? We know that this is a journey regulators cannot make alone. We have to partner with many other stakeholders.

Data is our friend, and we need to figure out where to begin to mine that data and for what purpose? It makes perfect sense to start by looking at practitioners. Who is most likely to be on that risk spectrum or not? And we need to know more about the complainants. How have they been informed? Are they people with a high level of health literacy? Can they go to board websites and easily learn how to file a complaint? What's the nature of someone who's informed enough or dissatisfied enough to bring a claim against a licensee?

We can also mine the information on how licensees perform on jurisprudence exams. We think there might be a relationship between ethics and choices and practice that might lead to risk. We can also look at NPTE performance for any correlation between high or low scores and licensees who may present more or less risk. From there we look at whether those risks go on to become harms. We have learned the newly established Healthcare Regulatory Research Institute will look at the data in the FSBPT's Exam, Licensure, and Disciplinary Database.

How can practitioners improve self-awareness and self-assessment when we know inherently we're bad at it? What is "Healthy Practice"? Starting with students in the classroom, how do we encourage them to be on fire for their entire careers and engage with continuous professional development plans? How can employers help in this process? And finally: What is that intersection between risk and this notion of regulation and where practice becomes involved? We think it has something to do with educating licensees. If only, "Here are some supports for you in the context of your practice." We think it may have something to do with getting ahead of the harm and in keeping the risk at a mitigated level in prevention.

The model that we are currently developing starts with a self-reflection on Risks and Supports. Questions are posed about the individual (e.g., age, gender) and about the current type of practice. Individual results are not provided to the licensing board. Instead, answers are aggregated by a third party that reports the aggregated data board. Individual information reported to the licensees merely identifies where they compare to their peers relative to their unique risks, and it identifies supports to take advantage of.

The second element of the model has to do with healthy practice. The developing healthy practice schematic contains elements focusing on the individual and the practice environment. These two

categories are further broken down into pieces such as work/life balance, engagement, outcomes, and best evidence. The goal is to identify those conditions under which healthy practice is most likely to thrive. This component of the model anticipates asking individuals to do a self-inventory, not provided to the licensing board, to determine what in their world contributes to healthy practice. This inventory hasn't been developed but would be reported to an outside third party. Individual feedback would be given to the licensee and aggregate feedback would be given to the licensing board. Again, we have to be able to collaborate with others to understand the bigger picture and have a strategy for getting that input as we move forward. Another challenge to our work is that we are bringing these ideas forward into the most complex health care environment that has ever existed.

The last element is the least defined at the moment — a practice or work assessment tool. This tool would tell me, as an individual providing physical therapy services in a certain specialty area, how my competence compares to that expected of a developing or master clinician. Any tool used must be tailored to the practice environment, as opposed to a generic, generalist type of inventory. FSBPT's existing oPTION tool is a solution, but there may be other tools developed at an institutional level, such as a performance appraisals or other formalized feedback systems.

There also needs to be a tool available for PTAs. We must also be able to accommodate licensees who are not in direct patient care, such as researchers, administrators, and educators. The hope is that this type of a tool would lead, along with the other elements of the continuing competence model, to a learning action plan — a continuing professional development plan that would be something that the licensee could continue to work on across the course of time. Of the four components of the developing model, the only piece likely to be shared with the board is the jurisprudence or ethics element.

This developing model will only work if it's customizable to the licensee, is done with sensitivity, and allows movement between practice environments and expertise. We hope to see this evolutionary model incorporated within the existing jurisdiction requirements. There are opportunities to partner with the American Physical Therapy Association and other stakeholders in this process, with a short term goal of piloting the new model in one or two jurisdictions.

Intrinsic Versus Extrinsic Motivation — Engagement is the Key

Is it the role of regulators to motivate engagement and competence? If there is some element of this, we have to look at this notion of intrinsic and extrinsic motivators. Psychologists would tell us that we as regulators are using the carrot-and-the-stick extrinsic motivator versus intrinsic motivators.

When we are with a patient and give them the belief that they are the only patient on our case load, we are so absorbed that the flow is directed 100 percent to them. That is intrinsic motivation, with the purpose of doing something that is far bigger than just ourselves — helping someone else. Research shows that there is compelling evidence that says, "When people are engaged, good things happen." Conversely, when extrinsic motivation is what drives us, we extinguish quicker. If we're driven by the faster car, the bigger house, the cabin up north, or what our title or pay is, at some point there's not going to be a process to get a bigger car, or to get more money, or the next best thing that identifies what is valuable to us. If you complete thirty hours of continuing education and you check that box, we'll give you a license — sign here.

This can lead to disengagement if the intrinsic motivator stops working. Then there comes the time when you don't get enough positive feedback. Nobody noticed how you went above and beyond, and that lack of extrinsic feedback can cause a competency drift.

If we are hoping to ensure competence for patient safety and improve quality, it's our job as regulators to focus on that and not on the bad apples. We have a much higher likelihood of doing that if we can promote

engagement and the proposed model that focuses on risks and supports. What we can accomplish if we look at licensees from a slightly different vantage point: what they are capable of doing versus the minimal they have to do to progress to the next grade. We present this notion of a paradigm shift toward being proactive and preventative and engaging, that competence is far more than about technical skill, it's about what we do. We have the benefit now of a global regulatory focus to help inform this process.



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