

## **Proposed Eligibility Requirements for OCS Exam DRAFT**

### **Proposed OCS Eligibility Changes History and Rationale**

In the coming months you may receive a request to participate in a survey about clinical specialization (the process that culminates in awarding the OCS designation). The Orthopedic Specialty Council has proposed changes to the eligibility requirements to sit for the exam, and the results of this survey will be used in the decision to accept or deny them. Therefore this survey is a critical factor in defining the future of the specialization process and it is important that you should participate if so asked.

#### **History**

Specialist certification is a young process in physical therapy relative to other professions. Consequently it continues to undergo changes as it matures. At its inception, applicants to sit for the exam were required to have 5 years (~10,000 hours) of clinical practice; 6,240 hours (3 years) of direct patient care in orthopedic practice within the last 6 years; provide evidence of teaching experience; submit a review of a research article; and provide three character references. The main reason for these requirements was that the exam itself had not been administered enough times to have earned any statistical power. As the exam matured, however, one by one the pre-exam requirements were eased or dropped. This culminated in 2001 with the American Board of Physical Therapy Specialties (ABPTS) easing the final original requirement, lowering the practice hours to 2,000, consistent with the other 6 areas of specialty practice. The arguments for doing this included that the maturity of the exam obviated the need for further requirements, and that 10,000 hours of practice was an arbitrary number lacking evidence showing it produced a clinician of superior knowledge and skill than did 2,000 hours. Concerns over the easing of the eligibility requirements came to a head at this point, voiced by the Orthopedic Specialty Council among others.<sup>1</sup> The primary concern was over the possibility that easing the requirements might reduce the perceived merit of the process from both outside our profession (by other medical professions, payors, and the public) and within our profession. Until recently the ABPTS rejected repeated attempts to return to the prior eligibility requirements.

This changed in May 2006, however, when in response to the concerns from the Orthopedic Specialty Council, voiced by the Orthopedic Section Board of Directors and echoed by the membership at the Section business meeting at CSM that year, the Council (Rob Landel, Bob Johnson, Aimee Klein) proposed to the ABPTS a change in the eligibility requirements to sit for the OCS exam. ABPTS supported the concept of additional eligibility requirements, furthermore suggesting that such requirements should be based on the knowledge and skills acquired during an APTA-credentialed orthopedic residency program.

This idea is reasonable on multiple fronts. In medicine, residency education is the normative model of post-graduate professional development, and graduation from a residency program is the pre-requisite for board certification and hospital practice privileges. Physical therapy is

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<sup>1</sup> The Orthopedic Specialty Council represents the interests of orthopedic PT practice and Orthopedic Clinical Specialists to ABPTS, develops and prepares the OCS exam, recommends eligibility requirements, and reviews re-certification applications. A comparable Council exists for each of the other 7 Specialty Areas.

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moving in the direction of requiring residency education for all those who wish to be recognized as a specialist in a particular area of practice.<sup>2</sup> Residency programs provide a structured curriculum and mentored clinical practice to advance the clinician's level of practice, and they ensure progress towards that goal via practical and oral exams. The OCS exam by design is a test of knowledge and reasoning, and cannot assess psychomotor skill. The two processes are complimentary, however: residency education prepares one for specialist practice, and the OCS exam ensures that one has met a nationally standardized level of expertise. Indeed, both the exam and the curricula of APTA-credentialed residencies in orthopedics are based on the same document, the *Orthopedic Description of Specialty Practice (DSP)*, which defines the practice of orthopedic physical therapy.

Requiring all who wish to sit for the specialist certification exam to have graduated from a residency is problematic right now. Although the number of residency sites is steadily increasing, there are still too few to allow all those wishing to specialize to attend one. Until such time as the number and geographical distribution of sites makes this possible, it makes sense to make the OCS eligibility requirements reflect the acquisition of knowledge, skills and abilities typically gained in an orthopedic residency program.

Accordingly, the Council met in late 2006 with a representative of the Orthopedic Section (Joe Godges) and orthopedic residency program faculty who are also OCS (Michael Miller, Steve Reischl) and developed a second proposal, presented in draft form to ABPTS at CSM Boston and formally submitted in May 2007. Subsequent discussions and revisions led to a third draft, tentatively accepted by ABPTS in September 2007 pending input from stakeholders (this is where the survey comes into play) and a review of the financial impact on the specialist certification process.

The proposed requirements are summarized below. Their development was based on two assumptions: 1) eventually the main requirement for sitting for the exam will be graduation from a residency program in that area of practice, and 2) the proposed requirements would serve until such time as there were enough orthopedic residency programs to meet the applicant demand.

To reiterate, the main reason for these proposed changes is to increase the perceived merit of the specialist certification process, both within and without our profession, and to begin the move towards matching the specialist requirements of other health professions. Both the Orthopedic Specialty Council and the Orthopedic Section Board of Directors believe that these changes are necessary. The results of the planned survey will be an important factor in the decision to adopt these changes. Two important constituencies will contribute to the survey: those who have already earned the OCS designation, and those who are contemplating pursuing specialist certification. What is your perception of the merit of the current process, and by extension, the OCS designation? How do you think physicians, payors, the public, and PT employers view the OCS? Does the OCS have value among your colleagues? If so, why? If not, why not, and what could be done to improve it? The answers to these questions could well determine the future of clinical specialization in orthopedic physical therapy for decades to come. *Please participate!*

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<sup>2</sup> The APTA's Education Strategic plan includes the development of residency programs. The Plan can be found at: <http://www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=43041>

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**PROPOSED OPTIONS TO SIT FOR OCS EXAM:** (Refer to **Table 1**)

Two options to meet the eligibility requirements are proposed.

Option 1: Completion of an APTA-credentialed Residency in Orthopedic PT.  
This is a current eligibility requirement for Orthopedics.

Option 2: Evidence of completion of the following two requirements:

1. Post-professional course work that encompasses all body regions of the orthopedic Description of Specialty Practice (DSP).
2. Evidence of 250 cases in the specialty area that includes: (a) activities in each of the elements of patient/client management\* applicable to the specialty area and included in the DSP, with (b) evidence of self-reflection for each case, documented via (c) a patient log, and (d) reviewed and signed by a recognized specialist. 100 of the cases must have been seen in the three years prior to application for the specialty exam.

\*These elements, as defined in the *Guide to Physical Therapist Practice*, are examination, evaluation, diagnosis, prognosis, and intervention.

*Requirement 1: Course work that encompasses all body regions of the orthopedic DSP*

Methods of achieving requirement:

1. Completion of a continuing professional education seminar and obtaining 0.7 CEU certificate or greater (7 hours minimum). All CEU's must be earned in courses that meet APTA guidelines for approved providers. Completion of an Independent Study Course from the Orthopedic Section with associated exam to award CEUs is acceptable.
2. Evidence of satisfactory completion of post-professional university level coursework that encompasses orthopedic physical therapy knowledge and skills in the DSP body regions.

The following are the recommended (Rec) hours for each body region:

<b>DSP Body Regions</b>	<b>% DSP</b>	<b>% of 120</b>	<b>Rec Hrs</b>
Cranial mandibular	5	6	7
Cervical spine	15	18	14
Thoracic spine/ribs	5	6	7
Lumbar spine	20	24	21
Pelvic girdle/SI/coccyx, abdomen	5	6	7
Shoulder/shoulder girdle	15	18	14
Arm/elbow	5	6	7
Wrist/hand	5	6	7
Hip	5	6	7
Thigh/knee	10	12	14
Leg/ankle/foot	10	12	14
Total		120	119

Allowable Substitutions:

- (a) Courses must be taken for each body region listed in the DSP (see table). Up to 40 hours of courses in the orthopedic domain but not organized by body region (e.g.

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- exercise, differential diagnosis) may be substituted for the equivalent number of hours of regional coursework.
- (b) Documentation of education publication and teaching experience in a particular requirement area can be substituted for the equivalent number of hours of regional coursework. Examples: Author or co-author of a publication (including abstracts) in a peer reviewed journal; platform or poster presentation at a professional meeting; instructor or assistant instructor of a continuing professional education seminar in a particular requirement area.

*Requirement 2: Submission of evidence of managing 250 patients in the specialty area:*

Format: Evidence of case management and self-reflection will be supported by a patient log that demonstrates experience with patients across all body regions as defined by the DSP, and evidence of self-reflection for each case. This type of patient log is consistent with residency program requirements. Patients will be grouped by body region, and logged chronologically within each body region. Prior to external review, the applicant will summarize what he/she has learned from reflection upon the outcomes in narrative form, and provide this summary to the reviewer. An experienced clinician will conduct two midway reviews of the log: the first no later than after 100 patients, the second no later than after 200 patients. The role of the reviewer is to pose questions that extend the writer's thought processes, encouraging broader and higher-order critical thinking. In addition, the outcome of each midway review is an action plan that delineates behavioral changes the applicant will make in response to his or her reflection. The reviewer will assist the applicant in assessing progress towards those behavioral goals. A final review is conducted at the completion of 250 cases, and the reviewer attests that the log is acceptable evidence of the applicant having achieved the requirement.

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**Table 1: Residency Program Components Compared with Proposed OCS Eligibility Requirements**

<b>Residency Components &amp; Criteria</b>	<b>Class Room/Lab Component 240 hours (consistent w/ DSP)</b>	<b>Clinical Supervision Component 150 hours 1:1 with Residency faculty</b>	<b>Clinical Practical Component 1200 hours</b>																												
<b>Measured in Residency via:</b>	<ul style="list-style-type: none"> <li>▪ <b>Written Exam</b></li> <li>▪ <b>Practical/Skills Exam</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Clinical Performance Evaluation &amp; passing clinical exam (consistent with DSP)</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>Hours of Clinical Time (patient log consistent with DSP Regions, Dx)</b></li> </ul>																												
<p><b>Proposed Eligibility Requirements</b></p> <p><u>Per DSP:</u> <b>Examination, Evaluation, Prognosis, Diagnosis, Interventions</b></p> <p><b>Courses meet APTA criteria for CEU's</b></p>	<table border="0" style="width: 100%;"> <tr> <td style="width: 70%;"><b>Verified CEU's in:</b></td> <td align="right"><b>Hours</b></td> </tr> <tr> <td><b><u>DSP Regions</u></b></td> <td align="right"><b><u>(follows % DSP)</u></b></td> </tr> <tr> <td>○ Craniomandibular</td> <td align="right">7</td> </tr> <tr> <td>○ Cervical</td> <td align="right">14</td> </tr> <tr> <td>○ Thoracic</td> <td align="right">7</td> </tr> <tr> <td>○ Lumbar</td> <td align="right">21</td> </tr> <tr> <td>○ Pelvic girdle</td> <td align="right">7</td> </tr> <tr> <td>○ Shoulder</td> <td align="right">14</td> </tr> <tr> <td>○ Elbow</td> <td align="right">7</td> </tr> <tr> <td>○ Wrist/Hand</td> <td align="right">7</td> </tr> <tr> <td>○ Hip</td> <td align="right">7</td> </tr> <tr> <td>○ Knee</td> <td align="right">14</td> </tr> <tr> <td>○ Ankle/Foot</td> <td align="right"><u>14</u></td> </tr> <tr> <td><b>TOTAL HOURS</b></td> <td align="right"><b>119*</b></td> </tr> </table> <p><b>Allowable substitutions:</b></p> <ul style="list-style-type: none"> <li>• <b>*40 Hours of courses that are not body region-based (e.g. exercise, medical screening)</b></li> <li>• <b>Documentation of education or knowledge in an area (e.g. author of peer reviewed publication or book chapter)</b></li> </ul> <p><b>Possible Venues:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Ortho Section ISC, ACP or other Continuing Ed, University Credit</b></li> </ul>	<b>Verified CEU's in:</b>	<b>Hours</b>	<b><u>DSP Regions</u></b>	<b><u>(follows % DSP)</u></b>	○ Craniomandibular	7	○ Cervical	14	○ Thoracic	7	○ Lumbar	21	○ Pelvic girdle	7	○ Shoulder	14	○ Elbow	7	○ Wrist/Hand	7	○ Hip	7	○ Knee	14	○ Ankle/Foot	<u>14</u>	<b>TOTAL HOURS</b>	<b>119*</b>	<p><b>Review of self-reflection on patient log by qualified clinician (OCS, residency faculty, APTA-credentialed CI). Reviewer affirms that the applicant has demonstrated significant changes in clinical practice.</b></p>	<p><b>Evidence of 250 cases, supported by patient logs that demonstrate experience with patients across all body regions as defined by the DSP, and evidence of self-reflection for each case. 100 of the cases must have been seen in the three years prior to application for the specialty exam.</b></p>
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