



August 26, 2019

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Dear Dr. Kim Curbow-Wilcox, ABPTRFE Board and Standards Committee Members,

The Academy of Orthopaedic Physical Therapy (AOPT) Board of Directors which represents 20,000 members is writing this letter on behalf of the Orthopaedic Residency and Fellowship Special Interest Group (ORF SIG) which represents over 130 Program Directors, 61 of which are Multi-Site Programs, representing a majority of orthopaedic residency graduates annually. The AOPT has been a strong supporter of the development of residency and fellowship training which culminated in the development of the ABPTRFE. Additionally, the AOPT has provided a significant amount of education on how to develop Orthopaedic residency and fellowship programs and continues to enhance educational resources for orthopaedic residency and fellowship curricula. We feel we are at a pivotal point in the development and advancement of residency and fellowship programs and want to offer our view of some disconnects in ABPTRFE policy creation with consideration of residency and fellowship development and sustainability.

We appreciate receiving the letter on June 3<sup>rd</sup> in response to the stakeholder's meeting at APTA to discuss the Substantive Change Policy 13.4.2. We hope that you would agree, the suspension of this policy was essential based on the unintended consequences of its implementation. We both understand and support the goal of ABPTRFE to generate standards to assess minimal competency in Residency and Fellowship education. We also fully support the need and desire for Residency and Fellowship growth and proliferation in order to advance the educational opportunities for physical therapists nationwide. As the need for the policy suspension indicates, there is a delicate balance between policy introduction, and sustainability and growth of current and developing programs. We are requesting that this example be fully evaluated to provide insight and knowledge necessary to avoid another such occurrence. We respectfully request that all policy and procedural changes undergo a "Program Impact Analysis" before they are suggested or implemented. While the intentions may have been noble to improve Resident/Fellow experience, in this case, the rationale remains unclear and the requirement is inconsistent with other current policies and procedures. We would

like to provide our perspective to the ABPTRFE Board in order to contribute to this learning experience and hope to assist in avoiding this level of disruption to Residency and Fellowship programs in the future.

The Academy proposes that all currently proposed and future policy changes be fundamentally based on evidence. ABPTRFE must first identify what is excellence in Residency and Fellowship training and identify the key critical components that must be present to ensure excellence in all programs. This knowledge should be *the* impetus for change in quality standards and policy. We believe this is an essential first step to inform all policy decisions and future procedural developments in Residency and Fellowship accreditation. Once these key components are identified and validated, all policies and procedures related to their required presence is justified and would be fully supported by the Academy. In the absence of this knowledge, decisions such as the implementation of the Substantive Change Policy are unwarranted, especially when inconsistent with initial accreditation processes.

In order to propose a procedure such as the Substantive Change Policy, ABPTRFE first must provide evidence that the addition of >2 sites is a critical risk to Residency and Fellowship quality. We would expect that ABPTRFE would identify that 1) the addition of >2 sites has a potential negative impact on Residency/Fellowship training and 2) the key indicators related to this negative impact are clearly identified, understood and can be assessed accurately on a site visit. The requirement for site visits for new training locations is based on the premise that a site visit guarantees a check off on a minimal quality level. There is a lack of evidence and clarity about what would be seen, recorded, or observed on the site visit to accurately and consistently achieve this goal. There is also no evidence that a site visit will even add value. In addition, when multi-site programs are currently accredited, a maximum of 5 sites are visited. So if all sites are not evaluated in person on initial accreditation, why would >2 new sites require a site visit? This inconsistency call in question the validity of the requirement as a whole.

Residency and Fellow mentorship was identified as a rational for site visits when >2 sites were added. This is clearly inconsistent with current policy and procedures for accreditation through ABPTRFE. First, mentorship must be identified as a critical factor for Residency and Fellowship excellence through data analysis. In the absence of this data, a procedure that can be punitive to specific program models and Residency and Fellowship program proliferation should neither be proposed nor implemented. The original proposal was flawed for many reasons. Currently in existing initial and re-accreditation procedures, all mentors are not vetted. During the accreditation site visit, the program itself hand picks a single mentor and a resident/fellow to be observed during a mentoring session. Depending on the size of the program, only a fraction of mentors are ever vetted or evaluated. To propose a pathway (required site visit for >2 sites) that requires mentor evaluation when >2 sites are added is arbitrary, financially punitive, and inconsistent with current accreditation procedures. If and when ABPTRFE identifies that

mentor assessment is a critical element of program quality, an assessment process should be developed and all clinical mentors for all residency and fellowship programs should be evaluated in the same way. In order to accurately assess mentors, the role of the mentor must be shown to be a key component of quality and excellence in residency or fellowship training and a corresponding evaluation should be developed and validated. To simply add procedures without the validation process is arbitrary and we hope is not a policy setting pathway that ABPTRFE will engage in moving forward. We are hopeful that ABPTRFE can see this inconsistency and we request that they apply this process of assessing the consistency of proposed policies and procedures against their own existing standards moving forward.

ABPTRFE must consider the multiple program design in their proposals. When a program is a multi-site program by definition, it has an education without walls. When a program achieves initial accreditation, ABPTRFE visits a sampling of their locations (max 5) and is certifying that the director and leadership has designed a program and put essential components in place to support quality education of Residents and Fellows. ABPTRFE fails to explain or articulate with supporting data, why this quality design and leadership confidence should be questioned when additional sites (>2) are utilized in place or in addition to sites established at initial accreditation. ABPTRFE must consider the variable design of current programs in their accreditation policies and procedures. In multi-site programs, individual locations are only one variable in Residency/Fellowship education. The concept that when new sites are added is “program growth” is also misleading. In many cases, this is not program growth, it is program maintenance; 15 residents in 15 sites are replaced by 15 residents in a different set of sites is not growth but program maintenance and is expected by design in many multi-site programs. This is not a variant but an expected process for program sustainability. Unless ABPTRFE is outlawing this Residency and Fellowship model, it should not punish this model with financially and arbitrary extra requirements beyond even what the programs underwent in initial accreditation without valid data to support it. We implore ABPTRFE to adhere to the first tenet; using evidence establish that >2 sites is a risk to quality, establish a critical element or elements that necessitate such an evaluation and justify why that information can be obtained by an on-site visit only. In the absence of this data, proposed requirements that target specific program types appears capricious and punitive.

Upon review of the June 3<sup>rd</sup> response letter we appreciated the attempt by the Standards Committee to resolve some of the several reported concerns from programs. The recommendations varied from a mentor credentialing process, to random or virtual site visits, program director oversight and type of practice site highlighting the unknown intended purpose of this policy. We agree with their recommendations in that future decisions should be based on evidence. In doing so, knowing exactly what the desired outcome will be imperative. We will comment on specific topics mentioned in the June 3<sup>rd</sup> letter below:

***A. Standardization of mentors across all programs.***

**Standards Committee: The committee agreed that there is value in APTA creating a process for mentor credentialing, including a skills assessment component, thereby ensuring quality mentor skills. If a mentor credentialing process is established, the committee noted that a site visit may not be required if the mentors at the newly added practice sites hold this certification.**

**ABPTRFE: The Board agreed that APTA should develop a mentor credentialing process, and requested staff begin to investigate the feasibility and timeline for developing this process.**

A charge to the APTA to develop a mentor credentialing process is premature until the components of Residency and Fellowship excellence are evaluated and mentorship is identified. Once mentoring is validated as key to excellence in residency and fellowship training, a charge to the APTA and/or the Academy/Specialty Sections of the APTA to apply that information to develop a mentoring credentialing process for clinical mentors of residency programs and for clinical mentors of fellowship programs is warranted.

*A. ABPTRFE conduct random onsite visits for practice sites being added, in lieu of current language in 13.4.2.*

**Standards Committee: The committee disagreed with this concept. While the committee unanimously agreed that ABPTRFE should not require an automatic site visit when a program files a substantive change for increasing practice sites, the committee recommends ABPTRFE develop thresholds, or a rubric, that indicates when a site visit is required.**

**ABPTRFE: The Board developed a subgroup to draft the thresholds that would warrant a site visit, and will present their work to the full Board during the September 2019 ABPTRFE meeting.**

This concept should not be rejected outright without due consideration. We are very hopeful that before any new policy is proposed or rejected, a universal definition of excellence in residency training and matched components and outcomes of a quality program are identified and validated.

**3. ABPTRFE allow use of virtual site visits, in lieu of current language in 13.4.2.**

**Standards Committee:** Although believing there is value in in-person site visits, the committee did state that if mentoring is not occurring at the site being added, then a virtual focused site visit could be conducted (e.g., interview with participants and faculty overseeing learning at these practice sites).

**ABPTRFE:** This option is being considered by the ABPTRFE subgroup as one of the above-mentioned rubric thresholds.

If no mentoring at a clinical site is occurring, it is incumbent on ABPTRFE to identify why an assessment of the clinic is needed. If established as critical, evidence should support the key components that must be evaluated with supporting evidence.

*Program director responsibility and oversight of sites being added to ensure quality.*

**Standards Committee:** The committee agreed that if a program has a clear process for adding new sites (e.g., standards for sites, program director or administration visiting the site prior to adding, established quality assurance processes) then a site visit may not be required.

**ABPTRFE:** This option is being considered by the ABPTRFE subgroup as one of the above-mentioned rubric thresholds.

A residency director determines resident selection, financial, curricular and mentor training design, and more. Residency directors currently make independent decisions including the vetting of residency sites. When a program achieves initial accreditation, ABPTRFE visits a sampling of their locations (max 5) and is certifying that the director and leadership has designed a program and put essential components in place to support quality education of Residents and Fellows. ABPTRFE fails to explain or articulate with supporting data, why this quality design and leadership confidence should be questioned when additional sites are utilized in place or in addition to sites established at initial accreditation.

**4. *Type of education being provided at the site (i.e., mentorship versus practice hours).***

**Standards Committee:** Related to outcome 3, the committee agreed that ABPTRFE should consider the type of education being provided at the site. If mentoring is occurring at the site being added, then a site visit should be required. If no mentoring, then a virtual focused site visit could be conducted (e.g., interview with participants and faculty overseeing learning at these practice sites).

**ABPTRFE:** This option is being considered by the ABPTRFE subgroup as one of the above-mentioned rubric thresholds.

Residency and Fellow mentorship was identified as a rationale for site visits when >2 new sites were added. This is clearly inconsistent with current policy and procedures for accreditation through ABPTRFE. First, mentorship must be identified as a critical factor for Residency and Fellowship excellence through data analysis. If and when ABPTRFE identifies that mentor assessment is a critical element of program quality, an assessment process should be developed and all clinical mentors for all residency and fellowship programs should be evaluated in the same way. In order to accurately assess mentors, the role of the mentor must be shown to be a key component of quality and excellence in residency or fellowship training and a corresponding evaluation should be developed and validated. To simply add procedures without the validation process is arbitrary and we hope is not a policy setting pathway that ABPTRFE will engage in moving forward.

**Currently, the ABPTRFE subgroup is reviewing all threshold recommendations for determining when a site visit is required. A report of their work will be presented to the full Board during the September 2019**

ABPTRFE must first identify what is excellence in Residency and Fellowship training and identify the key critical components that must be present to ensure excellence in all programs. This knowledge should be *the* impetus for change in quality standards and policy. We believe this is an essential first step and inform all policy decisions and future procedural developments in Residency and Fellowship accreditation. The Board should consider the use recent literature related to residency and fellowship program outcomes to determine when a site visit is necessary.

Two other main issues were mentioned at the Stakeholder's meeting and referred to at the end of the meeting as major outstanding concerns of the group. One was the collection and classification method for monitoring primary health conditions and the second was the requirement that fellow applicants have residency training or hold a previous board certification. We will address those independently.

In terms of **primary health conditions** for orthopaedic and sports residency programs we find the data being required is inconsistent with ICD -10 classification, CPG classification, and movement system diagnoses. Attached is a letter from Dr. Jay Irrgang stating his concern with this decision to go with 56 anatomical diagnoses versus collecting ICD-10 diagnoses to further develop the outcomes registry data base. This has been a burdensome process for residency programs as most billing systems require an ICD-10 identifier and not an anatomical diagnosis. Residents are forced to maintain a separate system to record each anatomic diagnosis. Program Directors and Clinical Mentors are now reviewing how many anatomic diagnoses each resident has seen. This requires time and effort to determine strategies of how to ensure each resident is meeting the arbitrary standard percentage. The premise of a residency is to ensure resident proficiency, the previous use of regions allowed programs to ensure ' breadth ' of exposure in

each region, thus proficiency in each region. Representatives of the disbanded accreditation council did not recommended adopting this process. We are urging ABPTRFE to collect usable and meaningful data as recommended by Dr. Irrgang.

Requiring fellow applicants hold a board certification has two critical concerns. Mentors in Fellowship programs are not required to be board certified. To require that an applicant must have a certification that the faculty who teach and mentor them do not lacks face validity. Secondly, based on where we are in the percentage of therapists holding the board certification designation, it is unreasonable to restrict all fellowship applicants to come from this small nationwide percentage of physical therapists. We are too early in the process to restrict admissions for clinicians to obtain improved proficiency and efficiency in clinical practice. There are also fellowship programs such as critical care, for which an appropriate board certification is not readily available. To restrict our applicant pool to this degree during a time where proliferation and growth is still a current goal is short-sighted and without sufficient merit to justify the unintended consequences of eviscerating the applicant pool of our current programs.

There have been so many changes recently that are creating a real and present danger to the current accredited programs and we implore ABPTRFE to perform a full “Program Impact Analysis” in order to determine which of the many other changes should also be “suspended” in order to support the mutual goal of the sustainability of various Residency and Fellowship models, the expansion of the program offerings, and the ability of all licensed physical therapists to pursue advanced training within this system. In order to facilitate this process, AOPT’s Orthopaedic Residency and Fellowship Special Interest Group (ORF SIG) have performed an exhaustive review of the recent changes, identified the actual and potential consequences of these decisions, and in the spirit of cooperation have offered potential solutions. This is an example of the type of “Program Impact Analysis” that we are hopeful will become a required element in the policy decision making of ABPTRFE.

Attached is the Orthopaedic Residency and Fellowship Special Interest Group’s (ORF SIG) “Program Impact Analysis” for your review.

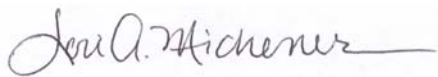
We appreciate the length of this communication, however, we felt that the critical nature of the challenges we are currently facing in Residency and Fellowship Accreditation deserved a complete and comprehensive outreach. We believe the identification of what is excellence in Residency and Fellowship training and the key critical components that must be present to ensure excellence in all programs is an essential first step to inform all policy decisions and future procedural developments in Residency and Fellowship accreditation and are very hopeful that the ABPTRFE Board is in agreement. This knowledge should be *the* impetus for change in quality standards and policy proposals and the review of such policies should also include a full

“Program Impact Analysis” to ensure that the mutually agreeable goal of expanding Residency and Fellowship to all current and future trained physical therapists is supported.

Respectfully Submitted,



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April 1, 2019

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Board Certified Specialist in Orthopaedic Physical Therapy  
Director, Academy of Orthopaedic Physical Therapy

Matt Haberl PT DPT ATC CSCS  
Board Certified Specialist in Orthopaedic Physical Therapy  
Fellow, American Academy of Orthopaedic Manual Therapy  
President, Orthopaedic Residency and Fellowship Special Interest Group, Academy of Orthopaedic Physical Therapy

Dear Aimee and Matt:

Thank you for your letter dated March 12, 2019 regarding ABPTRFE's Patient Health Conditions and Physical Therapy Outcomes Registry (Registry) that was a follow-up to our meeting at the Combined Sections Meeting on January 25, 2019 in Washington DC.

One of the initial tasks of the Registry's Scientific Advisory Panel (Panel) when it was assembled in 2016 was to review and approve the elements in the Registry's core data set. This review of the core data elements was undertaken by the Panel's Core Data Elements Subgroup (Subgroup).

The genesis of the initial list of data elements to be included in the Registry pre-dates the formation of the Panel and was at least in part the result of the work done at the Strategic Meeting on National Outcomes Database/Registry that was convened by APTA in January 2012. Based on the discussions at that meeting, it was recommended that "Rehabilitation/Medical ICD-9 Codes (single primary and all secondary listed)" should be included as data elements in the National Outcomes Database/Registry. As such, the Rehabilitation/Medical ICD-9 code was included in the core data set that was presented to the Subgroup for review and approval. It was also noted and understood that the ICD-9, and now ICD-10 codes should be mapped to a list of Primary Health Conditions (PHC).

After extensive deliberations by the Subgroup, the PHC was retained as a core data element for the Registry. It was understood that in the absence of an identified PHC that the first listed ICD-10 code would be used to identify the primary PHC. The Subgroup also recommended inclusion of all other listed ICD-10 codes as Secondary Health Conditions. The Subgroup and the Panel **has not discussed how the IDC-10 codes should be combined or categorized to create common subsets of patients/clients**. Additionally, to my knowledge the Panel **did not make any recommendations to ABPTRFE regarding what ICD-10 codes define orthopaedic specialty practice; however, the Panel did adopt the work of ABPTRFE to identify commonly used responses reported by residencies and fellowships as part of the accreditation process, to describe the patient's health condition.**

The Panel has not specifically discussed how the PHC will be used for reporting outcomes, however for orthopaedic conditions, the Registry team has discussed grouping ICD-10 codes by body region (neck, shoulder, thoracic spine, lumbo-sacral spine etc.) could be a good first approximation for reporting outcomes. Doing so would allow the Registry to report risk adjusted outcomes by body region, which would be a big advancement for the profession and the orthopaedic specialty area. The initial work on this process has been done by APTA and is summarized on the APTA website at: <http://www.apta.org/ICD10/IdentifyingCodes/> and in the attached Word document. The Residency and Fellowship Special Interest Group of the Academy of Orthopaedic Physical Therapy may consider reviewing this document to see if it meets the needs of residency and fellowship programs to support the training of specialists in orthopaedic physical therapy.

The Panel is also in support of a more specific approach to classification of patients/clients. The hope is that this approach to classification will make use of the "Movement System Diagnosis". The AOPT's role to define an ICF-based approach for sub-classifications within a body region that directs a physical therapist's intervention is something that the registry supports. An example of this is the treatment-based classification system described in the Neck Pain Clinical Practice Guidelines (i.e. neck pain with mobility deficits, neck pain with headache, neck pain with radiating pain and neck pain with impaired movement coordination). This would require the Academy to also specify the diagnostic criteria for each classification. The advantage of such a classification system would be that it would allow the Registry to generate reports of outcomes for those receiving matched vs. unmatched intervention for the individual's classification (movement diagnosis). Once this regional treatment-based classification system is defined, it would seem reasonable that the Academy would request the Registry to report outcomes utilizing this classification system. Additionally, it would seem reasonable that the Academy would also request the ABPTRFE to require residencies to utilize the same classification system in the accreditation process to determine if there are sufficient patient/client resources to support the training of residents and fellows in orthopaedic physical therapy.

I hope this response addresses your concerns that were expressed in our meeting on January 25, 2019 at the Combined Sections Meeting and in your letter dated March 12, 2019. I would be happy to answer any other questions you and the Academy have on this matter.

Best wishes.

A handwritten signature in black ink, appearing to read "James Irrgang". The signature is fluid and cursive, with a long horizontal stroke at the end.

James Irrgang PT PhD  
Catherine Worthingham Fellow, APTA  
Scientific Director of the Physical Therapy Outcomes Registry

## **Academy of Orthopaedic Physical Therapy Residency and Fellowship Special Interest Group Substantive Review of ABPTRFE Policies and Procedures.**

### **Objectives:**

Evaluate the established relationship criteria for physical therapy residency and fellowship programs (Programs) in their mutual agreement with the American Board of Physical Therapy Residency and Fellowship Educations' (ABPTRFE) Policies and Procedures regarding the accreditation and reaccreditation of Residency and Fellowship Programs in clinical post professional education.

### **Goals:**

1. Identify policies and procedures that will lead to unintended **consequences** regarding the sustainability and protection of both parties.
2. Describe the **Impact** of such policies and procedures on all parties.
3. Create **Solutions** in developing mutual protection and sustainability of all parties involved in **post professional clinical education.**

<p><b>2.5.1.1 Candidacy Status Disclosures</b></p>	<p><b>Consequence:</b>  This policy requires publishing the following disclosures on its website and/or marketing materials/documents that participants received notice of these disclosures.</p> <ul style="list-style-type: none"> <li>- <i>“ABPTRFE has granted (Name of Program) candidacy status. Candidacy status signifies satisfactory progress toward accreditation. Achieving candidacy status is not an indication that ABPTRFE will grant initial accreditation. Participants who graduate from a program in candidacy status are not deemed to have completed an accredited program.”</i></li> </ul> <ol style="list-style-type: none"> <li>1. Current language does not specify what is determined as sufficient documentation in meeting this requirement.</li> <li>2. Many program organizations have tightly controlled websites and marketing materials that will not allow such a disclosure to be published.</li> </ol> <p>This finding is consistent with the Accreditation Report Rubric for Program Outcomes.</p>	<p><b>Impact:</b>  Program:</p> <ol style="list-style-type: none"> <li>1. Such public disclosure may restrict applicants to apply to Candidacy Programs since it would not protect the applicants’ best interest in graduating from an “Accredited Program”.</li> <li>2. Programs who are unable to modify marketing content may lose the ability to become accredited/reaccredited.</li> </ol>	<p><b>Solution:</b></p> <ol style="list-style-type: none"> <li>1. The requirement of public disclosures on websites needs to be modified to applicants only so that programs can communicate to the applicant the process of accreditation. ABPTRFE should also consider these programs’ participants still as qualified graduates to protect their interest.</li> <li>2. Add a provision for organizations whose marketing departments will not allow this publication. Or eliminate this requirement altogether.</li> </ol> <p>See Appendix 1 for Accreditation Reporting Rubric.</p>
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<p><b>2.7- Request for additional information</b></p> <p><b>3.1 Participant Start Date</b></p>	<p><b>Consequence:</b>          Inconsistencies regarding timely response requirements of program (from 5-15 days) in comparison to timely response from ABPTRFE staff (30-45 days). In all noted policies, this creates an unjust opportunity for programs to provide adequate evaluation and ability to provide their “burden of proof.”</p> <p>In all noted policies, responses provided 10 days after notification dictates an automatic “waiver of rights.”</p>	<p><b>Impact:</b>          The expectation that ABPTRFE is provided 30 days and programs only 10 days to any ‘response matter’ further creates animosity between the accrediting body and the program. The animosity is created when an institution setting the evaluative criteria places their precedence of time over the evaluated. The assumption that program directors/coordinators and their faculty/staff schedules are less restrictive and busy makes a more punitive process rather than collaborative.</p> <p>In all cases the expectation of the Program is greater than that of the evaluator significantly placing the balance of power in one party over the other. This, in turn, makes an elective process less appealing to programs in having to demonstrate how they are meeting quality post professional education. The result then turns to current programs discontinuing this process and the potential to turn away quality developing programs.</p>	<p><b>Solution:</b>          Programs should have equal time for investigation and timely response as with any contractual agreement between two working parties.</p>
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<p><b>3.1 Participant Start Date</b></p>	<p><b>Consequence:</b>  Programs are notified of their “Candidacy Decision within 30 days following ABPTRFE meeting” with the expectation of enrolling their 1<sup>st</sup> participant within 5 months and then just have “Two weeks after a new resident starts a developing program must notify ABPTRFE.”</p>	<p><b>Impact:</b>  The 5-month required start date for a resident seems arbitrary which can negatively affect programs with a specified annual start date.</p> <p><u>Example:</u>  A program on track one is notified they are granted Candidacy status at the end of November. Their curriculum and program delivery is scheduled to start January 1<sup>st</sup> allowing only two months to recruit, interview, and offer a position. If a participant is recruited and accepted even prior to the start January start date, there is often up to a 90-day credentialing process before that participant can begin seeing patients. This process may inhibit the participant to complete in a timely manner.</p> <p>In the alternative scenario where a program is unable to recruit a participant within the selected timeframe are still now only allowed 5 months to enroll a participant despite their program delivery is scheduled to start in January.</p>	<p><b>Solution:</b>  Change notification of new resident to 30 days and adopt language that extends the opportunity for a program to enroll a participant based on their program delivery process in the case where a participant cannot be enrolled within the short 5-month window. Consider in a 12 month period which will allow recruitment and admission processes to be completed.</p>
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<p><b>4.2.1 Participant Satisfaction Surveys</b></p>	<p><b>Consequence:</b>          ABPTRFE is already requiring programs to survey outgoing graduates, survey graduates every 5 years, and now report on the ACIR 'what resident graduates have done in the past three years'.</p> <p>Now, ABPTRFE is also surveying satisfaction from graduates.</p>	<p><b>Impact:</b>          Participant survey fatigue and poor reporting.</p>	<p><b>Solution:</b>          Programs report Annual graduate survey response data and 5-year participant survey data on ACIR in support of their program outcomes and goals Exhibits 2 and 3.</p> <p>If ABPTRFE wishes to complete further satisfaction surveys they have all previous participant contact data on the Accreditation Management System and are responsible for collecting updated participant contact information and any other satisfaction surveys.</p>
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<p><b>5.1 Onsite visits</b> <b>5.2 Onsite team</b></p>	<p><b>Consequence:</b> Inconsistency between current language within the P&amp;P and what is expected for Review Council Members/ Onsite Team and their site visit expectations. Current P&amp;P notes:</p> <ul style="list-style-type: none"> <li>- “The onsite team conducts a minimum of a two-day visit.”</li> <li>- “*Onsite visits will consist of 3 site visitors for a minimum of 2 days. A maximum of 5 sites maybe visited. If any of these sites are beyond a reasonable distance from the program’s main address, these sites may require a separate 1 person, 1day regional site team member.”</li> </ul> <p>Expectations of Accreditation Council Site visitors:</p> <ul style="list-style-type: none"> <li>- “It is my understanding that site visits are intended to conclude in one day.”</li> <li>- “It is my understanding that only two members of the review team go on the site visit.”</li> </ul>	<p><b>Impact:</b> Variability in expectations, budget planning, and ABPTRFE transparency.</p> <p>Unclear if expectations differ between initial accreditation and reaccreditation.</p>	<p><b>Solution:</b> Clarify language within P&amp;P and expectations placed upon programs. This is further evaluated in next heading regarding the “Onsite Visit Team Responsibilities.” There is no reason for a two-day site visit for 1-5 residents. Two days is costly and unnecessary.</p>
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<p><b>5.4 Onsite Visit Team Responsibilities -Accreditation Report Rubric</b></p>	<p><b>Consequence:</b> Previous Onsite Visitor included two and have now increased to three including a Team Lead, Program Administrator, and Practice Area Expert all with a fee of \$600 per day resulting in a minimum fee of \$3600</p> <p><b>Program Administrator Responsibilities:</b> Reviewing Quality Standards 1, 4 and 5</p> <p>Under 1 they have two verifications onsite-</p> <ul style="list-style-type: none"> <li>- To identify if participants rotate to all sites</li> <li>- Verify the program is a not a Referral for profit</li> </ul> <p>No other responsibilities were listed as reviewing during the Onsite Visit within the Accreditation Report Rubric.</p> <p><b>The Practice Area Responsibilities:</b> Quality Standards 2, 3, and 6. Under 2 they have 3 primary responsibilities onsite.</p> <ol style="list-style-type: none"> <li>1. Onsite they determine if the Curriculum meets or does not meet the DRP/DFP requirements</li> <li>2. Onsite Mentor observation- This include one session of</li> </ol>	<p><b>Impact:</b> This represents a significant financial increase from the previous standard placing an undue financial hardship on programs seeking accreditation, re-accreditation, or are responsible for additional onsite visits due to substantive changes or special visits.</p>	<p><b>Solution:</b> <b>Program Administrator Responsibilities:</b></p> <ul style="list-style-type: none"> <li>- <b>Participant rotates to all location:</b> Instead of coming onsite can be done via phone or video conference communication with participants/faculty</li> <li>- <b>Not a Referral for Profit:</b> Can be done via communication with administration, review of contractual agreements, or web search site structure.</li> </ul> <p>Due to these two processes being completed virtually there likely is no need to complete on site.</p> <p><b>The Practice Area Expert 1. DRP/DFP requirements.</b></p> <ul style="list-style-type: none"> <li>- This is however expressed within the programs Exhibit 3 and reported via the Primary Health Conditions (PHC) chart which captures a larger picture of patient distribution. Additionally, nearly all programs now keep their curriculum in a virtual format indicating this can be viewed from anywhere.</li> <li>- We believe this could be completed via virtual</li> </ul>
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	<p>one mentor which does not address the ongoing process of Mentorship.</p> <p>3. Verifies Participant completion</p> <p>Under Standard 3 they have 1 onsite requirement.</p> <p>1. Evaluate Faculty Competence</p> <p><b>Team Lead Responsibilities:</b> Administers set up and completion of the site visit and compiles the reports following the visit.</p> <ul style="list-style-type: none"> <li>- They are not directly responsible for any specific portions of the Accreditation rubric on site.</li> </ul>		<p>assessment versus onsite if time was a limitation.</p> <p><b>2. Onsite Mentor observation:</b></p> <ul style="list-style-type: none"> <li>- Before using this as the primary assessment model of whether quality mentorship is occurring, further evaluation of mentorship strategies, and how they impact program outcomes needs to occur. Currently this is a priority within all Academy/Section Residency and Fellowship leadership. A collaborative effort in better understanding mentorship should be developed prior to an untested and validated requirement.</li> </ul> <p><b>3. Verifies Participant completion</b> Submission of Participant Certificates are already submitted with the ACIR to verify which residents have completed the program requirements. Additionally, the ACIR now captures how a program participant is or is not meeting program requirements.</p> <p><i>Quality Standard 3:</i></p> <p><b>1. Evaluate Faculty Competence.</b></p> <ul style="list-style-type: none"> <li>- Could likely be done virtually</li> </ul>
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			<p>with the Faculty Qualification Chart and virtual meeting with Faculty.</p> <p><b>Team Lead Responsibilities:</b> Given their duties are primarily administrative in nature we believe these processes could take place via virtual meeting without the necessary need to travel and be onsite for the specific evaluations given the responsibilities of the Practice Area Expert and Program Administrator.</p> <p>We recognize the importance of onsite visits however, given the minimal actual onsite requirements of being within the Program's brick and mortar we believe most of these confirmations can be completed via virtual communication to assist both the burden of ABPTRFE Review Council travel and time commitments to review a program as well as the financial and administrative time constraints of hosting a site visit for programs. Site visits could then be reduced back to 2 reviewers and within one day.</p>
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<p><b>6.4 Appealing the Boards Adverse Decision</b></p>	<p><b>Consequence:</b> 10-day program response requirement: Programs housed in larger institutions and Universities that require authorization of fees from multiple departments may not be able to submit fees within the 10-day period</p>	<p><b>Impact:</b> Programs would not be able to complete the appeals process and may result in a termination of their program</p>	<p><b>Solution:</b> Require programs up to 30 days to submit the required fees and payment plan</p>
<p><b>6.4 Appealing the Boards Adverse Decision</b></p>	<p><b>Consequence:</b> Significantly higher cost of an appeal fee (\$6000) compared to the remaining fee schedule</p>	<p><b>Impact:</b> Programs may be unable to afford costs for appeals and would be dissuaded from pursuing appeal process</p>	<p><b>Solution:</b> Transparency of why the costs are significantly higher for the appeal process and place a limit on how much these fees can increase annually.</p>
<p><b>6.4.2 Appeals Panel</b></p>	<p><b>Consequence:</b> Panel members selected by members of the current Board could be perceived as a means for potential bias of due process and imbalance of power in favor of the Board from programs appealing a decision from the Board</p>	<p><b>Impact:</b> Potential for a perceived selection bias may cause Program Directors to withdraw their appeal and terminate their program</p>	<p><b>Solution:</b> Create a Chair/Vice Chair position for the Appeals Panel who appoints the panel members for an appeal hearing from a list of qualified individuals agreed upon by ABPTRFE and Appeals Panel Chair/Vice Chair or subcommittee</p>
<p><b>6.5- Binding Arbitration</b></p>	<p><b>Consequence:</b> " <i>When the program remits an arbitration fee established by the Board,</i>" is how the language is worded in the Policy; Fee schedule should not appear arbitrary</p>	<p><b>Impact:</b> Consider revising the statement to reference the current fee schedule. (Appendix 3)-currently no arbitration fee.</p>	<p><b>Solution:</b> An outline of fees associated with the appeals and arbitration process should be clearly outlined in the initial letter from the Board once a program has initiated the appeals process</p>

<b>6.5- Binding Arbitration</b>	<b>Consequence:</b> Arbitrator is selected by the Board and not an outside representative.	<b>Impact:</b> Selection of an Arbitrator by the Board could appear as a selection bias by Programs	<b>Solution:</b> Involve a Chair/Vice Chair of the Appeals Panel in charge of appointing an Arbitrator versus the Board to avoid the perception of selection bias from the program.
<b>7.10- Correction of Misleading or Inaccurate Information</b>	<b>Consequence:</b> As currently written, the language is unclear as to the platform and context of misleading/inaccurate information (i.e., info in RF-PTCAS, information on websites, published advertisements, blogs) <b>Impact:</b>	<b>Impact:</b> Difficult for programs to follow guidelines with vagueness in the language	<b>Solution:</b> Clarify language
<b>9.3 Waiver Denied</b>	<b>Consequence:</b> Currently there is no appeals/arbitration process or outside evaluation regarding the impact a ABPTRFE Board decision may have on a Program who petitions for a Waiver Process when a Quality Standard may not impact the Mission of a program.	<b>Impact:</b> ABPTRFE serves as the sole determiner of petitions and waivers removing the protection of a Program to receive outside review for their petition.	<b>Solution:</b> Programs should be provided protection and the ability for outside review to hold ABPTRFE accountable for their decisions.
<b>10.3 Maintaining Accreditation-</b>	<b>Consequence:</b> No definitive deadline dates for	<b>Impact:</b> Restricts programs from desired	<b>Solution:</b> Programs are provided feedback

<p><b>ABPTRFE Review and Follow Up</b></p>	<p>ABPTRFE to complete ACIR and feedback to programs. However, Programs are required to submit this by January 31, 2019.</p>	<p>feedback for continuous improvement, annual planning, and time management for Program Directors to ensure ongoing excellence.</p> <p><i>Example:</i> Programs currently report ACIR in January and may have either a quarterly rolling admission starting in April, July, or September, therefore three new cohorts may start prior to receiving any feedback regarding their ACIR.</p>	<p>on their ACIR no later than March 31st regarding any request for additional information for ongoing compliance with current guidelines</p>
<p><b>10.3.1 Additional Clarifying Documentation</b></p>	<p><b>Consequence:</b> A program may be asked by ABPTRFE to submit additional information based on the activities reported from the previous year however no timeline is listed.</p>	<p><b>Impact:</b> Planning/logistics for giving additional information.</p>	<p><b>Solution:</b> When additional information is requested, programs should be asked to provide a 6-month progress report, with the expectation of full compliance by the next ACIR cycle.</p>
<p><b>10.3.2 Special Visits</b></p>	<p><b>Consequence:</b> Currently without a specified timeline for feedback there also is no timeline or process for when a special visit may be indicated.</p>	<p><b>Impact:</b> A special visit indicates an additional fee structure that Programs may not be able to budget for within their specified calendar year.</p>	<p><b>Solution:</b> If defined timelines and processes are put in place this will allow the program to make any necessary modifications and update processes. A special visit would then be reserved for any program who fails to demonstrate within their progress report and ACIR that program modifications have occurred. This protects the program in allowing enough time to plan, organize, budget and</p>

			implementation of necessary changes.
<b>11.2 Special Visits</b>	<b>Consequence:</b> Given timeframe of 12 months on when special visit will occur.	<b>Impact:</b> 12 months is not realistic for a resident/fellow who made the complaint and could potentially graduate in that timeframe.	<b>Solution:</b> Defined timelines based on severity or type of trigger for visit.
<b>12.0 Complaints</b>	<b>Consequence:</b> No discussion of allocation of complaints against a practice site versus the program implicating both parties despite factors not being within the sphere of control of the program.	<b>Impact:</b> Program's accreditation for all programs participants at other practice sites are now affected when incidence is localized to a single practice site outside of the programs control.	<b>Solution:</b> ABPTRFE identifies a process for the handling and routing of complaints outside of a program's control.  Programs have a teach-out commitment to participants as part of a practice site who underwent a complaint process against them.
<b>13.0 Substantive Changes and 14.0 Non-Substantive Changes.</b>			
<b>13.2.1-5 Change in Ownership</b>	<b>Consequence:</b> Often the details of this are not known until after the fact and it is common for there to be an evaluation period post sale which may unnecessarily put the program out of compliance. When sales occur the future of programs are an important discussion point, but often not highlighted	<b>Impact:</b> Programs lose accreditation and unintentionally destroy programs that would have continued if not interfered with.	<b>Solution:</b> Modify requirement as substantive change in that a program submit within 6 months after completed transaction. Substantive Change Documentation would simply include the notification that the new ownership is not a "Referral for Profit" organization and a statement from new ownership that there are no anticipated



			changes related to all aspects of the program with this transaction.
<b>13.3- Change in leadership</b>	<b>Consequence:</b> Programs being required to submit changes in leadership for approval decreases program accreditation autonomy.	<b>Impact:</b> Given in the large intervals between board meetings this would likely create huge voids of time where programs are operating without a director	<b>Solution:</b> Require notification of change and who will serve as the interim director but eliminate the board's responsibility to approve at board meetings. Program accountability defaults to Program Outcomes as reported on ACIR and not the Program Director alone.
<b>13.4.1 Change in Curriculum</b>	<b>Consequence:</b> There are 2 parts for participant practice/mentoring site approval.	<b>Impact:</b> Significant amount of time to approve sites with this two-step process delaying a participant's access to this education requirement.  <i>Example:</i> It takes two quarters (6 months) to approve additional practice site or participants due to the first application being submitted prior to a board meeting and then final decision based on second review of Part two.	<b>Solution:</b> Return to one approval application for sites and mentors due 30 days before ABPTRFE meeting or revert to monthly submissions to decrease workload.
<b>13.4.2 - Substantive Change Implementation.</b>	<b>Consequence:</b> Onsite visit required for added sites over 2 in 1 calendar year.	<b>Impact:</b> Financial implications on institution and possibly reflecting onto the participant in training. Program and clinic logistics in planning and implementation of visits. Micromanaging the program director's	<b>Solution:</b> Eliminate 13.4.2 or a revisiting of solutions from stakeholder meeting.

		autonomy.	
<b>13.4.3 Change in Curriculum Substantive Change Decision</b>	<b>Consequence:</b> Decisions given within 30 days of meeting.	<b>Impact:</b> Significant wait time for approval. Upwards of 5 months for full approval when most residency programs are 12-months in length.	<b>Solution:</b> If decision at meeting, decision will be submitted to program director within 7 days.
<b>14.1 Participant Positions</b>	<b>Consequence:</b> There is no explanation why 2 is the number of participants allowed without a substantive change.	<b>Impact:</b> Unnecessary reporting.	<b>Solution:</b> Identify realistic and supported factors for Substantive vs Non-Substantive changes.  To our current knowledge there is no understanding in determining this value. This should serve as the priority of investigation prior to the implementation of an unknown policy.  Until then, Programs should be protected if they are built to grow. Further data collection can then occur in understanding where a program fails to meet their outcomes based on their speed of growth.
<b>14.2 Participant Practice Sites</b>	<b>Consequence:</b> There is no explanation why 2 is the number of participant	<b>Impact:</b> Unnecessary reporting.	<b>Solution:</b> Identify realistic and supported factors for Substantive vs Non-

	<p>practice sites allowed without a substantive change.</p>		<p>Substantive changes.</p> <p>To our current knowledge there is no understanding in determining this value. This should serve as the priority of investigation prior to the implementation of an unknown policy.</p> <p>Until then, Programs should be protected if they are built to grow. Further data collection can then occur in understanding where a program fails to meet their outcomes based on their speed of growth.</p>
<p><b>15.0 Reviewing Adopting and Circulating Changes</b></p>			
<p><b>15.1 Seeking Feedback and 15.2 Review Process</b></p>	<p><b>Consequence:</b> Current process does not list specific APTA Academy and Section Leadership, or ABPTS as primary parties of interest.</p>	<p><b>Impact:</b> Creates a disconnect between Academy and Section Leadership strategic planning, clinical practice guideline development, educational programming, research initiatives, etc. which will directly affect physical therapy practice and how these are integrated into residency and fellowship education.</p> <p><i>Example-</i> Current disconnect between the tracking of new PHC required by Residency and Fellowship programs. This is inconsistent with the</p>	<p><b>Solution:</b> Required review and feedback from APTA Section/Academy Leadership and ABPTS on an annual basis with an in depth review every 5 years.</p> <p>Academy/Section Leadership are represented by apportionment on the Standards committee.</p>

		recommended movement terminology tied to current practice guidelines and patient care outcome tracking for future research initiatives, e.g. APTA Outcomes Registry does not support this method of tracking.	
<b>15.1 Seeking Feedback and 15.2 Review Process</b>	<b>Consequence:</b> Current process does not have a standardized ongoing communication process with programs	<b>Impact:</b> Programs should be able to routinely know when ABPTRFE Newsletters and an annual meeting (CSM) are scheduled and provided. Without a consistent publications' timeframe and multiple levels of dissemination (email, HUB delivery, and option for print) creates inconsistent communication and ongoing confusion for programs.  <b><u>Example:</u> Dates of current Newsletters on HUB</b> March 2017 August 2017 October 2017 January 2018 April 2018 June 2018 Nov 2018 June 2019	<b>Solution:</b> Quarterly scheduled ongoing communication that can be disseminated to Academy/Section Leadership prior to the release to members to ensure no confusion and enhance communication across all parties.  Ability to attend ABPTRFE Board meetings as a guest, similar to APTA Board of Director Meetings, would enhance communication and dissemination of information.
<b>15.3 Call for Comment and 15.4 Revision Approval</b>	<b>Consequence:</b> Current process does not include a minimum data set of required program and/or stakeholder responses to indicate that sufficient	<b>Impact:</b> Currently unknown how many programs were knowledgeable of the review process and timeline.  <b><u>Example:</u></b> Minimal information was	<b>Solution:</b> Set a minimum data set to demonstrate that sufficient review was completed by programs, and key stakeholders including review of all Policies

	<p>information and review was completed.</p>	<p>shared with programs regarding the recommendations and feedback provided to Susan Chiaramonte during her review process and what she shared with the ABPTRFE.</p> <p><i>Example:</i> Not all documents were provided as an option for review. Only the initial draft of Quality Standards in March 2017 for review without a crosswalk to current standards.</p> <p><i>Example:</i> No Call for Comment Period was used regarding updated ABPTRFE Policies and Procedures</p>	<p>and Procedures, Quality Standards, and accompanying documents. Policy proposals and the review of such policies should also include a full <b>“Program Impact Analysis”</b> to ensure that the mutually agreeable goal of expanding Residency and Fellowship to all current and future trained physical therapists is supported.</p>
<p><b>15.3 Call for Comment and 15.4 Revision Approval</b></p>	<p><b>Consequence:</b> Current process does not include a program “Impact Analysis” completed following the approval of initial revision review prior to Implementation.</p>	<p><b>Impact:</b> Implementation of P&amp;P changes prior to understanding the lasting impact this may have on program sustainability and growth.</p> <p><i>Example:</i> Current Policies and Procedures were accepted in July 2018 with expected implementation of January 2019 without any outside review. Substantive Change 13.4 created significant concern regarding sustainability among programs leading to additional stakeholder meeting and workarounds to a now suspended policy.</p> <p><i>Example:</i> 42% of surveyed Academy of Orthopaedic Physical Therapy</p>	<p><b>Solution:</b> Create the same level of protection for programs by adding a “Program Impact Analysis” as a final review prior to implementation for both Quality Standards and Policy/Procedures</p>

		<p>Residency and Fellowship SIG members responded they are unsure if they would keep their accreditation status with ABPTRFE making up 67% of Clinical Sites and 71% of Annual Graduates in 57 of 104 Orthopaedic programs that responded.</p> <p>77% of OMPT Fellowship Programs were not in favor of the new required Onsite visit.</p> <p><u>Please refer to Narrative Responses from Programs in Appendix 2</u></p>	
<p><b>15.5 Implementation and 15.6 Effective Dates</b></p>	<p><b>Consequence:</b> Current process does not describe any timeline or process in which ABPTRFE provides education to current accredited programs outside of a 12-month implementation of revisions and 24-month adoption date.</p>	<p><b>Impact 1 of 2:</b> Program confusion and delayed implementation of new or modified standards.</p> <p><u>Example:</u> Actual timeline for implementation not within current policy recommendations of 24-months after publication.</p> <ul style="list-style-type: none"> <li>- March 2016: External Auditor initiates review on 2013 Evaluative Criteria</li> <li>- March 2017: Call for Comment Period for new Quality Standards without a crosswalk to current standards</li> <li>- June 2017: New Quality Standards accepted with accompanying documents still being created.</li> </ul>	<p><b>Solution 1 of 2:</b> An established review timeline and process to educate and encourage program growth for implementation should be developed.</p> <p><b>Solution 2 of 2:</b> This process of review for ABPTRFE should mirror that of the accreditation process expected of programs. This should include a review of their outcomes (program satisfaction, number of developing programs, reaccredited programs, communication with programs, financial stability, and educational resources developed and provided to programs for ongoing excellence).</p>

		<ul style="list-style-type: none"> <li>- December 2017: Application for Candidacy and Self Evaluation forms accepted to current standards.</li> <li>- March 2018: ABPTRFE extends date of compliance to 2020 to programs started under old model in 2017.</li> <li>- June 2018: ABPTRFE Policies and Procedures adopted with Substantive Change documents still being created.</li> </ul> <p><b>Impact 2 of 2:</b> Significant burden on program director and program staff for continual review and modification of ABPTRFE reporting content.</p> <p><u>Example:</u> Initial release of new Quality Standards and expected implementation was 2019. Due to ongoing confusion for current accredited programs the deadline delayed to 2020 with Candidacy remaining at January 2019.</p> <p>A requirement of Candidacy Programs is to complete the Candidacy workshop which was not released until July 2019. The same is for programs undergoing reaccreditation as the Accreditation Workshops were not completed and released until July 2019 after the initial implementation deadline.</p>	
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<b>Appendix 3.0 Fees</b>			
<p><b>Appeals Fees:</b></p> <p><i>See section 5.0 above regarding the onsite visit fees for more context.</i></p>	<p><b>Consequence:</b> (See Appeals 6.4) Significantly higher cost (\$6000) for the appeals fee which is not refundable</p>	<p><b>Impact:</b> Cost of appeals could be a disincentive for a program to pursue an appeal process limiting the protection of the program.</p>	<p><b>Solution:</b> If the appeals process results in a reversal of the initial Board's decision, a portion of the appeals fee should be returned to the Program</p> <p>Reporting on past successful appeals could be helpful for programs to learn how to conduct a successful appeal process and reduce disincentives to appeal</p>
<p><b>Application for Candidacy:</b></p>	<p><b>Consequence:</b> \$3,210 (candidacy fee) + \$3600 (onsite minimum) may be too high for some programs.</p>	<p><b>Impact:</b> It is unknown what the fiscal barrier to entry is for new programs.</p>	<p><b>Solution:</b> Survey community to determine barrier to entry and maintenance of accreditation fees.</p> <p>Consider adjusting fees PRN (notably onsite fees)</p> <p>Expand grant options for new programs from academies or other sources</p>



<p><b>Biennial Fee increase:</b></p>	<p><b>Consequence</b> There currently is no limit to what fees could increase on a biennial basis.</p> <p>No Reaccreditation fee listed.</p>	<p><b>Impact:</b> Does not protect programs from excessive rate hikes to maintain accreditation or reaccreditation.</p> <p><u>Example:</u> Accreditation Fees:</p> <ul style="list-style-type: none"> <li>- From 2010 to 2020 fees have increased from \$1500 to \$3210 demonstrating a 114% increase in fees <ul style="list-style-type: none"> <li>- <b>10% increase annually</b></li> </ul> </li> </ul> <p>Annual fees</p> <ul style="list-style-type: none"> <li>- From 2013 to 2021 fees have increased from \$862.50 to \$1177 demonstrating a 36% increase <ul style="list-style-type: none"> <li>- <b>5% increase annually</b></li> </ul> </li> </ul>	<p><b>Solution:</b> Insert language noting fees cannot increase beyond normal inflation rates of more than 2% annually.</p> <p>There should be transparency re: fee process with fees identified on ABPTRFE website. Presently only states “<i>The fees for residency and fellowship accreditation are established by ABPTRFE and are subject to change every 2 years.</i>”</p> <p>No information related to reaccreditation fees.</p>
<p><b>Appendix 4.0</b></p>			
<p><b>Accreditation Team</b></p>	<p><b>Consequence:</b> New self-evaluation report and exhibits, a critical component that the Candidacy Review Council, is being used to evaluate programs for candidacy status</p>	<p><b>Impact:</b> Due to limited education and expectations regarding the New Self-Evaluation Tool and Exhibits, this has created confusion among programs. In doing so this has expended what little time Programs have to spend on accreditation requirements.</p> <p><u>Example:</u> There were high levels of variability identified in interpreting these forms during the Residency/Fellowship pre-con course</p>	<p><b>Solution:</b> Ensure system is in place to adequately train programs, provide various examples, and ensure the ABPTRFE will provide feedback prior to critical candidacy decisions.</p> <p>Ongoing reporting to the community on pitfalls, pearls, etc. to ensure that existing and new programs are on track.</p>

		<p>at CSM 2019 (just prior to their first submission during the 2018 ACIR cycle).</p> <p>The impact of this interpretation on programs is still unknown as programs have not yet received ACIR feedback. <b>The ACIR new Exhibit 2 and 3 were submitted by January 31, 2018 and to date a majority of programs have not received feedback as of August 22, 2019.</b></p>	
<p><b>Standard Committee: Public Comment</b></p>	<p><b>Consequence:</b> It's noted that ABPTRFE will forward proposed revisions for public comment period of 6-8 weeks however it does not list in what this means and what level of feedback is required for acceptance.</p>	<p><b>Impact:</b> Public comment periods of 6-8 weeks for major policy changes implemented by the accreditation team have proven to be problematic and will likely continue if there remains a lack of awareness of these comment periods.</p>	<p><b>Solution:</b> Have a clear and easy pathway outlined for programs to ensure the ability to participate in these comment periods. Have some way of validating a substantial portion of programs have weighed in on said policy decisions (e.g. through a survey)</p> <p>New policy initiatives should perhaps include a trial period where programs actually have to comply with the policy for 1 annual cycle and appropriate data can be gathered on its effect on programs prior to being used punitively against programs.</p>
<p><b>Standards Committee: Members</b></p>	<p><b>Consequence:</b> ABPTRFE currently appoints these members without</p>	<p><b>Impact:</b> A disconnect between Academy/Section Leadership with</p>	<p><b>Solution:</b> Standards committee should include representatives of each</p>

	<p>guidelines for qualification. Additionally, there are no requirements to involve Academy and Section Leadership.</p>	<p>ABPTRFE.</p> <p>Public perception of hand-picked reviewers to comply with the current members of ABPTRFE staff.</p>	<p>of the APTA Academy/Section leadership to ensure policies and processes are consistent.</p> <p>Programs should elect the qualified members to represent them consistent with our other governing bodies.</p>
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**Appendix 5.0**

<p><b>Petitioner Guide for Establishing a New Area of PT Res/Fellowship Practice.</b></p>	<p><b>Consequences:</b>          To petition for a new area of practice, it is estimated to cost approximately \$15,000 (using the recent AOPT Foot and Ankle SIG analysis as an example) and take ~2 years of work from a large team of volunteers. The bulk of this fee is estimated to be \$5,000-7500 for a consultant and \$5,000 application fee. Also, it is difficult to find people with practice analysis experience which adds to the difficulty of securing consultants and negotiating with them on their fees</p> <p>Since only one program has completed a practice analysis considering these new petitioner guidelines (Performing Arts DFP), the true cost, resources involved, and actual processes</p>	<p><b>Impact:</b>          There are very little criteria in the petitioners guide to determine what a “viable” practice analysis result should look like. This could lead to a substantial loss of resources for teams to pursue a practice analysis that is destined to fail</p>	<p><b>Solutions:</b>          Provide more grant funding, resources, training, and staff resources to reduce the barrier to entry for needed new practice areas</p> <p>Require those completing a practice analysis to report on critical steps taken to complete analysis (if this is already the case, then have this published openly on the ABPTRFE website). This could help reduce the consulting fees and the workload of the volunteer teams.</p> <p>ABPTRFE should consider reporting which analyses groups have notified ABPTRFE of their intent to submit on the ABPTRFE website to reduce duplicative work as soon as possible. Also, a historical record of these</p>
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	<p>implemented are somewhat unknown to the broader Residency/Fellowship community.</p>		<p>analyses should be left on the website forever so the community can understand the past, present, and future of these initiatives (halted, failed, and obviously successful analyses...not just the DRP or DFP)</p> <p>ABPTRFE should likely also report who the team includes (consultant, principal investigators, and task force) to ease collaboration, notably finding and negotiating with a consultant.</p>
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**APPENDIX 1: Accreditation Report Rubric Excerpt**

5.7 **Outcomes Publication:** The program annually publishes **outcomes** data that communicates program performance indicative of participant achievement.

<b>Exceeds Expectations</b>		<b>Meets Expectations</b>		<b>Needs Improvement*</b>		<b>Inadequate*</b>	
Program annually publishes on its website <b>outcomes</b> data that communicate <b>comprehensive</b> and <b>specific</b> program performance	<input type="checkbox"/>	Program annually publishes on its website <b>outcomes</b> data that communicate program performance indicative of	<input type="checkbox"/>	Program annually <b>partially</b> publishes on its website <b>outcomes</b> data that communicate program performance indicative of participant achievement.	<input type="checkbox"/>	Program <b>does not</b> annually publish on its website <b>outcome</b> s data that communicate program performance indicative of	<input type="checkbox"/>

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53

indicative of participant achievement.		participant achievement.				participant achievement.	
<b>CRC Required Actions*:</b>	[Insert for all Findings of Needs Improvement or Inadequate]						
<b>CRC Comments:</b>	[Insert Comments Regardless of Finding on the Program's Overall Compliance with this Standard.]						
<b>Onsite Finding:</b>	[Insert Finding]						
<b>Onsite Required Actions*:</b>	[Insert for Findings of Needs Improvement or Inadequate]						
<b>Onsite Comments:</b>	[Insert Comments Regardless of Finding on the Program's Overall Compliance with this Standard.]						
<b>Program Response:</b>							
<b>ABPTRFE Decision:</b>							

**Consequence**

- There is a new requirement to publish outcomes annually

**Impact**

- Publishing outcomes publicly may not be tenable for sponsoring organization, and may be anti-competitive

**Solution**

- Give the option to publish internally or externally
- Have ABPTRFE collate data, scrub (private) and publish outcomes on it's own website aggregately

## APPENDIX 2: PROGRAM SURVEY RESPONSES

Question: Are you in support of the ABPTRFE's policies on requiring additional site visits (beyond those required in standard accreditation/re-accreditation processes) as outlined in the new Substantive Change Implementation policies?

### Residency Program Comments:

- I believe if the program is expanding and they have a detailed criteria for a residency site within their program AND that has been approved by the board then there is no need for a paid site visit.
- The continual changes and potential cost increases may reach a point where our organization may need to consider abandoning the residency program.
- This policy would substantially add to the cost of running our program which is a multi-site, hybrid-distance program. I'm not sure what a site visit adds beyond what can be assessed virtually.
- This is unreasonable and unsustainable. We are reconsidering growth plans in light of this and will not be increasing our class size as planned.
- Recognize concern, but when most programs have low numbers and are close to break even, adding more work and cost does not make growth attractive (and some days just keeping going as we are? EG: is this worth the time / effort?)
- The question above pertaining to "adding" sites was answered as we will not "add" sites EACH year. We will keep our current 2 sites.
- The policy is nonsensical and not based on any relevant data.
- If adding another site and everything else is the same, what is the goal of the visit?
- This will place SIGNIFICANT burden on our program and residents, likely not allowing our program to continue.
- As a part of a large specialty orthopedic PT practice with multiple sites, we commonly experience shifting/movement of providers based on personal and business factors. Being able to be nimble and change the clinical sites allows us to continue to provide patient volume and quality mentoring without additional barriers.

-I appreciate the reasons behind ABPTRFE's attempt to increase program oversight and thereby to improve the quality of our programs. And while these changes would not dramatically increase the administrative burden to our program, I could see how it would for many other programs - who might be unprepared/unable to meet these additional administrative and financial burdens. If continued and further administrative and financial requirements are passed down from ABPTRFE, I would be concerned about what could happen to private practice based residencies and fellowships.

-This APTA policy needs to be rescinded immediately.

-ABPTRFE is failing to account for the financial impact that this requirement will make. I do not support this requirement and am confident that my leadership will not either; thus making the sustainability of our program(s) a challenge.

-I am very concerned about this. I agree that a site visit is required when moving to a model that will involve multiple sites. But the site visit should not be for every single extra site. Perhaps a site visit could be added for each 3rd or 4th additional site added.

-I would prefer that the Board make this as an option should they feel that if an additional site visit is necessary then they could call on one. I don't think it should be an 'automatic' site visit if a site is adding 3 residents. If a place is resourced to handle an increase like that then an additional site visit seems like an unnecessary administrative burden and cost. But if the board is not sufficiently convinced via the substantive change form that the program can pull it off, then I think they are within their scope to call for a follow up site visit.

-I agree with additional site visits when a program is moving from single to multi-site or when adding sites. I am not sure that an on-site visit is necessary when curriculum changes are made as these would be more reviewed on paper as opposed to seen in practice during an on-site visit.

-I agree with the need for ABPTRFE to closely monitor and regulate the quality of residency education to ensure high quality of training. I do have concerns that the demand for residency programs and subsequent growth in # of programs could water down the quality of training across programs. The reason my response is 'unsure' regarding this policy is that it seems a little too sensitive to change such that it will be a disincentive for programs that want to strengthen their program through curriculum changes. Seems like this could be done with a description of change in the substantive change form/request and ABPTRFE reviewing the materials. Perhaps a phone conversation for follow up Q&A but a site visit in such an instance would be unnecessarily costly and time consuming. Finally, I would err on the side of quality assurance rather than convenience to residency programs, in the end this should be about protecting the residents and building up the profession. We should be able to do that without hurting the programs taking up this task of building up the profession.

-Site visits are expensive and time consuming. My preference would be one site visit at the primary location of the residency program, with supportive documentation provided for the other sites where mentoring also takes place

-I think it is beneficial to ensure consistency across programming, however the cost and burden of time incurred with multiple site visits is unrealistic.

-In our multi-site residency we have 4 independent business entities that collaborate, two of whom are the official sponsors and the others affiliates. All of our entities have multiple sites but only use 1 (primary sponsoring organization has 2). We may choose to change the specific location of the approved business entity based on current market share considerations and/or mentor availability (LOA) to make sure we are optimizing the resident experience. There is no change in the sponsoring organizations and affiliated partners, so changes to mission, values, and objectives remains unchanged. If in a given year we happened to have a patient volume scenario that drove us to change a site in one institution and an LOA to change the mentor in another, we would need to undergo a site visit which is both time intensive and financially prohibitive in the current healthcare environment of decreasing reimbursement.

- I also feel the current policy lacks flexibility for unforeseen events. If something required action and we were not in the window of 30 days before the board meets, what is the impact to the program and residents? The residents should not have to put their program on hold if a reasonable solution can be accommodated by the sponsoring site. Things that come to mind are natural disasters that may close a clinic, a staff resignation of a mentor, or an LOA by a mentor. Other scenarios may also apply.

-The administrative burden for ABPTRFE and the program seems unnecessarily large, unless the policy states that 1-3 visits for a program with multiple sites is sufficient. In that case, I'll switch my answer to yes. I can appreciate that seeing 2-3 sites gets close to some form of quality control.

-Requiring programs to fund site visits for adding more than sites or residents or making curriculum changes will be unduly burdensome. It is already costly to stay accredited. If a program can demonstrate in writing that there are an adequate number of qualified mentors, an increase in number of residents should not trigger a site visit. Information on new sites and curriculum changes can also be delivered in writing.

-I would like to understand more about the value of those site visits. If this somehow makes a residency program more likely to be of high quality, better outcomes, or catch outliers that could damage the reputation of residency programs then yes, of course.

Given the ABPTRFE policy changes requiring programs to fund additional site visits, will your program continue to maintain your accreditation requirements with the ABPTRFE?

-As of right now the current policy notes that programs cannot have any variability in the number of participants/sites. Given our current model we provide training to participants at facilities based on THEIR needs. If the expectation of Res/Fellowship education is to be based on standard academic timelines and models we will likely find alternative methods to provide post-professional education.



- We will maintain accreditation but we likely will not continue to expand
- Our program is currently evaluating the continued feasibility of continuing to financially support the program.
- It is becoming less and less viable. We have begun strategic conversations to evaluate the benefit of this accreditation process.
- likely we will, but will evaluate if worth the cost to grow or if there are other options
- Policies becoming burdensome to the point our site is
- We debate from time to time if it's worth the expenses and hassle to be accredited, essentially still offering a residency, but w/o the APTA stamp.
- Our University is undergoing many changes in regards to patient care policies and procedures, so we are unsure of how this will affect our current program. This takes priority over expansion of our current program.
- We will be evaluating other means to continue post professional education eliminating our available Residency or Fellowship positions.
- We are unsure if we will be able to meet the financial burden this presents. The cost would likely flow downhill to the resident whom already has significant burden.
- Dependent on cost of site visits. This would be a considerable barrier to continuing to provide quality mentoring and adequate patient volumes.
- It may hamper our ability to grow, but our program is locally based and additional sites would be added relatively slowly and we could afford the cost. However, with each expansion site, we would need to be far more judicious in the evaluating the cost-benefit of adding additional sites.
- Will depend upon the actual amount beyond the accreditation cost. Are the site visitors local, less expensive, vs. if site visitors need to travel a distance, e.g. plane fare etc.
- Have to discuss as a group, up for re certification in 5 years
- In light of this information, we will not follow through with plans to convert from multi-facility to multi-site as well as increase the number of program participants we accept annually (increase from 3 to 6)
- At present, yes. Will be determined as this moves forward and impact realized.

-We run this program on a very tight budget and the additional expense would be a major concern.

-cost will need to be reviewed by administration

-We do not change our program much so I don't see the substantive change policy having much impact on us. We are talking about some curriculum modifications in the future, my response may change after I determine whether our ideas are substantive change worthy or not.

-We are an employment based program and have multi-site for clinical mentoring. Based on additional costs if all of our sites are considered "additional" we will likely evaluate other means to continue post professional education and mentoring.

-I can't imagine paying for site visits with identical curriculum and oversight for a residency that is already accredited.

-we do not intend to add additional sites

-Yes, for the current time period. Will continue to observe and re-evaluate.

-We likely will not add additional sites from this point forward as we cannot foresee the staffing -changes that may result in annual changes. We had been in discussion with another entity.

-Hopefully there is a cadre of regional people that can do this work. So it would depend a bit on if I really need to cover flights, hotels...or just mileage/stipend.

-Not anticipating any affect.

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Given ABPTRFE's change in policy requiring site visits after 3 additional sites/participants are added, how will this affect your program?

-I intend to keep my residency cohort to 2-4 residents a year for the foreseeable future

-it will not affect us

-will not affect us

-it will not

-We will be challenges by affording the cost of the additional site visits.

- The current policy will greatly limit our ability to provide post professional residency education and clinical mentoring to rural areas in Wisconsin, Iowa and Minnesota. Overall this will greatly impact the level of patient care being provided in these areas as well as recruitment measures for these clinics to recruit and retain superior physical therapy staff.
- This will affect our future plans for expansion since that is a cost that was not considered when determining future growth
- It will not affect our program until 2-3 years from now and I am not sure how it will impact.
- The additional time and cost requirement may limit our willingness/ability to grow.
- Substantially add to the cost and administrative burden.
- We are not moving forward with a planned increase in training slots. This was to be a 25% increase.
- We would probably add less sites
- We use multiple sites and often have to swap facilities based on where mentors move and their availability. This makes it MUCH more difficult to consider flexibility and may make the facilities we collaborate with less interested in continuing. Not clear if we add other affiliated sites (EG: we have 3 health care organizations and within each organization, they often move the resident from site to site.) We also are looking at adding other organizations as well so could get too expensive when our University is already really looking at our residency due to lack of 'significant' income. We've been able to continue break even, but this may be a dagger.
- it will not affect us
- It shouldn't at first, but this appears to be an unneeded expense to the site, which I am -concerned is only designed to make ABPTRFE revenue positive.
- It will not affect our program
- Unsure, as we are a residency that has residents from outside our health system, as well as residents from within. This could force us to change our model and just limit residents to employee's only.
- If we are allowed to maintain our current status of 2 sites and 3 residents, it should not affect our program. We currently have a 2:1 faculty to resident ratio. Forcing expansion of sites and more residents would jeopardize the ratio and quality of our product. We could not sustain consistent expansion with our staffing and financial needs.
- I will be unable to accommodate residency applicants as I do not have a budget to support on-site visits for adding new clinics. How can you allow a multi-site program to have X number of slots but not give them the latitude to add clinics to meet the

demand?

-Not sure that it will affect our Residency

-Significant financial burden, likely raising tuition 100%. Substantial decrease in number of slots. Likely decreased number of faculty that are willing to support a this unnecessary policy.

-This will be a considerable barrier to providing quality mentoring. It may make us re-consider continuing accreditation.

-No effect as we are not planning on adding additional sites.

-As I'm reading over the change in curriculum section (13.4) it appears to be me that so long as a program grows by 2 or less participants or 2 or less sites in a calendar, it does not trigger a site visit. If this is the case, it would be unlikely that we would grow by 3 or more sites within one year and so would not be that impactful on our program. We, historically, have typically grow 1-2 residents / sites per year.

-Could financially affect the program, as well as limit the ability to collaborate with potential clinical partners

-We plan on maintaining our current status as we do not have the resources for continual annual additions of residents and/or sites

-Significant operational costs increase in both time and man power.

-Significant increase in operational costs and man power

-We will maintain the sites we have now

-Possibly contraction of sites/residents

-Per above, we will not increase the number of program participants we accept annually.

-No immediate impact. But would affect us in future if we decide to expand our model.

-Financial burden that will ultimately be passed on to residents

-Will not

-it will not

-No effect.

-At the present time, our program will not be directly affected; however, as we do plan to expand in the future, we may need to comply with the changes. I expect that we might try to plan expansion around re-accreditation to allow for a single site visit to cover both requirements

-We are a small program. It's easy to foresee growth that may require site visits yearly for the next 3-4 years. The cost consideration may not be favorable for continuing accreditation.

-This will not affect our program immediately, but I support ABPTRFE's desire to assure that programs maintain high-level clinical setting for prospective residents, in addition to their interest in making sure programs do not expand their classes beyond their ability to do so. I would welcome a site visit if our program underwent such expansion, which is a goal of ours in the future.

-We add many slots per year, and this process will likely significantly negatively impact the ability of a resident to complete the program in a timely fashion. Our facilities are nation-wide, so efficiency of visits is not likely. Additionally, significant coordination will need to be made with independent clinics that are not under the Evidence in Motion purview, and it is not known how supportive they will be of this change and impact during visits.

-We would likely be very cautious and strategic in adding sites in order to avoid this mandatory site visit.

-Likely will not change, so minimal impact

-not at all

-No impact. We have used just 2-sites for ~6 years and do not see the need to change that. If we increase our # of residents from 2 to 4 in the future then more sites may be needed but likely not more than adding two.

-We are not likely to have a significant change in additional participants but are likely to expand our private practice and add sites for potential residents. Considering that ABPTRFE will likely consider these sites as additional to an already multi-site program we will be re-evaluating our desire to remain an accredited program.

-We do not plan on adding sites/residency positions at this time so this will not affect our residency.

-We will not be adding any additional sites once we reach that threshold. I can imagine if there is not a geographical connection to a previous site, but all of our sites are geographically connected within 15-20 miles being the largest span. I'd be interested in knowing what -knowledge is gained by performing a site visit.

-we do not intend to add additional sites

-We will have to consider how program expansion will occur into new regions

-currently, minimal impact

-I will likely cap participants at my affiliated sites.

-we cannot afford to add sites if that is the case

-We add 3-6 clinics per year. Any clinic has potential to host a resident as we run the program centrally. Does this mean that we would need a site visit every year?

-It will slow our growth.

-At this time, I don't think it will effect it much at all. I only anticipate this to change our budget to less than \$1000 per year, probably closer to \$500 per year. That's basically one extra patient a year to pay for this.

-This will have both a strong financial impact to consider in addition to the administrative component

-Certainly adds a greater financial and time strain to the program. Additionally, this will cause a delay in starting up any new sites in which really the resident would suffer.

-At this time it will not affect our program.