Paris Distinguished Service Award Lecture

Transform Society Through Service

Joe Godges, DPT

Here are two statements that I think are appropriate to initiate my conversation about this Distinguished Service Award.

> ***Vision without execution is hallucination.***
> – quote attributed to Thomas Edison
>
> ***"Strategy is a commodity; execution is an art."***
> – Peter Drucker

Service is the critical element, with the typical focus to address an issue or perceived need, and most effective when a team with a common vision works toward addressing the need.

> Service
> is the critical element
> always part of a team
> attempting to address a perceived issue
>
> (there is nothing worse than industrious stupidity)

I was always part of a team in my roles at providing service to our Academy. Thus, I actually feel quite uncomfortable receiving this award because it was always a team effort that accomplished the items that Jay summarized in the introduction. It was never one person doing the service.

Hence, with loads of appreciation, I will point out a few of the many team members who served with me. I always felt like I was the fortunate one. I would also like to mention that I am so grateful for Gerard and members of his team who put in the effort to recognize me – it is quite humbling. I am also grateful for all of you attending this evening's event. It is really quite an honor.

> ***"Strategy is a commodity; execution is an art."***
> – Peter Drucker

Getting back to Peter Drucker's quote, Strategy is a commodity. I would say a common commodity - that attempts to address a perceived issue. And, I like how Dr. Drucker puts it, the art is in execution of that strategy, or of our strategic plans. But, I always keep in mind something I learned from my father-in-law – and something I have repeatedly experienced throughout my life.

> ***(There is nothing worse than industrious stupidity.)***

So, since I am old, and at this service of our Orthopaedic Academy and the APTA for 40 wonderful years, I can speak about history – history that I lived. Sometimes artful, sometimes stupid, at times wroth with hallucinations, and at times wonderfully strategic and successful.

> **1980s issues**
> following treatment orders
> treating a medical disorder or dysfunction
> vs
> profession that can make clinical decisions
> based upon subgroup classifications

In the 1980s, with regards to the management of common musculoskeletal conditions by physical therapists, the common belief was that that physical therapists were a profession that followed treatment orders from medical practitioners, and thus, carried out a prescription that was treating a perceived tissue disorder.

Nice thought, but looking back and knowing what we know now – that is, reading the key concepts and recommendations from current clinical practice guidelines, I think the vision that following of a prescription to treat a perceived tissue disorder, was, as Thomas Edison is attributed to say, a hallucination. On the other hand, there were trend-setters that promoted that clinicians in the physical therapy profession who work with patients with common musculoskeletal disorders can make clinical decisions based upon suspected subgroup classifications, and then focus the treatment to address the common impairment pattern, or clinical findings associated with that classification.

> **1980s issues**
> profession and competence defined
> by continuing education
>
> McKenzie Certification
> Paris Certification
> PNF training in Vallejo
> Rolfing Certification
> Michigan State Osteopathic Series
> Maitland focused Residencies
> Norwegian focused Residencies

Another issue of the 1980s was that clinical excellence in orthopaedic physical therapy was defined by continuing education seminars. That is, to be a skilled clinician, one had to invest time, energy, and financial assets to complete a variety of continuing education offerings. I actually spent about 12 years and did the first 5 listed.

I was even an instructor for one on the list. One which has the same name as the Service Award I am receiving this evening. Many memories, right Stanley?

> **1980s problem**
> took decades for a clinician to learn clinical
> decision making for differing subgroups
> and to
> effectively apply matched treatment

It seemed like this was a problem— a problem because it took several years to become comfortable with making clinical decisions about what we would now call differing subgroups and effectively applying the treatment that was best for that subgroup.

Think of the contrast of how our medical or dental colleagues receive clinical training. After they receive their MD, DO, or DDS, they do not go from one con-ed series to another over the course of several years to become a specialized practitioner, such as a pediatrician or endodontist. They go to a specialized, clinical residency - a residency that has progressive and guided clinical supervision that follows a standardized training curriculum of best practice in that field.

> **1990s issues/strategies**
> define Ortho PT expertise for the stakeholders
> (PTs, Medical Professionals, Payors, Public)
> and
> create efficient training programs for expertise
> (accepted residency and fellowship models)
> and
> train clinical supervisors/mentors
> of PT interns, residents, fellows

So, in the 90s, there were several strategies that seemed sensible to be on the "need to do list." Simply put, we had to define what the standard of care was, create efficient and effective programs to train that standard, and train clinical supervisors who can exponentially expand the positive influence in society by implementing that standard and train others.

I would like to point out that one thing that we did not think about was sustainability of a particular strategy. That is, if we were able to accomplish a strategic objective, we did not focus on what would we need to do to put incentives in place to sustain, nurture, or grow that strategic objective?

1990s issues
Team members in defining expertise
Tony Delitto, Julie Fritz, Steve George,
Chris Powers, Linda Van Dillen,
Lynn Snyder-Mackler
JOSPT & PTJ & Ortho Section/Academy
& APTA

Team members in clinical residency development
Ann Ryder, Naomi Schwartzer, Renee Rommero
Katie Gillis, Joy Yakura, Richard Jackson
Alan Lee, Denis Dempsey, Nicole Christensen

There were several stars of the 1990s and early 2000s that set the stage for the accomplishments in the following years. When it came to defining our practice, there was a huge value to define what we do as physical therapists in high impact, peer-reviewed scientific journals rather than books and seminar course notes full of testimonials and beliefs of how to best treat a particular patient subgroup.

As we have learned in the last few decades, our hard-working colleagues on our practice affairs committees at the federal and state level can at least argue for paying for physical therapy evaluation and treatments that are consistent with the recommendations in medical journals. Arguing for what is in textbooks or CEU course notes does not typically provide our political action committees any traction with payors.

I would like to give a shout out to some of the leaders and their many colleagues at their respective universities when it comes to publishing the evidence for our practice. In my role as coordinator and editor of the clinical practice guidelines over the last two decades, the recommendations in the guidelines would not be powerful without the contributions of Tony and his colleagues at Pitt, Julie and her colleagues at Utah, Steve and his colleagues at Florida and now Duke, Chris and his colleagues at USC, Linda and her colleagues at Wash U, and Lynn and her colleagues at Delaware. There were also several leaders and their colleagues in the Shoulder and Elbow Society whose contributions were instrumental in defining the best practice for evaluating and treating shoulder conditions, such as Phil McClure, Paula Ludewig, and Lori Michener.

And, when it comes to clinical practice, I have a soft spot in my heart for the administrators at Kaiser Permanente in Los Angeles – Ann, Naomi, and Renee – for taking a gamble in 1990 and implementing a vision of clinical residencies following the OCS practice description that trained so many of today's clinical leaders in the United States and around the world. And, the leadership of the original clinical mentors of our residency in Los Angeles was amazing – Katie, Joy, Richard, Alan, Denis, and Nicole – your legacy truly lives on through your mentees, who, are now leading-edge mentors of others.

1990s strategic goal
Create practice privileges for clinicians practicing
at an advanced level
and
Create clinical educators who can train clinician that the stakeholders can trust
(PTs, Medical Professionals, Payors, Public)
and
create science
("if it is not published in a peer-reviewed journal… it did not happen")
Steve Rose

These professors and researchers and clinical supervisors were darn effective at publishing the science and training the clinicians that our stakeholders (PTs, medical professionals, payors, public) can trust.

It was a goal of mine to help our profession create practice privileges for clinicians who are practicing at an advanced level – and thus, providing services in the optimal manner to sustain high levels of clinical excellence that is truly distinct from the novice or entry-level practitioner. I was following the economic principle that for a product or service to have sustainability in a market, there needs to be some perceived value of the service and some incentive, such as pay, promotions, or practice privileges, for those providing the service.

I have a quick survey. Please raise your hand if you have attained board certification in orthopaedics or sports physical therapy. Hands down. Put your hand up if that certification has resulted in you being paid at a higher level than your other physical therapists in your community who are not board certified - or - have the ability or get promoted to more esteemed job titles, - or - if you have practice privileges, such as being reimbursed at a higher rate for management of particular patient subgroups that require more training - or - have the privilege and responsibility to apply specific, specialized evaluation or intervention strategies. Hmmm. The small number of hands in the air is telling. In contrast, note that not every dentist has the privilege and responsibility to perform a root canal, or to straighten teeth. And, not every physician has the privilege and responsibility to manage patients with schizophrenia, or to diagnosis, remove, and manage an individual's basal cell carcinoma.

It will be interesting to observe over the next couple of decades if physical therapy board certification is a sustainable entity. I am a bit concerned. There was, and still is, a tremendous effort put it to promote and sustain board specialization in physical therapy. As you know, I was part of that huge effort. However, except for those who have attained ECS, I am not seeing the incentives to sustain the process – as it now stands. Maybe something will change in the future. I would hate to think that this was an example of industrious stupidity. Time will tell. Perhaps, we need to do something different to provide incentives to promote and sustain high levels of expert care.

Creating practice privileges for PT specialists
probably a hallucination

Creating credible clinical educators and CE sites
there are many shining stars! (so proud of them!)
but the wide variation in our clinical education
and thus, our practitioner's behavior and
outcomes is an ongoing (and not well
addressed) problem

Creating science
substantial foundational success

A parallel, related issue of the 1990s, and still an issue today, is the problem of unwarranted variation of physical therapist practitioners' clinical practice.

Think of the scenario where one of your relatives or friends or colleagues, and I am talking about a relative or acquaintance that you like, calls you or texts you and asks you for a referral for a "good" physical therapist in the city where they live. How many options can you comfortably give them, compared to the number of physical therapist practitioners in that city for which you would not feel comfortable with as a PT for your family member or colleague?

Raise your hand if you can relate to that dilemma.

I am always amazed at how much one can get paid in the medical profession for being mediocre, or even worse, for promoting disablement in individuals who come to them for health care. I am sure I am jaded, but my residents and fellows that I supervise typically have the privilege and responsibility of evalu-

ating and going into therapy with individuals who are difficult. And the definition of difficulty typically means the patient, or his/her health insurance, have paid for many visits of “health care” that was not close to following a clinical practice guideline and, unfortunately, this particular patient actually needed good health care to facilitate his/her recovery.

At the moment, I think that I, and we, still have a lot of work ahead of us to achieve the strategic goal of creating practice privileges for physical therapist specialists and with reducing unwarranted practice variation.

I also think that I have learned/we have learned, from our failures, which gives me hope and a reason to keep at it. That is, keep serving. It is an honor to receive this service award. But, holy Toledo, we really do have some unfinished business. You can count on me to stay in the business of working at this art – the art of executing the strategic plans of our Academy.

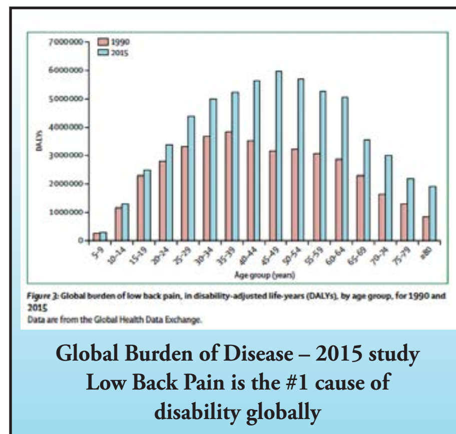
2000s Issues/Strategies

Payors want to pay for what works
(requesting clinical guideline recommendations)
and
Published evidence grows for science of PT
(USC, Pitt, Utah, UDel, UF, WashU, Baylor, ASSET, lead the way)
and
Medical model of expert driven care not working
(sick care business thrives, health of population declines)

In the 2000s, the theme of the major payors, such as the United States Department of Health and Human Services, was to “pay for what works.” With the rising national debt of many governments, coinciding with the continual, rapid, rise of health care costs in most countries, the large institutional payors of medical services, including physical therapy, have cut back on reimbursement. And, one clear strategy for these institutional payers is to use available funds to pay for what works and refrain from paying for what does not work. Thus, it has become imperative for health care professions to clearly describe to payers and the public what physical therapy services are predictably valuable for particular patient subgroups. Hence, the need for clinical practice guidelines to guide the decisions of payers, policy makers, and the public when it comes to allocating their available resources for medical services.

Clinical practice guidelines are only as powerful as the evidence in the peer-reviewed literature that is available to be reviewed. The researchers and clinicians at several of the institutions across the United States and the world have really led the way and gave our profession the foundation to describe its practice and to train our clinical educators.

However, in the past decade, more and more experts, including researchers, economists, and clinicians, have recognized that professionals responsible for caring for patients with common musculoskeletal disorders are really good at sick care and not so good at health care.



Global Burden of Disease – 2015 study
Low Back Pain is the #1 cause of disability globally

For example, data from 2015 shows that low back pain was the number one cause of global disablement – and not on the decline from the 1990s.[1,2] So, I/we can interpret this as demonstrating that in spite of all of the research and clinical care and payment for our services, we as health care professionals not performing. I think we should take some responsibility for this. I feel that we should actually be embarrassed, or, at least be willing to try something different.

Low back pain: a call for action
Lancet Low Back Pain Series Working Group
Panel: Call for actions to meet the challenges associated with prevention of disabling low back pain
Change systems and change practice
- Integrate back pain care with public health initiatives providing credible advice that people who develop low back pain should stay active and remain working, and that people with low back pain should be supported in early return to work
- Develop and implement strategies to ensure early identification and adequate education of patients with low back pain at risk for persistence of pain and disability

www.thelancet.com Published online March 21, 2018
USC Division of Biokinesiology and Physical Therapy

I love the theme of this publication in *The Lancet* in March 2018, entitled, Low Back Pain, A Call to Action.[3]

A publication of a working group of world-wide experts in the care of low back pain.

It calls for us to be responsible. It calls for us to “change systems and change practice.”

Lancet Low Back Pain Series Working Group
Low back pain: a call for action
Panel: Call for actions to meet the challenges associated with prevention of disabling low back pain
Health-care challenge: move away from emphasis on a biomedical and fragmented model of care
Change culture
- Promote the concept of living well with low back pain: person-centred care focusing on self-management and healthy lifestyles as a means of restoring and maintaining function and optimising participation

www.thelancet.com Published online March 21, 2018
USC Division of Biokinesiology and Physical Therapy

It calls for us to “change culture” and “move away from a biomedical and fragmental model of care.”

www.thelancet.com Published online March 21, 2018
Prevention and treatment of low back pain: evidence, challenges, and promising directions
Key messages
- Guidelines recommend self-management, physical and psychological therapies, and some forms of complementary medicine, and place less emphasis on pharmacological and surgical treatments; routine use of imaging and investigations is not recommended
- Little prevention research exists, with the only known effective interventions for secondary prevention being exercise combined with education, and exercise alone

USC Division of Biokinesiology and Physical Therapy

And a parallel publication by this work group in the same issue of *The Lancet* titled, Prevention and Treatment of Low Back Pain: Evidence, Challenges, and Promising Directions,[4] summarizes clinical practice guideline recommendations, that should be implemented. And these recommendations highlight some sweet spots that physical therapist should own, such as: self-management, physical and psychological therapies, exercise alone, and exercise combined with education.

Promising Directions
Physical and Psychological Therapies
Exercise
Exercise Combined with Education

The table is set for our profession. It is our time to execute. We have a beautiful vision to transform society by improving the way people move. But, remember, vision without execution can be considered a hallucination.

Prevention and Treatment of Low Back Pain: Evidence, Challenges, and Promising Directions
Author/Work Group: …Julie Fritz…

I must again call out Julie Fritz. Notice who is representing the scientific evidence in literature for physical therapy and other movement-related therapies on this esteem workgroup of experts. We are very fortunate to have colleagues, such as Julie, that are so

highly respected in the international scientific community to represent the best practice in the scientific literature for the management of common neck and back conditions.

Academy of Orthopaedic Physical Therapy, APTA

LEADERS
INNOVATORS
CHANGEMAKERS

our logo is very fitting for the present and future leaders but it also describes the recent past leaders

I feel that the reason the table was set for the next generation of physical therapists to execute and thrive was because of the leadership, innovative, and changemakers within the Academy of Orthopaedic Physical therapy.

2000s Issues/Strategies
Innovators & supporters of the AOPT/JOSPT, CPGs
Section/Academy Board of Directors
Mike Cibulka, Jay Irrgang, Steve McDavitt
and Finance Committee

CPG body region workgroup leaders
John Childs, Rob Wainer, Tim Flynn
Phil McClure, Joy MacDermid, Tony Delitto
Mike Cibulka, Doug White
Lynn Snyder-Mackler, Tom McPoil

Current CPG Editors
Christine McDonough, RobRoy Martin,
Guy Simoneau

Quick story, in 2004, I was voluntold onto a committee for the California PT Chapter that was responding to a request from the California Division of Workers' Compensation. The Division of Workers' Compensation was requesting guidance for the problem of physical therapists who, for example, after providing 70 visits of ultrasound to treat plantar fasciitis, the physical therapist is requesting more visits because the workers' problems have not resolved. Another committee member, Leslie Torburn and I went to the Orthopaedic Section Board of Directors at that time and asked: "Can the Section take the lead and create guidelines for our stakeholders for managing common musculoskeletal conditions?" And this was just on the heels of the American College of Occupational and Environmental Medicine publication of their book – their guide to practice – describing the "best practice" for managing common musculoskeletal conditions. So, we had clear evidence that either we define our profession's best practice or others will do it for us. Well, the Board at that time said, "Yes! Let's give it a shot. We can do this – and the rest is history. Jay and I went to leaders of our profession, and they uniformly said, yes, let's do it!

Again, as you see, it was such a great team of volunteer leaders addressing a need - from the workgroup leaders for each body region, the CPG Editors, the authors for each guideline, the contributors and reviewers of each guideline, to the guideline implementation teams, including the translators.

2000s Issues/Strategies
Clinical Practice Guidelines Heavy Hitters
Author Leaders
David Logerstadt, RobRoy Martin, Pete Blanchard
Chris Carcia, Keelan Enseki, Martin Kelly
Mia Erickson, Amelia Arundale, Richard Wiley

Contributors and Reviewers
Julie Fritz, Paul Beattie, Amanda Ferland
John DeWitt, Tim Flynn, Julie Whitman
Leslie Torbin, Joy MacDermid
Roy Altman, Paul Shekelle, Julie Tilson

and 100s more!
including the Chinese, Korean, Greek,
and Spanish Translators

2000s Service Outcomes

CPGs tell payors what to pay –
what is best practice for a specific subgroup of patients
and
CPGs guide clinicians in recognizing
clinical patterns and matched interventions
and
CPGs guide clinicians and other stakeholders in
functional and outcome measure options

I am pleased to say that CPGs did, and continue to, accomplish their strategic objectives of helping payors to "pay for what works," providing tools for clinicians to facilitate their pattern recognition skills and clinical decision making, and guiding clinicians and stakeholders outcome and functional measures to use to measure progress.

I want to express my
GRATITUDE
to my team members
to my strategic plan implementors
for the trust, sharing, challenges, celebrations, & reflections

clinical specialization
clinical residency
finance committee
clinical practice guidelines
JOSPT

I want to express my
GRATITUDE
to my mentors in leadership

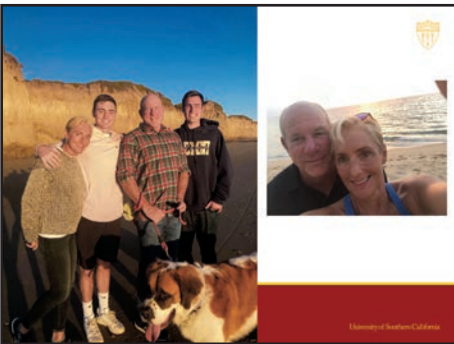
Renee Rommero
Kaiser Permanente

Edd Ashley
Loma Linda University

Jim Gordon
University of Southern California

All of those serving the Academy, including me, serve as unpaid volunteers. Thus, we are all sustained by our bosses of our "day jobs." I have been fortunate to have bosses who have been my mentors in leadership. Thanks Renee, Edd, and Jim.

and, importantly,
I am very grateful for my primary influencers
Arlette
Mark
Ryan
(and Shadow, Freddy, Osa, & Gus)



in closing

We have reasons to do our best to stay healthy
and continue to be a force for good
as we transform the world.

We have a huge decade in front of us.

(Continued on page 68)

2020s Challenges & Opportunities

Transform society in a positive manner

Continue to publish evidence to guide care

Continue with ongoing practice guideline revisions

Embrace guideline implementation – including International Classification of Functioning models – facilitating health, wellness, and self confidence

Create awareness that credible clinical education matters – and implement transformative models

As we move into the 2020s

Continue to go in gratitude

Continue to transform

Thank You All for the Opportunity

Lastly, I would like to end with a quote from Peter Drucker.

"The best way to predict the future is to create it."
– Peter Drucker

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EDITOR'S NOTE

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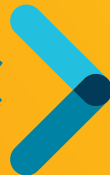
ACADEMY OF ORTHOPAEDIC PHYSICAL THERAPY



2020 Election Call For Candidates:

Treasurer
Director
Nominating Committee Member

The Academy of Orthopaedic Physical Therapy's Nominating Committee is seeking qualified candidates for THREE positions open for election: Treasurer, Director, and Nominating Committee Member.

If you are interested in running, or know someone who might be interested, please visit the following link to access our Potential Candidate Form and position descriptions:

https://www.orthopt.org/content/governance/committees/nominating/2020-aopt-election

The AOPT 2020 Election will take place during the month of August 2020.