Expanding the Role of the Physical Therapist by Integrating Practice Management Skills into Entry-Level Physical Therapist Preparation in the United States

Jennifer E. Green-Wilson
St. John Fisher College

Follow this and additional works at: https://fisherpub.sjfc.edu/education_etd

Part of the Education Commons

How has open access to Fisher Digital Publications benefited you?

Recommended Citation

Please note that the Recommended Citation provides general citation information and may not be appropriate for your discipline. To receive help in creating a citation based on your discipline, please visit http://libguides.sjfc.edu/citations.

This document is posted at https://fisherpub.sjfc.edu/education_etd/32 and is brought to you for free and open access by Fisher Digital Publications at St. John Fisher College. For more information, please contact fisherpub@sjfc.edu.
Expanding the Role of the Physical Therapist by Integrating Practice Management Skills into Entry-Level Physical Therapist Preparation in the United States

Abstract
Problem Statement Core competencies are expanding in physical therapist practice to include practice management knowledge and skills (Guide; Lopopolo, Schafer, & Nosse, 2004). There appears, however, to be minimal integration of these skills into entry-level preparation (Lopopolo, et. al; Schafer, Lopopolo, Luedtke-Hoffmann, 2007). Purpose The purpose of this research study is to identify the perceptions of physical therapist faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapist programs in the United States. For this study, the FINHOP framework (finance, information management, networking, human resource management, operations, planning and forecasting) will provide a working definition of these skills (Schafer, et.al, 2007). Research Question The purpose of this research study is to identify the perceptions of physical therapist faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapist programs in the United States. Methods A qualitative method was selected as the design for this research study. Focus groups, participant journal entries, member checking, and bracketing or EPOCHE for the researcher were used for data collection. Significance New graduates in physical therapy are expected to be prepared to fulfill multiple professional roles, including administration or management (Guide). Yet, practice management content is often viewed as being discrete from, and to some extent less critical than, what is seen as more essential content (Lopopolo and Schafer, 2004). Despite evidence that shows the need to integrate these skills into entry-level physical therapist education, there still remains a gap in the curriculum (Lopopolo and Schafer). Investigating a model of planned change may provide some insight into this phenomenon occurring within the physical therapist profession.

Document Type
Dissertation

Degree Name
Doctor of Education (EdD)

Department
Executive Leadership

First Supervisor
Dianne Cooney-Miner

Second Supervisor
Cynthia McCloskey

Subject Categories
Education

This dissertation is available at Fisher Digital Publications: https://fisherpub.sjfc.edu/education_etd/32
Expanding the Role of the Physical Therapist by Integrating Practice Management Skills into Entry-Level Physical Therapist Preparation in the United States

By

Jennifer E. Green-Wilson

Submitted in partial fulfillment of the requirements for the degree Ed.D. in Executive Leadership

Supervised by
Dr. Dianne Cooney-Miner

Committee Members
Dr. Cynthia McCloskey

Ralph C. Wilson, Jr. School of Education
St. John Fisher College

May 2011
Dedication

To my mentors – Susan Shafer, Dianne Cooney-Miner, Cynthia McCloskey, Z. Annette Iglarsh, Angie Phillips - for believing in me and supporting me from start to finish. To my children – Ericka, Jessie, and Jeremy - for your love, for cheering me on, for taking away my cell phone, for grocery shopping, and for keeping me focused on the ‘light at the end of the tunnel’. To my dogs – Ellison, Machia, and Gracie - for being close, hour after hour after hour. To my colleague - Stacey Zeigler – a huge thank you for your unlimited passion, for our ‘retreat’, her ‘special box’, our road trips, and for all the ‘telephone check-ins’. To my mom and dad – Mary Lou and A. Wesley Green – a heartfelt thank you for covering my ‘random and intense travel schedule’, especially during my final year at school. To Betty S. Knapp – this milestone is dedicated to you in your memory. Even though you are not here, please know that I could not have done this without your love and friendship.
Biographical Sketch

Jennifer E. Green-Wilson is the Principal for The Leadership Institute, the Director of the Institute for Leadership in Physical Therapy (LAMP) of the Health Policy and Administration (HPA) Section of the American Physical Therapy Association (APTA), and Adjunct Professor for the Ithaca College’s Physical Therapy Program (Rochester Center), Rochester, NY and the Department of Physical Therapy, Springfield College, Springfield, MA. Ms. Wilson attended Queen’s University in Kingston, Ontario, Canada from 1980-1984 and graduated with a Bachelor of Sciences degree in Physical Therapy in 1984. She attended the Rochester Institute of Technology (RIT) from 1993-1997 and graduated with a Masters of Business Administration (MBA) degree in 1997. She came to St. John Fisher College in the summer of 2008 and began doctoral studies in the Ed.D. Program in Executive Leadership. Ms. Wilson pursued her research investigating the integration of practice management skills into entry-level physical therapist preparation under the direction of Dr. Dianne Cooney-Miner and received the Ed.D. degree in 2010.
Acknowledgements

I want to acknowledge and express a sincere thank you to the Research Committee of the Section on Health Policy and Administration (HPA) of the American Physical Therapy Association (APTA), under the leadership of Gary Brooks PT, DrPH, CCS, for approving a $9,220 research grant to support this research study.
Abstract

Problem Statement

Core competencies are expanding in physical therapist practice to include practice management knowledge and skills (Guide; Lopopolo, Schafer, & Nosse, 2004). There appears, however, to be minimal integration of these skills into entry-level preparation (Lopopolo, et. al; Schafer, Lopopolo, Luedtke-Hoffmann, 2007).

Purpose

The purpose of this research study is to identify the perceptions of physical therapist faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapist programs in the United States. For this study, the FINHOP framework (finance, information management, networking, human resource management, operations, planning and forecasting) will provide a working definition of these skills (Schafer, et.al, 2007).

Research Question

The purpose of this research study is to identify the perceptions of physical therapist faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapist programs in the United States.

Methods

A qualitative method was selected as the design for this research study. Focus groups, participant journal entries, member checking, and bracketing or EPOCHE for the researcher were used for data collection.
Significance

New graduates in physical therapy are expected to be prepared to fulfill multiple professional roles, including administration or management (Guide). Yet, practice management content is often viewed as being discrete from, and to some extent less critical than, what is seen as more essential content (Lopopolo and Schafer, 2004). Despite evidence that shows the need to integrate these skills into entry-level physical therapist education, there still remains a gap in the curriculum (Lopopolo and Schafer). Investigating a model of planned change may provide some insight into this phenomenon occurring within the physical therapist profession.
Table of Contents

Dedication ........................................................................................................................................... ii

Biographical Sketch ......................................................................................................................... iii

Acknowledgements ............................................................................................................................ iv

Abstract .............................................................................................................................................. v

Chapter 1: Introduction ...................................................................................................................... 1

  Problem Statement ............................................................................................................................ 1

  Theoretical Rationale ...................................................................................................................... 10

  Significance of the Study ............................................................................................................... 19

  Statement of Purpose .................................................................................................................... 22

  Research Question ......................................................................................................................... 22

  Definition of Terms ......................................................................................................................... 23

  Summary of Remaining Chapters ............................................................................................... 25

Chapter 2: Review of the Literature ................................................................................................. 26

  Purpose ........................................................................................................................................... 26

  Topic Analysis ................................................................................................................................. 27

  Summary ......................................................................................................................................... 61

Chapter 3: Research Design Methodology ....................................................................................... 66

  Introduction ..................................................................................................................................... 66

  Research Context ............................................................................................................................ 67

  Research Participants ..................................................................................................................... 68
### List of Tables

<table>
<thead>
<tr>
<th>Item</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 4.1</td>
<td>Focus Group Participant Demographic Information</td>
<td>83</td>
</tr>
<tr>
<td>Table 4.2</td>
<td>Focus Group Participant Teaching Experience</td>
<td>84</td>
</tr>
<tr>
<td>Table 4.3</td>
<td>Focus Group Participant Entry-Level PT Program Information Related to Practice Management</td>
<td>88</td>
</tr>
<tr>
<td>Table 4.4</td>
<td>Focus Group Participant Teaching Methods Used for Teaching Practice Management at Entry-Level</td>
<td>89</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

Problem Statement

Core competencies are expanding in physical therapist practice (Guide). This expansion is needed to transform physical therapy (PT) to a doctoral level profession, autonomous practice, and to meet the evolving needs of health care consumers. The functions required at the entry-level of professional practice have expanded significantly, to the point where supervision, consultation, teaching, and evaluation are included, in addition to the traditional treatment role (Aston-McCrimmon and Hamel, 1983). Also, physical therapists provide administrative services in many different types of practice, research, and education settings (CAPTE). Therefore, practice management is essential for physical therapist practice (Schafer, Lopopolo, & Ludetke-Hoffmann, 2007; Lopopolo, Schafer, & Nosse, 2004). The American Physical Therapy Association (APTA) defines practice management as the coordination, promotion, and resource (financial and human) management of practice that follows regulatory and legal guidelines (Normative Model). The physical therapy profession’s commitment to society is to promote optimal health and function in individuals by pursuing excellence in practice (APTA). To achieve this goal, Lopopolo, et al. suggests that practice management knowledge and skills are required upon entry into the profession.

A physical therapist is responsible for the direction of physical therapy services (APTA). The APTA has developed and updated several core or guiding documents to reflect the new minimum skills or competencies and practice expectations required upon
graduation from an accredited entry-level DPT program. These documents now specify that new graduates in physical therapy need to be prepared to fulfill multiple professional roles, including administration or management, in addition to the role of clinician in contemporary physical therapist practice (APTA). Administration includes the management, by individual physical therapists, of resources for patient/client management and for organizational operations (Guide). New content in practice management has been added to DPT curricula to reflect this new need (Normative Model). Although a few studies have identified levels of knowledge and skills needed in practice management in PT at entry-level, there appears to be minimal integration of practice management skills into entry-level preparation. This suggests further investigation is needed into the integration of practice management skills in entry-level preparation.

Background

The profession of physical therapy is transforming to a doctoring profession, direct access, and autonomous practice (APTA). The knowledge explosion in health care has led several health care professions to expand their academic standards by requiring a professional doctorate as the entry-level degree (Brudvig and Colbeck, 2007). The clinical doctorate degree (DPT) is becoming the entry-level degree for physical therapist educational programs. As of January 2010, 203 out of 212 (96%) physical therapist educational programs accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) offered the DPT in the United States (U.S.) (personal communication, Scott Ward, APTA President of Board of Directors, September 8, 2010). CAPTE (2006) suggests that professional education programs and the accreditation
process be responsive to the health care needs of citizens and communities and the health care system, and that practitioners must be prepared to participate in the contemporary health care environment.

The profession of physical therapy in the U.S. has demonstrated a history of responsiveness to the needs of society and the provision of care for people in need of rehabilitation (Threlkeld and Paschal, 2007). This may indicate that the length, intensity, and regulation of U.S. physical therapist educational programs have evolved to keep pace with the increasingly complex societal demands, emerging emphasis on health and wellness, in addition to the key role of rehabilitation in the medical model (Threlkeld and Paschal).

Rapid changes in the health care industry have increased the need for enhanced business skills and knowledge and have created a demand for physicians and other health care professionals who have business skills (Henson, Pressley, & Korfmann, 2008; Roemer, 1996; Young, Hough & Peskin, 2003). In light of changes in practice and the system of care, national organizations endorse new content under 10 curriculum domains, including one domain as practice management, for both medical school and residency education (Halperin, Lee, Boulter, & Phillips, 2001). Several physicians and other health care professionals decide to obtain a Master of Business Administration (MBA) degree to understand the business of medicine (Parekh and Singh, 2007). A need for practice management skills in the chiropractic profession has been identified (Henson, et al., 2008). Nurse practitioner curricula must provide basic practice management skills to meet the standards set by the American Association of Colleges of Nursing (AACN) (Sportsman, Hawley, Pollack, & Varnell, 2001). Business skills are widely perceived as
skills required to succeed in a traditional veterinary career by veterinarians in private practice, industry, academics, and government (Kogan, McConnell, & Schenfeld-Tacher, 2005). Recently graduated occupational therapists reported an increased need to develop administration and managerial skills at entry-level (Christiansen, 1975). The House of Delegates (HOD) of the APTA adopted and currently promotes the “Standards of Practice for Physical Therapy”. These standards are the profession’s statements of conditions and performances that are essential for provision of high-quality physical therapy and provide a foundation for assessment of physical therapy practice (APTA). The standards for the administration or practice management of the physical therapy service include the following: (a) statement of mission, purpose, and goals; (b) organizational plan; (c) policies and procedures; (d) administration; (e) fiscal management; (f) improvement of quality care and performance; (g) staffing; (h) staff development; (i) physical setting; and (j) collaboration (APTA).

Practice management competence is essential for physical therapist practice (Schafer, et al., 2007; Lopopolo, et al., 2004). The APTA defines competence as the possession and application of contemporary knowledge, skills, and abilities commensurate with a physical therapist’s role within the context of public health, welfare, and safety. It is difficult for any clinician in a contemporary health care environment to manage the care of patients or clients without considering their resources, the reimbursement that may be received for the services provided, and a multitude of factors related to the organization and operation of the clinical practice (Schafer, et al.). The role of administrator or manager is one of five core professional roles assumed by physical therapists (Guide). A physical therapist is responsible for the direction or
administration of the physical therapy service (APTA). A revised conceptual model proposed by Schafer and Lopopolo (2004) emphasized the integration of clinical practice with practice management. The belief that every physical therapist is a leader, administrator, or manager of his or her own practice regardless of practice setting or job title has been advocated by the Section on Health Policy and Administration (HPA) of the APTA since the publication of the Leadership (L), Administration (A), Management (M), and Professionalism (P) (LAMP) document in 1999 (Lopopolo and Schafer; Kovacek, Powers, and Iglarsh, 1999).

Practice management knowledge and skills are required upon entry into the profession (Lopopolo, et al., 2007). New content in practice management has been added to DPT curricula as listed the 2004 Normative Model. The 2004 Normative Model is used to guide physical therapist curriculum content in terms of educational outcomes and performance and behavioral expectations for entry-level physical therapists (APTA). The five categories of practice management content listed in the APTA’s Normative Model include the following: (a) direction and supervision of human resources; (b) participation in financial management; (c) establishment of a business plan on a programmatic level; (d) participation in marketing and public relations; and (e) management of practice in accordance with regulatory and legal requirements (Normative Model). The APTA Board of Directors (BOD) adopted the “Minimum Required Skills of Physical Therapist Graduates at Entry Level” in 2005, to delineate a practice management category that includes the following: (a) quality improvement; (b) marketing and public relations; (c) management of computerized information or informatics; (d) risk management; and (e) productivity. The APTA BOD defined minimum skills as foundational skills that are
indispensable for a new graduate physical therapist to perform on patients/clients in a competent and coordinated manner. The CAPTE, adopted and made effective in 2006, the “Evaluative Criteria for Accreditation of Education Programs for the Preparation of Physical Therapists”, that includes a set of practice management criteria and lists professional practice expectations, thus reinforcing the inclusion of the practice management content in PT educational programs.

The LAMP concepts are interdependent with one another, interrelated with the elements of the patient/client model from the Guide to Physical Therapist Practice, and included many of the generic abilities that have been referenced to guide professional behaviors (Schafer, et al.). Respondents in the study conducted by Lopopolo, et al. (2004) perceived that almost all 178 LAMP components identified are important in the management of a clinical practice, and indicated that new graduates needed: (a) moderate to extensive knowledge in 44% of LAMP components; (b) no skill in 29% of the components; (c) at least intermediate skill in 22%. This study laid the groundwork for identifying practice management content that should be included in professional physical therapist curricula (Schafer, et al., 2007). Schafer, et al. used FINHOP (finance, information management, networking, human resource management, operations, planning and forecasting) as an organizing framework for practice management content to isolate a suggested hierarchy of practice management skill acquisition for the new graduate physical therapist in 2010 regardless of practice setting. In this study, 121 practice management skills and 16 skill groups, and varying levels of independence or competence expected in practice management knowledge and skills among DPT graduates at entry-level were identified (Schafer, et al.). Of note, no differences were
found among respondents based on role, work setting, or experience, so the data were
combined for factor analyses, producing 16 practice management skill groups (Schafer, et
al., 2007). Findings suggest that the most independence was expected in skills related to
self-management, compliance with rules, ethical behavior, and insurance coding whereas
skills requiring the most assistance were marketing and strategic planning, financial
analysis and budgeting, and environmental assessment. Schafer, et al., using the
FINHOP model: (a) provided empirical evidence suggesting which practice management
skills should be included in DPT curricula; (b) identified the level of independence for
practice management skills needed by new DPT graduates; and (c) suggested a pattern of
practice management skill acquisition that applies directly to the new therapist. For the
purposes of this study, the FINHOP model will be used to define practice management
skills needed in physical therapist practice.

Existing business skills are well below needed levels (Henson, Pressley, and
Korffmann, 2008; Christiansen, 1975). The gap existing between business skills needed
and business skills prevalent indicates that current training and education programs are
not providing adequate business skills training (Henson, Pressley, and Korffmann).
Despite changes to core documents, evidence supporting that practice management
competence is essential for physical therapist practice, and emerging evidence defining
practice management skills which are needed at entry-level (Schafer, et al., 2007;
Lopopolo, et al., 2004; APTA), practice management content is viewed often as being
discrete and to some extent less critical to the preparation of physical therapists
(Lopopolo and Schafer). Teaching practice management content still appears to be a gap
in entry-level physical therapist curriculum. The breadth and depth of practice
management content appears to be lacking consistency across educational programs (Lopopolo and Schafer, 2004). Scholars have inferred that those competencies that do not have a direct implication for the health care services of the client are not considered to be very important (Aston-McCrimmon and Hamel, 1983). Nevertheless, a major goal of any health care education program is to prepare a practitioner for a designated role in contemporary health care practice (Aston-McCrimmon). Lopopolo and Schafer report that some physical therapist students perceive practice management content to be less important to their clinical practice, as exemplified by the statement “I am interested in treating patients, not running a department.” (p. 4). Additionally, only 30% of educators teaching in physical therapist educational programs were familiar with the LAMP document (Schafer, 2001). Fewer than half (42%) of instructors of the practice management content had a degree in management (Schafer, 2002). These findings may suggest that the instructors of this content lacked foundational knowledge and skills to develop and integrate practice management content effectively in the PT curriculum. A need for empirical research exists as it relates to the proposed area of study while investigating a model of planned change may provide some insight into this phenomenon occurring within the physical therapist profession.

Demographic Information

APTA’s 2009 Workforce Survey revealed 240,935 licensed residents in the United States (APTA). The APTA is a national voluntary professional organization representing more than 73,000 members and its goal is to foster advancements in physical therapy practice, research, and education. The mission of the APTA, the principal membership organization representing and promoting the profession of physical therapy,
is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public (APTA). APTA’s Physical Therapist Member Demographic Profile (2009) revealed the following information about its membership: (a) respondents have remained predominantly female; (b) more than nine of ten of all respondents are white; (c) the mean number of years that respondents had been in practice in 2008 was 17.4 years with the largest cohort in practice for 21-30 years (21.8%); (d) the percentage of respondents with post baccalaureate degrees in 2008 increased to 32.9%; (e) the professional (entry-level) degree held by the largest percentage of respondents (47.4%) continued to be the baccalaureate degree; (f) the percentage of recipients of a DPT degree increased to 13.0%; (g) the vast majority of respondents were practicing on either a full or part-time basis; (h) the largest percentage of respondents reported being employed in outpatient settings; and (i) nearly one-third of respondents (32.4%) were employed in private practice settings whereas an additional 21.6% were employed in health system or hospital based outpatient facilities.

There were 203 accredited and developing DPT programs and 9 accredited Master’s PT programs reported by CAPTE in 2010; there are no baccalaureate programs remaining. The total number of PT degrees awarded in 2006 was 5,337 (CAPTE). The total number of full-time core faculty positions in all programs reported by CAPTE in 2008 was 1,896 whereas the total number of part-time core faculty positions was 284. Only 4% of core faculty indicated that administration and management was their secondary area of content expertise (ranking 9th out of the top 10 areas reported) whereas no core faculty reported administration and management as one of the top ten primary
areas of content expertise (CAPTE). Interestingly, 6.8% of adjunct faculty listed administration and management as their area of expertise (ranking 4th out of 10 reported areas) (CAPTE).

Theoretical Rationale

There is a plethora of discussion in the literature with regard to managing or facilitating change. Change, defined as a verb, is to become or make different (Encarta Dictionary, accessed February 24, 2009). Change may develop from within an organization or as a result of adopting or adapting to something new imposed external to it (Watson, 1971). Scholars distinguish between different types of change contrasting episodic, discontinuous, and intermittent change against continuous, evolving, incremental, and cumulative change. Researchers describe change as planned, ongoing, radical, chaotic, or transformational and have attempted to identify the underlying reasons why change occurs, investigating failures or opportunities for growth as possibilities. Experts, as a result of studying the phenomenon of change, have proposed various models of change to help lead, manage, and facilitate effective change in different situations. Therefore, change as it relates to organizational development (OD), is a set of behavioral science-based theories, values, strategies, and techniques aimed at planned change of the organizational work setting for the purpose of enhancing individual development and improving organizational performance, through the alteration of organizational members’ on-the-job behaviors. (Weick and Quinn, 1999, p. 363)
Change processes, describing how organizations develop or change, can be viewed as sequences of individual and collective events, actions, and activities unfolding over time within a context (Ford and Greer, 2006). Managing change is seen as being skilled at creating, acquiring, and transferring knowledge thereby modifying behavior to reflect new knowledge and skills (Garvin, 1993).

Kurt Lewin (1947) implied that resolving social conflict, such as religious, racial, marital or industrial: (a) could improve the human condition; (b) was significant; (c) facilitated learning; and (d) enabled individuals to understand and restructure their perceptions of the world around them. Kurt Lewin developed a theory or model of planned change based on three successive stages or phases of change: (a) unfreezing; (b) moving or changing; and (c) refreezing. Lewin described ‘unfreezing’ of the existing system of interests and relationships as the stage of liberating the organization for possible change, ‘moving’ the organization to the planned structures, and ‘refreezing’ the system as the integration of the changes. Lewin suggested that: (a) organizations had to become unfrozen to offset complacency, status quo, and stasis by displacing customary patterns and routines; (b) natural forces press for restabilization thereby making the moving stage a relatively short stressful period; and (c) the system has to settle down or restabilize in the refreezing period.

Episodic change describes organizational change that tends to be infrequent, discontinuous, and intentional (Weick and Quinn, 1999). Mintzberg and Westley (1992) suggest that change typically takes the form of episodes or distinct periods in which some shift or a set of shifts take place. Episodic change implies that an organization, a social entity, has the following characteristics: (a) thick tightly coupled interdependencies
among subunits; (b) efficiency as a core value; (c) a fixation with short-run alteration rather than long-run adaptability; (d) institutionalization which limits action; (e) powerful norms embedded in strong subcultures; and (f) imitation as a major motivation for change (Weick and Quinn, 1999). Lewin’s (1947) work describes five assumptions about episodic or planned change: (a) change is linear or movement from one state to another in a forward direction through time; (b) change is movement from a lesser state to a progressive state; (c) change is movement toward a specified goal or end state; (d) change or movement requires disequilibrium; and (e) change or movement is planned and managed by people apart or separate from the system. “Planned change involves carrying out a decision to effect improvements in a given setting by means of a systematic methodology.” (Crookston and Blaesser, 1962, p. 611) “Understanding the process of planned change and the elements necessary for successful implementation is an essential undertaking for managers.” (Ford and Greer, 2006, p. 420)

Lewin (1947) developed a Force Field Analysis (FFA) which also provided insight into the factors or forces that promote the acceptance of change and those factors that may discourage change within an organization. Force field analysis has been used as a planning mechanism for many years and provides a systematic method to analyze an objective and define the forces facilitating or inhibiting its attainment (Todd et al., 1977). Lewin conceived that all behavior arose from a ‘dynamic field’ that changed its state over a given unit of time. Any individual, at any moment, is subject to a collective combination of coexisting and interdependent factors or forces in the field, called the ‘life space’ (Lewin, 1947). Lewin contended that any new behavior is a consequence of the
interaction between the person and the environment or the result of some change in the field.

Lewin (1947) proposed that an individual’s relationship to their life space is never static. Lewin conceives that people can move within their ‘life space’, referring to this motion as ‘locomotion’. Behavior is a change of position (i.e., locomotion); the change in position therefore changes the situation. The locomotions that are possible are determined by the structure of the ‘life space’ at a given point in time. All the various factors relevant to a specific goal that exist within a life space exert their valences; a driving force pushes motion whereas a restraining force, which does not cause motion toward a goal by itself, restrains one of the driving forces. Lewin claims that a positive valence pulls toward the goal, a negative valence pushes away from the goal, while restraining forces act as brakes in either direction. These all sum to some resultant force that then controls movement with relation to that goal. Crookston and Blaesser (1962) support the notion that it is important to identify all relevant driving and restraining forces impinging upon the given situation in planning for change. Taking many neutral, uncommitted, or unknown forces into account in planning for change is also important (Crookston and Blaesser).

Inertia exists in organizations (Weick and Quinn, 1999). Inertia is defined as apathy, the inability or unwillingness to move or act (Encarta Dictionary, accessed February 24, 2009). In physics, inertia, or resistance to change, is defined as the property of a body by which it remains at rest or continues moving in a straight line unless acted upon by a directional force (Encarta Dictionary, accessed February 24, 2009). The notion of resistance to change is credited to Kurt Lewin (Dent and Goldberg, 1999). Lewin
(1947), as part of his field theory, believed that the status quo represented the equilibrium between the barriers to change and the forces supporting change. The assumption of episodic change is that change occurs when organizations move away from their equilibrium positions or during periods of divergence (Weick and Quinn, 1999). Divergence results from a growing misalignment between an organization’s deep structure to a changing environment and perceived environmental demands (Weick and Quinn). Lewin’s concepts assumed that inertia, in the form of ‘quasi-stationary equilibrium’, is the main impediment to change. He proposed that the equilibrium would change more easily if restraining forces, such as personal defenses, group norms, or organizational culture, were unfrozen by being neutralized or transformed (Lewin; Rosch, 2002; Watson, 1971).

Lewin (1947) states that ‘unfreezing’ of the current state may involve entirely different problems in different cases. Additionally, “To break open the shell of complacency and self-righteousness it is sometimes necessary to bring about deliberately an emotional stir-up.” (Lewin, 1947, p. 330) Furthermore, Lewin proposes that one of the causes of resistance to change lies in the relation between the individual and the value of the group standards. Lewin suggests that it is usually easier to change individuals formed into a group than to change any one of them separately. Lewin proposes that when the social value of a group standard is great then the resistance of the individual group member to move away from this level also is great. As long as group values are unchanged the individual will resist changes more strongly especially the further the departure from the group standards. However if the group standard is changed, several resultant changes may occur due to the relation between individual and group standard:
(a) the resistance will be eliminated; (b) the force field will tend to facilitate changing the individual; and (c) the force field will tend to stabilize the individual conduct on a new group level (p. 332).

Many others, since Lewin, have developed multi-phase models for implementing change (Aremenakis and Bedeian, 1999). Kotter (1995), building on Lewin’s work, recommended eight steps for change agents to follow in implementing fundamental organizational change that include: (a) establishing a sense of urgency; (b) forming a coalition of individuals who embrace the need for change and who can rally others to support the effort; (c) creating a vision to accomplish the desired end-result; (d) communicating the vision through numerous communication channels; (e) empowering others to act on the vision to facilitate implementation; (f) creating short term wins by publicizing success, thereby building momentum for continued change; (g) consolidating improvements and changing other structures, systems, procedures, and policies not consistent with the vision; and (h) institutionalizing the new approaches by publicizing the connection between the change effort and organizational success. Kotter’s first five phases may align somewhat with Lewin’s unfreezing stage thus providing another perspective about the importance of preparing for change. Alternatively, Galpin (1996) proposed a process model of change as a wheel including the following nine wedges: (a) establishing the need to change; (b) developing and disseminating a vision of planned change; (c) diagnosing and analyzing the current situation; (d) generating recommendations; (e) detailing the recommendations; (f) pilot testing the recommendations; (g) preparing the recommendations for rollout; (h) rolling out the recommendations; and measuring, reinforcing and refining the change. Galpin suggests
that understanding an organization’s culture, as revealed in its rules, policies, customs, norms, ceremonies, and rewards, is important in a change process. Armenakis, et al. (1999) proposed another model for change that incorporated elements of Lewin’s (1947) model. Armenakis et al. described three steps of gradual change that included: readiness, adoption, and institutionalization. This model highlights the creation of a readiness for change and that resistance to change can be minimized by converting the constituencies affected by a change into agents of change (Armenakis, et al.). Readiness is similar to Lewin’s state of unfreezing and is reflected in attitudes of organizational members (Bernerth, 2004).

Lewin’s planned approach to change has been criticized as newer perspectives on organizational life and change have emerged since the 1980s (Burnes, 2004). Burnes cites four criticisms of Lewin’s model that include: (a) the planned approach is too simplistic and mechanistic when organizational change is seen as a continuous, open-ended process; (b) Lewin’s work is only relevant to incremental and isolated change projects and does not incorporate radical, transformational change; (c) Lewin is accused of ignoring the role of power, politics, and conflict in organizational life; and (d) Lewin advocates for a top-down, management-driven approach to change and ignores situations requiring bottom-up change. Additionally, when management theories are compared, then change is viewed differently. For example, the Classical Management Theory assumes that organizations exist in equilibrium, change is not a normal process, and it should be controlled (Lichtenstein, 2000). Conversely, the Complex Adaptive Systems Theory assumes that change and transformation are continuous and that the inherent qualities of these dynamic systems actually encourage change (Lichtenstein). The
Classical Management Theory assumes that linear regression models explain most of the variance of organizational change, whereas the Complex Adaptive Management Theory proposes that new models and methods are needed to explain change (Lichtenstein).

Lewin’s model of planned episodic change, therefore, is not applicable when change is viewed as continuous, complex, and nondiscrete (Weick and Quinn, 1999). Change is seen as constant, evolving and cumulative when organizations are viewed as emergent and self-organizing (Weick and Quinn). Weick and Quinn claim that freeze, rebalance, and unfreeze is a change sequence for continuous change. The assumptions proposed in this model include the following: (a) freezing continuous change makes a sequence visible, shows patterns, and explains what is happening through cognitive maps, schemas and stories; (b) rebalancing reinterprets, relabels, and resequences these patterns so they unfold with fewer blockages (i.e., reframing issues as opportunities); and (c) unfreezing (after rebalancing) resumes processes that are more mindful of sequences, more resilient to anomalies, and more flexible in their execution. (Purser and Petranker, 2005; Weick and Quinn).

Lewin’s work is foundational to the modern study of the field of change (Burnes, 2004). His model is widely accepted in the field of organizational development and is often referred to as the classic change model. Although other planned change models exist now, many still retain the essential characteristics of Lewin’s original 3-Step model (Burnes). The influence or importance of driving forces that favor change and restraining forces that suppress change may be determined by applying the FFA to a situation. Applying the concept of unfreezing when planning for change may help to build a readiness for change and strategies to overcome resistance to change. Giardino, et al.
Believe that “FFA offers the medical educator a framework from which to plan
and organize change efforts, beginning with the identification of those forces operating in
the system that promote the change and those that detract from its implementation” (p.
153). Force-field analysis is the core of an approach which colleges and universities may
find useful (Crookston and Blaesser, 1962, p. 616). Because the force field analysis
describes the motives and forces which affect a situation, this information may be used
by the change agent or innovation champion to decide on strategies to encourage the
change or innovation (Levi and Lawn, 1993). Therefore, Lewin’s (1947) concepts of: (a)
‘unfreezing’ deeply held values, norms, and behaviors by outside change agents; (b)
analyzing the change process to address individual driving and restraining forces; and (c)
determining how to diminish negative factors and enhance positive forces may provide
insight into why some change is not happening in entry-level physical therapy education
and specifically, why practice management skills may not be integrated adequately within
entry-level physical therapist education programs.

Even though the contemporary health care industry is characterized by continuous
and dynamic change, Lewin’s three stage model of planned change still may be the most
appropriate change model to provide insight into this proposed area of study for the
following reasons: (a) the change within the physical therapy profession and within entry-
level physical therapist education is intentional and planned; (b) academic cultures tend
to be slow in changing; (c) the profession may in the ‘unfreezing’ stage as it relates to my
proposed topic; (d) ‘unfreezing’ provides a tested concept that may help to explain what
is going on in physical therapist education; (e) the concepts provided by Lewin’s model,
such as driving and restraining forces, may provide some tested language to help explain
why my problem or topic is occurring; (f) it is a model of change that has been used effectively by others to explain various phenomenon of reform or transformation; and (g) this model is foundational, thus providing a model of change that is credible.

Significance of the Study

The profession of physical therapy is intentionally transforming as indicated by the APTA’s Vision Sentence for Physical Therapy 2020,

By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health (Appendix A).

Yet, the proof of the effectiveness of the change process is whether the changes actually take place and are sustained (Giardino et al., 1994). Effective or successful change occurs when the people involved with or affected by the changes develop new attitudes or responses to them and actually carry them out (Giardino et al.). The APTA may have imposed changes upon entry-level physical therapist education that make strategic sense but may have done so without taking time first to unfreeze the profession, identify driving and restraining forces of change, and prepare it for change. The overall speed at which entry-level PT programs are changing from the master’s level to the doctorate level is rapid (approximately within ten years) as compared to the historical 22 years it took to convert entry-level PT programs from a bachelor’s to a master’s program. Something appears to be facilitating change in a different way. Yet, despite evidence
from core documents and recent research studies that show the need and expectation to integrate practice management skills into entry-level physical therapist education, there still remains somewhat of a gap in the curriculum. There may be tension and resistance from programs to add more content to the curriculum, especially content that is not well defined and is emerging. Also, minimal empirical evidence exists related to practice management and it seems that only a limited number of researchers have been involved in defining practice management competence in physical therapist practice. Furthermore, there is a significant difference in the level of agreement between academic and clinical PTs regarding the addition of reimbursement, legal issues, ethics, and managed care content to DPT curricula (Brudvig and Colbeck, 2007). These findings might indicate that clinical PTs see a stronger need for the addition of practice management curricular content areas than academic faculty (Brudvig and Colbeck). More evidence is needed to investigate the phenomenon occurring in PT education as it relates to the integration of practice management skills into the curriculum.

Lewin’s model of planned change provides insight into why my proposed topic or problem is occurring as it is in physical therapy for a few reasons. The APTA has planned two changes that have impacted the educational preparation of entry-level physical therapists. Previously, the Association changed the minimum entry-level standard from a baccalaureate degree to a master’s degree, and currently, it is changing the minimum entry-level standard from a master’s degree to a clinical doctorate degree. In both cases, it appears that these changes in entry-level physical therapist education have been planned by the APTA intentionally and explicitly to position the profession at a higher level within the health care community and to respond to the changing needs of
the health care environment and its consumer. However, the APTA may have planned these changes without taking time to assess the profession’s readiness for change, to identify the driving forces of change, or to assess the potential restraining forces to change. Previously, it took twenty-two (22) years for the PT profession to implement the change from a baccalaureate level to a master’s level (personal communication, Scott Ward, March 2008). Conversely and currently, over ninety-six percent (96%) of the existing PT programs in the United States have changed from the master’s degree to the clinical doctorate (DPT) (personal communication, Scott Ward, September, 2010). It is important to note that although the planned change appears to be happening differently this time, there seems to be forces restraining the deep and broad transformational changes needed to occur to take entry-level preparation to the doctoral level while other forces are driving some new and innovative change. Different forces happening simultaneously during the start of the change process may explain the current gap and the inconsistent integration of practice management skills content into the core curriculum in physical therapist programs. Thus, exploring and applying the concepts provided by the ‘unfreezing’ phase of Lewin’s 3 Step Change Model, including driving and restraining forces, helps to uncover some reasons why and how this situation is occurring within the physical therapy profession.

The profession of physical therapy, as it relates to the proposed topic, is in the ‘unfreezing’ stage. Key components of unfreezing that Lewin may recommend to the APTA include: (a) the equilibrium within entry-level physical therapist education may need to be destabilized before old behaviors can be discarded; (b) many restraining forces may exist in entry-level programs thus inhibiting driving forces; (c) the perceived group
standard in developing clinical skills as the priority in entry-level physical therapists may be creating resistance from academic faculty preventing integration of practice management skills; (d) individual faculty, who teach the practice management content, may not have the necessary skills to facilitate the needed change; (e) core faculty do not typically teach this content as their primary content area acting to reinforce the group standard emphasizing clinical skill development; (f) too many changes may be expected of entry-level physical therapist programs at the same time thus overloading the change process; (g) the APTA may not have created an ‘emotional stir-up’ to deliberately unfreeze the status quo in entry-level education; and (h) slow changing cultures within academic institutions may be breeding pervasive inertia.

Statement of Purpose

The primary purpose of this research study is to identify the perceptions of physical therapist faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapist programs in the United States. For the purposes of this study, the principal investigator will intentionally include faculty and program directors, who are physical therapists and members of the APTA, to explore their perceptions. A secondary purpose of this study is to attempt to identify basic demographic information about faculty teaching practice management skills in entry level physical therapist programs in the United States.

Research Question

The proposed research question is: “What are the perceptions of physical therapist faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapist programs in the United States?”
Definitions of Terms

**Physical Therapist Faculty:**

*Program Administrator.* – the individual employed full-time by the institution, as a member of the core faculty, to serve as the professional physical therapist education program’s academic administrator: Dean, Chair, Director, Coordinator, etc. (CAPTE)

*Core Faculty.* – Those individuals appointed to and employed primarily in the program, including the program administrator, the Academic Coordinator of Clinical Education/Director of Clinical Education (ACCE/DCE) and other faculty who report to the program administrator. The core faculty has the responsibility and authority to establish academic regulations and to design, implement, and evaluate the curriculum. Members of the core faculty typically have full-time appointments, although some part-time faculty members may be included among the core faculty. The core faculty includes physical therapists and may include others with expertise to meet specific curricular needs. (CAPTE)

*Associated Faculty.* – Those individuals who have classroom and/or laboratory teaching responsibilities in the curriculum and who are not core faculty or clinical education faculty.

**Driving Forces:** A driving force pushes motion (Lewin, 1947).

**Restraining Forces:** A restraining force, which does not cause motion toward a goal by itself, restrains one of the driving forces (Lewin, 1947). Lewin (1947) claims that a positive valence pulls toward the goal, a negative valence pushes away from the goal,
while restraining forces act as brakes in either direction in terms of movement towards a goal.

*Practice Management Skills:* For the purposes of this study, the FINHOP framework (finance, information management, networking, human resource management, operations, planning and forecasting) used by Schafer, Lopopol, & Ludetke-Hoffmann (2007), will be used to provide the working definition for practice management skills needed in physical therapist practice. Schafer, et. al (2007) used the FINHOP framework as an organizing framework for practice management content to isolate a suggested hierarchy of practice management skill acquisition for the new graduate physical therapist in 2010.

*Accredited Entry-Level Physical Therapist Programs:*

*Professional Curriculum.* – The portion of the curriculum plan that is designed to provide the student with the knowledge, skills, and behaviors required for entry into the practice of physical therapy. The professional curriculum is the responsibility of and is taught by the core, associated, and clinical education faculty. (CAPTE)

*CAPTE – The Commission on Accreditation in Physical Therapy Education.* - (CAPTE or the Commission) is the only agency in the United States recognized to accredit education programs for the preparation of physical therapists. (CAPTE) CAPTE attempts to ensure that accredited programs prepare graduates who will be effective contemporary practitioners of physical therapy. (CAPTE)
Summary of Remaining Chapters

Chapter 2: Review of the Literature

This chapter provides a review of the literature investigating topical concepts related to this study.

Chapter 3: Research Design Methodology

This chapter describes the research context, including the research question, research participants, data collection instruments and procedures, data analysis and interpretations.

Chapter 4: Results

This chapter presents the results of this research study, including data analysis, findings, and a summary.

Chapter 5: Discussion

This chapter presents the discussion and interpretation of the results detailed in Chapter 4.
Chapter 2: Review of the Literature

Purpose

The purpose of this literature review is to examine the following concepts: (a) changing responsibilities in health care include practice management; (b) core competencies are changing in physical therapist practice; (c) acquiring a role is a process; (d) essential practice management skills needed by health care professionals; (e) essential practice management skills needed by physical therapists at entry-level; (f) changing curriculum; (g) drivers and restrainers of change; (h) changing the preparation of entry-level physical therapists; (i) the need for empirical research as it relates to the proposed research study; (j) using phenomenological studies to capture the essence of lived experiences; and (k) focus groups are useful as a data collection strategy to capture data about perceptions. Several databases were searched for relevant research studies. These databases included: ProQuest, ERIC, Medline, Sage, and APAPsychNet. In addition, the following online journals and American Physical Therapy’s (APTA) website were reviewed for online research articles: Physical Therapy, Journal of Physical Therapy Education (JOPTE), Physiotherapy Canada, The American Journal of Occupational Therapy, and Physiotherapy and Practice. An attempt was made to review and select research that was relatively current or published within 10 years. Although the preferred range of dates for research studies was 1999-2009, the actual studies selected ranged from 1975 to 2009. Keywords used in searching these databases and websites were: practice management skills, physical therapy, health professions, physical therapy education, health professions education, management, and business skills.

Topic Analysis
Changing Responsibilities in Health Care include Practice Management

Kleinman (2003) surveyed nurses in management positions to obtain information about their perceptions regarding nurse manager and nurse executive roles and the competencies and educational preparation required for these roles. The questionnaire contained 22 items, including Likert and rank order questions and fill-in demographic questions about the respondent. The respondents included 35 nurse managers and 93 nurse executives. The data was calculated based on frequency of response (%) and revealed that: (a) both nurse manager groups agreed that staffing and scheduling, management, and human resources are the three most important competencies for nurse managers; (b) nurse managers rated finance and management as the two most important competencies for nurse executives; (c) nurse executives perceived strategic planning, finance, and human resources to be the competency areas most important for nurse executives; (d) a higher percentage of nurse managers (20%) perceived an MSN in nursing administration to be preferable to a dual MSN/MBA degree (17%); and (e) nurse executives (34%) perceived an MSN/MBA to be preferable compared to an MSN with a major in nursing administration (20%). The nurse executive group had a higher percentage of respondents who possessed a master’s degree (84%) compared to the nurse manager group (31.5%). Kleinman suggests that the disparities in the level of graduate education between the two groups may explain the differences in perceptions regarding the most desirable graduate degree to possess. The results of this study indicate that: nursing and healthcare administrators must support the possession or eventual acquisition of a graduate degree as an essential requirement for nurse managers, and there is a need to educate nurse managers about the necessity for this requirement. Additionally,
Kleinman suggests that nurse executives are well aware of: (a) the expanded nursing management roles at all levels in healthcare systems; (b) the need to operate clinical units from a business perspective, and (c) the resulting need for concurrent knowledge in both nursing and business administration.

Henson, Pressley, and Korfmann (2008) studied the perceived need for business skills among chiropractors. An online survey was completed by 64 chiropractors (15.57% response rate). The survey included sixteen questions on a five-point scale (ranging from very low level to very high level) with the questions capturing the knowledge needed and the current level of knowledge in eight business fields. The respondents indicated either a high or very high level of knowledge is needed by chiropractors in the following: (a) organizational behavior and human resources (89%); (b) strategic management (86%); (c) finance (83%); and (d) marketing (82%). Conversely, respondents reported very little existing knowledge about business tasks. Only 25% of the respondents said chiropractors have a high level or very high level of knowledge about law and ethics (the category in which they know the most) and 5% of the respondents said chiropractors have a high level or very high level of knowledge about accounting (the category in which they know the least). Henson, Pressley, and Korfmann identified the gaps in business knowledge by comparing the differences between the percentages of respondents who described the level of required knowledge as high or very high and the percentage of respondents who described the current level of knowledge as high or very high. Results show that the largest gap among the business tasks is in accounting (72% gap) followed by finance (70% gap) and strategic management (68%). Findings suggest that existing business skills are well below needed
levels. These researchers imply that the existing gap between needed business skills and existing business skills indicates that current training and education programs are not providing adequate business skills training. The authors conclude that the chiropractic profession needs significantly greater business and practice management skills.

Smith (1988), responding to suggestions by employers, surveyed nursing service administrators to obtain their opinions regarding the addition of business, economics, and management content to the undergraduate baccalaureate nursing curriculum. The survey instrument, developed by faculty, posed five questions; three questions were open-ended. Fifty-one (68%) of the surveys were returned. The results of the survey question asking, “Do you think that the graduate with a BSN degree needs more management/business skills?” included the following responses: (a) thirty one of the respondents (61%) answered “yes”; (b) fourteen respondents (36%) answered “no”; and (c) six respondents were undecided. The ‘undecided’ respondents put forward the following responses: (a) “If adding business skills will detract from nursing skills, then I say no.”; (b) “What do you plan to drop from the nursing courses?”; (c) “I would not want the business focus to dilute the nursing focus.”; and (d) “It’s desirable for them to have these skills; they must be balanced against other educational needs.” Respondents, asked to identify the economic, management, and business skills they considered necessary in their nurse employees, identified the most commonly identified necessary “skills” to include: (a) budgeting and finance; (b) personnel management; and (c) knowledge of organizations. Smith presented the following diverse responses given in answering the question how they might employ a BSN graduate with nursing and business skills: (a) this graduate would have greater and more rapid advancement within the institution (representing a
statement from several administrators); (b) “Nurses coming to our institution with these skills would reduce the costs of training in these areas.” (representing a statement from one administrator); (c) “This type of preparation would be beneficial in any nursing position.” (one administrator); and (d) “Not at all”, representing a statement from one administrator). Smith considered the survey responses, as well as their mission and philosophy, to design a new Nursing/Business program in a response to a changing health care practice arena.

Young, Hough, and Peskin (2003) investigated: (a) the expectations that graduates of one business of medicine program had upon enrollment; (b) the fulfillment of those expectations after completion; (c) the extent to which participating in the program improved business skills; and (d) the extent to which participating in the program led to advancement in office practice or career development. A post mail survey was conducted of graduates of The John Hopkins University’s Business of Medicine Program, a year-long, four course certificate program designed to educate mid-career academic and nonacademic physicians and other health care professionals about fundamental business practices and their application to health care. Surveys responses were received from 136 (48%) graduates. Results indicated that: (a) all respondents agreed (or strongly agreed) that they expected the program to expand their management skills; (b) almost all (98%) expected the program to enhance their knowledge of marketplace trends; and (c) 87% expected the program to advance their careers. The researchers did not correlate these results with respondents’ age, sex, or profession (i.e., physician, nonphysician). More than 87% of respondents agreed that their overall expectations had been fulfilled by the time they completed the survey. Young, Hough, and Peskin suggest that the results of the
survey provide preliminary evidence of the benefits of a formalized business education program for physicians and other health care professionals. These authors suggest that it might be more valuable to assess the benefits of business education for physicians by surveying participants’ expectations before the course work begins. Additionally, the authors advise that programs designed to educate physicians and other healthcare professionals about the business aspects of medicine need to be designed carefully to integrate business theory and application to the medical setting.

Christiansen (1975) surveyed recently graduated occupational therapists to determine their perceptions of the adequacy of their professional training. Therapists evaluated their undergraduate professional preparation, through a mailed questionnaire, based on their clinical experiences since graduation. Additional suggestions were solicited regarding possible areas of curriculum change. Responses were examined by identifying common areas and possible use in curriculum planning and modification. Data was based on 77 usable responses representing 28 accredited basic professional curricula in occupational therapy. Sixty-one (77.2%) of the respondents indicated that they would recommend additional course requirements at the basic professional level. Results indicated that 58.2% of the respondents see a need for increased attention to the development of administrative and managerial skills. Based on the survey results, Christiansen recommends that additional training in administrative and managerial skills be given since many graduates assume managerial responsibilities early in their professional careers, or before they have had the opportunity to gain knowledge from work experience.
Schafer (2002) studied the perceived importance of managerial role and skill categories among three groups of physical therapists to better understand the work priorities of physical therapist managers. Three groups were surveyed simultaneously using the same instrument. Two groups of subjects were physical therapist managers in hospitals or private practices while the third group was comprised of faculty members in professional physical therapist education programs. Respondents (n=343; response rate of 41.3%) rated the importance of 75 managerial activities on a Likert-type scale of importance ranging in scores from 1 (“no importance”) to 5 (“great importance”). Responses related to 16 predetermined work categories were placed in rank order by group and a MANOVA was used to identify differences among groups. All groups identified the 5 most important categories as: communication, financial control, entrepreneur, resource allocator, and leader while rating technical expert and figurehead as least important. The MANOVA showed differences in the following areas: (a) between faculty members and private practice managers in 15 work categories; (b) between hospital-based managers and private practice managers in 9 categories; and (c) between faculty members and hospital-based managers in 8 categories. Findings suggest that work setting appears to have an impact on the level of importance placed on managerial work categories. The strongest possibilities for “universal” physical therapist managerial work categories were communication, financial control, and resource allocator because these work categories were ranked highly by all 3 groups. Schafer reports that 15 of the 61 professional physical therapist education programs, represented in this study, offered the bachelor’s degree while 46 offered the master’s degree. Noteworthy, Schafer indicates that fewer than half (42%) of the instructors of the
administration/management content had a degree in management and the average number of years teaching this content was 6.2 years (range = 1-24).

Core Competencies in Physical Therapist Practice are Changing

Aston-McCrimmon and Hamel (1983) designed a study, as an initial step toward curricula reevaluation and change, to develop a list of competencies that could be applicable for entry-level physical therapists and appropriate for meeting present-day rehabilitation needs in the province of Quebec, Canada. A comprehensive set of 224 competence statements or items pertaining to physical therapist practice were compiled, edited, field tested, and sent, in the form of a questionnaire, to practicing physical therapists in Quebec for verification and rating. These competence statements/items had been grouped into 11 categories including “administrative skills” as one category. In this study, respondents rated the importance level of the 224 competence statements/items in relation to their own professional practice. Aston-McCrimmon and Hamel imply that the level of importance ratings in professional practice of the 224 competence statements/items gave indications as to their applicability in the workplace. The total response was 176 replies (50.4%). The frequency percentages of the high importance ratings of the 11 categories range from a high of 78.8% (average mean of 7.16) for “planning of treatment services” to a low of 27.5% (average mean of 5.49) for “research skills and creative thinking”. In these ratings, all categories, except three (“treatment skills and the implementation of client care services”, “societal awareness”, and “research skills and creative thinking”) had overall high importance ratings. The category of administrative skills, composed of 14 items related to managerial and administrative activities, had an overall importance rating of 51.1% and ranked eighth (of 11 categories)
in importance with an average mean of 6.33. The ratings of importance of each category were further analyzed in relation to the respondent’s years of professional practice, place of training, type of position held, and work setting using a one way ANOVA and it was found that only the years of experience and the place of training showed significant differences in response levels ($p < 0.05$). Neither the position held by the physical therapist nor the type of place of work changed the response rate significantly. The authors suggest that the results of this study indicate that the functions required at entry-level of professional practice have expanded significantly, to the point where supervision, consultation, teaching, and evaluation are included in addition to the traditional treatment role. Aston-McCrimmon and Hamel state the results of this study also indicate: (a) a need for an ongoing evaluation of the role of the physical therapist in the clinical setting; (b) a list of competencies to be used for curricula revision should be updated periodically; and (c) consideration must be given to those competencies which are appropriate for entry-level practice in contrast to those competencies which are needed in more diverse professional roles, such as administration. These researchers conclude that the response ratings given to the competence statements and the categories may help to influence possible educational curricula changes that would meet market demands, both at the undergraduate and graduate levels as well as in the area of continuing education programs.

Aston-McCrimmon (1986) investigated a previously field tested and rated comprehensive list of competencies as a preliminary step for curriculum review, reevaluation, and change for a physical therapy undergraduate education program. A questionnaire listing the 224 competency statements was developed and distributed to a
target population of physical therapists, comprised of physical therapy graduates and
directors of physical therapy services, in the province of Quebec, Canada. The 224
competency statements were randomized and listed without category headings to
minimize response bias. Physical therapists were instructed to score each statement
twice: once, according to their perceived level of importance in their clinical practice by
rating each statement on a scale of 1 (“not important”) to 8 (“very important”), and a
second time, according to the respondents’ self-evaluation of their level of competence
by rating the statement on a scale of 1 (“lack of competence”) to 8 (“high level of
competence”). The 176 responses returned (50.4%) were analyzed by calculating the
average means of each of the 224 statements and of each of the 11 categories to
determine the ratings of the level of importance and the level of competence. An average
mean score of 6 or greater, on a rating scale of 1 to 8, was considered to indicate a
consensus of high importance or of a high level of competence. The findings show that
eight categories had a consensus rating of high importance between 6.33 and 7.16, with
administrative skills at 6.33. Conversely, three categories had average mean competency
scores in the 5.00 to 5.99 range or lower competence range with administrative skills at
5.53. These findings indicate that the average mean competency rating for administrative
skills was lower than the average mean importance rating. Aston-McCrimmon suggests
that a picture of present-day professional practice emerges when clinicians in physical
therapy rate a series of competency statements according to their perception of the level
of importance in their own clinical practice and according to their own level of
competence. This researcher points out that the variables of position and years of
experience must be considered. Aston-McCrimmon reports that staff physical therapists
with limited professional experience rated items/categories identified as administration and management activities as lower in importance and they rated their own level of competence for those same items as lower than did experienced therapists. This author recommends that a curriculum provide adequate preparation for clinical practice, incentives for continued learning, and the stimulus for the development of managerial and administrative skills.

Pescatello, Glenney, and Certo (2000) studied expert opinion from health care managers (HC) (n=68) and non-HC managers (n=15) on the issues likely to impact the work of entry level physical therapists and the managers’ professions and settings. Students enrolled in a professional phase physical therapy (PT) course conducted 83 manager interviews and asked four standard open-ended questions in each interview. The authors arrived at consensus regarding manager opinions on important HC issues and qualities for employment success with a modified Delphi technique. The Chi-square test was used to determine if HC issues and employment qualities differed among the managers’ professions and settings. Results indicated that: (a) managers (70% physical therapy managers, n=50; 55.6% other HC managers, n = 18) considered “greater reliance upon business skills” as the third most important HC issue; (b) HC managers (66.2%, n = 68) considered “business savvy” as the fourth most important issue likely to impact health care service delivery as compared to non-HC managers (80%; n = 15) who considered “business savvy” to be tied for the most important issue; (c) only 22.1% of HC managers felt that the possession of business skills was an important quality for a staff physical therapist; whereas 66.7% of non-HC managers believed it to be critical for career success (p = 0.001); and (d) there were no differences between the importance of
HC issues by manager facility type ($p>0.05$). Pescatello, Glenney, and Certo, highlighting that HC managers differed from non-HC managers in the importance they placed on business savvy, imply that some managers embrace this new role, while others resist it and do not recognize it to be an essential survival skill for PT staff in today’s HC environment. The authors propose that these findings support the use of innovative instructional strategies that offer students multiple perspectives on the realities of HC to optimize employment success. Additionally, the authors suggest that further study is warranted using a larger, more appropriately stratified sample and a survey instrument that is more easily quantifiable and less subject to interpretation.

*Acquiring a Role is a Process*

Yellin (1999) conducted a qualitative study to explore the process of role acquisition through content analysis of a wide range of roles. The sample was purposively drawn from college students enrolled in Introductory Sociology courses at two large universities in the Los Angeles metropolitan area from 1989 to 1996, with the goal of selecting a diverse distribution with respect to gender and race/ethnicity. Subjects’ participation occurred prior to the study of models of role acquisition. Participants were invited to describe in writing the socialization they had experienced to date regarding one position they occupy and the associated roles they perform. Yellin obtained first-person narratives, five to eight pages in length, describing the acquisition of a variety of roles from a sample of 420 college students. Documents (n=420) were separated randomly into two groups: data set I (n=310) was employed to develop the proposed model; and data set II (n=110) was used to test the model. Analysis occurred in three steps. In the first step, content analysis of data set I (n=310) was used to identify
commonalities and differences in how learning to perform a new role was described. Essential themes generated in this first phase included the following coding categories: (a) factors characterizing various stages in the process; (b) the nature, sequence, and duration of these aspects; (c) the type of interactions with role partners; (d) changes in self-evaluation of role performance; (e) level of identification with the role; (f) aspects in the social situation influencing role performance; (g) meanings attached to role performance; and (h) the effects of gender, race, and ethnicity. In the second step, the data obtained were organized, essential themes were recorded, sequences of experiences were compared, and connections between variables were analyzed. Several constituent themes emerged in this second phase as recurrent in the majority of documents, including: (a) the learning of role performance is viewed as a process, not a one-time event; (b) the learning of role performance is seen as a progression of experiences involving increased ability in performing the new role; and (c) the experiences in the progression differ significantly and sequentially at four phases in the process. A four stage model of role acquisition was constructed utilizing the data from the first two steps of analysis, including a sequence characterized as follows: (a) ambivalence; (b) absorption; (c) commitment; and (d) confidence.

Data set II (n=110) was subjected to content analysis in the third step to test the validity of the model and the four stages were used to generate coding categories. Yellin (1999) indicates a general support for the model ($p<.15$) based on the findings. Specifically, content analysis of data set II shows the following results: 83% of the documents contained suggestions to behaviors later classified as stage 2; 72% contained suggestions to behaviors later classified as stage 3; and 66% contained suggestions to
behaviors later classified as stage 4. References to behaviors later classified as stage 1 appeared in only 29% of the cases due largely to 53 of the 78 documents containing no data about the first experience of role performance. This lack of data was due to narratives starting after role acquisition rather than before. Findings suggest that each stage of role acquisition, as proposed by this model, is marked by the person having a different affective orientation toward the role and a qualitatively different relationship between role partners. Findings also suggest that navigating successfully through these four stages produces skill in role performance and feelings of identification, competence, and self-worth in the role.

Essential Practice Management Skills Needed by Health Care Professionals

Parekh and Singh (2007) conducted a retrospective study attempting: (a) to understand why a physician would enroll in a business school; (b) to discover the utility of the Master of Business Administration (MBA) degree; and (c) how this degree changed the career path for the practicing clinician. In this study, 161 physician graduates of three East Coast business schools were mailed and emailed a twenty-seven question survey. Eighty-seven physicians (54%) responded while eight surveys were discarded because of incomplete data or stray marks, leaving 79 survey results to analyze. The average age of the respondents was 41.4 years. The physicians completed their MBA degrees at an average of 8.64 years after graduating from medical school. The top three reasons for completing an MBA degree among the physicians included learning about the business aspects of the health care system (53 respondents; 67%), obtaining a more interesting job (41; 52%), and surviving better in the new health care system (37; 47%). Enhancing personal finances was cited as one of the top three reasons for pursuing an
MBA degree by only twenty respondents (25%). Prior to enrollment in business school, respondents committed approximately 58.3% of their time to patient care as compared to 11.8% to administrative responsibilities. After completing the MBA program, the respondents reported a significant change in the allocation of their time with an average of 31.8% spent on patient care ($p<0.001$) as compared to 33.5% on administrative tasks ($p<0.001$). Five skills acquired during business school that the respondents stated were the most pertinent to their careers were related to evaluating system operations and implementing improvements (39 respondents; 49%), learning how to be a more effective leader (35; 44%), comprehending financial principles (33; 42%), working within a team setting (27; 34%), and negotiating effectively (25; 32%). Sixty-four physicians (81%) believed that their business degree had been very useful or essential in advancing their careers. Parekh and Singh suggest that it is essential to continue educating a proportion of physicians in both medicine and business in order for physicians to overcome the complex challenges of the evolving healthcare system. Furthermore, these researchers provided evidence that physician practice patterns changed substantially after they completed the business degree reflected by the increased time spent on administrative responsibilities.

Sportsman, Hawley, Pollack, and Varnell (2001) designed their study to address issues involved in preparing the nurse practitioner for the challenges of practice management in the clinical environment. The purposes of their study were to: (a) identify business concepts necessary to successfully manage a primary care practice; (b) determine which of these concepts should be incorporated into a family nurse practitioner (FNP) curriculum; and (c) clarify information to be taught regarding each identified
concept. The researchers identified fifty-four business concepts related to primary care from a literature review. Five FNP faculty and seven experts responded to a survey that was developed to assess the extent to which the concepts identified were necessary for an FNP to manage a practice effectively. The authors, using a Content Validity Index (CVI), established content validity of several items beyond the .05 level of significance. The experts were asked to rate each identified business concept on a four-point scale (from “Not an important concept” to “An extremely important concept”) to determine the importance for the practice management skills of an FNP. A number of concepts of practice management skills of an FNP were identified as important, each by at least five experts, in this initial survey response with some experts identifying additional business concepts deemed “important”. The original survey instrument was revised to include these additional concepts, administered a second time, and results revealed only one concept was rejected in this round. A focus group, conducted by interactive television, was then used to determine which of the business concepts should be presented as part of the FNP curriculum and to clarify the information taught regarding each concept to be included. The focus group included four faculty members from the participating program (three of whom were nurse practitioners) and five FNPs working in three different geographic locations. After reviewing the business concepts considered to be valid by both the panel of experts and the group of nurse practitioner faculty, the participants of the focus group agreed by consensus that: there were no further business concepts describing practice management skills that should be included; and the group agreed that all of the concepts that were ranked as important or extremely important in the survey should be included in a well-designed FNP curriculum. Results from the focus group
determined that all 20 of the identified concepts should be included in an FNP curriculum. Additionally, the focus group clarified relevant information to be taught regarding each concept. The authors suggest that the results of this study could provide a framework for nurse practitioner faculties to meet the needs of both the students and the expectations of the workplace.

*Essential Practice Management Skills in Physical Therapist Practice*

Schafer, Lopopolo, and Luedtke-Hoffmann (2007) identified which administrative (A) and management (M) (A&M) skills will be most critical for future Doctor of Physical Therapy (DPT) graduates to possess upon entry into clinical practice. Using a 7-point scale, 435 randomly selected APTA members (physical therapists) rated 121 A&M skills based on expectation of the level of independence or competence required by a new DPT graduate. These authors used FINHOP (finance, information, networking, human resources, operations, planning) as an organizing framework for A&M content to isolate a suggested hierarchy of A&M skill acquisition for the new graduate physical therapist in 2010 regardless of practice setting. Because no differences were found among respondents based on role, work setting, or experience, the data were combined for factor analyses, producing 16 A&M skill groups. Median scores, derived from a factor analysis, were calculated for each FINHOP category, skill group, and individual skill. At the category (FINHOP) level, a hierarchy of A&M skills began to emerge with human resource, information, and operations skills having higher median scores (5.3-5.6) than networking, planning and forecasting, and finance skills (4.6-5.0). The results of this study identified: (a) 121 A and M skills; (b) 16 skill groups; and (c) varying levels of independence, or competence, expected in A&M knowledge and skills.
among DPT graduates at entry-level. Findings suggest that the most independence was expected in skills related to self-management, compliance with rules, ethical behavior, and insurance coding whereas skills requiring the most assistance were marketing and strategic planning, financial analysis and budgeting, and environmental assessment. Schafer, Lopopolo, and Luedtke-Hoffmann identified the following three limitations to this study: (a) it was not possible to control whether respondents answered each item in the context of what will be expected of DPT graduates in the year 2010; (b) the overall return rate of 17.4% was low for a survey; and (c) the use of one scale to capture 2 constructs (skills and knowledge) may have limited the potential range of responses.

Using the FINHOP model, Schafer, Lopopolo, and Luedtke-Hoffmann: (a) provided empirical evidence suggesting which A&M skills should be included in DPT curricula; (b) identified the level of independence for the A&M skills needed by new DPT graduates; and (c) suggested a pattern of A&M skill acquisition that applies directly to the new therapist.

Schafer (2001) studied and compared the patterns of agreement-disagreement among Texas-based physical therapist educators, clinicians, and students on the LAMP (Leadership (L), Administration (A), Management (M)) belief statements and determined whether differences existed among these groups on any of the statements. Using mailed questionnaires, these three groups were surveyed. The response rate varied: 62% for clinicians (102 out of 162 useable questionnaires returned); (b) 69% for educators (58 out of 84 responding); and (c) 75% for students (140 out of 187 questionnaires returned). The belief statements were rank ordered after the scores per item per group were averaged. Differences among groups were investigated using a multivariate analysis of variance.
MANOVA. The strongest held belief overall stated that generic abilities are essential to clinical success. The belief with the lowest rank stated that business values promote the core values of physical therapists. Differences among groups were found on six of the 17 belief statements. These differences could be explained by respondents’ familiarity or actual experience with the concepts being rated: (a) only 21% of clinicians reported being familiar with the LAMP document; (b) only 30% of educators were familiar; and (c) only 7% of students were familiar. Respondents appear most ready to accept LAMP skills that address generic abilities, assessment of self, leadership, and management and appeared less ready to accept skills that address assessment of systems, administration, and business-related concepts. The results of this study suggest that three groups related to physical therapist education and practice have similar opinions concerning 17 LAMP belief statements. Schafer believes that these results provide baseline data from which to plan and assess future LAMP skill dissemination efforts.

Lopopolo, Schafer, and Nosse (2004) sought to define the range of LAMP content pertinent to physical therapy clinical management and to explore LAMP knowledge and skills required of physical therapists upon entry into the profession. Thirty-four physical therapist managers participated in a Delphi study to: (a) create a comprehensive list of defined LAMP components; (b) determine the perceived importance of each component in the management of clinical practices; and (c) identify the level of knowledge and skill for each component believed to be necessary for a new physical therapist graduate. Respondents agreed that 178 items should be on the LAMP component list. They perceived that almost all 178 LAMP components identified are important in the management of a clinical practice and indicated that new graduates needed: (a) moderate
to extensive knowledge in 44% of LAMP components; (b) no skill in 29% of the components; (c) at least intermediate skill in 22%. Top-ranked component categories across the three scales (importance, knowledge, and skill) were communication, professional involvement and ethical practice, delegation and supervision, stress management, reimbursement sources, time management, and health care industry scanning. Lopopolo, Schafer and Nosse believe this study provides further exploration of which LAMP components should be included in professional (entry-level) physical therapist curricula and which components should be learned after graduation.

Changing Curriculum

Bellack, Graber, O’Neil, Musham, et al. (1999), as part of a comprehensive survey of 11 health profession education programs, studied the extent to which nurse practitioner (NP) education programs are addressing curriculum topics related to practice competencies needed for the next century as recommended by several professional organizations. The other health profession programs were selected for inclusion because of their strong focus on preparing graduates for generalist and primary care practice roles. The survey instrument consisted of 46 items in a five-point Likert scale format (“Not at all” to “To a great extent”) with one open-ended question for comments. A total of 966 usable completed surveys from the comprehensive study were returned, for an overall response rate of 55%; the response rate for NP programs was 60% (84 usable returns). NP program directors indicated greatest dissatisfaction with curriculum coverage of “use of electronic information systems” and “business management of practice”. The three most important curriculum topics identified by respondents were “primary care”, “health promotion/disease prevention”, and “effective patient-provider
relationships/communication”, identical to the three topics rated most important by all groups combined. Findings show NP program directors perceive they are doing an effective job addressing most of the 33 curriculum topics, but they also recognize a need to continue to improve their curricula in response to the ever-changing health-care environment. The three barriers, “an already crowded curriculum”, “inadequate funding”, and “limited availability of learning sites”, were viewed as significant by the NP program directors, with all three rated 3.85 or higher (the next highest rating was nearly a full point lower). The difference between the mean rating of the NP program directors and all other survey groups for the barriers, “limited availability of learning sites” and “community resistance” was statistically significant ($p < .001$), with the former perceived as a significant barrier while the latter viewed as not significant. External barriers, such as “accreditation criteria”, licensing regulations”, and “community resistance”, were not viewed as particularly significant obstacles by the NP program directors despite the fact that often the two are cited by faculty as reasons they are inhibited in making curriculum changes. Bellack, Graber, O’Neil, Musham, et al. suggest that NP program directors and faculty must take a critical look at their current curricula to determine the extent to which they emphasize the development of essential competencies or need to find ways to do so.

Foord-May (2006) investigated a physical therapist program faculty’s experience in transitioning from traditional instruction to problem-based instructional methods in response to the changing demands of the practice environment. Face-to-face semi-structured interviews followed by a focus group were conducted with 7 faculty members guided by questions about factors that influenced instructors’ experience of changing
instructional methods. A constant-comparative method was used to analyze the typed transcripts. Nine themes emerged from the data to delineate this group’s change process and described the faculty’s experience of change: perception of need for teaching change, personal knowledge of problem-based learning, decision-making process, peer support, partial adoption, values related to teaching and learning, significant response from the community, administrative support, and perceived barriers to incorporation of problem-based methods. Limitations of the study include: (a) the collection of data by self-report which carries limitations and biases; (b) recalling events that may have occurred 12 years prior to the study; and (c) a small sample size. The findings of this study, offer four conclusions relating to the change process under study: (a) effective curricular change requires a change agent or change leader; (b) a strong network of support is vital to support different rates of change for each individual and to ensure enough group adherence to sustain the change momentum; (c) instructors perceive effective faculty development programs to be essential to provide the education and training that they need to ensure they correctly and efficiently implement unfamiliar instructional methods; and (d) sustaining meaningful change requires external financial and philosophical leadership resources, as well as expert guidance in the proposed change. Foord-May proposes that knowledge about change in higher education could be expanded by studying other types of curricular change.

Driving and Restraining Forces of Change

Ford and Greer (2006) used profile analysis in a cross-sectional study to test two hypotheses related to Lewin’s three-step model of change to demonstrate the usefulness of this approach in change process research. The hypotheses assumed that change process
profiles will display: higher levels of movement and refreezing factors as implementation progresses (hypothesis 1); and higher levels of unfreezing, movement, and refreezing factors when associated with higher degrees of implementation success (hypothesis 2).

Data was obtained from managers, while they were participating in change management seminars sponsored by an industrial coalition, who were involved in implementing change. Ford and Greer secured 107 usable questionnaires from managers representing 43 organizations divided evenly between manufacturing (49%) and service (51%) organizations. A total of 57 unique reference changes were assessed by the respondents.

A MANCOVA was conducted to test both hypotheses using the change process variables of goal setting, skill development, feedback, management control, and implementation success as dependent variables. The MANCOVA (hypothesis 1) indicated no significant overall difference across the implementation groups although the $p$ value approached the 10% level ($\text{Wilks's Lambda}= .781$, $F=1.46$, $p = .117$). The univariate ANOVAs indicated that the change process variables of feedback ($p = .038$) and management control ($p = .004$) significantly differed across implementation groups. The implementation success variable was also significant ($p = .001$), as was the previous implementation success contextual variable. Results (hypothesis 2) indicated a highly significant overall difference across the outcome groups ($\text{Wilks's Lambda} = .505$, $F = 8.76$, $p = .000$). Univariate ANOVAs indicated that the levels of the four change process variables differed strongly across groups ($p = .000$). The context variables of percentage implementation and previous implementation success were also significant. Findings from this empirical study supported: a general progression from unfreezing to refreezing as theorized by Lewin (hypothesis 1); and that higher levels of implementation success
were related to a higher use of the change process factors such as, unfreezing, movement, and refreezing (hypothesis 2). Findings also suggest that effective organizations employ change process activities at higher levels of intensity than do less effective organizations. The researchers identify that the self-reported measures may be a limitation of this study because individual respondents might be influenced by their own personal experiences with the change process. Ford and Greer suggest that future work could investigate the extent to which change process profiles differ depending on organizational factors.

Levi and Lawn (1993) modified Lewin’s Force Field Analysis (FFA) procedure to test the usefulness of this approach by studying the technological innovation process in three companies. The purpose of their study was to develop a method to examine the forces which encourage or drive and restrain or resist technological innovation. A two phase procedure was used that included: phase one - an open ended survey to generate a list of issues, classified by type, location and controllability, that drive and restrain technological innovation; and phase two - a more structured survey, based on the results in phase one, allowing participants to rate these issues on importance to their organization’s change activities and manageability.

The surveys in Phase 1 were sent to 65 professors in technology related departments with 24 completed surveys returned (37% return rate). The survey generated 130 suggested driving and restraining forces which affect why organizations adopt (or fail to adopt) technological innovations. Findings revealed that: the location of the forces were primarily internal to the organization, with 62% classified as internal and 38% classified as external; and internal forces were primarily financial (43%), followed by individual (27%), organizational (24%), and technological factors (6%). The survey,
developed for Phase 2, was distributed to three electronics manufacturing companies. The response rate was 46.7% or 70 completed surveys returned out of a possible 150 distributed. In this phase, participants were asked to rate the importance of eight drivers and eight restrainers of technological change on a seven point scale and then to rate the same set of issues on a seven point scale for how manageable or controllable these factors were by the organization.

Overall, survey results show that the forces driving technological innovation were rated as more important than the restraining forces \(F(1,69) = 16.93, p<0.001\). The financial and technological factors were rated as more important drivers of technological innovation than restrainers \(t(69)=4.07, p<0.001; t(69)=6.55, p<0.001\) respectively. However, there was no significant difference between the importance of driving versus restraining forces for the organizational and individual factors. Overall the driving forces were rated as more manageable than the restraining forces \(F(1,69)=10.60, p<0.01\). However, this difference is due entirely to the technological factor because the technological restraining forces were viewed as less manageable than the technological driving forces \(t(69)=5.24, p<0.001\). The results of these two studies provide some insight into the relationships among the factors that affect technological innovations. Financial and technological factors are strong driving forces for innovation, and financial factors are also strong restraining forces against innovation. Organizational and individual factors are less strong of an influence than financial factors and are important as both driving and restraining forces. The researchers suggest that the method used in these studies may be modified for use by innovation champions and a future study could use a group discussion approach with an interdepartmental project team to generate the
list of driving and restraining forces for an organization. Then the results of this group
discussion could be used to develop a survey (similar to the one used in Phase 2) to be
distributed to the employees in the organization. In this way, problems and opportunities
could be identified during the innovation process. Finally, these authors recommend that
the focus of the change agent’s efforts should be on the restraining forces which tend to
be internal to the organization.

Lifter, Kruger, Okun, Tabol, et al. (2005), in a case report, described how they
transformed their interdisciplinary personnel preparation program in early intervention
from a traditional classroom format to a primarily Web-based format. A survey was
conducted, mostly through telephone interviews, with twenty-one practitioners to gain
information about the external environment while the internal environment was assessed
by means of face-to-face interviews with seven program faculty. These researchers used
force field analysis, informed by survey results, to examine the external and internal
factors that served as driving and restraining forces. Results showed internal forces, such
as idea champions and the university’s organization, were crucial components in driving
change. In addition, data-based decision-making was essential to informing the direction
of change. The researchers suggest that: (a) the responsibilities that faculty members had
across multiple programs, as indicated in the faculty survey results, was a serious
organizational level restraining force; (b) these multiple roles and responsibilities
contributed to an unequal division of labor thereby restraining the engagement in
anything new; and (c) the driving forces outnumbered the restraining forces which
created disequilibrium. Several lessons learned were reported that included: (a) it was
easier to start something new than maintain it and keep it going; (b) the use of force field
analysis for conceptualizing organizational change was important; (c) a participatory approach to data collection to inform decisions about change was valuable; (d) creating a disequilibrium for change is important; and (e) reconceptualizing some restraining forces as potential forces can be advantageous.

Giardino, Giardino, MacLaren, and Buro (1994), in a case analysis, used Lewin’s FFA retrospectively as a framework to describe and explain the change process experienced in the reform of a clinical evaluation system in a medical school. The authors divided the case analysis into unfreezing, changing, and refreezing descriptions, provided a detailed examination of the reform process over an 8-year period, and highlighted the complexity facing medical educators as they embark various reform efforts in the medical school environment. The process of uncovering the driving and restraining forces present in the school started through meetings with administrators, faculty, and students. Forces working in favor of the change were identified and included: (a) the students’ desire for both performance feedback and consistency in grading criteria; (b) faculty’s desire for accountability for students’ clinical education; and (c) the value placed by the medical school on having a reputation for effective and fair clinical evaluation practices. Restraining forces identified through the unfreezing process included: (a) concerns, including poorly defined performance criteria for courses, making it difficult to complete the clinical evaluation effectively; (b) faculty discomfort with documenting criticism of student performance, and (c) a lack of a reward system to merit evaluators’ efforts to complete performance evaluation. Giardino, Giardino, MacLaren, and Buro suggest that: (a) Lewin’s conceptualization for change using the concepts of unfreezing, changing, and refreezing, as well as driving and restraining forces, offers a model for understanding
institutional change; (b) FFA addresses the difficulties that face innovators as they get on board with dissolving a stable yet ineffective system, reshaping it, and then determining whether the restructured system operates at a higher level of functioning; and (c) the success of integrating reform efforts into medical school curricula or programs depends on how successful the innovators are at managing individual, social, and organizational resistance that occurs during change. These authors propose that medical educators could use FFA prospectively as an organizational tool to identify potential resistance to proposed changes to assist in the planning and implementation of reform efforts.

Beverland and Lindgreen (2007) used a multiple case study approach to examine the change programs of two New Zealand-based agricultural organizations in moving to a market orientation. The authors selected the cases using theoretical sampling, conducted nine in-depth interviews to collect data, and stopped interviewing when saturation occurred. Interview questions focused on gaining a descriptive history of the pressures for and against change, major objections, supportive programs, and ultimate successes/reasons for failure. Also, multiple secondary sources were used in collecting data. These authors used Lewin’s three-stage change process model (unfreezing-movement-refreezing) and identified that the creation of a market orientation involves uncovering long-held assumptions about the nature of commodity products, the nature of production and marketplace power, and the commodity cycle. They also identified that moving the firm towards a new set of values involves changes in the role of leadership, the use of market intelligence, and organizational learning styles. The authors suggest that Lewin’s three-stage model of change was appropriate for capturing the change processes of both cases and explains the differences in outcomes between the two cases.
The authors identified that the study of processes would be improved if it were conducted in real time and longitudinally rather than relying on historical information and interviewee recall. Additionally, Beverland and Lindgreen propose that the results could have been improved by interviewing other key stakeholders of the programs, such as the farmers, to uncover further cultural assumptions behind opposition to change.

Hadley and Hugman (1991), using a single case study, described the progress of a re-organization in a social services department in order to learn from the systematic monitoring of its own activities while undertaking major changes. The change process was evaluated over a three year period with data being gathered through staff and management surveys supplemented by management information. The study involved three surveys: at the beginning of the reorganization, after one year, and a final one two years later. The researchers used Lewin’s three-stage change process as a framework for analyzing the change. Change was measured in relation to specific structural dimensions: overall organizational environment, strategic, technological, human/cultural, structural and managerial subsystems. Hadley and Hugman added a preliminary stage to the change process, emphasizing the importance of establishing the essential preconditions for successful change. These authors suggest that the framework used for analyzing change offers a means for understanding the internal factors which may have contributed to sub-system inconsistencies that emerged and acted as constraints on the reorganization of a social services department over a three-year period. As a result of their case example, these authors indicate there is potential value from applying a more systematic analysis derived from organization theory to the process of change.

*Changing the Preparation of Entry-Level Physical Therapists*
Brudvig and Colbeck (2007) investigated physical therapist education programs as they make the transition from the entry-level Master of Physical Therapy (MPT) degree to the entry-level Doctor of Physical Therapy (DPT) degree to identify: (a) what clinical and academic physical therapists (PTs) think should be added to physical therapist education curricula in order to produce autonomous professional (entry-level) physical therapist graduates; (b) the changes physical therapist educators are making to curricula in order to meet the goal of producing autonomous professional physical therapist graduates; and (c) similarities and discrepancies between what clinical and academic PTs think should be added to the curriculum and the actual changes educators are implementing in their curricula as programs make this transition. The subjects consisted of randomly selected physical therapists, who were members of the APTA (762), randomly selected academic PTs (318), and program directors of physical therapist education programs (194). A written questionnaire was distributed to 1,284 physical therapists with a 54% return rate and 194 program directors with a 50% return rate. Data were statistically analyzed using descriptive statistics, cross tabulations, and Chi-square tests. The results of this study indicated that both academic and clinical PTs support that all 12 curricular content areas, used for the purposes of this study, should be added to the curricula as programs make the transition from the MPT degree to the DPT degree. Clinical PTs indicated an 89.6% agreement (“agree”, “strongly agree”, or “very strongly agree”) while academic PTs indicated an 87.1% agreement with the addition of administration content. Conversely, clinical PTs indicated a 10.4% disagreement (“disagree”, “strongly disagree”, or “very strongly disagree”) while academic PTs indicated a 12.9% disagreement with the addition of administration content. The top 5
curricular areas that academic and clinical physical therapist thought should be added (radiology, pharmacology, pathology, evidence-based practice, and differential diagnosis) were reported most often by program directors as those being added or being considered to be added to the curricula. A majority of the program directors (48%, n = 97) reported their programs are not adding administration to the curricula whereas 42% reported they are adding it to the curricula.

Brudvig and Colbeck (2007) identify several limitations to this study that include the following: (a) generalizing the results of this study is limited to physical therapists who are members of the APTA; (b) academic physical therapists responding to the survey might have been influenced by what changes were being made to the curriculum in which they were teaching, rather than indicating what they felt should be happening in general to curricula as programs make the transition to the DPT degree; and (c) no information was gathered as to why these changes are being made. The authors imply that the findings from this study are not consistent with what program directors are reporting they are adding to the curricula as programs make the transition. Therefore, further investigation on what clinical therapists see in the clinic and how these perspectives influence their opinions of the need for the addition of reimbursement, legal issues, ethics, and managed care to curricula would provide both program directors and faculty with supplementary information to enhance curricula.

Using Phenomenological Studies to Capture the Essence of Lived Experiences

Blau, Bolus, Carolan, Kramer, et. al (2002) used a phenomenological study, guided by van Manen’s approach, to describe the experience of staff physical therapists during a time of systemic change within a large urban academic medical center. Five
physical therapists working in various clinical settings within the medical center were the participants interviewed for this study. The sample size was determined by thematic saturation and the researchers stated this occurred with a sample of 5 participants. The initial interview was driven by one main question: “Over the past 4 years, there have been major changes in your work environment. What has it been like for you working as a clinician during this time of change” (p. 651). Interviews were recorded and transcribed. The transcripts of each participant’s experiences were analyzed, using van Manen’s method, through reading, discussing, and rereading the participants’ responses to extract and reflect on essential themes. All members of the research team continued to reflect and discuss the data until several essential themes emerged that seemed to characterize the phenomenon of providing physical therapy in a changing health care environment. Themes were described using a combination of the participants’ words and the personal experiences of the investigators. Noteworthy, the authors reported that the initial data analysis process took 4 months to complete. Once the themes were extracted from the transcripts, a written summary of the themes was mailed to the participants, a second interview was conducted by telephone, and the themes were presented to the participants for validation. The authors attempted to ensure rigor through bracketing, the second participant interview, and the review by experts in phenomenology. Five common themes emerged from the experiences described by participants and included the following: (a) loss of control; (b) stress; (c) discontent; (d) disenheartenment; and (e) finding the “silver lining”. The authors concluded that most of the feelings associated with change in this setting were negative. Yet, these authors also reported findings that suggested the physical therapists valued their profession and their colleagues and took pride in
providing excellent patient care. The authors conclude that emphasizing the components of the practice environment that bring positives and satisfaction may help those involved during systemic change.

Brown (2009) designed a research study to assess the meaning of caring for self by registered nurse leaders who had participated in a holistic caring-for-self project. Brown used a hermeneutic phenomenological research method, as interpreted by van Manen, to explore the lived experience of caring for self from the perspective of 10 nursing leaders working in a 185-bed community hospital. Individual interviews were taped while being conducted with participants in a private room in their work setting. The nursing leaders communicated four common themes: (a) reflection on the journey of life; (b) why to care for self on the journey; (c) how to care for self on the journey; and (d) the wisdom learned along the path. This research provided insight into the experience of caring for self illuminated by nurse leaders. By better understanding and focusing on care of self, nurses may make choices that provide personal well-being and may promote personal and professional growth. Based on the reflections of the nursing leaders, recommendations include implementing creative holistic methods to encourage self-renewal in the work environment. The possible limitations of this study include that the setting was one community hospital environment and that the participants were all female. Time and comfort restrictions may have been experienced by the participants as the interview were conducted in the work setting. The subjects may have been hesitant to share negative aspects of caring for self in the taped interviews, as the researcher was known professionally to the participants of the study.
McWilliam and Ward-Griffin (2009) explored the shared experience of organizational change from a centralized allocation and control of services and resources approach to an empowering partnership approach to service delivery in one Canadian home care program. The researchers, applying an interpretive phenomenological design, analyzed data collected from indepth interviews with a purposeful sample (n=28) of providers, clients, and informal caregivers. A semi-structured interview guide facilitated the data collection on the participants’ thoughts, feelings, motives, expectations, beliefs, ideals, actions and interactions. Interviews averaged 58 minutes in length (range = 40-120 minutes). The data were analyzed using hermeneutic techniques and validated by member checking and peer review. The researchers reported the following two dynamic change patterns that emerged from the overall experience of change: extrinsically introduced organizational development, facilitated by contextual factors; and intrinsically developed transformational change, impeded by the same contextual factors. McWilliam and Ward-Griffin (2009) state that even though the findings of interpretive phenomenology are not generalizable, the insights gained from this experience of implementing an empowering partnering approach to health and social services delivery may have applicability to others wanting to achieve similar organizational change. The authors suggest that the findings of this study clarify the importance of the following: (a) choosing change strategies appropriate for the intended change, (b) addressing what change may mean to all involved; and (c) confronting the contextual factors that undermine the change.

*Focus Groups are Useful to Capture Data about Perceptions*
Morcke, Wichmann-Hansen, Nielsen, and Eika (2006) used twelve homogeneous focus group interviews with a total of 88 students, house officers, senior doctors, and nurses to understand the core curriculum design of an undergraduate emergency medicine curriculum and involvement of stakeholders. The researchers used the focus group method, based primarily on Morgan, to explore experiences and attitudes. All focus groups were concluded in 2 hours. During the last interviews, the researchers reported that the results were reproduced reaching data saturation. After coding transcripts, the researchers analyzed the content by condensation, categorization, and qualitative content analyses. The results revealed the following: (a) focus group participants gave a range of reasons for defining objectives and outcomes; (b) focus group participants found their involvement in the process essential; (c) focus group participants’ argumentation and beliefs differed significantly, revealing 2 opposite perspectives with regard to objectives; (d) participants interpreted competence consistently; and (e) participants mixed concepts such as knowledge, observation, supervision, experience, and expertise. The authors acknowledged that the participating novices’ perspectives on objectives differed completely from expertise level participants. Additionally they suggest that these differences can lead easily to misunderstandings among stakeholders, or between stakeholders, educational leaders and curriculum designers.

O’Keefe and Jones (2007) explored and compared lay and faculty perceptions around lay participation in medical school curriculum development at one medical school. Thirty-two lay volunteers responded to a newspaper advertisement. Seventeen volunteers subsequently participated in 1 of 3 lay focus group discussions. Ten academic staff attended a separate faculty focus group. The researchers analyzed the 3 lay
participants and 1 faculty focus group transcripts independently and then compared these using an iterative process of theme identification and hypothesis testing. The researchers reported evident and contrasting perspectives of lay and faculty participants. Specifically, they stated that lay participants reported that some sharing of curriculum ownership by medical experts was regarded as necessary to: create environments that legitimized lay status; and acknowledged the importance of lay perspectives whereas, faculty participants presumed ownership of curriculum development giving rise to: a paternalistic approach to controlling resources; and an assumed responsibility (as experts) to define the parameters of lay participation.

Summary

Studies show that responsibilities in health care are changing and include practice management (Kleinman, 2003; Henson, Pressley and Korffmann, 2008; Smith, 1988; Young, Hough and Peskin, 2003; Christiansen, 1975; Schafer, 2002). Evidence suggests that health care professionals need practice management skills to be successful in contemporary practice (Parekh and Singh, 2007; Henson, Pressley and Korffmann, 2008; Smith, 1988; Young, Hough and Peskin, 2003). Evidence supports that core competencies in physical therapist practice include practice management (Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986; Pescatello, Glenney and Certo, 2000). Acquiring a new role is a process (Yellin, 1999). Essential practice management skills needed by health care professionals and physical therapists are being identified (Sportsman, Hawley, Pollack and Varnell, 2001; Schafer, Lopopo and Luedtke-Hoffmann, 2007; Schafer, 2001; Lopopo, Schafer and Nosse, 2004).
Evidence suggests that the development of practice management skills needs to occur during entry-level preparation of health care professionals (Christiansen, 1975; Schafer, Lopopoło and Luedtke-Hoffmann, 2007; Lopopoło, Schafer and Nosse, 2004; Aston-McCrimmon, 1986). Studies provide support for practice management skills to be integrated into entry-level curriculum (Schafer, Lopopoło and Luedtke-Hoffmann, 2007; Lopopoło, Schafer and Nosse, 2004). Two studies investigated gaps in the perceived need of certain skills in practice as compared to existing level of competence (Henson, Pressley and Korfmann, 2008; Aston-McCrimmon, 1986).

One study shows that entry-level curriculum is changing in physical therapy education (Budvig and Colbeck, 2007). Studies show that changing curriculum is a process (Bellack, Graber, O’Neil, Musham, et al. 1999; Foord-May, 2006). One study provides evidence regarding lessons learned based on the perceptions of a curricular change in physical therapist education (Foord-May, 2006). Evidence shows that identifying drivers and resistors in a planned change process may be useful (Lifter, Kruger, Okun, Tabol, et al. 2005; Giardino, Giardino, MacLaren, and Buro, 1994; Heiney, Adams, Cunningham, McKenzie, et al. 2006; Beverland and Lindgreen, 2007; Hadley and Hugman, 1991).

Several of the studies reviewed were conducted over 25 years ago (Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986; Christiansen, 1975) and a few were conducted in another country (Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986). It may be useful to repeat similar studies in 2009 in the United States to compare how competencies and needs in practice have changed over the past 25
years. These studies may provide useful information for faculty responsible for designing entry-level learning experiences.

Almost all of the reviewed studies investigating practice management skills in health care or physical therapy used a survey approach to collect data (Kleinman, 2003; Henson, Pressley, and Korfmann, 2008; Smith, 1988; Young, Hough, and Peskin, 2003; Christiansen, 1975; Schafer, 2002; Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986; Sportsman, Hawley, Pollack, and Varnell, 2001, Schafer, Lopopolo and Luedtke-Hoffmann, 2007, Lopopolo, Schafer and Nosse, 2004; Schafer, 2001; Bellack, Graber, O’Neil, Musham, et al. 1999, one study used focus groups and interviews (Foord-May, 2006, and one study used interviews only (Pescatello, Glenney, and Certo, 2000). Several of the researchers, investigating the drivers and resistors in a process of change, presented their findings as a case report (Lifter, Kruger, Okun, Tabol, et al. 2005; Giardino, Giardino, MacLaren, and Buro, 1994; Heiney, Adams, Cunningham, McKenzie, et al. 2006; Beverland and Lindgreen, 2007; Hadley and Hugman, 1991).

Evidence supports that existing business skills are well below needed levels (Henson, Pressley, and Korfmann, 2008; Aston-McCrimmon, 1986). No evidence was found that investigated the current level of integration of practice management skills in entry-level professional preparation in physical therapy. One study revealed that there appears to be inconsistent integration of administrative content in entry-level DPT education (Brudvig and Colbeck, 2007). Therefore, identifying the drivers and resistors as perceived by faculty to integrating practice management skills in this process of
change may provide some insight into the phenomenon occurring in entry-level physical therapy education in the United States.

Evidence supports the use of qualitative studies, phenomenological approaches to inquiry, and the use of focus groups to gather data about perceptions and lived experiences (Blau, Bolus, Carolan, Kramer, et. al 2002; Brown, 2009; McWilliam and Ward-Griffin, 2009; Morcke, Wichmann-Hansen, Nielsen, & Eika, 2006; O’Keefe and Jones, 2007; Foord-May, 2006). Therefore, conducting a qualitative study using a phenomenological approach to inquiry and focus groups may be a useful and an appropriate research method to use to answer the proposed research question, “What are the perceptions of physical therapist faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapist programs in the United States?”

Need for Empirical Research

It appears that universal competencies and best practice in practice management in physical therapy are not defined and both are emerging topics of interest. Minimal empirical evidence exists related to practice management in physical therapist practice. Additionally, it seems that only a limited number of researchers have been involved in defining business and practice management competence (skills and knowledge) in physical therapist practice. Furthermore, the literature suggests expertise in practice management in PT is difficult to identify and define. Although recent studies by Schafer, et al. (2007) and Lopopolo, et al. (2004) identify levels of knowledge and skills needed in administration and management in PT at entry-level, there appears to be inconsistent integration of practice management with clinical practice. No evidence exists regarding
practice management skills and knowledge needed for best practice. These findings may suggest there is a need to continue to build evidence investigating the role of practice management competence in clinical practice and the preparation in practice management skills needed at entry-level in physical therapy education.
Chapter 3: Research Design Methodology

Introduction

A qualitative method, based mainly on a hermeneutical phenomenological approach of inquiry, was selected as the design for this research study. Phenomenology research allows the researcher to identify the essence of human experiences, as described by a small number of informed participants, related to this phenomenon under investigation (Creswell, 2009). Phenomenology is considered an interpretive process in which the researcher makes an interpretation of the lived experience, or negotiates between different meanings of the lived experience (Creswell, 2007; van Manen, 1997). Hermeneutical phenomenology is a form of phenomenology in which research is oriented toward interpreting the “texts” of life (hermeneutical) and lived experiences (phenomenology) (Creswell, 2007; van Manen, 1997). Phenomenological research is a dynamic interaction among the following research activities: (a) first, the researcher turns to a phenomenon which seriously interests her; (b) the researcher, in the process of identifying a phenomenon, reflects on essential themes or what constitutes the nature of the lived experience; and (c) the researcher writes a description of the phenomenon, maintaining a strong relation to the topic of inquiry and balancing the parts of the writing to the whole (Creswell, 2007; van Manen, 1997). Focus groups were utilized for data collection. The group interaction of participants provided a collective meaning of physical therapy faculty about the inclusion of practice management content into the entry-level curriculum.
For the purposes of this study, the FINHOP model (finance, information management, networking, human resources management, operations, planning and forecasting), used by Schafer, et al. (2007) in their study as an organizing framework for practice management content, provided the operational definition for practice management skills needed in physical therapist practice (Appendix B). Participant journal entries and member checking were used to triangulate the data collected in the focus groups. Additionally, the researcher attempted to suspend past knowledge and experience through self-reflective journaling for the following reasons: (a) to understand the phenomenon from other viewpoints; b) to attempt to approach the participants’ lived experience without judgment; (c) to elicit rich and descriptive data; and (d) to minimize potential researcher bias (Creswell, 2007; van Manen, 1997).

The Research Context

The American Physical Therapy Association’s (APTA) Combined Sections Meeting (CSM), a conference held in February each year, focuses on programming designed by all 18 of APTA's specialty or special-interest sections (APTA). CSM brings together more than 7,000 physical therapy professionals from across the nation annually for 5 days of conference sessions, networking opportunities, and an exhibit hall filled with products and services with the goal of keeping physical therapists, physical therapist assistants, and students current (APTA). This event was chosen for conducting the focus groups for reasons that include the following: (a) CSM is the most attended national event sponsored by APTA; (b) APTA members are informed about contemporary physical therapist practice; and (c) professionals who attend CSM are informed about the profession’s Vision 2020 and planned changes for the profession.
The principal investigator facilitated four face-to-face semi-structured focus groups during the Combined Sections Meeting (CSM) in February 2010 in San Diego, California. A pilot focus group was conducted two weeks prior to CSM. Data was collected until saturation was reached (Krueger and Casey, 2009). Determining if saturation has been reached, or the point at which the range of ideas has been heard and new information is not being gathered, occurred after conducting the four focus groups (Krueger and Casey, 2009). The focus groups were held in the same small meeting room, reserved in advance, in the Hilton San Diego Bayfront, the designated ‘Headquarter Hotel’, on Wednesday February 17, 2010, Thursday February 18, and Friday February 19. Three participants were recruited to take part in a pilot focus group, held on February 4, 2010 at SUNY Upstate Medical University in Syracuse, NY. Costs incurred for the room rental and food was covered by the HPA Research grant which was approved on June 12, 2009 (Appendix B).

The Research Participants

The sample for this study was selected using a purposeful sample, an intentionally selected sample, to provide information that contributed to understanding what physical therapist faculty teaching practice management skills perceive to be supportive or resistant in the field to this practice. The ‘faculty’ participants recruited for this study were: (a) active full-time faculty (‘core’) and/or part-time faculty (‘adjunct’ or ‘associate’) who teach practice management skills in accredited entry-level physical therapist programs in the United States; and (b) active full-time faculty (‘core’) and (‘program director’) who provide administrative oversight for the PT program; and (c) faculty who teach practice management content and who may or may not teach practice
management skills in accredited entry-level physical therapist programs in the United States. All participants: (a) were APTA members and therefore were physical therapists; (b) were or were not members of the Health Policy and Administration (HPA) Section; or (c) had or did not have a Masters in Business Administration degree; (d) had or did not have a doctorate degree in physical therapy (DPT); (e) attended the APTA’s Combined Sections Meeting (CSM) in San Diego, California February 16-20, 2010; and (f) had or did not have more than 3 years of experience in the role as faculty or program director.

*Protecting Human Subjects*

The principal investigator sought an expedited Institutional Review Board (IRB) approval from the IRB Committee at St. John Fisher College (SJFC) in September 2009. The principal investigator also worked with HPA’s Research Committee when appropriate. These actions were taken in an attempt to respect and minimize any potential risk for the focus group participants and sites selected and to ensure confidentiality and anonymity of the participants, roles, and incidents in this research study (Creswell, 2009). All focus group participants signed the informed consent form before they engaged in the focus group discussion (Creswell, 2009). The informed consent acknowledged that participants’ rights were protected during data collection and their agreement to participate in and complete the expected steps of the research study. Additionally, the informed consent identified the extent of time, the potential impact, and the outcomes of the research study (Appendix D).

*Data Collection - Instruments*

The following instruments were used in this study to collect data: (a) informed consent for participants; (b) focus groups; (c) participant journal entries; (d) a participant
demographic survey; (e) member checking; and (f) bracketing or EPOCHE for the researcher. Additional data sources were used to triangulate the data collected in this study. Each participant signed the informed consent form in advance of their participation and was guaranteed anonymity for their participation. All procedures for participants were outlined in the informed consent.

Focus Groups

Four face-to-face focus groups were conducted for ‘faculty’ at CSM 2010, including six to eight participants in each focus group. One pilot focus group was conducted two weeks prior to CSM, including three participants. A focus group, a special type of group in terms of purpose, size, composition, and procedures, is useful in the following situations: (a) as a self-contained means of collecting data; (b) to determine the perceptions, feelings, and thinking of individuals about issues, services or opportunities; (c) when understanding the differences in perspectives between groups or categories of people is desired; (d) to uncover when and what factors influence opinions, behaviors, and motivations thereby providing insight into complicated topics; (e) to allow ideas to emerge from a group; and (f) to collect information to design a large-scale quantitative research study (Morgan, 1996; Krueger and Casey, 2009).

Participant Journal Entries

The participants were notified in advance and were invited to complete the following tasks prior to the focus group: (a) review the FINHOP model used by Schafer, et al. (2007) (Appendix B); and (b) complete a reflective journal entry (Appendix E).
**Participant Demographic Survey**

A secondary purpose of this study is to attempt to identify basic demographic information about faculty teaching practice management skills in accredited entry-level physical therapist programs in the United States. Demographic information was gathered from focus group participants at the conclusion of each focus group at CSM and at the end of the pilot focus group (Appendix G).

**Member Checking**

Member checking was used to enhance the dependability of the research results (Patten, 2007; Krueger and Casey, 2009). Essentially, the participants in the study were viewed as “members” of the research team (Patten, 2007). The researcher attempted to have the participants/members review the results of the analysis on one separate occasion and therefore, was able to determine whether the results “rang true” to the participants (Patten, 2007). If not, adjustments were made in the description of the results (Patten, 2007).

*Bracketing or EPOCHE*

The principal investigator used EPOCHE (bracketing) in an attempt to take a fresh perspective toward the phenomenon under study. The investigator summarized and deliberately set aside her experiences, thoughts, and feelings as much as possible through journaling. This was done to allow the researcher to see faculties’ experience as it is lived (van Manen, 1997).
Data Collection-Procedures

Focus Groups

Each focus group lasted no longer than 90 minutes, with one exception. Phenomenological studies begin with a question about the meaning of participants’ experiences of a phenomenon for which the researcher has a serious interest and commitment (van Manen, 1997). Participants were invited to answer a few key open-ended questions that encouraged faculty to describe their thoughts and feelings of the experience under investigation. Although phenomenology calls for the researcher to adopt a nondirective approach, an interview guide was developed and was used to help faculty tell their story (Appendix D) (Wilkins and Woodgate, 2007). The interview guide was developed from key themes identified in a review of the literature and from the researchers' experiences in integrating practice management skills in entry-level curriculum. The prompt questions were open enough to allow faculty to develop the conversation so that it was specific to their situation. Faculty were asked to describe: (a) their experiences in integrating practice management skills in entry-level PT curriculum; (b) their feelings about integrating practice management skills in entry-level PT programs; (c) their roles in integrating practice management skills in entry-level PT curriculum; (d) faculty discussions to integrating practice management skills in entry-level PT curriculum; (e) faculty decision-making to integrating practice management skills in entry-level PT curriculum; and (f) their suggestions to other faculty about this topic. The focus groups were audiotaped using a digital tape recorder. These recordings were outsourced and professionally transcribed. Throughout the focus groups, the investigator took occasional notes (‘memoing’).
Participant Recruitment Strategies

The desired number of participants needed to conduct four focus groups of ‘faculty’ (6 to 8 per focus group) is 24-32 participants. The principal investigator gained access to a network of faculty identified by APTA members and/or CAPTE as ‘faculty’ teaching practice management skills in entry-level physical therapy programs in the United States, and a list of faculty who were ‘program directors’ and who did or did not teach this particular curricular content. The investigator invited ‘faculty’ by email if they were willing to participate in a focus group and if they planned on attending the CSM in San Diego, CA in February 2010. Following IRB approval, initial invitations were distributed to faculty in November and December 2009. The investigator sent a follow-up email two weeks after the initial email invitation and completed a second round of follow-up emails. A pool of potential participants was started in case of cancellations and to ensure achievement of the desired focus group participants.

A final list of 28 participants was included and confirmed to participate in one of the four face-to-face focus groups based on the following final selection criteria, ensuring: (a) representation from a variety of schools (ideally, one faculty per school and a mix between private and public institutions); (b) representation from different geographical areas; and (c) if needed, representation from different backgrounds (i.e., qualifications, years of experience). Three participants were recruited, primarily based on faculty position, content expertise, and geography, to participate in the pilot focus group.

Participant recruitment was feasible for this proposed venue. There are approximately 200 accredited entry-level PT programs in the United States. The
attendance at CSM continues to increase each year; noteworthy, a record attendance of approximately 8,400 participants was reached at CSM 2009 (APTA). The principal investigator was well-connected with faculties whom teach this content area and was confident, based on her previous informal interactions with these individuals, that there was interest in investigating this proposed phenomenon. Each participant was offered a travel stipend of one hundred and fifty dollars ($150.00) as a token of appreciation for participation. This stipend allowance was approved as part of the HPA Research grant (Appendix B).

Participant Journal Entries

Participants were notified in advance and were invited to complete the following tasks prior to the focus group: (a) review the FINHOP model used by Schafer, et al. (2007) (Appendix A); and (b) complete at least one participant journal entry (Appendix D). Additionally, participants were invited to submit journal entries after the completion of the focus groups. All journal entries were reviewed after completing the focus group data analysis.

Participant Demographic Survey

At the end of each focus group, the participants were invited to answer a series of brief questions on a 1 page survey to gather basic demographic information (Appendix F). This information is summarized in a Table in Chapter 4.

Member Checking

One phase of member checking was conducted with participants. After data analysis, an attempt was made to contact participants to give each participant the opportunity to assess whether or not his or her and the groups’ perceptions were
portrayed accurately by the investigator. A draft of tentative themes was sent by email to the participants requesting input with regard to the representation of the themes.

**Bracketing or EPOCHE**

The researcher described her own experience, thoughts, and feelings of the phenomenon under investigation to bracket out her views before proceeding with the experiences of the focus group participants. The researcher wrote journal entries to capture her perceptions, thoughts, and feelings of the following topics: (a) past experiences with integrating practice management skills in an entry-level master’s degree program from 2004-2008; (b) thoughts and feelings about integrating practice management skills at entry-level; (c) perceptions of driving forces to integrating practice management skills in entry-level physical therapist education; and (d) perceptions of restraining forces to integrating practice management skills in entry-level physical therapist.

**Credibility and Trustworthiness of Findings**

Data was collected from one type of participant (‘faculty’) using multiple methods, allowing for triangulation of data, or the comparison of multiple data sources (Patten, 2007). Issues of accuracy were addressed by triangulating the following data sources: (a) focus groups; (b) participant journaling; and (c) member checking (Creswell, 2007). Triangulation, commonly used in qualitative research, is similar to procedures used for establishing validity and reliability in quantitative research (Patten, 2007). By triangulating, or comparing multiple data sources, overlapping and confirming results were generated adding credibility to the findings and increasing the confidence that the conclusions drawn may be true (Creswall, 2009; Krueger and Casey, 2009).
Data Analysis and Interpretation

Data was analyzed guided by the philosophy of hermeneutic phenomenology qualitative research study, as interpreted by van Manen (1997). Hermeneutic phenomenology seeks to "uncover the structure, the internal meaning structures, of lived experience." (van Manen, 1997, p. 10). Data analysis required the researcher to become immersed in the data. Each recorded focus group was listened to after the focus group; before transcription, to review the focus group participants’ experience; and after transcription, supporting the immersion process. Interpretation of the data was achieved through a process of phenomenological reflection (van Manen, 1997). Key steps of this method included the following: (a) uncovering thematic aspects; (b) isolating thematic statements; and (c) writing and rewriting themes (van Manen, 1997). Paragraphs about the essential themes were written, and examples were used to illustrate how the description develops (van Manen, 1997). Systematic coding provided a set of potential quotations to illustrate the dynamic nature resulting from the group interactions (Krueger and Casey, 2009).

Once the focus group transcriptions were analyzed, the principal investigator analyzed the participant journal entry transcriptions. Key steps of this method included the following: (a) uncovering thematic aspects; (b) isolating thematic statements; and (c) writing and rewriting themes (van Manen, 1997). These themes were compared with the descriptive themes that emerged from the data analysis of the focus groups.

Summary of Methodology

In this study, qualitative research was selected as this approach allows for the exploration and understanding of meanings individuals or groups assign to a social or
human problem. Furthermore, using qualitative research in this study was useful because of the following situations: (a) the questions and procedures related to integrating practice management skills in entry-level physical therapist preparation are emerging; (b) the data analysis was built inductively from particulars to general themes; and (c) the researcher made interpretations of the meaning of the data (Creswell, 2009).

The main advantage focus groups offer is the opportunity to observe a large amount of interaction on a topic in a limited period of time (Morgan, 1996, p. 15). A number of criticisms have been directed at focus group interviewing and include the following: (a) focus group participants tend to intellectualize; (b) focus groups don’t tap into emotions; (c) focus group participants may make up answer; (d) focus groups produce trivial results; (e) dominant individuals can influence results; and (f) focus group research is not dependable (Krueger and Casey, 2009). These problems were minimized by adopting the following strategies: (a) multiple strategies of inquiry were used; (b) questions were asked about perceptions; (c) questions were asked to avoid the intellectualizing response; (d) group size was restricted; and (e) an environment was created that allowed focus group participants to reflect on various arguments without pressure (Krueger and Casey, 2009).

This chapter has explained the methods that were used in this qualitative study in an attempt to identify perceptions of faculty of the drivers and resistors to integrating practice management skills in accredited entry-level physical therapist programs in the United States. The next chapter will present the results obtained using these research methods.
Chapter 4: Results

Introduction

The purpose of this chapter is to present the findings from the data analysis. Data analysis reveals demographic information regarding the participants included in the study as well as the essential themes and associated sub-themes emerging from the data collected to characterize perceptions of faculty of the driving and restraining forces to integrating practice management skills in accredited entry-level physical therapist programs in the United States. Phenomenological research allows the researcher to identify the essence of human experiences, as described by a small number of informed participants, related to the phenomenon under investigation (Creswell, 2009). Phenomenological method was used for this study in an attempt to identify and describe the perceptions of faculty of the driving and restraining forces to integrating practice management skills in accredited entry-level physical therapy programs. Perceptions of participants in different roles are reported, including: (a) Program Chairs or Deans; (b) academic faculty; (c) clinical faculty, including the Director of Clinical Education (DCE); (d) clinical faculty; and (d) Clinical Instructors (CIs). In a couple of instances, faculty also shared perceptions of students based on their own experiences.

Phenomenology is considered an interpretive process in which the researcher makes an interpretation of the lived experience, or negotiates between different meanings of the lived experience (Creswell, 2009; van Manen, 1990). Data was analyzed guided by the philosophy of an hermeneutic phenomenology qualitative research study, as
interpreted by van Manen. Data analysis required the researcher to become immersed in
the data and interpretation of the data was achieved through a process of
phenomenological reflection (van Manen). Thematic saturation occurs when the
researcher determines that themes suggested by participant focus groups begin to repeat
themselves and subsequent focus groups yield no new themes (Krueger and Casey,
2009). In the researcher’s opinion, thematic saturation occurred with the sample of 29
focus group participants involved in this study. Data was collected using multiple
methods, allowing for triangulation of data, or the comparison of multiple data sources
(Patten, 2007). By triangulating, overlapping and confirming results adds credibility to
these findings and increases the confidence that the conclusions drawn will be true
(Creswell; Krueger and Casey).

Using van Manen’s method of analysis (1990), four essential themes emerged
from the data collected that are characterized by the following: (a) role reframing; (b)
role dissonance; (c) role resistance; and (d) role expansion. Various sub-themes emerged
for each constituent theme. These four constituent themes and associated sub-themes are
discussed in detail in the following chapter.

Research Question

The research question is: “What are the perceptions of physical therapist faculty
of the driving and restraining forces to integrating practice management skills into
accredited entry-level physical therapist programs in the United States?”
Data Analysis and Findings

Participants

Purposeful sampling was used to ensure inclusion of participants informed about the study focus to provide a deeper understanding of the perceptions of faculty of the driving and restraining forces to integrating practice management skills into entry-level physical therapist preparation. The principal investigator gained access to a network of ‘faculty’ identified by APTA members and/or CAPTE as ‘faculty’ teaching practice management skills in entry-level physical therapy programs in the United States, and a list of faculty who were ‘program directors’ and who did or did not teach this particular curricular content. The investigator invited ‘faculty’ by email if they were willing to participate in a focus group and if they planned on attending the CSM in San Diego, CA in February 2010. A final list of 28 participants was confirmed to participate in one of the four face-to-face focus groups at CSM. Three participants were recruited, primarily based on faculty position, content expertise, and geography, to participate in the pilot focus group. Each participant was offered a travel stipend of one hundred and fifty dollars ($150.00) as a token of appreciation for participation and this stipend allowance was approved as part of the HPA Research grant (Appendix C).

Twenty-nine participants contributed to this research study. Three participants were recruited to take part in a pilot focus group, held on February 4, 2010 at SUNY Upstate Medical University in Syracuse, NY, two weeks prior to the four focus groups held in San Diego, California. The pilot focus group was conducted to prepare for the American Physical Therapy Association’s (APTA) Combined Sections Meeting (CSM) and to test the following: (a) focus group questions; (b) approach to facilitation; (c)
demographic survey instrument; and (d) digital recording and transcript processes. While twenty-eight participants acknowledged they were willing to participate in one of the four focus groups at CSM, two participants no-showed for the fourth focus group leaving a total of twenty-six participants contributing to focus group discussions in San Diego, CA.

There were others who expressed interest in participating in this research study. While seeking participants initially, four faculty acknowledged through email correspondence that they were not attending CSM but were willing to participate in the study. At CSM, two additional faculty and one clinician approached the researcher stating that they were willing to join a focus group or contribute to the discussion at another time. These participants were not included in the study because it was decided by the researcher that they would not have adequate time to complete the pre-work or reflective journaling which was an integral part of the data collection process.

Twenty-eight of the 29 participants completed the demographic survey, administered during the focus groups. Tables 4.1 and 4.2 provide a summary of their demographics and teaching experiences. Ten of the 28 participants (36%) who completed the demographic survey, teach administration and management as their primary content area whereas, 9 of the 28 participants (32%) teach administration and management as their secondary content area. Thus in total, 19 of the 28 participants (69%) teach administration and management as their primary or secondary content area. Twenty of the 28 participants (71%) teach the practice management content primarily in their programs. Twenty-two participants (79%) identified the baccalaureate degree as the level of professional (entry-level) education completed to become a physical therapist. Ten participants (36%) indicated that they had a business degree, while 21 participants
(75%) indicated that they had completed professional development related to the areas of practice management. Twenty-eight of the 28 participants (100%) indicated that they have held a management, leadership, or supervisory role in physical therapy; 24 of the 28 participants (86%) indicated they have more than 5 years of management, leadership, and supervisory experience while 4 participants (14%) indicated they had 3 to 4 years of experience in these roles.

Participants were invited to review the FINHOP model and to answer a few reflective questions prior to participating in the focus group. For the purposes of this study, the FINHOP model (finance, information management, networking, human resources management, operations, planning and forecasting), used by Schafer, et al. (2007) in their study as an organizing framework for practice management content, provided the operational definition for practice management skills needed in physical therapist practice (Appendix B). Nineteen of the twenty nine participants (66%) submitted a reflective journal entry; 18 entries were completed prior to participating in the focus group discussion and one was completed after CSM. Sixteen of the nineteen participants (84%) indicated that they were previously familiar with the FINHOP framework/study and 12 of the 19 respondents (63%) indicated that they use this framework/study to integrate practice management skills in their PT program. One respondent, not previously familiar with the FINHOP framework/study, indicated a decision to start using this framework while another indicated a decision to possibly start using. A few participants asked questions during the focus groups attempting to clarify the range and importance of various practice management skills needing development at
Table 4.1

*Focus Group Participant Demographic Information*

<table>
<thead>
<tr>
<th>Primary Role</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dean or Associate Dean</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Program Chair or Director</td>
<td>10</td>
<td>36%</td>
</tr>
<tr>
<td>Faculty, Full-time, Associate Professor</td>
<td>5</td>
<td>18%</td>
</tr>
<tr>
<td>Faculty, Full-time, Assistant Professor</td>
<td>5</td>
<td>18%</td>
</tr>
<tr>
<td>Clinical Faculty, Full-time</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Adjunct/Associate Faculty, Part-time</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of Time in Role</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>5</td>
<td>18%</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>18</td>
<td>64%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6</td>
<td>21%</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>79%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35 years</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>35-45 years</td>
<td>8</td>
<td>29%</td>
</tr>
<tr>
<td>45-55 years</td>
<td>6</td>
<td>21%</td>
</tr>
<tr>
<td>55-65 years</td>
<td>13</td>
<td>46%</td>
</tr>
<tr>
<td>More than 65 years</td>
<td>1</td>
<td>3%</td>
</tr>
</tbody>
</table>

n=28; 1 missing
Table 4.2

*Focus Group Participant Teaching Experience*

<table>
<thead>
<tr>
<th>Content Areas</th>
<th>Teach Primarily</th>
<th>Teach Secondly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
</tr>
<tr>
<td>Administration/Management</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>Professional Issues</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Neuromuscular</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Clinical Education</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neuroscience</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Anatomy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Research</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Cardiopulmonary</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physiology</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Therapeutic Exercise</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Electrotherapy/Modalities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>14%</td>
</tr>
</tbody>
</table>

Length of Time Teaching

<table>
<thead>
<tr>
<th></th>
<th>Teach Primarily</th>
<th>Teach Secondly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1–2 years</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3–4 years</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>22</td>
<td>23</td>
</tr>
</tbody>
</table>
entry-level using the FINHOP model as a reference point for the discussion. Several participants expressed disagreement with some of the findings (Field Notes).

Beyond demographics, each of these participants was an engaged and interactive participant in this process of discovery. Each participant came to the focus group with a willingness to contribute and provided answers to the questions asked. Five of the 25 participants (20%) at CSM expressed surprise when they received their travel stipend at the end of the focus group and stated that they joined the discussion because they were interested in helping with the study. Additionally, several participants shared ideas with the principal investigator before and after each focus group and throughout the conference; these ideas were captured in the researcher’s field notes. During the pilot focus group, participants were reserved in nature, whereas the discussions during the focus groups at CSM were enthusiastic and lively. Participants used rich, descriptive, and animated language in their responses. Participants shared a range of experiences and perceptions associated with integrating practice management skills into entry-level preparation through their choice of words including: passion, fun, discouragement, and frustration. A few obscenities were used for emphasis. At CSM, at times the conversation flowed from one participant to another in a more orderly fashion while other times, the conversation bounced back and forth and across the table in a random manner. There were no periods of silence observed. Several times, a participant interrupted another participant in support of what was being stated or to express another perspective. Participants laughed during the focus group discussions after a response resonated with their own experiences. The principal investigator needed to interrupt the discussion
during two of the focus groups to ask the final three questions and only once, had to ask permission of the group to extend the time limit by twenty minutes. Participants were observed taking notes during the discussions and were heard commenting on new ideas they gained from the group discussions and new approaches they would try in their programs. A small group of participants stayed at the end of three focus groups to continue talking about the topic under investigation and ideas generated from these discussions were captured in the researcher’s field notes.

Except for pilot focus group participants, the participants asked to be introduced to each other, before they started to answer the first question. Participants expressed an interest in knowing each others’ names, backgrounds, roles, and academic programs. These names were not included in the reporting of the data.

The first question of the focus group stimulated a range of extensive responses from each of the participants. When asked to share about their experiences in integrating practice management skills in entry-level PT preparation, some participants initially described their experiences drawing from a role perspective, either as the Dean or chair of the physical therapy program, as faculty teaching the practice management content, or as the director of clinical education (DCE). Some of the participants stated that they assumed the responsibility for and interest in the practice management content because of their administrative role for the PT program:

I have been the chair of the department since 2006 so it is really at that point that I started thinking about specifically the practice management integration. [Text 1, p. 1]
My teaching area is not this,…, but as chairperson of the department I am keenly interested in this for the curriculum,…[Text 2, p. 1]

Even though a few of the participants were not actively involved in delivering the actual content in their programs, they were aware of how the practice management content was taught. A few participants stated that they became responsible for or interested in this content because of their previous management or ownership roles and experiences in physical therapist practice.

Other participants started the discussion by describing a specific curricular design, particular courses, different learning experiences, student work loads, and various teaching methods. It was evident from the discussions that, between programs, there were similarities, differences, and variability in the design of: (a) the curricula; (b) specific courses; (c) learning experiences; and (d) teaching methods. Table 4.3 provides information about the types of courses including practice management content used by the different programs. Responses show that 53% of the programs included in this study offer a dedicated course in practice management and include some practice management content in other professional issues courses. Table 4.4 provides a summary of the various learning experiences used by the participants as reflected in their demographic survey responses. Participants were not restricted to only one response and were invited to check all of the teaching methods that they used in their programs. This data shows that faculty who participated in this study use multiple teaching methods and learning experiences to teach practice management at entry-level.
### Table 4.3

*Focus Group Participant Entry-Level PT Program Information Related to Practice Management*

<table>
<thead>
<tr>
<th>Type of Courses including Practice Management Content</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated course in practice management, stand-alone; one semester</td>
<td>7</td>
<td>25%</td>
</tr>
<tr>
<td>Series of practice management courses over several semesters</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Dedicated course in practice management plus some practice management content included in Professional Issues course(s)</td>
<td>15</td>
<td>53%</td>
</tr>
<tr>
<td>No dedicated course in practice management; content only in Professional Issues course(s)</td>
<td>3</td>
<td>11%</td>
</tr>
<tr>
<td>Combination of classroom and clinical learning experiences</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4%</td>
</tr>
</tbody>
</table>

Total estimated # of credit hours dedicated to practice management content*

| Less than 3 credit hours | 5 | 18% |
| 3 credit hours | 4 | 14% |
| 3-5 credit hours | 13 | 46% |
| More than 5 credit hours | 6 | 21% |

**Entry-level Program - Type of Institution**

| Private | 13 | 46% |
| Public | 15 | 54% |

n=28; 1 missing

*Numbers (%) do not equal 100% due to rounding*
Table 4.4

**Focus Group Participant Teaching Methods Used for Teaching Practice Management at Entry-Level**

<table>
<thead>
<tr>
<th>Teach Methods Used</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture</td>
<td>25</td>
</tr>
<tr>
<td>Discussion</td>
<td>26</td>
</tr>
<tr>
<td>Small group work</td>
<td>23</td>
</tr>
<tr>
<td>Case-based</td>
<td>16</td>
</tr>
<tr>
<td>Role playing</td>
<td>11</td>
</tr>
<tr>
<td>Experiential learning (applied)</td>
<td>14</td>
</tr>
<tr>
<td>Guest lectures</td>
<td>20</td>
</tr>
<tr>
<td>Journal review/discussion</td>
<td>6</td>
</tr>
<tr>
<td>Capstone project (business plan)</td>
<td>18</td>
</tr>
<tr>
<td>Clinical experiences</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
</tr>
</tbody>
</table>

n=28; 1 missing

Data Analysis – Focus Groups

Transcripts for each focus group were analyzed, using van Manen’s method (1990), through reading, reflecting, discussing, and rereading the participants’ responses to extract and reflect on essential themes. This process of reflection and immersion in the data continued until four essential themes emerged that seemed to characterize the perceptions of faculty of the driving forces and restraining forces to integrating practice management skills into entry-level physical therapy curriculum, including: (a) role reframing; (b) role dissonance; (c) role resistance; and (d) role expansion. Sub-themes
emerged for each constituent theme. This data analysis process took 6 months. Themes were described through a combination of the participants’ words and a set of quotations to illustrate the dynamic nature resulting from the group interactions (Krueger and Casey, 2009). Once the themes were extracted from the focus group transcripts, a written summary of the themes was presented by email to a subset of the participants from the focus groups for validation. Additional comments were invited and seven participants responded by email. Results generated from this member checking process are included as part of the data analysis.

Participants proposed that there is a need to reframe the role of the physical therapist in contemporary physical therapist practice. Participants identified several sub-themes critical to reframing the role of the physical therapist in contemporary physical therapist practice including: (a) mindset; (b) responsibility; (c) leadership; and (d) role modeling. Reframing the role of the physical therapist will facilitate greater integration of practice management skills at entry-level. Participants emphasized that faculty, including clinical faculty, play an influential role, as role models, advocates, and leaders, to instill and reinforce a different mindset and as early as possible.

Role dissonance appeared to be characterized by a strong identity to the role of the physical therapist as a clinician and a negative perception of the physical therapist as a manager or business person. Participants suggested that the role of the physical therapist as a manager or business person may not be valued by some faculty, clinicians, and students and not seen as relevant as the clinical role. Sub-themes related to and causing role dissonance include: (a) a strong identity to the physical therapist as a clinician; (b) a negative perception of the physical therapist as a manager or business
person; and (c) areas of disorganization cause discomfort and unclear expectations for the integration of practice management content. Participants indicated that students perceive time spent developing practice management skills as competing for time they could spend developing clinical skills.

Sub-themes for role resistance include naiveté and apathy. Participants implied that the presence of naiveté and apathy create resistance from faculty, clinicians, and students to role expansion and limits the development of practice management skills at entry-level.

Sub-themes related to role expansion are pressure due to a ‘bulging’ curriculum and movement in the curriculum toward developing practice management skills. Pressure to expand the role of the physical therapist is due to a combination of external as well as internal forces. External forces result from practice being more complex requiring different skills at entry-level and the lack of requirements established on the national licensing exam for ‘testing’ practice management content. Constraints within the curriculum, as dictated by accreditation standards for clinical doctoral degrees, creates internal pressure by overloading the curriculum while APTA’s Vision 2020 imposed upon physical therapist practice produces internal as well as external pressure to expand the role of the physical therapist. Additionally, student interest in becoming a practice owner creates perceptions of both positive as well as negative internal pressure. Movement in the curriculum to develop practice management skills is occurring in the following ways: (a) faculty, informed of the need to expand the role of the physical therapist, act as change agents to make change happen and keep visioning for new opportunities; (b) faculty make practice management a curricular thread; (c) faculty
integrate the development of practice management skills into clinical coursework and clinical learning experiences; (d) faculty facilitate and explore different learning experiences to expand the development of practice management skills and move this content around to achieve better sequencing of the material.

Essential Theme I: Role Reframing

Participants proposed that there is a need to reframe the role of the physical therapist in contemporary physical therapist practice. Reframing requires the ability to look at, present, or think of beliefs, ideas, relationships, or roles in a new or different way or to change the focus or perspective of a view or role through a certain lens (thefreedictionary.com). Participants identified several sub-themes critical to reframing the role of the physical therapist in contemporary physical therapist practice including: (a) mindset; (b) responsibility; (c) leadership; and (d) role modeling. Reframing the role of the PT would facilitate greater integration of practice management skills at entry-level.

Role reframing – mindset. Participants emphasized the importance of framing a different mindset as a way to help clarify the importance of the physical therapist as a manager or business person. This would facilitate the development of practice management skills at entry-level:

…, I did some investigation in the chiropractic and the dental professions and a vast majority, 95% or more, go directly into their own businesses and for some reason we were just not making that translation which concerned me a great deal because, if you sell that mindset, try to change it then the whole way the students are thinking about leadership, getting along with each other and taking on new challenges changes. [Text 1, p. 4]
…, you have to think of yourself as a business of one,… [Text 2, p. 21]

…, what I feel I give these students is not preparation to be a manager totally but to understand the managerial perspective,…[Text 2, p. 3]

…, we break it into all of the facets of what any administrator would do in any setting with the understanding of they are going to be autonomous in any setting they are in,…[Text 2, p. 5]

…, management is a process rather than a title. …, it seems like it is a role that no one else has so if no one else has it then you don’t have to be interested in it but if everybody,…, has it from the gate on. It’s just like education, we used to teach people in class that they were educators and then finally they said why are we doing this, we know this and I said well that’s just great so 30 years ago you had to teach PTs that they were educators, now you don’t have to teach that. So some time in the future maybe we won’t have to teach that they are managers, they will just embody the processes. [Text 3, p. 13]

…, trying to get them energized, trying to get them to understand why they’re coming to the course, …, I would explain to them right off the bat that this course is not about owning your own practice, it is about practicing ownership and through that it is a day to day process and I don’t care what setting that you are practicing in, you have to practice an ownership mentality of that and these are the skills you need in order to be able do that. So some of that draws into leadership as well as the administration and management and that seemed to be something they understood or can understand a little bit better. [Text 4, p. 10]
…, it’s the *how* you practice which is, and I tell them about my experiences in management as a department leader that I can tell you that what really determines success and failure both as a student and as a professional is not so much the *what*, you can be a competent hands on person but it is the *how* the context of knowing how to behave as a professional and how to manage your practice and every clinician is a manager, every therapist is a manager. [Text 4, p. 23]

A few participants suggested that emphasizing personal factors for the students might make it easier to integrate business concepts because it would frame the mindset to make business concepts more relevant to the student:

…, that it’s an integral part of professional life and it’s the fuel that makes the clinical bus go that you can make yourself more marketable if you have these interests and skills, I think they can use it to their advantage professionally,…

[Text 5, p. 18]

Students are ‘investing’ $100,000 for their education – that’s a pretty substantial personal business decision they have made. So what do they get for their investment? What are academic programs doing to ensure that students feel they are getting their money’s worth? The only real answer to this would have to be that we make certain students are *empowered* enough to protect their investment, to be able to make key decisions regarding their education, and to learn about the business and leadership skills to be capable of advocating for themselves and their own learning. [Member Check 6]
Role reframing – responsibility. Critical to reframing the role, participants stressed the importance of emphasizing the responsibility of the physical therapist as a doctoring professional in contemporary practice:

…, getting away from assuming people were going to be employees and/or employers and thinking a little bit bigger about being an autonomous practitioner, they have a responsibility to change what they don’t like or what could be better and how could they go about doing that,…[Text 1, p. 13]

Basically, we need to think more like physicians and less like technical clinicians. The students need to feel RESPONSIBLE for their patient and their practice patterns. They need to take ownership and develop their own “following” so it becomes more than just a job. [Member Check 1]

One participant implied that responsibility included making a commitment to learning:

…, whether part of that is staying blind to the admin side of patient care because it is easier not to know. Making a conscious choice not to know is not the same thing as being naïve….When I conduct my midterm visits, I always ask about billing and coding and productivity and I am amazed at how many clinics have a front office that takes care of these duties. Some CIs don’t even know what I am talking about when I ask if the student’s documentation supports the codes that are being submitted. So, yes, this is naïveté, but it also seems to me that it is a lack of commitment to learning. [Member Check 7]

One participant suggested that some clinical instructors (referred to as ‘they’ in the following quote) don’t assume the responsibility to expand the role of the physical
therapist during clinical learning experiences and actually undo efforts made by faculty to reframe the role:

   Our students go out there,…, we try so hard to find good clinical sites for them and they undo, it is easier to be lazy than it is to be good and when the students see people being lazy and getting by,… I say to the students you know, you are spending a $100,000 to get a DPT and I expect you to go out there and change the world. You don’t have to be like them. You decide how it’s going to be. [Text 4, p. 28]

Interestingly, some participants suggested that students assume a responsibility to reframe the role of the physical therapist. In this way, students act as change agents to inform practice:

   …, in the last couple of years we have had several students sort of demand the answer to why don’t you teach finance of practice, why don’t you teach us this in this curriculum,…, there must be something that faculty are doing in the 1st year that are making them impatient,…[Text 3, p. 17]

   …, the practice managers have asked the students to do the presentation to the staff because the staff have no concept about what’s billed for things,…[Text 4, p. 4]

And most of the students come back from internship and saying that their CI said they learned so much from the student just by them asking them those sorts of questions because they realized how much they didn’t know about what was going on on a day to day basis so when the student asked the CI, …, how much would you actually receive in payment, not how much do you charge. 90% of the
CIs don’t know how to answer that question. They assume that what’s being billed is what’s being received and that’s a real eye opener from both sides, the students are like, wow I knew something. [Text 4, p. 7]

Role reframing – leadership. Participants implied that using “leader” instead of “manager” may help to reframe the role of the physical therapist at entry-level:

…, I would just use different terminology. The term practice management implies that you are going to be an administrator in a practice and some students will not do that and they don’t want to do that,…, at some point in time you will be a leader even if it is just a committee, you will be chair of a committee and you are going to be using so many of these skills that you are going to be learning here to manage a clinical department just on a much, much smaller scale. I would use different terminology so that it would capture those students,… [Text 1, pp. 12-13]

Don’t use the word management, use leadership. You know that personal autonomy, personal responsibility, that you really are the master of your own life,…, I am thinking it could be more acceptable if we did talk about personal leadership that moves into professional leadership,…, I think you are exactly right that there is a leadership without being the boss. [Text 1, p. 14]

… I prefer titles like leaders,…, I don’t even think administrator is a very good title,… [Text 3, p. 13]

Participants emphasized the need to add leadership skills to the core practice management skills developed at entry-level. Additionally, members highlighted that leadership skills were missing from the FINHOP framework/study. Participants
suggested that reframing the role of the physical therapist as a leader could facilitate better integration of practice management content throughout the curriculum:

…, I want to add a piece,…, the FINHOP model,…, I am familiar with that research and I think a piece that is missing from it is the word leadership. …, the overall thing that holds it together is leadership and I’ve changed and transformed what I do from the old, old component silo approach to teaching the first unit I always lead with is leadership. [Text 3, p. 14]

The piece I am working on right now with our faculty is that I mentioned to them about leadership skills being a basis for being an autonomous practitioner and they,…, don’t see the link between the two at all and,…, okay so I’ve got the next couple of years cut out for me. [Text 4, p. 22]

Two participants, in their reflective journals, indicated the need to develop leadership skills at entry-level:

The one area that seems to be missing is leadership development and mentoring. This is a skill that will be required as we move closer to Vision 2020 and begin to integrate our knowledge and expertise beyond the “walls” of traditional physical therapist practice. PT’s will move into non-traditional roles; administrators, management in health care systems, legislators, etc. and as such will need a different skill set that the FINHOP currently describes. [Journal Entry 2]

I think something that is missing as a first element is “leadership”. This is the first module I start with in my course. These are critical elements, but the glue is leadership that holds it all together. [Journal Entry 7]
Role reframing - role modeling. Participants implied that faculty and clinicians acts as role models and advocates to instill and reframe mindsets at entry-level:

…, opening the door for them for mentorship and being a mentor, that they are going to be both,…[Text 2, p. 9]

…, we experience the same phenomenon from the practice management side that we experience on the clinical side,…, you start talking about the way the world should work,…, some of them see great role models and get exposed early on and catch the wave and excitement and that sustains them,…[Text 3, p. 7]

…, I think about role modeling and if you can have your faculty role modeling then, the students kind of get it as a personal value, they are not going to challenge their CIs in the clinic but maybe they will say I don’t want to do this,… [Text 4, p. 20]

…, for the longest time I kind of struggled when people asked what I taught, okay I teach professionalism and I teach the practice management and then it dawned on me, no I am teaching more than that. …, it is the LAMP stuff so the leadership part, one of the students piped up because we go around, you know at orientation and all the faculty members say this is what we teach,…, and I said I teach leadership and administration management and professionalism and one of the students actually raised their hand and said when do we get to learn about the leadership part and I almost dropped dead,…, but I said,…, you are learning about leadership through your entire curriculum, there is no one course in leadership and I said every single faculty member here demonstrates leadership, we are role models for that and most of the faculty wrote to me and on the next faculty
meeting that was on the agenda. We went around the room and I said let’s identify what you are doing as a leader and it was eye opening for the faculty member that they didn’t even realize, …, I said you are role models and this is how we are doing this and we are all teachers of the leadership in this program and that seemed to be a slight turning point, not a major but a slight turning point for us to be able to kind of advertise to the students how we are each demonstrating that in our own way. Some of us are leaders more towards the research area, towards your specific content area, some of us are more involved with service but it starts to show them how the leadership pulls in. [Text 4, p. 21] …, if they don’t get a chance to practice it in the curriculum I don’t see how you could really expect them to just go out in a clinic unless they have a great CI that models that behavior and grooms them and really I think that is what CIs should be doing. …, that should be their role because we can’t be all things to the students and we make them aware,…,we give them their objectives and when you go out to your clinic this is one of the things I expect you to be able to do when you come back and the CI should understand what the objectives are and give the student the environment to practice that and work on their skills. [Text 5, p. 15]

**Essential Theme II: Role Dissonance**

Participants implied that a strong identity to the physical therapist as a clinician and a negative perception of the physical therapist as a manager or business person is creating role dissonance. Dissonance is defined as “a lack of agreement; inconsistency between the beliefs one holds or between one's actions and one's beliefs” (merriam-webster.com). Participants used words such as, “discomfort”, “concern”, and
“frustration” in describing their attempts to integrate practice management skills throughout entry-level preparation and suggested that role dissonance creates an inadequate understanding of the skills needed at entry-level. Also, participants identified that areas of disorganization and unclear expectations causes discomfort, creates confusion, and limits the integration of practice management content.

*Role dissonance - strong identity to role of physical therapist as clinician.*

Participants identified that faculty and clinicians proclaim a strong identity to the role of the physical therapist as a clinician:

The agenda of that course is to broaden their understanding and scope of what a physical therapist does,… I have to admit the focus of the course is your role as a clinician. [Text 1, pp. 11-12]

Participants implied that some perceive the role of the physical therapist as a clinician and the role of the physical therapist as a manager or business person as mutually exclusive roles and that teaching continues to reinforce these separate roles:

…, we are teaching them how to be employers and the rest of the curriculum teaches them how to be an employee,…, the clinical physical therapist,… [Text 1, p. 4]

That’s why I became a clinician so I don’t have to do that stuff. You know, I’m a PT. [Text 2, p. 13]

Participants suggested that this strong identity to the clinician role reinforces a priority to develop clinical skills at entry-level, thus overshadowing the need to develop practice management skills at entry-level:
I think maybe we need to start focusing the faculty on its not just patient care, I am going to make a note to myself. [Text 4, p. 17]

I have a quote. Why are we spending so much time on those non PT courses? It’s an exact quote that I’ve heard so multiple times. And you want to go aghhh. [Text 5, p. 5]

Participants implied that the strong identity to the role of the physical therapist as a clinician creates ‘curricular silos’ limiting faculty decision-making, willingness, and efforts to integrate practice management content into the curriculum as indicated by the following comments:

We do curriculum review for each semester so, of course, that course comes up,…, but as far as faculty decision making on it,…, everybody gets into their little silo to try to protect their turf. [Text 2, p. 16]

We still have very much a traditional curriculum structure so things tend to be encapsulated in the course where they’re taught,…, and part of it is that my colleagues are not really comfortable teaching the content or integrating the content. It is not what they have done experientially and it is not their expertise so I’m trying to find ways to connect those dots and that is where we are. [Text 3, p. 1]

…, I don’t like to use the word silo but even teachers,…, tend to do that and here’s our little niche and this is where we like to be and sometimes we miss the big picture. [Text 3, p. 11]

A few participants inferred the existence of ‘curricular silos’ when other faculty has referred to the practice management content as ‘your course’:
..., issues of reimbursement or budget planning or staffing, that’s your course and as long as you are teaching it well, great, you do a great job in that. [Text 1, p. 6]

..., it was a discussion when we were revising the curriculum and then unless I bring it up it’s not a discussion. It’s kind of one of those, it’s not in my course, ..., it’s not my primary responsibility. ..., so it’s very focused on me and they let me do whatever I want which is nice but, ..., we could probably do a better job on, ..., the billing and the coding piece in particular. [Text 5, p. 10]

Participants indicated that clinicians generally have students focus on developing their clinical skills and resist students developing practice management skills during clinical learning experiences, implying role conflict:

I don’t think often the clinicians think that students need to learn that and we have to change that mindset. They think well they are going to come out and be clinicians and so why do they need to learn that. [Text 2, p. 12]

We got some pushback from clinical instructors (CIs), ..., because the CIs wanted the students to be looking at patients, diagnoses, interventions, make a plan what we are going to do tomorrow, ...[Text 4, p. 7]

Participants acknowledged that students also identify strongly with the role of the physical therapist as the clinician:

..., I am not going to teach it as practice management because, ...., when they come in they are so interested in the clinical part, give me those clinical skills and I think there is a lot of dismissal of that other stuff, ..., they don’t see the relevance and they don’t see it until later on, .... You know saying these are skills that you will need and you will use these in the clinic, making it relevant but just to say
practice management, they are going to think of that as, …, being the boss and they just really want to get into the clinic, that I don’t want to do that, they want to work with people. Administration and practice management I think does come up as one of the roles but I think sometimes even that last semester before they go out on clinical they are like, I am never going to do this. [Text 1, p. 12]

…, they see themselves as clinicians and this is,…, secondary,…, [Text 2, p. 8]

…, as being the Director of Clinical Education (DCE), I also have them do discussion board postings. So if it is an 8 week clinical usually every couple two weeks I,…, always try to pull a practice management or autonomous practice question into that and the students struggle because they are more interested in talking about caring for the patients and I am making them think about, …, where’s the manager, what’s the manager’s responsibility, what other activities are you involved in other than just patient care and they don’t like that. I can’t say all of them but a lot of them don’t. The depth and the richness of the discussions aren’t the same. [Text 2, pp. 6-7]

…, the feedback I had gotten, I reviewed the student surveys from the previous years and it was that most hated class of the entire curriculum. They felt it was stuck in the worst time slot and nobody looked forward to it and they thought the projects were useless and it went on and on and on and I was like wow did I get stuck with the class there. That’s not how I feel about clinical management and so it’s hard,…[Text 3, p. 6]

Our students, if it’s not hands on patient care they tend not to value it. [Text 5, p. 6]
Participants shared that students perceive time spent developing practice management skills as competing for the time they needed to develop clinical skills:

…, it may be because you are competing with clinically important information but it may also be that students and even people don’t value what it takes to be a manager. [Text 1, p. 12]

*Role dissonance - negative perception of role of physical therapist as a manager or business person.* Participants voiced a collective understanding that developing practice management skills at entry-level was needed in order to expand the role of the physical therapist as a manager or business person. Yet, participants implied that faculty, clinicians, and students perceive this role of the physical therapist as a manager or business person in a negative way and that this negative perception creates resistance to developing practice management skills:

I think there is just that management bias. [Text 1, p. 12]

What did I mean by that? It’s the nonverbal I get when you use the term management. It is just like the light in the eyes goes out. [Text 1, p. 13]

…, they are all worried about the clinical side and I am saying to them, hey there is another side of practice which you must know, that this is what holds everything together. This is why you will have a job. [Text 2, p. 10]

It’s been a taboo. I’m not interested in business because that’s somebody else’s problem, that’s the accountant’s problem. They can’t talk about the money stuff, I’m the clinician and I treat people, I treat people, I don’t treat their pocketbook. But we all know that this is changing and I think it is going to continue to change
and I think it’s going to continue to be more and more and more difficult. [Text 2, p. 23]

Participants perceive that the role of the physical therapist as a business person creates discomfort:

… as a faculty... we do use performance to challenge our own assumptions about how we are teaching and what we are teaching and where does it belong but I think that we do also go to our comfort zone and the reality is that half of our faculty hasn’t practiced in years and ¾ if not more have never been managers in the formal sense of that word so that is not comfortable content,… [Text 3, p. 12]

They were uncomfortable as others said having the responsibility to go develop a whole content, a knowledge base in something that was new,… [Text 5, p. 11]

Participants described how they set expectations and use the evidence available as early as possible to support the role of the physical therapist as a manager or business person, identify the essential need to develop practice management skills, and to define the skills needing development at entry-level:

…, when I open up my intro to every course, I like to talk about the evidence and the use of the FINHOP model as part of the evidence and some other tools that I use from APTA in terms of their core documents and the vision of autonomous practitioner,… [Text 2, p. 2]

We’ve talked about managing expectations and how can we manage their expectations and how can we upfront say we know this is going to feel like it competes for your time but in fact something like quality improvement transcends
acute care, outpatient, home health, it transcends every clinical thing you are
going to ever do and so does ethics,… [Text 5, p. 6]

One participant’s reflective journal entry stated that the FINHOP
framework/study was useful for students because it provided evidence and reinforced the
need for developing practice management skills:

..., when they think they have achieved all the skills they feel they need to
know for a therapist, and then they are awakened to the bread and butter of the
real working world. [Journal Entry 4]

*Role dissonance – disorganization.* Participants identified areas of disorganization
related to developing practice management skills at entry-level. Participants suggested
that a lack of knowledge and understanding about the role of the physical therapist as a
manager or business person, the lack of clear nomenclature related to practice
management, the lack of clarity identifying what skills needed to be developed at entry-
level, and the limited evidence supporting the practice management skills needed at
entry-level causes and maintains role dissonance:

Are there uniform expectations or understandings of what fraud and abuse is?
[Text 1, p. 6]

..., consider finding out from academic programs what drives their content in the
administration management areas and see if it aligns with the clinical manager
perceptions of what the need is. Because sometimes the perceptions is different,
well it’s their reality and the perceptions could be a whole lot different than what
you anticipate their perceptions are and how everything fits together. [Text 2, p. 23]
…, there’s a need for everyone to be passionate even if you are not teaching this. I don’t teach the practice management content as it is in this final course but I know from being a social scientist it is hard for some faculty to become very passionate about the social science until they really understand that they are using it every day so not just telling but modeling how exciting it is,…, how it’s so relevant, how you can’t do orthopedics without the content we are talking about here. You can’t do anything because you don’t have the infrastructure to do it in so I think it’s partly just continuing to try to find ways to attach the passion to the discussion with groups or in individual faculty,… [Text 3, p. 15]

Participants voiced some frustration and concern that outside entities create confusion and additional disorganization because they set expectations to integrate practice management content but minimize the role of the physical therapist as a manager or business person. This disorganization preserves role dissonance by reinforcing the role of the physical therapist as the clinician:

…, without the National Physical Therapy Exam (NPTE) supporting it and saying we’ve got to get our first time pass rate up and how can we do that when we are using time for other fluff courses. [Text 2, p. 15]

…, one thing frustrating for me, we mentioned CAPTE and now we have the Federation which has its view of clinical practice which is a little bit different from what CAPTE’s view is, but what does it really mean to be a manager today and most of our students will become some type of clinical manager within a year of graduation. Will they all start their own private practice? Probably not but they will all be a manager at some level doing something. But I’m not sure that they
buy into that initially as a student or if the faculty really buy into that initially.

[Text 3, p. 11]

Participants, expressing impatience, implied that professional core documents are lagging or inadequate in support for the integration of practice management skills in entry-level preparation. This also preserves role dissonance:

The Federation is about to embark on their new, every 5 years they look at the practice analysis so that they can come up with what’s going to be on the exam so it is going to be interesting to see if there has been change at all in terms of what is coming because business has been not so great and people were feeling that new grads have to come in, …, ready to jump in for the business perspective and not be so naïve about how reimbursement works. [Text 2, p. 17]

Participants implied that the new online Clinical Performance Instrument (CPI) and the licensing examination, or the National Physical Therapy Examination (NPTE), were moving in the opposite direction in establishing the need to integrate practice management skills at entry-level by eliminating content related to practice management [Field Notes]. Participants observed that programs, such as the APTA’s National Student Conclave (NSC), offers programming heavy in clinical content but lacking in content related to practice management skills and suggested that this further reinforces the role of the physical therapist as a clinician for the students. [Field Notes]

Participants suggested that using different terminology, instead of terminology commonly used when describing practice management skills, may help to organize and clarify the role of the physical therapist as the manager or business person for faculty,
clinicians, and students. One participant suggested a way to explain practice management to an incoming student:

As an incoming student? I might not use practice management in talking with them. …, I would take some of the principles and it would be more implicit than explicit that this was practice management. I don’t think when they first come in that practice management are the words they want to hear and I think they just kind of tune out then. [Text 1, p. 11]

Put it down into the terms that the average clinician knows, …, are you getting reimbursed or is the revenue sufficient to pay your salary, putting it at a level that it makes sense to them versus using terms that seem, …, pie in the sky or in somebody else’s terms, put it in their terms,… [Text 2, p. 23]

**Essential Theme III: Role Resistance**

Resistance is “the act or power of resisting, opposing, or withstanding” (dictionary.reference.com). A theme of role resistance suggests that motion towards a particular role is retarded or opposed by some force. In other words, reframing and expanding the role of the physical therapist by integrating the role of the PT as a manager or business person is meeting resistance or opposition. Participants identified naïveté and apathy as two forces or sub-themes related to role resistance.

*Role resistance – naïveté.* Participants, expressing frustration, perceive naïveté related to the need to develop practice management skills at entry-level and suggested that this naïveté creates resistance to integrating these skills into the curriculum. Naïve is defined as “deficient in worldly wisdom or informed judgment” while naïveté is defined as “lack of sophistication or worldliness; tendency to believe too readily and therefore to
be easily deceived” (thefreedictionary.com; Merriam-webster.com/dictionary).

Participants implied that naiveté stems from faculty and clinicians being out-of-touch with clinical practice, including faculty who are not practicing, faculty who have not practiced for an extended period of time, and clinicians in practice who are not informed:

That was really one of the biggest reasons I wanted to go back into the clinic on a limited basis was to see what practice was like and it is really different,…, the ethics and the professional behaviors and those dilemmas that we never even dreamed of when we were full time practicing. [Text 1, pp. 9-10]

…, we have some wonderful clinical instructors (CIs) but they are not enlightened to the business side… [Text 2, p. 13]

…, I’m finding that the faculty that gives us the most difficulty with integrating practice management into the clinical courses is the faculty members who are so out of touch with the clinic, that they have no clue that this is a necessary part of clinical practice. [Text 2, p. 19]

…, to increase faculty enthusiasm is to make the faculty less naïve about business,…, I found that sharing some of the business aspects of the program help the faculty be less naïve then I think that will help the students be less naïve,…, I still think there is an intimate relationship between what the faculty understand about the business of the situation in which they work and how they could then translate that into interest in practice management. [Text 3, p. 7]

…, it was the older members of our faculty, the ones that have been faculty for a long, long time were definitely the most resistant, …[Text 4, p. 16]
I find that it needs improvement not, that it doesn’t need improvement academically, but it is in the clinical faculty. Most of them as someone pointed out don’t even know about their codes and notes,…[Text 4, p. 19]

One participant implied that naïveté to the need to develop practice management skills creates resistance:

Too many credits allotted to this particular thread when we really need these clinical courses,… [Text 2, p. 15]

One participant questioned whether it was naïveté or a lack of responsibility on the part of faculty:

Making a conscious choice not to know is not the same thing as being naïve….When I conduct my midterm visits, I always ask about billing and coding and productivity and I am amazed at how many clinics have a front office that takes care of these duties. Some CIs don’t even know what I am talking about when I ask if the student’s documentation supports the codes that are being submitted. So, yes, this is naïveté, but it also seems to me that it is a lack of commitment to learning. [Member Check 7]

Participants also acknowledged that some naïveté stems from a general lack of experience of students at entry-level:

We interview our students and the question that I always ask is about the state of our health care system and how does PT fit into it and it’s very interesting the responses you get because they don’t have any experience and you get these grandiose ideas and we just listen to them and I shake my head and oh, they are in for a rude awakening. [Text 2, p. 21]
..., they are very naïve, are graduating within, ..., a few weeks from now and are pretty naïve what’s going on out there.  [Text 3, p. 3]

..., one of the things that I noticed that was surprising to me was even though they had gone out on their clinicals they really still had no grasp when they came back about reimbursement and productivity issues, ... [Text 5, p. 3]

..., they don’t know what they need, what they don’t need, what they are going to need in the future and at what level they are going to need it.  [Text 5, p. 7]

*Role resistance – apathy.* Some participants described faculty as being apathetic, or indifferent, towards developing practice management skills. This apathy was creating role resistance:

I have been real resistant to incorporating reimbursement things in there because A. It is boring. B. I know nothing about it. C. I don’t really want to know anything about it.  [Text 1, p. 5]

I have one faculty member who is very willing to work with me, the others are just kind of so-so, ...[Text 2, p. 6]

I’ve had some resistance, it’s not really resistance as much as it was they don’t care as much about that as they do what they are teaching,…  [Text 4, p. 16]

Participants voiced concerns that students also display apathy or resistance to developing practice management skills:

..., it’s from the students saying we should be spending more time on, okay name a patient management course, orthopedics, cardiopulmonary, acute care, neuro, whatever it is that is competing during that semester and they see it as competing for their time,..., they all complain about the amount of work they have, ..., they
have a ton of work but they really feel that it competes unfairly and that it’s not that important. Some of them have come in and said can’t we just do this, let’s do it in 1 credit instead of 3 credits or could we do it, …, like a weekend thing, we don’t really need that much. [Text 5, p. 6]

While some participants identified an increasing student interest in becoming a practice owner or manager, other participants reported observing that this interest decreases once students have been exposed to the challenges and complexities of practice. This indicates role resistance:

…, as the students go out and experience more from the first semester until the time they graduate, there are not as many interested in opening up a private practice. They would rather go work for somebody than have to do that all themselves than take the risk and all that. [Text 2, p. 8]

*Essential Theme IV: Role Expansion*

Participants stated that the role of the physical therapist is expanding. Role is defined as “prescribed or expected behavior associated with a particular position or status in a group or organization” (businessdictionary.com). Participants acknowledged how much physical therapist practice has changed making it more complex and challenging and used words, such as “survival”, “fear”, and “surprise,” in association with clinical practice. They stated that role expansion required faculty to prepare physical therapist students at entry-level differently and that developing practice management skills was essential in order to achieve role expansion:

…, you are a business of one, always a business of one, you need to learn how to market you as well as market a program,…[Text 2, p. 2]
I tell the students, …, that every one of them is a manager and even at this point.

Here is a list of your business for the day and you are going to manage,…

Whether they know it or not, every one of them is a manager,… [Text 3, p. 11]

Participants identified ‘pressure created by a bulging curriculum’ and ‘movement in the curriculum toward developing practice management skills’ as two sub-themes related to the theme of role expansion.

Pressure to expand the role of the physical therapist is due to a combination of external as well as internal forces. External forces result from practice being more complex requiring different skills at entry-level and the lack of requirements established on the national licensing exam for ‘testing’ practice management content. Constraints within the curriculum, as dictated by accreditation standards for clinical doctoral degrees, creates internal pressure by overloading the curriculum while APTA’s Vision 2020 imposed upon physical therapist practice produces internal as well as external pressure to expand the role of the physical therapist. Additionally, student interest in becoming a practice owner creates perceptions of both positive as well as negative internal pressure.

Movement in the curriculum to develop practice management skills is occurring in the following ways: (a) faculty, informed of the need to expand the role of the physical therapist, act as change agents to make change happen and keep visioning for new opportunities; (b) faculty make practice management a curricular thread; (c) faculty integrate the development of practice management skills into clinical coursework and clinical learning experiences; and (d) faculty facilitate and explore different learning experiences to expand the development of practice management skills and move this content around to achieve better sequencing of the material.
Role expansion - pressure created by a ‘bulging’ curriculum. Participants discussed at length how the complexity of physical therapist practice has created external pressure to develop different and additional skills at entry-level to be successful in clinical practice:

…, they are getting into a really complex environment and yet I am not sure that all of us are really in good positions to know,…, because we may not be practicing. [Text 1, p. 10]

…, PT positions, …. you’re dispensable and you’re potentially dispensable now and for the future and you are going to have to sometimes fight for your job and you may need to get a job in a rural area or a job that you don’t want to have because from a business perspective they don’t have a position to hire you and maybe they will never have a position to hire you. …, patients are saying I can’t pay that $30 co-pay and I can’t come in twice a week anymore. It’s just too much that I can afford and they are hearing those things and now they have to become more creative,… [Text 2, p. 17]

…, we need to make the faculty understand that practice management skills are essential for student success. I am not sure that everyone has that in,…, their top 10 list. [Text 4, p. 19]

…, health care is a business, …. in order to meet our patients’ and our clients’ needs we need to stay in business and that means we need to understand reimbursement, we need to be aware of our revenue and our expense streams, …, we need to know how to manage things, to be effective and efficient, …. whether they want to admit it or not, health care is a business which means the dollars and
cents matter even if they are not touching it and not knowing what the numbers are, somebody is watching and every decision they make has a dollar and cent sign attached to it. [Text 5, p. 18]

Participants described hearing a sense of “fear” and “surprise” from students once exposed to clinical practice. These reactions indicate a gap in preparing students adequately for exposure to clinical practice:

…, the students are,…. getting surprised at some of the things they are seeing in the clinic and they are afraid to even talk about it or raise it, … [Text 1, p. 7]

…, many come back and, …, are afraid they’re going to jail because they have now figured out,… the billing and coding,…, in terms of aspiration for things to improve,…, to create tools that we can help our clinical managers to use with our students to try to standardize the experience,… [Text 3, pp. 7-8]

..., they know a student whose boyfriend, …, she was working on him and they broke up and he sued her for practicing without a license and he won,… [Text 3, p. 11]

…, it’s a scary world out there, I’m glad I live in my little ivory tower. [Text 4, p. 5]

Participants perceive pressure to “survive” in practice. This is forcing a need to expand the role of the physical therapist as a manager or business person by developing essential practice management skills for the physical therapist at entry-level:

I always wait for the one student that about half way through the course that we deal,…, with the coding,…, some student in the back will raise their hand and say
so do we make a living, so what happens here? …, it’s like this reality check all of a sudden. [Text 2, p. 21]

…, they hear from their clinical instructor’s how important it is and how unfun it is (learning about practice management) but a necessary evil,… [Text 3, p. 2]

…, where it really hits them on the head that they can’t go out asking for $80,000 if they are only going to be billing for $50 an hour. [Text 4, p. 4]

While analyzing the focus group transcripts and reflective journal entries, a word count revealed that participants used the word “survival” explicitly five times while implying “survival” four times:

…, if you are a clinician you really have to understand what the organization is all about in terms of survival. [Text 2, p. 5]

…, you can’t teach a student to be a clinician if you can’t teach them to be able to survive in the current business climate, it’s pretty damn ugly and I think that we haven’t been vocal enough about the fact that, …, a clinician isn’t just somebody that you can lay your hands on, they have to think about managing the whole patient and using their money wisely and that might be a better sell to people who are dedicated to the quality of patient care, it doesn’t matter what it is you do with the patient if you can’t argue to get that patient the care,…[Text 4, p. 17]

…, I can’t speak to every clinic but the general thing you see a lot of times is that most clinics right now are in survival mode and they have to do what’s viable for the clinic,… [Text 5, p. 16]

I use the quote, …, “no margin, no mission”,… [Text 5, p. 19]
Additionally, one participant revealed in a reflective journal entry that students are required to review the FINHOP framework/study before responding to the following question:

…, what top administration/management skills do you feel you need to develop and survive in the workplace? [Journal Entry 5]

Participants identified that skills essential for reimbursement, billing, coding, ethical decision-making, risk management, and other practice management skills are fundamental for clinical practice and insisted that these skills be developed at entry-level:

…, the reimbursement piece is such an issue in the profession and engaging them in that whole thought process early, preparing them to be advocates for ourselves in that arena. [Text 1, p. 5]

…, there are a lot of therapists now who are contracting with hospitals and so they need to understand that whole reimbursement on the acute care side so it’s very different from the part B side,… [Text 2, p. 7]

What’s the importance of learning ultrasound if you find you can’t get reimbursement for it? [Text 2, p. 21]

…, it is so important that they understand that CPT code that they are billing for and making sure that their language and documentation matches,…[Text 4, p. 4]

The inclusion of finance and information management is essential to contemporary practice. [Journal Entry 5]

Participants discussed how APTA’s Vision 2020 has imposed external as well as internal pressures to expand the role of the physical therapist in practice and to change physical therapist preparation at entry-level through establishing the expectations of
direct access, a doctoring profession, and autonomous practice. They suggested that these imposed expectations necessitate the development of different skills at entry-level, including practice management:

…, now with direct access and independent owned physical therapist services, …, now being predominant over hospital based services in terms of,…, employment, I think it is essential that it is part of the curriculum and it be taught well. [Text 1, p. 9]

…, we talk a lot about autonomy whether it’s you are going to bat for your patient because their insurance was denied or the physician is arguing with you about what treatment or you are advocating at your state and chapter level or whatever so we try to bring it in from that perspective that they are learning to be autonomous,… [Text 2, p. 21]

…, we are developing a new breed of individuals and we have to do it differently,… [Text 4, p. 27]

Participants acknowledged that there is too much curriculum to fit into entry-level programs. This limits the development of practice management skills. Participants identified internal constraints existing within the curriculum, as dictated by accreditation standards, causing pressure and limiting role expansion at entry-level because there is no room:

…, our ortho content is down. I don’t have time to teach all the tests and measures that I need to teach, how can I do CPT codes when I’ve got to get all these special tests in,… [Text 2, p. 15]
I haven’t even thought about expanding because I know that from discussions about there is no place for anything else [Text 2, p. 16]

…, what really are the skills? This is great but what really do our students need right now or even in 5 years or 10 years and how do we handle all that and mesh with that with all the other content that we have to get in before the exam, you know, what’s the most important. [Text 2, p. 23]

…, I happen to be in a 2 ½ year curriculum and things are jam packed and so it is really hard for me to advocate for the other classes to touch upon other aspects of clinical management,… [Text 3, p. 6]

Somebody commented earlier on how jam packed the courses are and they look at me and say I would love to do it but when? What can I take out? [Text 3, p. 11]

I would suspect that everybody would say there are a lot of things we want the students to be much more independent in by the time they leave us and I’m not clear that that is a realistic expectation given the constraints that we have,…[Text 3, p. 20]

…, during my focus group was information about curricular obesity and this being an issue of ‘fitting in’ more information on practice management into an already bulging curriculum….I know that this has been a big issue for me in getting more practice management content covered – if we add something then something else has to disappear and that is what the rest of the faculty usually is most resistant to because it would have to be something clinically oriented that was reduced. [Member Check 6]
Additionally, participants suggested that the national licensing examination causes external pressure by minimizing the need to expand the role of the physical therapist by not ‘testing’ the integration of practice management skills into the curriculum:

…. you are fighting to keep yours, I can’t garner any more away from my clinical focus but I think we need more in this thread. But what I also have found interesting in the last couple of years in my faculty is I’m getting an awful lot of push back in regards to the NPTE exam and the balance of content, …. I can’t lobby for this content, it is hard to find it on the content on the NPTE exam. So I have to admit, …, it is framing,…. our curricular discussions as we know the body of knowledge is so huge, right? [Text 2, p. 15]

Role expansion - movement in curriculum toward developing practice management skills. Participants identified that movement is occurring in the curriculum toward developing practice management skills at entry-level and this curricular movement is supporting role expansion. Participants suggested that faculty and clinical faculty actively involved in clinical practice, as well as faculty who teach practice management content, are informed of the need to integrate practice management skills into entry-level preparation and act as change agents to move the curriculum. Participants indicated that they create opportunities to integrate practice management skills into the curriculum to make change happen. They shared that they are having some success at integrating practice management content into the curriculum by facilitating and actively exploring different learning experiences:

…. what I have been talking with our faculty about is the semester that they get their first business class, the faculty then in the clinical content whether it is
musculoskeletal, neuromuscular, they are starting to try to incorporate using the 
*Guide* and the ICD9 codes and finding the CPT codes based upon whatever cases 
they are given.  [Text 1, p. 6]

I have just brought in a physical therapist, who recently got his MBA, and 
I am offering a one credit elective, our students have to take elective courses and 
I’m thinking about making it mandatory but I have really pushed hard for them to 
take this. He’s come in and done a wonderful tutorial about really having the 
entry level student,…, understand the management whether you are in a hospital 
based department and the manager or starting your own business,…[Text 2, p. 4] 
…, I have the unique experience of having a full time clinic setting in the 
university setting and all of our students having the experience of seeing the 
practical application of management first hand and then being able to take the 
content course after they’ve all been in clinic so pretty much equivalent in coming 
into the class I think more proactive, …, knowing what they don’t know and 
knowing what they need to know more of,…, so I do think integrating that 
application piece really helps.  (Text 3, p. 2)

We actually created a lunch panel series because the students volunteer to come, 
choose to come so, it’s not everybody in the class but that easily tripled, I would 
say, the interest level of students,…[Text 3, p. 4]

We have some alternative clinicals that are business owning so they are not 
clinical based,…[Text 4, p. 10]

Faculty identified the opportunity to make practice management a curricular 
thread:
I hadn’t practiced in years although I have had administrative experience and leadership experience it has been in an academic setting, not in a clinical setting and so I felt I was teaching the theoretical part of that and not from the practical experience and the person who picked it up continues to have an active clinical practice,…, she still has an active administrative role so I believe that the students are getting much more realistic instruction in that area and you know the answers to questions are from personal experience rather than theoretical textbook material.  [Text 1, p. 4]

We have a fair amount of faculty that are also out in the world practicing that I think are really integrating things into their classes,…  [Text 3, p. 3]

Participants shared that making practice management a curricular thread helps to support role expansion by reinforcing the importance of the role of the physical therapist as a manager or business person and strengthens the integration of practice management content somewhat throughout the curriculum:

…, we really have conceptualized this as a thread throughout the curriculum,…[Text 2, p. 4]

…, when we redesigned our curriculum for the DPT we have themes across the curriculum so everyone is responsible for these themes and they could be gender and pain and professional issues, practice management and you have to every year look at all of what you do and see where you fit in and where you may interface with others so because all the themes are in front of everyone it raises the awareness which I don’t think 30 years ago was really there.  [Text 3, p. 2]
When we transitioned from the MPT to the DPT,…, what we did was basically took practice management which had been an 8 credit hour course at the end and basically it is throughout the entire curriculum, not in separate courses but tied into every course that they take. So essentially anything to do with billing when they are doing orthopedics, we talk about outpatient orthopedics billing, when we are talking about neuro we talk about inpatient rehab facilities, we talk about,…, the health policy issues that go along with those particular settings that they are likely to encounter and then because their clinical education is spread out we also have assignments that they are to do so they have a total of 8 fairly decent sized assignments throughout the curriculum particular to practice management and they are all tied in directly to the patient care,… [Text 4, p. 5]

…, we identified certain themes,…, that should be threaded and some of those are ethics, human resources, how to delegate and supervise, …, payment, reimbursement, billing, and so,… they are threaded, …, just having them thinking about those things so it isn’t a separate part of clinical life. [Text 5, p. 11]

Participants emphasized the importance of integrating practice management learning experiences throughout clinical learning experiences to make practice management skill development more relevant. This action helps to support the importance of expanding the role of the physical therapist in practice:

…, what we are not doing well enough yet is that whole integration into the clinical courses so they are not seen as separate. [Text 2, p. 10]
…, there is room for improvement in sending an expectation out to our clinical educators that we value and need more of their help, you know to prepare our students in this area. [Text 2, p. 13]

…, we have integrated some of the projects related to practice management into the clinical education so that brought an association not just in excitement,…, but an involvement while you’re there and that means that the clinical education team, who are not primarily the people who teach the content are intimately associated with the outcomes of those projects, that has helped us be less siloed. [Text 3, p. 2]

…, the opportunity is the better exposure in the clinical setting than the more standardized exposure,…[Text 3, 20]

…, as soon as you put the objectives in that clin ed course you need a lot of education,…, it worked out fine,…, we all do midterm, …, visits or calls,…, we just incorporate that into, how are they coming along with their practice management skills, …[Text 4, p. 11]

…, you can change the curriculum all you want but unless it’s in the clinic too I don’t think it will be what we want it to be. [Text 5, p. 16]

Some participants indicated that they are having some success at moving practice management content into clinical learning experiences:

We send them out with not to actually do the assignment but to gather the information to do the assignment when they come back so they are looking for a business issue and they are also looking for an ethics issue and they,…, plug those into the 2 courses when they come back. But it is interesting because a lot of time
they can’t identify anything until they are actually in the course and then they see the light bulb goes off. [Text 2, p. 13]

They discussed how they have moved the practice management content around in the curriculum to achieve better sequencing of the material and suggested that practice management content also be woven into clinical courses to make it more relevant:

…, we moved the whole sequence later,…, the first course follows their first clinical experience and the second course follows their second clinical experience and it is so much more meaningful for them. They now see the meaning of this and how they can apply this knowledge and skills into the clinical arena that they experienced. [Text 1, p. 15]

…, we have the campus clinic we host from the 1st week of school until the end of school and they have to learn CPT codes, the whole thing the whole time so it starts at the beginning and by the time they finally get to the business class, our practice management class the last semester it’s already become part of it so I think it’s helped them to recognize the importance. [Text 3, p. 2]

A few participants indicated that they see themselves as a driving force to create movement or change within entry-level preparation and shared visions of how to embed practice management content even deeper into the curriculum:

I manage now three entry level students who have chosen a managerial, leadership, and entrepreneurial fellowship,… [Text 1, p. 2]

…, our students with their clinical background would gain so much if a part of or one small affiliation focused on the business of practice of running a practice or a program that would have a more intense focus of not just the clinical. …, that
would make the business side of it the focus versus the clinical and I wouldn’t do 
it right out of the gate. I would like to see it at the end,… maybe in the near future 
we are going to have a research related affiliation and I think a business related 
one. [Text 2, p. 10]

…, we’ve partnered with the MBA program at my university and our students get 
some course credit based on DPT courses that they take that apply toward their 
MBA and we have 3 or 4 students every year that take that option. It’s extra 
work, it’s extra tuition but I love it and I wish more of them would do it. [Text 3, 
p. 5]

There was some disagreement in perceptions of student interest in becoming a 
practice owner or manager. Some participants shared that they are noticing an increasing 
student interest in practice ownership and management indicating movement towards role 
expansion:

…, when I used to ask how many of you see yourself as a manager in the next 5 
years and have 2 males in the back of the room raise their hand. That was it and I 
am not even saying how many see themselves in private practice or anything just 
managers. Now, you know pretty much the whole class, they may not like raising 
their hand, they don’t want to do it but they see themselves as having more of a 
managerial type of role. [Text 2, p. 8]

…, a huge influx of interest in private practice by our students so it used to be no 
one at the entry level was brave enough, interested enough, I don’t know, felt 
capable enough to even ask the question or say I plan to open my own clinic in 
two years and here is what my professional experiences will have to be. There are
many more people who are doing that which I think is very positive,… [Text 3, p. 4]

…, we are seeing a much bigger influence of women who are willing and interested in going into private practice,…[Text 3, p. 4]

My experience is that each year when I ask the students how many are anticipating going into private practice within the first 5 years out, there are more and more who raise their hands. Generally after the business planning experience, while their eyes are definitely more wide open, the students tell me that they will still plan to execute their plan for owning their own practice – so that’s good.

[Member Check 6]

Participants acknowledged that although some movement is happening in the curriculum in developing practice management skills, the change is not enough:

When it comes to the reimbursement piece from my perspective we haven’t gotten very far in trying to integrate that across the curriculum. [Text 1, p. 5]

I do think there is room for improvement in sending an expectation out to our clinical educators that we value and need more of their help,…, to prepare our students in this area. [Text 2, p. 13]

…our curriculum would have to radically change and probably expand,…,

Two participants implied the need for more change or movement within entry-level curriculum:

…, we need things like your dissertation to come out and say hey guys wake up and smell the roses. [Text 4, p. 18]
Summary of Results

The findings of this study are insightful and rich thereby, allowing for an analysis that is informative, meaningful, and enlightening. Participants, included in this study, are informed about the needs of contemporary physical therapist practice and emphasized that developing practice management skills is essential to entry-level preparation in physical therapy. In this study, four essential themes emerged that reveal the perceptions of faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapy curriculum. These themes can be characterized by: (a) role reframing; (b) role dissonance; (c) role resistance; and (d) role expansion.

Participants proposed that there is a need to reframe the role of the physical therapist in contemporary physical therapist practice. Reframing requires the ability to look at, present, or think of beliefs, ideas, relationships, or roles in a new or different way or to change the focus or perspective of a view or role through a certain lens (thefreedictionary.com). Participants identified several sub-themes critical to reframing the role of the physical therapist in contemporary physical therapist practice including: (a) mindset; (b) responsibility; (c) leadership; and (d) role modeling. Reframing the role of the physical therapist will facilitate greater integration of practice management skills at entry-level. Participants emphasized that faculty, including clinical faculty, play an influential role, as role models, advocates, and leaders, in instilling and reinforcing a different mindset and as early as possible.

Role dissonance appeared to be characterized by a strong identity to the role of the physical therapist as a clinician and a negative perception of the physical therapist as
a manager or business person. Participants suggested that the role of the physical therapist as a manager or business person may not be valued by some faculty, clinicians, and students and not seen as relevant as the clinical role. Sub-themes related to and causing role dissonance include: (a) a strong identity to the physical therapist as a clinician; (b) a negative perception of the physical therapist as a manager or business person; (c) areas of disorganization cause discomfort and unclear expectations for the integration of practice management content. Participants indicated that students perceive time spent developing practice management skills as competing for time they could spend developing clinical skills.

Sub-themes for role resistance include naiveté and apathy. Participants implied that the presence of naiveté and apathy create resistance from faculty, clinicians and students to role expansion and limits the development of practice management skills at entry-level.

Sub-themes related to role expansion are pressure created by an obese curriculum and movement in the curriculum toward developing practice management skills. Pressure to expand the role of the physical therapist is due to external as well as internal forces, including: (a) practice being more complex and the requirements established on the national licensing exam produce external pressure; (b) constraints within the curriculum, as dictated by accreditation standards, creates internal pressure; (c) APTA’s Vision 2020 imposed upon physical therapist practice produces internal as well as external pressure to expand the role of the physical therapist; and (d) student interest in becoming a practice owner creates both positive as well as negative internal pressure. Movement in the curriculum to develop practice management skills is occurring in the
following ways: (a) faculty, informed of the need to expand the role of the physical therapist, act as change agents to make change happen and keep visioning for new opportunities; (b) faculty make practice management a curricular thread; (c) faculty integrate the development of practice management skills into clinical coursework and clinical learning experiences; (d) faculty facilitate and explore different learning experiences to expand the development of practice management skills and move this content around to achieve better sequencing of the material.

Participants suggested several ways to gain greater integration of practice management skills thereby, making the role of the physical therapist as a manager or business person more of an integral part of entry-level preparation, including: (a) make practice management a curricular thread; (b) integrate the development of practice management skills into clinical learning experiences; (c) use different nomenclature and terminology; (d) require faculty and clinical instructors to become and stay more informed about the emerging and complex needs of clinical practice; and (e) reframe the role of the physical therapist as a leader.

This chapter has explained the essential themes and associated sub-themes emerging from the data collected to characterize perceptions of faculty of the driving and restraining forces to integrating practice management skills in accredited entry-level physical therapist programs in the United States. The next chapter will discuss the implications of these essential themes and sub-themes emerging from this study and the implications of these findings on education, practice, future research, and the executive leader in physical therapist practice.
Chapter 5: Discussion

Introduction

The purpose of this chapter is to provide a summary of the study, discuss this study’s findings as compared to the literature, and discuss the implications of this study’s findings to inform and provide direction for education, practice, future research, and the executive leader in physical therapy. Essential themes of *role reframing*, *role dissonance*, *role resistance*, and *role expansion* characterize the perceptions of faculty who are working to integrate practice management skills in accredited entry-level physical therapy preparation.

Perceptions are characterized further by sub-themes identified and related to each essential theme as discussed in detail in Chapter 4. This study’s findings reveal sub-themes critical to *reframing* the role of the physical therapist in contemporary physical therapist practice, and these include: (a) mindset; (b) responsibility; (c) leadership; and (d) role modeling. Sub-themes related to and causing *role dissonance* include: (a) a strong identity to the physical therapist as a clinician; (b) a negative perception of the physical therapist as a manager or business person; and (c) a general sense of disorganization or ‘grayness’ surrounding the integration of practice management content into entry-level preparation causing discomfort, confusion, and unclear expectations for the development of practice management skills. This study’s findings suggest that the role of the physical therapist as a manager or business person may not be valued by some faculty, clinicians, and students and not seen as relevant as the clinical role. Sub-themes
emerging from this study for the essential theme of *role resistance* include naiveté and apathy; participants imply that the presence of naiveté and apathy create resistance from faculty, clinicians, and students to *role expansion* limiting the development of practice management skills at entry-level. Participants report that integrating practice management skills at entry-level will strengthen the role of the physical therapist as a manager or business person thereby, *expanding the role* of the physical therapist. Ultimately, this role expansion will transform the role of the physical therapist in clinical practice. Sub-themes related to *role expansion* are pressure created by a ‘bulging’, ‘jam packed’, or ‘obese’ curriculum and movement in the curriculum toward developing practice management skills.

This study’s findings are significant for faculty responsible for developing essential skills needed by students for entry-level physical therapist preparation. Findings from this study suggest that these *themes* and *sub-themes* act as driving or restraining forces, and sometimes both, to the integration of practice management skills into entry-level preparation. The significance of this study’s findings is in the *direction* they provide for faculty to facilitate the *role expansion* process better through the identification of perceived driving and restraining forces to integrating practice management skills into the curriculum. This study’s findings extend beyond entry-level preparation to physical therapist practice in general. Findings of this study are supported by the literature.

**Summary of Study**

A qualitative method, based mainly on a hermeneutical phenomenological approach of inquiry as interpreted by van Manen (1997), was selected as the design for
this research study. Purposeful sampling was used to ensure inclusion of participants informed about the study focus to provide a deeper understanding of the perceptions of faculty of the driving and restraining forces to integrating practice management skills into entry-level physical therapist preparation. For the purposes of this study, the FINHOP model (finance, information management, networking, human resources management, operations, planning and forecasting), used by Schafer, et al. (2007) in their study as an organizing framework for practice management content, provided the operational definition for practice management skills needed in physical therapist practice (Appendix B).

Data was collected from one type of participant (‘faculty’) using multiple methods including focus groups, participant reflective journaling, member checking, and bracketing or EPOCH, allowing for triangulation of data, or the comparison of multiple data sources (Patten, 2007). By triangulating, overlapping and confirming results adds credibility to these findings and increases the confidence that the conclusions drawn will be true (Creswell, 2007; Krueger and Casey, 2009). Twenty-nine participants contributed to this research study, including three participants recruited to take part in a pilot focus group conducted two weeks prior to APTA’s Combined Sections Meeting 2010 (CSM). Four face-to-face focus groups were conducted for ‘faculty’ at CSM 2010, including six to eight participants in each focus group. All focus group participants signed the informed consent form before they engaged in the focus group discussion (Creswell). Perceptions of participants in different roles are reported, including: (a) Program Chairs or Deans; (b) academic faculty; (c) clinical faculty, including the Director of Clinical
Education (DCE); (d) clinical faculty; and (d) Clinical Instuctors (CIs). In a couple of instances, faculty also shared perceptions of students based on their own experiences.

Data analysis, guided by the philosophy of hermeneutic phenomenology approach as interpreted by van Manen (1997), required the researcher to become immersed in the data while interpretation of the data was achieved through a process of phenomenological reflection (van Manen). In the researcher’s opinion, thematic saturation occurred with the sample of 29 focus group participants involved in this study. Data analysis reveals four essential themes: *role reframing, role dissonance, role resistance, and role expansion*; various sub-themes associated with each essential theme; and demographic information regarding the participants included in the study. Twenty-eight of the 29 participants completed the demographic survey, administered during the focus groups. In total, 19 of the 28 participants (69%) teach administration and management as their primary or secondary content area; twenty of the 28 participants (71%) teach the practice management content primarily in their programs. Twenty-two participants (79%) identified the baccalaureate degree as the level of professional (entry-level) education completed to become a physical therapist. Ten participants (36%) indicated that they had a business degree, while 21 participants (75%) indicated that they had completed professional development related to the areas of practice management. Twenty-eight of the 28 participants (100%) indicated that they have held a management, leadership, or supervisory role in physical therapy; 24 of the 28 participants (86%) indicated they have more than 5 years of management, leadership, and supervisory experience while 4 participants (14%) indicated they had 3 to 4 years of experience in these roles.
Implication of Findings

Usefulness of Lewin’s Model of Planned Change

Kurt Lewin’s 3 Step Change Model (1947), including its concepts of driving and restraining forces, was the theoretical model providing direction to this study. Evidence found in the literature supports the usefulness of Lewin’s model and the concepts of driving and restraining forces to understand the process of a change (Ford and Greer, 2006; Levi and Lawn, 1993; Lifter, Kruger, Okun, Tabol, et al., 2005; Giardino, Giardino, MacLaren, and Buro, 1994; Beverland and Lindgreen, 2007; Hadley and Hugman, 1991). Lewin’s model was used to provide direction to this study because the profession of physical therapy is transforming intentionally as a result of the American Physical Therapy Association (APTA) implementing a planned change initiative, namely Vision 2020. Also, this particular theoretical model was used because the physical therapy profession is in the stage of ‘unfreezing’ as it relates to integrating practice management skills into the entry-level curriculum. This study’s findings suggest that the role of the physical therapist also is in the stage of ‘unfreezing’ as it expands to meet the complex needs of contemporary practice and the expectations to move to a doctoring profession set by APTA’s Vision 2020. Lewin’s model and its concepts of ‘unfreezing’, ‘driving forces’, and ‘restraining forces’ provided insight, and clarity in determining the implications of findings revealed in this study. By applying Lewin’s change model (1947) to the themes and sub-themes emerging from this study, data analysis suggests that these four essential themes and various sub-themes act as driving and restraining forces to integrating practice management skills into entry-level preparation, ultimately impacting the processes of curricular change and role expansion. Of note, a few driving
forces and few restraining forces co-exist, in other words, these forces exist together or at the same time (Merriam-webster.com).

Lewin described ‘unfreezing’ of the existing system of interests and relationships as the stage of liberating the organization for possible change and suggested that organizations had to become unfrozen by displacing customary patterns and routines to offset the status quo. Lewin, as part of his field theory, believed that the status quo represented the equilibrium between the barriers to change and the forces supporting change. He proposed that the equilibrium would change more easily if restraining forces, such as personal defenses, group norms, or organizational culture, were unfrozen by being neutralized or transformed (Lewin; Rosch, 2002; Watson, 1971). Lewin’s (1947) concepts assumed that inertia, in the form of ‘quasi-stationary equilibrium’, is the main impediment to change.

Lewin (1947) proposed that one of the causes of resistance to change lies in the relation between the individual and the value of the group standards. He contended that any new behavior is a consequence of the interaction between the person and the environment or the result of some change in the field and suggests that it is usually easier to change individuals formed into a group than to change any one of them separately. Lewin proposed that when the social value of a group standard is great then the resistance of the individual group member to move away from this level also is great. As long as group values are unchanged the individual will resist changes more strongly especially the further the departure from the group standards (Lewin). However if the group standard is changed, several resultant changes may occur due to the relation between individual and group standard: (a) the resistance will be eliminated; (b) the force field
will tend to facilitate changing the individual; and (c) the force field will tend to stabilize
the individual conduct on a new group level (Lewin, p. 332).

These discoveries provide insight into several opportunities to influence change in
entry-level preparation. The perceived group standard in developing clinical skills as the
priority in entry-level physical therapists is creating resistance from academic and
clinical faculty preventing integration of practice management skills. The development
and integration of practice management skills at entry-level could be enhanced by
facilitating forces identified that are driving change, such as faculty and students acting as
change agents and consultants to inform entry-level preparation and practice. Several of
the restraining forces identified, such as lagging core documents, could be neutralized or
transformed to enhance the influence of existing driving forces, and significant resisting
forces, such as naïveté and apathy, could be isolated in order to prioritize efforts of
change. Of note, the APTA may not have created enough of an ‘emotional stir-up’ to
deliberately unfreeze the status quo in entry-level education and the change process might
be overloaded because too many changes have been expected of entry-level physical
therapist programs at the same time. Slow changing cultures within academic institutions
may be breeding pervasive inertia or helping to maintain the status quo therefore, the
equilibrium within entry-level physical therapist education may need to be destabilized
before old behaviors can be discarded. Faculty, who teach the practice management
content as well as faculty who do not teach this content, need to assume responsibility to
become and stay informed about the needs and opportunities to expand the role of the
physical therapist in contemporary practice, especially during a period of national health
care reform.
Implication of Findings by Essential Theme

Essential Theme I: Role Reframing

*Sub-themes.* Findings from this study identify a need to *reframe* the role of the physical therapist in contemporary physical therapist practice. Reframing requires the ability to look at, present, or consider beliefs, ideas, relationships, or roles in a new or different way or to change the focus or perspective of a view or role through a certain lens ([thefreedictionary.com](http://thefreedictionary.com)). Findings emerging from this study suggest that reframing the role of the physical therapist will facilitate greater integration of practice management skills at entry-level.

This study’s findings reveal sub-themes critical to reframing the role of the physical therapist in contemporary physical therapist practice, and these include: (a) mindset; (b) responsibility; (c) leadership; and (d) role modeling. Participants in this study propose that instilling the mindset and the role of the physical therapist as a leader, more so than as a manager or business person, may be an effective approach to reframe the role of the physical therapist because leadership is perceived to transcend every role expected of a physical therapist in practice. Evidence in the literature shows that ‘leadership theory’ ranked second in the level of importance of 38 leadership, administration, management, and professionalism (LAMP) categories ranked by average score ([Lopopolo, et. al, 2004](http://lopopo.com)). Learning how to be a more effective leader (35 respondents; 44%) was one of the five skills acquired during business school that the respondents stated were the most pertinent to their careers ([Parekh and Singh, 2007](http://parekh.com)). Participants in this study also emphasized that faculty, including clinical faculty, play an
influential role for students, as role models, advocates, and leaders, in instilling and reinforcing a different mindset and at the start of entry-level preparation.

*Role reframing - driving forces.* This study’s findings reveal several driving forces related to the theme of role reframing and according to these findings, *role reframing* has the potential to act as a significant driving force in the long term.

Participants in this study emphasize that faculty see the benefits of framing a different mindset to establish the expectations of a doctoring profession as early as possible during entry-level preparation. Participants also see the value in enforcing and reinforcing the relevance of developing practice management skills at entry-level in order to practice successfully in health care. Smith (1988) indicated that an employed BSN graduate, with a nursing degree and business skills, would have greater and more rapid advancement within the institution. Participants in this study emphasize that faculty act as role models to instill and shift mindsets and that students play a role as change agents to inform practice. Yellin (1999), referring to the role acquisition process, states:

> As the novice begins to demonstrate engagement, the awarding of positive sanctions, or at least the withholding of negative sanctions by role partners, others enacting the same role, and society-at-large, facilitates this change in the person’s orientation toward role enactment and role partners, marking transition to the next stage. (p. 246)

*Role reframing - restraining forces.* Participants in this study suggest that the lack of commitment by faculty, clinicians, and students to learning new skills, such as billing, coding, and reimbursement, demonstrates a lack of responsibility for the expanded role of the physical therapist needed in contemporary practice. This study’s findings indicate
that this lack of responsibility, as shown as a lack of commitment acts as a restraining forces to role reframing.

Role reframing – forces which both drive and restrain change. The standards set by the APTA act as a driving force and a restraining force simultaneously or in co-existence. Essentially, APTA’s Vision 2020 envisions a reframed role of the physical therapist for the future. Yet, the core documents produced by the APTA act as restraining forces because participants in this study report that they are lagging in evidence, clarity, and lack clear nomenclature related to the practice management skills needing integration into entry-level preparation.

Participants in this study imply that reframing the role of the physical therapist as a leader and expecting the PT to assume more responsibility for practice could act as a driving force and a restraining force at the same time. Participants suggest that reframing the role of the physical therapist as a leader, more so than a manager or business person, could neutralize or transform a negative perception of the physical therapist as a business person into a more positively perceived role of the physical therapist as a leader. In this way, reframing the role of the physical therapist as a leader could become a driving force. Yet while the findings in this study indicate that while some embrace that notion that all physical therapists need to assume more responsibility for practice and as a leader (‘driving forces’), participants report that not all practitioners feel this way and actually resist embracing a role that is different from the clinical role (‘restraining force’). These findings will be discussed further in the discussion of role resistance.
Essential Theme II: Role Dissonance

Sub-themes. Dissonance, used as a noun, is defined as “lack of agreement, consistency, or harmony; conflict” (thefreedictionary.com). Sub-themes, revealed in this study, related to and causing role dissonance include: (a) a strong identity to the physical therapist as a clinician; (b) a negative perception of the physical therapist as a manager or business person; and (c) a general sense of disorganization or ‘grayness’ surrounding the integration of practice management content into entry-level preparation causes discomfort, confusion, and unclear expectations for the development of practice management skills. Findings in this study imply that the pervasive identity or ‘status quo’ is the role of the physical therapist as a clinician, while integrating the role of the physical therapist as a manager or business person represents a deviation from the status quo and the accepted norm. Thus, changing or expanding the role of the physical therapist in clinical practice presents challenges to various stakeholders - students, faculty, and policy makers.

Evidence found in the literature supports that core competencies in physical therapist practice are changing (Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986; Pescatello, Glenney and Certo, 2000) and include practice management (Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986; Pescatello, Glenney and Certo, 2000; Schafer, Lopopolo, and Luedtke-Hoffmann, 2007; Schafer, 2001; Lopopolo, Schafer, and Nosse, 2004). Results from a study conducted by Christiansen and published in 1975 indicated that 58.2% of the study’s respondents (n=77) saw a need for increased attention to develop administrative and managerial skills. Yet, there is evidence indicating that existing business skills are well below the levels of
Role dissonance maintains the ‘status quo’ or the role of the physical therapist as a clinician, limiting role expansion. This study’s findings suggest that the role of the physical therapist as a manager or business person may not be valued by some faculty, clinicians, and students and not seen as relevant as the clinical role. Participants in this study indicate that students perceive time spent developing practice management skills as competing for time they could spend developing clinical skills. Pescatello, Glenney, and Certo (2000) highlight that health care (HC) managers differed from non-HC managers in the importance they placed on business savvy and implied that some managers embraced this new role, while others resisted it even to the point of acknowledging that business savvy is not an essential PT staff survival skill in today’s HC environment. These researchers propose that their findings support the use of innovative instructional strategies that offer students multiple perspectives on the realities of HC to optimize employment success.

Role dissonance - restraining forces. This study’s findings reveal several restraining forces related to the theme of role dissonance, including: (a) the strong identity to the role of the PT as a clinician reinforces development of clinical skills as a priority at entry-level; (b) this strong identity creates ‘curricular silos’ limiting the integration practice
management skills throughout the curriculum; (c) clinical instructors (CIs) and clinicians develop clinical skills during clinical experiences as a priority and limit or resist the development of practice management skills; (d) PT students identify strongly to the clinical role and see developing clinical skills as a priority; and (e) external agencies and lagging core documents reinforce the ‘status quo’ or the role of the PT as a clinician as the priority for the profession. Noteworthy, evidence found in the literature indicates that external barriers, such as “accreditation criteria”, licensing regulations”, and “community resistance”, were not viewed as particularly significant obstacles by NP program directors despite the fact that often the two are cited by faculty as reasons they are inhibited in making curriculum changes (Bellack, Graber, O’Neil, Musham, et al., 1999).

The findings from this study imply that the existence of disorganization or ‘grayness’ surrounding the development of practice management skills at entry-level reinforces a negative perception of the physical therapist as a manager or business person. Participants report that this disorganization acts as a restraining force by creating discomfort, unclear expectations, and confusion in the following areas: (a) there is a lack of knowledge and understanding about the role of the physical therapist as a manager or business person; (b) there is a lack of clear nomenclature related to practice management in physical therapist practice; (c) there is not a consensus and there is a lack of clarity identifying what knowledge and skills need to be developed at entry-level; and (d) there is limited evidence supporting what practice management skills need to be developed at entry-level. Yellin (1999) suggests that an individual, while acquiring a new role, meets unfamiliar and unarticulated expectations transmitted by role partners, him or herself, others, enacting the same role, and society-at-large. Evidence found in the literature did
support disagreement, differing perceptions, and a lack of consensus and clarity related to management roles in health care and physical therapy and the subsequent skills and competencies that need to be developed (Kleinman, 2003; Henson, Pressley, and Korfmann, 2008; Smith, 1988; Parekh and Singh, 2007; Sportsman, Hawley, Pollack, and Varnell, 2001; Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986; Pescatello, Glenney and Certo, 2000; Schafer, Lopopolo, and Luedtke-Hoffmann, 2007; Schafer, 2001; Lopopolo, Schafer, and Nosse, 2004). Results from one study revealed a significant difference in the level of agreement between academic and clinical PTs regarding the addition of reimbursement, legal issues, ethics, and managed care content to DPT curricula (Brudvig and Colbeck, 2007). Brudvig and Colbeck suggest that clinical PTs see a stronger need for the addition of practice management curricular content areas than academic faculty. Findings from the study conducted by Kleinman (2003) reveal that perceptions of roles, competencies, and educational preparation required for nurse manager and nurse executive roles vary depending on the manager’s role per se. Results revealed from investigating the perceived importance of managerial role and skill categories among three groups of physical therapists to better understand the work priorities of physical therapist managers showed differences between faculty members and private practice managers in 15 of the 16 predetermined work categories between hospital-based managers and private practice managers in 9 of the 16 categories; and between faculty members and hospital-based managers in 8 of the 16 categories (Schafer, 2002).

*Role dissonance - driving forces.* Participants identify a few *driving forces* related to the theme of role dissonance are revealed in this study. Participants report that they
use existing evidence, including the FINHOP model/framework, to inform and reinforce the fundamental need for developing management and business skills as part of entry-level preparation and to provide support for the role of the physical therapist as a manager or business person. Participants state that the FINHOP model/framework provides some clarity, but not consensus, in defining some administrative and management skills needed at entry-level. This study’s findings suggest that using different terminology, such as leadership versus administrator, facilitates an easier integration and discussion of practice management content somewhat. In this way, using different terminology would act as a driving force.

*Role dissonance - forces which both drive and restrain change.* This study’s findings show that outside agencies, such as the APTA and CAPTE, appear to encourage the development of the physical therapist as the manager or business person somewhat yet simultaneously, continue to emphasize the role of the physical therapist as a clinician. In this way, the lack of a consistent and well-defined expanded role of the physical therapist in contemporary practice coupled with lagging evidence from outside or external agencies as to the core knowledge and skills or competencies needed at entry-level preserves the ‘status quo’ or the emphasis on the role of the physical therapist as the clinician.

**Essential Theme III: Role Resistance**

*Sub-themes.* Sub-themes for role resistance emerging from this study include naïveté and apathy. Naïve is defined as “deficient in worldly wisdom or informed judgment” while naïveté is defined as “lack of sophistication or worldliness; tendency to believe too readily and therefore to be easily deceived” (thefreedictionary.com; Merriam-
Apathy is defined as “lack of enthusiasm or energy; lack of interest in anything or the absence of any wish to do anything” (Encarta Dictionary). In this study, participants imply that the presence of naïveté and apathy towards developing and expanding practice management knowledge and skills at entry-level creates resistance from faculty, clinicians, and students and that this resistance limits the development of the role of the physical therapist as a manager or business person.

Evidence found in the literature proposes that role acquisition is an adaptive process that occurs sequentially in four stages based on the interaction between the person and the role; that each stage involves a different affective orientation on the part of the person toward the role and a qualitatively different relationship between the person and role partners (Yellin, 1999). Yellin identified four stages of role acquisition: ambivalence, absorption, commitment, and confidence, and suggests that learning role performance is not a one-time event but rather a process, seen as a progression of differing experiences that connect with an increased ability to perform in a new role. Ambivalence is defined as the presence of two opposing ideas, attitudes, or emotions at the same time and a feeling of uncertainty about something due to a mental conflict (Encarta Dictionary). Yellin proposes that a new role status initiates interactions with a new social network, and as a result:

…, the individual experiences ambivalence toward the new role, a result of disengagement from prior role relationships and loss of an earlier self, while not yet engaged in new role relationships and possessing only a hazy conception of what the new role entails. (p. 244)
Yellin states that “Ambivalence is experienced most keenly when the individual is aware of the role acquisition.” (p. 244)

*Role resistance - driving force.* This study’s findings reveal several driving forces for role resistance and these appear to be significant. Participants report that naiveté stems from a mixture of driving forces, including: (a) faculty who are not practicing; (b) faculty who have not practiced for an extended period of time; (c) a general lack of experience of the student at entry-level; and (d) clinicians in practice who are not informed. This study’s findings also indicate that some faculty and clinicians demonstrate apathy, or indifference, towards developing practice management skills while students also display apathy to developing practice management skills by affirming a preference to treating patients as a priority. While this study’s findings suggest an increasing student interest in becoming a practice owner or manager, other findings revealed in this study indicate that this interest decreases once students have been exposed to clinical practice. Participants emphasize that this decreased interest indicates role resistance.

Some of this study’s findings were supported by the evidence. When Schafer (2001) studied and compared patterns of agreement-disagreement among Texas-based physical therapist educators, clinicians, and students on the Leadership (L), Administration (A), Management (M) (LAMP) belief statements, she determined differences among these groups. Schafer explained differences by investigating respondents’ familiarity or actual experience with the concepts being rated and indicated that: 79% of clinicians were not familiar with the LAMP document; 70% of educators were not familiar; and 93% of students were not familiar. Schafer (2002) also indicates
that fewer than half (42%) of the instructors of the administration/management content had a degree in management and the average number of years teaching this content was 6.2 years (range = 1-24).

*Role resistance - restraining forces.* No restraining forces emerged from this study related to the essential theme of *role resistance.*

**Essential Theme IV: Role Expansion**

*Sub-themes.* Participants in this study propose that the integration of practice management skills at entry-level will strengthen the role of the physical therapist as a manager or business person thereby, *expanding the role* of the physical therapist. Participants imply that ultimately, this role expansion will transform the role of the physical therapist in clinical practice. Sub-themes revealed in this study and related to role expansion are *pressure* created by a ‘bulging’, ‘jam packed’, or ‘obese’ curriculum and *movement* in the curriculum toward developing practice management skills. This study’s findings indicate that pressure to expand the role of the physical therapist is due to a combination of external as well as internal forces. Participants in this study report that external forces materialize from the *evolving* needs of contemporary practice, health care, and health care reform, as well as the requirements established on the national licensing exam, while internal forces result from constraints existing in the curriculum as dictated by growing accreditation standards. Participants suggest that additional internal as well as external forces to expand the role of the physical therapist result from: APTA’s Vision 2020 that was imposed upon physical therapist practice, entry-level education’s move to a clinical doctorate degree, and student interest in becoming a practice owner produce.
Findings in this study reveal that movement in the curriculum to develop practice management skills is occurring in several ways. Participants in this study report that faculty, informed of the need to expand the role of the physical therapist, act as change agents to make change happen and keep visioning for new opportunities. Foord-May (2006) indicated that effective curricular change requires a change agent or change leader. Participants report that some faculty make practice management a *curricular thread* and integrate the development of practice management skills into clinical coursework as well as clinical learning experiences. Participants discussed how faculty facilitate and explore different learning experiences to expand the development of practice management skills and move this content around to achieve better sequencing of the material. Foord-May indicated that expert guidance is needed to sustain meaningful change.

Participants in this study discussed at length how dramatically physical therapist practice has changed implying that different skills, such as practice management, are needed at entry-level. This discussion is consistent and supported by the literature. Studies show that responsibilities in health care are changing and include practice management (Kleinman, 2003; Henson, Pressley and Korfmann, 2008; Smith, 1988; Young, Hough and Peskin, 2003; Christiansen, 1975; Schafer, 2002). Evidence suggests that health care professionals need practice management skills to be successful in contemporary practice (Henson, Pressley and Korfmann; Smith; Young, Hough and Peskin). Pescatello, Glenney, and Certo (2000), arriving at consensus regarding manager opinions on important HC issues and qualities for employment success, indicate that: managers considered “greater reliance upon business skills” as the third most important
HC issue; HC managers considered “business savvy” as the fourth most important issue likely to impact health care service delivery as compared to non-HC managers who considered “business savvy” to be tied for the most important issue; and only 22.1% of HC managers felt that the possession of business skills was an important quality for a staff physical therapist whereas 66.7% of non-HC managers believed it to be critical for career success. Aston-McCrimmon and Hamel (1983) suggest that the functions required by entry-level physical therapists have expanded significantly, to the point where supervision, consultation, teaching, and evaluation are included in addition to the traditional treatment role. Physicians, after earning a Master of Business Administration (MBA) degree, changed their practice patterns substantially as reflected by increased time spent on administrative responsibilities (Parekh and Singh, 2007). Surviving better in the new health care system was identified as one of the top three motivations for completing a MBA degree among the physicians. (Parekh and Singh).

Role expansion - driving forces. This study’s findings imply that the essential theme of role expansion acts as a significant driving force because it creates the urgency and the need for change in entry-level preparation. Both sub-themes of pressure created by a ‘bulging’ curriculum and movement within the curriculum to develop practice management skills act as driving forces to integrating practice management content into entry-level preparation. This study’s findings also reveal several other driving forces favoring change that relate to the theme of role expansion. Participants emphasize that financial realities and complexities of contemporary practice, as well as pending national health care reform, create a sense of “survival” in practice and the need to develop practice management skills at entry-level. Participants in this study indicate that some
faculty and clinicians, informed about current realities, complexities, and needs of
practice, act as change agents to ensure development of practice management skills at
entry-level. Participants indicate also that faculty makes practice management a
curricular thread to facilitate a better integration of practice management content
throughout the curriculum and some faculty attempt to develop practice management
skills during clinical learning experiences to increase relevancy. Findings in this study
indicate that faculty move practice management content around in the curriculum,
sometimes back and forth, to enhance sequencing and learning and weave practice
management content into ‘traditional’ clinical courses to reinforce the integral need for
this content in all areas of clinical practice. Participants report that faculty, in an attempt
to foster role expansion, explore new ways to deepen the development of practice skills at
entry-level by partnering with business schools and by establishing business-focused
clinical learning experiences. Although there was some disagreement among participants
in perceptions of student interest in becoming a practice owner or manager, participants
in this study suggest that increased student interest also acts as a driving force related to
role expansion.

*Role expansion - restraining forces.* This study’s findings reveal a few yet
significant restraining forces related to the theme of *role expansion* to impede many of
the driving forces associated with role expansion. Participants reveal that constraints
imposed by accreditation requirements on an already ‘jam packed’, ‘bulging’, or ‘obese’
curriculum limit the room available in the curriculum to add additional practice
already crowded curriculum” was one of three barriers viewed as significant by NP
program directors. Participants indicate that external forces, such as the National Physical Therapist Licensing Examination (NPTE) and lagging core documents, such as the Clinical Performance Instrument (CPI), minimize the need to integrate this content at entry-level as shown by the absence of “testing” or “measuring” practice management skills in these instruments. Findings in this study identify tension and resistance from programs and faculty to add more content to the curriculum, especially content that is not valued, not well defined or understood, and is still emerging.

*Role expansion - forces which both drive and restrain change.* Participants emphasize that APTA’s Vision 2020 acts as a driving force as well as a restraining force impacting *role expansion*. Participants in this study indicate that this vision has imposed external as well as internal forces to change and to expand physical therapist preparation at entry-level through establishing the expectations of direct access, a doctoring profession, and autonomous practice. Participants suggest that these imposed expectations necessitate the development of different skills at entry-level, including practice management. Yet, participants acknowledge that the cumulative effect of newly imposed accreditation standards act as a restraining force because these new standards require additional content to be added into the curriculum in several areas all at once; thereby creating a bulging curriculum and limiting room to expand practice management content.

*Implications of Findings for Physical Therapist Education*

This study’s findings disclose many *driving forces* to integrating practice management skills into entry-level preparation. Findings from this study identify faculty perceptions that the role of the physical therapist is expanding, that developing practice
management skills at entry-level is essential to expand the role of the physical therapist as a manager or business person, and that this role expansion is needed in order to be successful in contemporary clinical practice. Findings from this study suggest that role expansion requires faculty to prepare physical therapist students at entry-level differently.

This study’s findings indicate movement is occurring in the curriculum in different ways and with some success in developing and integrating practice management skills at entry-level. Yet, participants emphasize that the changes occurring in entry-level preparation are not enough as it relates to the integration of practice management skills and that a gap in the curriculum still exists. Additionally, participants in this study reveal that there is a gap in understanding the need to expand the role of the physical therapist by developing practice management skills and that this gap in understanding helps to explain why some students express fear, concern, and some lose interest in owning their own practice after being exposed to clinical practice. Based on this study’s findings, it seems plausible that students are not being prepared well enough in advance for all of the demands of contemporary practice before starting their clinical learning experiences. It also seems feasible that naiveté, emerging as a sub-theme in this study and acting as a driving force for role resistance, could be lessened or transformed if faculty, clinicians, and students become and stay more informed of all of the complexities of contemporary practice.

This study’s findings indicate that restraining forces identified and related to role dissonance and driving forces related to role resistance are significant and may need to be neutralized or transformed in order for role expansion of the physical therapist in practice to occur. Levi and Lawn (1993) recommend that the focus of the change agent’s
efforts should be on the *restraining forces* which tend to be internal to the organization. Lifter, Kruger, Okun, Tabol, et al. (2005) showed that internal forces, such as idea champions and the university’s organization, were crucial components in driving change as well as data-based decision-making used to inform the *direction* of change. Of note, it is important to acknowledge that some level of *role dissonance* and *role resistance* will always exist between the role of the physical therapist as the clinician and the role of the physical therapist as the manager or business person. Therefore, it seems reasonable to speculate that this *role tension* is essential for growth and for the ongoing development of the profession. Also, it seems possible to predict, based on individual interests and passions, that there will always be a core group of physical therapists who want to focus on clinical practice only and another core group wanting to focus primarily on the business or management of clinical practice.

A need to develop business skills during professional training was identified over 25 years ago (Christiansen, 1975). Evidence found in the literature and faculty perceptions, revealed in this study, support that core competencies in physical therapist practice include practice management (Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986; Pescatello, Glenney and Certo, 2000). Evidence suggests that the development of practice management skills needs to occur during entry-level level preparation of health care professionals (Christiansen, 1975; Schafer, Lopopolo and Luedtke-Hoffmann, 2007; Lopopolo, Schafer and Nosse, 2004; Aston-McCrimmon). A few studies provide support for practice management skills to be integrated into entry-level physical therapist curriculum (Schafer, et al.; Lopopolo, et al.) and one study discusses the integration of selected administrative content in entry-level DPT education.
(Brudvig and Colbeck, 2007). Other studies identified essential practice management skills needed by health care professionals and physical therapists (Sportsman, Hawley, Pollack and Varnell, 2001; Schafer, et al.; Schafer, 2001; Lopopolo, et al.).

This study’s findings indicate that there is no consensus yet as to the core practice management knowledge and skills needed by a physical therapist at entry-level. This study’s finding highlights, as a critical next step, the opportunity to recruit ‘thought leaders’ from academia as well as clinical practice to identify, define, interpret, and clearly communicate core practice management knowledge and skills needed by all physical therapists as part of entry-level preparation.

Evidence found in the literature indicates that role acquisition is a process (Yellin, 1999). According to the results of this study, reframing the role of the physical therapist needs to occur at entry-level. Findings from this study propose that reframing the physical therapist as a leader, developing leadership skills as part of entry-level preparation, and expecting the PT to assume more responsibility for practice are needed in order for physical therapists to achieve role expansion. This study’s findings suggest that faculty play a critical leadership role in reframing this expanded role and can facilitate this role expansion process in the following ways: (a) by instilling a new mindset as soon as entry-level preparation starts to set expectations for role expansion; (b) by reinforcing this new mindset throughout entry-level preparation, including clinical experiences; and (c) by developing leadership skills during entry-level. Findings revealed in this study emphasize the importance of faculty acting as role models for students suggesting that faculty need to stay informed about the needs and demands of contemporary practice.
Current literature shows that changing curriculum is a process (Bellack, Graber, O’Neil, Musham, et al. 1999; Foord-May, 2006). This study’s findings suggest making practice management an explicit curricular thread to ensure more consistent integration of practice management content throughout the entire curriculum. By making this content a curricular thread, participants emphasize that all faculty would be accountable for ensuring that practice management skills are developed at entry-level and therefore, all faculty would need to be informed about how and why these skills impact physical therapist practice and how and why developing these skills are needed to expand the role of the physical therapist. This study’s findings indicate that faculty, who currently teach the practice management content, could assume a ‘consultant role’ to assist faculty, peers, and clinicians design integrated learning experiences to ensure the development of practice management skills throughout clinical coursework and clinical learning experiences.

Participants in this study stress the importance of expecting the development of practice management skills as an integral part of clinical learning experiences. Participants state that once practice management is deemed a curricular thread then, this curricular change could occur and would be expected. It seems feasible that integrating practice management skills into clinical learning experiences would facilitate the following changes: (a) developing practice management skills would become more applied and therefore more relevant for the student; (b) faculty, in charge of clinical experiences, would be held accountable for ensuring these skills were developed and therefore would become more informed and responsible; (c) clinical instructors would be expected to facilitate learning experiences that included developing practice management
skills as well as clinical skills and therefore would become more informed and responsible; (d) core documents (i.e., CPI) would change to reflect new expectations; and (e) entry-level physical therapists, exposed to these integrated clinical learning experiences, could act as change agents upon graduation to inform practice and to role model the new behaviors and practice patterns expected of the expanded role of the physical therapist in practice.

This study’s findings suggest that some students and graduates also act as change agents to inform practice and have the potential to reinforce the evolving and expanding role that is needed by physical therapists in contemporary practice and to achieve APTA’s Vision 2020 by transforming the profession of physical therapy to a doctoral level. It seems reasonable that assuming the role of the ‘change agent’ identifies a need for students to learn explicitly during their entry-level preparation about the process of change and to develop skills to become more empowered and skilled as change agents.

Implications for Physical Therapist Practice

Participants in this study emphasize that until role dissonance and role resistance are neutralized and transformed, in other words, as long as the group standard and values support the physical therapist as the clinician and continues to support a negative perception of the physical therapist as a manager or business person, then a gap in the curriculum will persist, integration of practice management skills will be fragmented, and sporadic role expansion will continue to occur. However, participants imply that by reframing the mindset of the physical therapist as early as possible during entry-level preparation, it seems feasible that some of the curricular constraints, limiting role expansion, could be overcome. Participants propose reframing the role of the physical
therapist as a leader to foster a different mindset and a greater sense of responsibility. Findings from this study emphasize the critical role that all faculty and clinicians play in shifting mindsets, being leaders and role models for students, and for transforming the role of physical therapists at entry-level and in practice. Participants suggest that if the collective group or the PT profession reframes the mindset and the role of the physical therapist as a leader then, faculty and PT programs could gain greater momentum for change in order to achieve role expansion.

Participants in this study emphasize that the need to develop practice management skills at entry-level is more than just a concern for educators. In other words, the findings from this study reveal that integrating practice management skills at entry-level is a concern for clinical practice as well. Two studies found in the literature investigated gaps in the perceived need of certain skills in practice as compared to existing level of competence (Henson, Pressley and Korfmann, 2008; Aston-McCrimmon, 1986). Results from these studies imply that the existing gap between business skills needed and the level of business skills existing indicates that current training and education programs are not providing adequate business skills training for clinical practice (Henson, et. al; Aston-McCrimmon). Preliminary evidence in the literature shows benefits of a formalized business education program for physicians and other health care professionals and substantial changes in physician practice patterns occurring after they complete a business degree (Young, Hough, and Peskin, 2003). Findings emerging from this study suggest that the development of practice management skills at entry-level is needed to achieve role expansion in order to change practice patterns and enhance success in contemporary physical therapist practice.
Participants in this study indicate that clinical practice would be impacted directly and indirectly by requiring the development of practice management skills during student clinical learning experiences. Participants point out the important and influential role assumed by clinical instructors (CIs) as mentors and role models for students. Participants state that CIs, who supervise physical therapist students during clinical learning experiences, would have to become more informed about the role of the physical therapist as the manager or business person in order to support, facilitate, and measure the development of practice management skills by students during these experiences. Participants speculate that a different level of CI mentorship could be modeled and that this new level of mentorship is desirable.

Implications for Future Research

Participants in this study indicate there is a need for further research as it relates to the integration of practice management skills into entry-level preparation and how integrating these skills will facilitate the expansion of the role of the physical therapist in practice. Studies by Schafer, et al. (2007) and Lopopolo, et al. (2004) identify levels of knowledge and skills needed in administration and management in PT at entry-level yet, no evidence exists regarding practice management skills and knowledge needed for best practice in physical therapy. Noteworthy, participants in this study discussed levels of practice management skills needing development during entry-level preparation that differ from the findings revealed by Schafer, et al.. Also of note, a few of the studies reviewed were conducted over 25 years ago and a few were conducted in another country (Aston-McCrimmon and Hamel, 1983; Aston-McCrimmon, 1986; Christiansen, 1975). It could be useful to repeat studies previously conducted to investigate the current levels of
competencies and needs in physical therapist practice in 2011 in the United States in order to provide up-to-date yet evolving information to faculty responsible for designing entry-level learning experiences.

This study’s findings reveal that there is no shared understanding or consensus as to the core practice management knowledge and skills needed at entry-level. Furthermore, the literature suggests expertise in practice management in PT is difficult to identify and define, yet it appears to be an emerging area in physical therapist practice. This suggests there is a need to continue to explore, define, and clarify ‘practice management’ competence (knowledge and skills) essential for physical therapist practice in order to inform and clarify expectations for faculty responsible for entry-level preparation. This study’s findings also imply a need to explore the role of the physical therapist as a manager and business person further as well as the role of the physical therapist as a leader to discover how role reframing and role expansion can impact differentiated practice in physical therapy, especially during a time of national health care reform.

Using the findings emerging from this study as a starting point, the principal investigator proposes that it could be useful to conduct a quantitative study at the national level to explore the prevalence of the various perceptions of driving and restraining forces to integrating practice management skills at entry-level. Also, it could be useful to repeat this qualitative phenomenological study at the national level to identify perceptions of different stakeholders who also influence entry-level physical therapist preparation; these stakeholders could include: DPT students in their final year of professional preparation; PT graduates one or two years after graduation and in full-time
practice; employers of new physical therapist graduates; and clinical instructors who supervise PT students regularly. Results from these additional studies may provide support for the findings revealed in this research study and/or may uncover different driving and restraining forces and additional ways facilitate greater and sustained integration of practice management skills into entry-level preparation.

Implications for the Executive Leader

Yellin (1999) proposes that role acquisition is “experienced as an ongoing adaptive process”, and occurs “sequentially in four phases based on the interaction between the person and the role” (p. 251). The Program Chair or Dean of each physical therapist program assumes an executive leadership role in entry-level physical therapist education. Participants indicate that this executive leader can be influential to facilitate: (a) the vision and the expectation for the integration of practice management content into entry-level preparation; (b) the requirement to deem practice management a curricular thread; (c) the expectation to develop practice management skills during clinical experiences; and (d) the expectation for all faculty to stay informed of the needs, challenges, and demands of contemporary clinical practice. This executive leader assumes a critical position in entry-level education and surrounding communities to role model a reframed role for academic faculty, clinical faculty, clinical instructors, students, and graduates. Additionally, the academic chairperson is responsible for holding the faculty accountable to ensure that the integration of practice management content occurs and that practice management skills are developed. This executive leader is positioned to influence ‘unfreezing’ of the change process in entry-level preparation in order to facilitate greater and more consistent integration of practice management skills and, by
doing so, will facilitate role reframing and subsequently role expansion of the physical therapist in practice.

Participants imply that multiple leaders at multiple levels are needed to move entry-level preparation from the status quo or the ‘unfreezing stage’ to the expanded role or ‘change stage’. Fortunately, there are other leaders who play a role in facilitating the integration of practice management skills into entry-level physical therapist preparation. Participants suggest that faculty who teach the practice management content assume a leadership role as a ‘content expert’, consultant, and a change agent to inform peers, students, and in some cases, clinical practice while assuming responsibility to facilitate a variety of ways for developing practice management skills. This study’s findings suggest that the Director of Clinical Education (DCE) plays a leadership role in communicating the expectation and building accountability for clinical instructors and students to develop practice management skills during clinical learning experiences. Participants state clearly that clinical instructors (CIs) play an influential leadership role as a professional mentor in clinical practice through role modeling the need to develop a comprehensive range of skills for contemporary practice. Collectively, these “grassroots leaders” will start to explicitly state, inform, role model, and reinforce the importance of practice management knowledge and skill development as an integral part of the expanded role of the PT that is needed in contemporary clinical practice.

This study’s participants imply that the APTA, the principal membership organization representing and promoting the profession of physical therapy, assumes a leadership role and in this role, can influence change. The results of this study suggest that the APTA acts as a driving force as well as a restraining force and that these forces
Participants in this study indicate that the APTA could act more as a driving force and less as a restraining force in several ways. This study’s findings encourage the APTA to look at the internal restraining forces, or those forces within the profession of physical therapy, that can be transformed or neutralized to hasten the ability of existing driving forces. For example, the APTA in its leadership role could help minimize ‘disorganization’ significantly by accelerating the clarity and consistency of documented and published expectations and role competencies needed for role expansion.

Specifically, the APTA could: (a) accelerate and facilitate more pressure and movement in the curriculum by updating and creating new core documents to make expectations clearer and less disorganized as to the integral need to develop practice management skills at entry-level; (b) set expectations to develop practice management skills during clinical learning experiences by re-instating the development and measurement of these skills back into the Clinical Performance Instrument (CPI); (c) assist and facilitate more room in the curriculum by re-looking at and modifying expectations for clinical skill development at the doctoral level; (d) encourage and recommend the development of management or business-focused clinical learning experiences; and (e) provide more business-related professional development opportunities.

Limitations

There were several difficulties and limitations in conducting this research study. This study investigates a relatively new conversation emerging within physical therapist education and not much is known about this topic. There is no shared understanding of the practice management knowledge and skills needed at entry-level in physical therapist practice because these are not standardized and are not well-understood. Even though the
FINHOP model was used in an effort to minimize these limitations, it is evident that limitations still exist by the participants’ questions asked during the data collection process. Not only did participants ask questions to clarify the scope of practice management skills, they also voiced some disagreement with the results of the FINHOP study related to the practice management skills needed at entry-level.

The investigator recognizes that there was a bias in participant inclusion. In other words, faculty who are most interested in the focus of this study agreed quickly to participate in the focus groups. Even though participants were invited to share their positive as well as negative perceptions, it would be interesting to conduct another study to investigate perceptions of participants who primarily oppose the need to integrate practice management skills during entry-level preparation.

The investigator is aware that her previous years of experience in integrating practice management skills in an entry-level physical therapy program may be perceived as a bias in conducting this study. Van Manen’s (1990) approach required the investigator to reflect on and consciously set aside, or bracket, any preconceived beliefs or feelings pertaining to the research topic so that data collection and analysis were approached from a nonjudgmental state. Also, member checking was conducted to increase the trustworthiness of the data collected and analyzed.

Finally, the investigator acknowledges that although the attempt was made to capture the ‘lived experiences’ of faculty, it seems that the study findings reveal the ‘perceptions’ of faculty more so than the actual ‘lived experiences’. This indicates a possibility for a secondary analysis of the data to reveal information more representative
of the ‘lived experiences’ of faculty or perhaps, an opportunity to repeat this study in a
different way.

**Recommendations**

This study’s findings suggest that the physical therapy profession is in the stage of
‘unfreezing’ as it relates to integrating practice management skills into the entry-level
physical therapist curriculum and that the role of the physical therapist is in the stage of
‘unfreezing’ as it expands to meet the complex needs of contemporary practice and the
expectations set by the American Physical Therapy Association’s (APTA) Vision 2020.
The perceptions of faculty of the driving forces and restraining forces to integrating
practice management skills in accredited entry-level physical therapy preparation are
characterized by: *role reframing, role dissonance, role resistance, and role expansion.*

Findings from this study reveal sub-themes critical to *reframing* the role of the
physical therapist in contemporary physical therapist practice, and these include: (a)
mindset; (b) responsibility; (c) leadership; and (d) role modeling. Sub-themes related to
and causing *role dissonance* include: (a) a strong identity to the physical therapist as a
clinician; (b) a negative perception of the physical therapist as a manager or business
person; and (c) a general sense of disorganization or ‘grayness’ surrounding the
integration of practice management content into entry-level preparation causing
discomfort, confusion, and unclear expectations for the development of practice
management skills. This study’s findings suggest that the role of the physical therapist as
a manager or business person may not be valued by some faculty, clinicians, and students
and not seen as relevant as the clinical role. Sub-themes emerging from this study for the
essential theme of *role resistance* include naiveté and apathy; participants imply that the
presence of naiveté and apathy create resistance from faculty, clinicians, and students to role expansion limiting the development of practice management skills at entry-level. Participants report that integrating practice management skills at entry-level will strengthen the role of the physical therapist as a manager or business person thereby, expanding the role of the physical therapist. Ultimately, this role expansion will transform the role of the physical therapist in clinical practice. Sub-themes related to role expansion are pressure created by a ‘bulging’, ‘jam packed’, or ‘obese’ curriculum and movement in the curriculum toward developing practice management skills.

This study’s findings suggest that these essential themes and associated sub-themes act either as driving forces or restraining forces, and sometimes both, to integrating practice management skills into entry-level preparation during the process of ‘unfreezing’. Findings from this study indicate that role dissonance acts as a significant restraining force while role resistance acts as significant driving force and both impede driving forces for role expansion. Participants in this study suggest possible ways to transform or neutralize restraining forces so that driving forces can influence movement and change to integrating practice management skills into entry-level preparation. Participants suggest that reframing the mindset and the role of the physical therapist as a leader in a doctoring profession at the start of entry-level preparation emphasizes the opportunity for PT students and future professionals to assume the responsibility for ‘practicing ownership’. Participants indicate that reframing the role of the physical therapist as a leader would require faculty to develop leadership skills explicitly during entry-level preparation. Participants also imply that reframing the role of the physical therapist requires a collective effort at multiple levels to change group values and norms.
and this process will identify new opportunities to reconcile role dissonance and role resistance. This collective effort would facilitate the forces driving role expansion to become ‘unfrozen’ thereby, creating change at entry-level.

This study’s findings reveal support for faculty to make practice management a curricular thread and to integrate and measure the development of practice management skills during clinical experiences. In order to ensure successful integration, participants emphasize the importance of continuing to identify, clarify, and define practice management skills and knowledge needed at entry-level. Faculty participating in this study suggest forming collaborative “grassroots” teams including: faculty who are ‘content experts’, clinicians, DCEs, and faculty teaching clinical coursework, to develop integrated learning experiences for practice management content so that it can be woven throughout the curriculum. They also recommend developing and building a repository of resources and case examples at a national level to facilitate the sharing of ideas and to strengthen a more collective effort for change by faculty, acting as change agents within PT programs.

Additionally, this study’s participants reveal the need for further investigation and research to: (a) explore perceptions of different stakeholders responsible for preparing physical therapist students of the driving and restraining forces to integrating practice management skills at entry-level in an attempt to uncover all restraining forces and driving forces inherent in this ‘unfreezing’ stage; (b) conduct studies to identify gaps in competencies and needs inherent in contemporary clinical practice and in anticipation of the needs emerging as a result of national health care reform; and (c) conduct studies to
advance competency expectations needed for contemporary clinical practice at entry-level and to continue to refine practice management terminology.

Participants involved in this study are informed of the essential need to integrate practice management skills into entry-level preparation. Twenty-eight of the 28 participants (100%) indicated that they have held a management, leadership, or supervisory role in physical therapy; 24 of the 28 participants (86%) indicated they have more than 5 years of management, leadership, and supervisory experience while four participants (14%) indicated they had three to four years of experience in these roles. Clearly, these findings reinforce the importance of experience informing teaching. It is possible that faculty, not included in this study and who teach the practice management content, may not have the necessary position, ‘voice’, knowledge or skills needed to facilitate change at the programmatic level. When programs make practice management a curricular thread, then faculty with expertise and experience in practice management will become more of an integral part of the core faculty team.

Participants emphasize that faculty and clinicians not informed of the need to expand the role of the physical therapist as a manager, business person, and leader become informed of the demands of contemporary physical therapist practice, especially during a time of national health care reform. This study’s participants imply that the PT program executive leader plays an important role to set the vision for the program to include the integration of practice management content. Additionally, participants emphasize that the Program Chair is responsible to hold faculty accountable to become informed through various means, including: a return to clinical practice, participation in professional development, or other opportunities, in order to expand their knowledge,
decrease their naiveté, and ultimately participate in the integration of practice management skills throughout the curriculum.

Findings in this study indicate there is an opportunity to consider and explore new and innovative approaches to teaching practice management content. Participants suggest a few new approaches, including: (a) develop clinical experiences that focus on the management or business side of clinical practice; (b) consider formal partnerships with business schools to provide dual degree opportunities such as, MBA-DPT degrees; and (c) develop formal specialty management, business, and leadership tracts. This study’s participants also identify an opportunity to leverage and empower physical therapist students and graduates more as change agents to inform practice and to develop and role model the new skills needed of the role of the physical therapist undergoing its expansion. This action will require students to understand more about the process of change and to develop the knowledge and skills at entry-level needed to be effective as agents of change.

**Conclusion**

The role of the physical therapist is *expanding* in response to the changing and complex needs of clinical practice as well as the expectations imposed by APTA’s Vision 2020. Evidence supports that core competencies are expanding in physical therapist practice (Guide). New graduates in physical therapy are expected to be prepared to fulfill multiple professional roles, including administration or management, and to thoroughly assume the role of the clinician in contemporary physical therapist practice (Guide). Practice management knowledge and skills are required upon entry into the profession and are essential to entry-level preparation (Lopopolo, Schafer, & Nosse, 2004).
The profession of physical therapy is intentionally transforming the role of the physical therapist in practice as indicated by the APTA’s Vision Sentence for Physical Therapy 2020. Yet, the proof of the effectiveness of the change process is whether the changes actually take place and are sustained (Giardino et al., 1994). Effective or successful change occurs when the people involved with or affected by the changes develop new attitudes or responses to them and actually carry them out (Giardino et al.).

Lewin’s (1947) concepts of: (a) ‘unfreezing’ deeply held values, norms, and behaviors by outside change agents; (b) analyzing the change process to address individual driving and restraining forces; and (c) determining how to diminish negative factors and enhance positive forces provide insight into why practice management skills are not being integrated adequately within all entry-level physical therapist education programs and highlights areas for improvement.

Lewin’s 3 Step Change Model (1947), including the concepts of driving and restraining forces, provides direction and insight into what is occurring in entry-level physical therapist education. The perceptions of faculty of the driving and restraining forces to integrating practice management skills at entry-level are characterized by: role reframing, role dissonance, role resistance, and role expansion. The findings of this study suggest that the physical therapy profession is in the stage of ‘unfreezing’ as it relates to role expansion. Findings also suggest that the role of the physical therapist is in the stage of ‘unfreezing’ as it transforms to meet the needs of contemporary practice and the role expectations established by APTA’s Vision 2020.

Participants in this study emphasize that the integration of practice management skills at entry-level will strengthen the role of the physical therapist as a manager or
business person thereby, expanding the role of the physical therapist. Ultimately, this role expansion will transform the role of the physical therapist in clinical practice. Reframing the role of the physical therapist in practice is needed to neutralize and transform the restraining forces supporting role dissonance and the driving forces supporting role resistance, limiting role expansion at entry-level. Also, reframing the role of the physical therapist as a leader requires the development of leadership skills at entry-level.

This investigation was worthwhile and timely. Evidence, as well as the findings of this study, identify that curricular change is a process and is occurring (Bellack, Graber, O’Neil, Musham, et al., 1999; Foord-May, 2006). Additionally, this study’s finding supports evidence that acquiring a new role is a process and requires a collective effort to facilitate change (Yellin, 1999). This study’s findings provide direction for leaders at multiple levels within the physical therapist profession to move in the direction of change and growth for the profession. Participants in this study provide several recommendations for facilitating greater integration of practice management at entry-level. For example, embedding practice management as a curricular thread facilitates ‘unfreezing’ by making this content explicit and expected across all PT programs. As a result of this change, faculty, clinicians, and students will become more accountable and responsible for developing practice management skills collectively and they will become more informed, thereby decreasing naiveté. When faculty, students, and clinicians become less naïve and more informed, then role resistance will diminish, role dissonance will reconcile, and role expansion will occur. Reframing will ultimately help to position and guide the role expansion process.
References


http://www.apta.org/AM/Template.cfm?Section=Home&Template=CM/ContentDisplay.cfm&ContentID=43038.


http://www.apta.org/AM/Template.cfm?Section=Surveys_and_Stats/&Template=/MembersOnly.cfm&ContentID=57922.


65) [Position]. Retrieved {September 13, 2008} from

http://www.apta.org/AM/Template.cfm?Section=Professional_PT&TEMPLATE=
/CM/ContentDisplay.cfm?&CONTENTID=27559.

American Physical Therapy Association. Standards Of Practice For Physical Therapy

[HOD S06-03-9-10 (Program 32) [Standard]]. Retrieved {July 11, 2009} from

http://www.apta.org/AM/Template.cfm?Section=Policies_and_Bylaws&CONTE
NTID=33912&TEMPLATE=/cm/ContentDisplay.cfm.


{July 26, 2009} from

http:www.apta.org/AM/Template.cfm?Section=Physical_Therapy_Workforce&T
EMPLATE=/CM/ContentDisplay.cfm&CONTENTID=61540.

American Physical Therapy Association. Working Operational Definitions of Elements

of Vision 2020 From the Task Force on Strategic Plan to Achieve Vision 2020.

Retrieved {September 13, 2008} from

m&ContentID=39951.


Study. Physiotherapy Canada, 35(2), 77-83.


Therapy Practice. Physical Therapy, 66(6), 954-960.


Curriculum Trends in Nurse Practitioner Programs: Current and Ideal. Journal of


entDisplay.cfm&ContentID=19980.


Appendix A

Working Operational Definitions of Elements of Vision 2020
From the Task Force on Strategic Plan to Achieve Vision 2020
June 2007

APTA Vision Sentence for Physical Therapy 2020
By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

APTA Vision Statement for Physical Therapy 2020
Physical therapy, by 2020, will be provided by physical therapists who are doctors of physical therapy and who may be board-certified specialists. Consumers will have direct access to physical therapists in all environments for patient/client management, prevention, and wellness services. Physical therapists will be practitioners of choice in patients’/clients’ health networks and will hold all privileges of autonomous practice. Physical therapists may be assisted by physical therapist assistants who are educated and licensed to provide physical therapist directed and supervised components of interventions. Guided by integrity, life-long learning, and a commitment to comprehensive and accessible health programs for all people, physical therapists and physical therapist assistants will render evidence-based services throughout the continuum of care and improve quality of life for society. They will provide culturally sensitive care distinguished by trust, respect, and an appreciation for individual differences. While fully availing themselves of new technologies, as well as basic and clinical research, physical therapists will continue to provide direct patient/client care. They will maintain active responsibility for the growth of the physical therapy profession and the health of the people it serves.

Working Operational Definitions of Elements of Vision 2020:
Autonomous Physical Therapist Practice
Physical therapists accept the responsibility to practice autonomously and collaboratively in all practice environments to provide best practice to the patient/client. Autonomous physical therapist practice is characterized by independent, self-determined, professional judgment and action.

Direct Access
Every consumer has the legal right to directly access a physical therapist throughout his/her lifespan for the diagnosis of, interventions for, and prevention of, impairments, functional limitations, and disabilities related to movement, function and health.

Doctor of Physical Therapy and Lifelong Education
The Doctor of Physical Therapy (DPT) is a clinical doctoral degree (entry level degree) that reflects the growth in the body of knowledge and expected responsibilities that a
professional physical therapist must master to provide best practice to the consumer. All physical therapists and physical therapist assistants are obligated to engage in the continual acquisition of knowledge, skills, and abilities to advance the science of physical therapy and its role in the delivery of health care.

Evidence-Based Practice
Evidence-based practice is access to, and application and integration of evidence to guide clinical decision making to provide best practice for the patient/client. Evidence-based practice includes the integration of best available research, clinical expertise, and patient/client values and circumstances related to patient/client management, practice management, and health care policy decision making. Aims of evidence-based practice include enhancing patient/client management and reducing unwarranted variation in the provision of physical therapy services.

Practitioner of Choice
Physical therapists personify the elements of Vision 2020 and are recognized as the preferred providers among consumers and other health care professionals for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

Professionalism
Physical therapists and physical therapist assistants consistently demonstrate core values by aspiring to and wisely applying principles of altruism, excellence, caring, ethics, respect, communication and accountability, and by working together with other professionals to achieve optimal health and wellness in individuals and communities.


Appendix B

*FINHOP@ Categories and Definitions*

<table>
<thead>
<tr>
<th>Category Name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>Planning, controlling the financial operation of a business</td>
</tr>
<tr>
<td>Information management</td>
<td>Managing tangible information</td>
</tr>
<tr>
<td>Networking</td>
<td>Managing the interactions of various individuals or groups</td>
</tr>
<tr>
<td>Human resource management</td>
<td>Managing personnel who provide direct or indirect service to customers</td>
</tr>
<tr>
<td>Operations</td>
<td>Managing day-to-day nonpersonnel matters within the organization</td>
</tr>
<tr>
<td>Planning and forecasting</td>
<td>Being involved in determining the future course of action for the organization.</td>
</tr>
</tbody>
</table>

@ The acronym “FINHOP” represents the 6 categories of the administration and management model.

Appendix C

*HPA Section Research Grant Budget & Justification*

<table>
<thead>
<tr>
<th>Activity &amp; Justification</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase list from APTA/CAPTE (PT programs; list of faculty and Program Directors)</td>
<td>$100 est.</td>
</tr>
<tr>
<td>Long distance phone calls (for participant recruitment)</td>
<td>$100</td>
</tr>
<tr>
<td>Purchase ATLAS Ti software (pending investigation)</td>
<td>$130 (student version) (pending)</td>
</tr>
<tr>
<td><strong>Focus Group (CSM 2010)</strong></td>
<td></td>
</tr>
<tr>
<td>Travel stipend-CSM 2010 (32 participants at $150 each) and ‘travel pool’ ($2,000) for discretionary allocation needed (to ensure successful recruitment of participants)</td>
<td>$6,800</td>
</tr>
<tr>
<td>2-Digital tape recorders (for transcription) + extra microphones needed for focus group</td>
<td>$150</td>
</tr>
<tr>
<td>HPA Suite – room rental fee</td>
<td>$300 est.</td>
</tr>
<tr>
<td>Food &amp; refreshments during focus groups (32 x $10 per person)</td>
<td>$320</td>
</tr>
<tr>
<td>Transcription services</td>
<td>$1,000 est.</td>
</tr>
<tr>
<td>Small token as thank you for participation (32 participants x $10)</td>
<td>$320</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$9,220</strong></td>
</tr>
</tbody>
</table>

Approved by HPA Board June 1, 2009 in Baltimore, MD.
INFORMED CONSENT FORM

Title of study: **Perceptions of Physical Therapist Faculty of the Driving and Restraining Forces to Integrating Practice Management Skills into Accredited Entry-Level Physical Therapist Programs in the United States**

Name(s) of researcher(s): Jennifer E. Wilson, PT, MBA  
Doctoral Candidate, Ed.D Program in Executive Leadership  
Ralph C. Wilson, Jr School of Education

Faculty Supervisor: Dianne Cooney-Miner  
Phone for further information: 585-747-9622

**Purpose of study:** The primary purpose of this research study is to identify the perceptions of physical therapist faculty of the driving and restraining forces to integrating practice management skills into accredited entry-level physical therapist programs in the United States. The secondary purpose of this study is to attempt to identify basic demographic information about faculty teaching practice management skills in entry level physical therapist programs in the United States.

**Approval of study:** This study has been reviewed and approved by the St. John Fisher College Institutional Review Board (IRB).

**Place of study:** The focus groups will be held Wednesday February 17 through Friday February 19, 2010 during the Combined Sections Meeting (CSM) in February in the Hilton San Diego Bayfront San Diego, California. Journaling and member checking will take place wherever the participant chooses to journal.

**Participants will be asked to participate** in all of the data collection strategies: focus groups, completion of a brief demographic survey, and will be given an opportunity to submit other thoughts via journal entries and member checking.

**Length of participation:**

**Time Estimates Per Participant:**

*Prior to Focus Group*

Review FINHOP model.  
Complete journal entry.  
30 minutes  
30 minutes

*Focus Group*

Member checking (round 1)  
Member checking (round 2; if needed)  
90 minutes  
30 minutes

*Post-Focus Group*

Total Estimated Time Per Participant:  
4 hours
Risks and benefits: The expected risks and benefits of participation in this study are explained below:
There are no anticipated risks to participants in this study. Participation in this study is completely voluntary and participants will be reminded that they may refuse to answer or participate in any discussion. Due to the nature of qualitative questions, participants determine what they do and do not want to reveal in response to the interview and focus group questions.

Benefits for Participating:
1. Each participant will be offered a travel stipend of one hundred and fifty dollars ($150.00) as a token of appreciation for participation. This stipend allowance was approved as part of the HPA Research grant.
2. Participants will contribute to identifying perceptions of faculty to driving and restraining forces to integrating practice management skills in accredited entry-level physical therapist programs in the United States. The researcher plans to publish the results of this study in a national publication.
3. Participants may be able to expand their national network of peers with similar content expertise and who teach similar content areas.
4. There will be refreshments available during the focus group.
5. Participants may be given a small token of appreciation for participating (as the budget allows).

Potential Impact and the Outcomes of the Research Study:
1. Increase awareness of the phenomenon occurring in physical therapy education and the profession.
2. Using data collected from this qualitative study, conduct a national quantitative research study to identify the prevalence of the perceived driving and restraining forces to integrating practice management skills in accredited entry-level PT programs.
3. Repeat this qualitative study and gather data regarding the perceptions of: (a) students; (b) New Professionals; (c) employers; and (d) clinicians.
4. Develop a collaborative grassroots effort to integrate practice management skills better into entry-level PT programs.
5. Increase the depth and breadth of practice management content integrated into entry-level PT curriculum.

Method for protecting confidentiality/privacy: The focus groups will be audiotaped and transcribed. Only the researcher and the transcriber will have access to the tapes and transcripts. The tapes and transcripts will be kept in a secure location in the researcher’s office. Participants will be asked if they would like their first names used or if not, they can select an alias to be used in the transcription. Data will be reported using the first name that the participant selects. The data will be analyzed and brought back to the participants for validation possibly two times before being published.

Your rights:
As a research participant, you have the right to:
1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to you.
5. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

Print name (Participant)  Signature
Date

Print name (Investigator)  Signature
Date

If you have any further questions regarding this study, please contact the researcher listed above. If you experience emotional or physical discomfort due to participation in this study, please contact the Office of Academic Affairs at 385-8034 or the Wellness Center at 385-8280 for appropriate referrals.

Researcher:  Jennifer E. Wilson, PT, MBA

Sponsoring institution:  Ralph C. Wilson, Jr. School of Education,
St. John Fisher College (SJFC), Rochester, NY
Appendix E

Reflective Journaling Exercise

Directions:


Step 2: Answer the following questions.

Were you previously familiar with the FINHOP framework/study?
Yes/No

If yes, do you use this framework/study to integrate practice management skills in your PT program? Yes/No

If yes, please tell me how you use it.

If no, would you start using this framework/study in the future? Yes/No

If yes, tell me how you could use it? Please explain.

If no, describe your initial impressions after reading this study. Specifically, describe your initial impressions regarding the FINHOP model.

Tell me your overall impressions of the FINHOP model?

Tell me, if any, recommendations you would make to these researchers or faculty/researchers using this study/FINHOP as a reference?

Please tell me about other documents and resources you use to inform/guide the integration of practice management skills in the PT curriculum?
Appendix F

Focus Group (FG) Interview Schedule

FG Participants
☐ Faculty & Program Directors

Preparation:
All FG participants will be:
1. Invited to review FINHOP model.
2. Journal before participating in the focus group
   a. Informed consent (get signatures)

Opening:
Thank you very much for your willingness to participate in this discussion today. You are here because of your unique positions, experiences, and knowledge. Please use first names only to ensure anonymity and confidentiality. Want to hear from you to gain all perspectives, positive as well as negative.

Grand Tour Question:
Tell me about your experience in integrating practice management skills in entry-level PT curriculum.

Tell me about your feelings about integrating practice management skills in entry-level PT programs.
Tell me about your roles in integrating practice management skills in entry-level PT curriculum.
Tell me about faculty discussions to integrating practice management skills in entry-level PT curriculum.
Tell me about faculty decision-making to integrating practice management skills in entry-level PT curriculum.
Are there other experiences like that?
Tell me about your experience of your students in integrating practice management skills in their entry-level preparation.

Ending Questions:
What would you tell other ‘faculty’ about this topic?
What would you tell students entering a PT program?
Is there anything that we missed? Is there anything that you came wanting to say that you didn’t get a chance to say?

Closing
Complete 1 page demographic survey for all FG participants:
Announce member checking (1 round and approx. timeframe).
Appendix G

Focus Group Demographic Participant Information Survey

Section 1A: Information about You

Teaching Experience

In what content area do you teach primarily? MARK (X) ONE

- Administration/Management [1]
- Professional Issues [2]
- Musculoskeletal [3]
- Neuromuscular [4]
- Clinical Education [5]
- Pediatrics [6]
- Neuroscience [7]
- Anatomy [8]
- Research [9]
- Cardiopulmonary [10]
- Physiology [11]
- Therapeutic Exercise [12]
- Electrotherapy/Modalities [13]
- Geriatrics [14]
- Other: (please list) [99]

Length of time teaching in your primary area?

- Less than 1 year [1]
- 1-2 years [2]
- 3-4 years [3]
- More than 5 years [4]

In what content area do you teach secondarily? MARK (X) ONE

- Administration/Management [1]
- Professional Issues [2]
- Musculoskeletal [3]
- Neuromuscular [4]
- Clinical Education [5]
- Pediatrics [6]
- Neuroscience [7]
- Anatomy [8]
- Research [9]
- Cardiopulmonary [10]
- Physiology [11]
- Therapeutic Exercise [12]
- Electrotherapy/Modalities [13]
- Geriatrics [14]
- Other: (please list) [99]

Length of time teaching in your secondary area?

- Less than 1 year [1]
- 1-2 years [2]
- 3-4 years [3]
- More than 5 years [4]

Do you primarily teach the practice management content in your program? MARK (X) ONE

- Yes [1]
- No [0]

How long have you been teaching the practice management content in your entry-level PT program? MARK (X) ONE

- Less than 1 year [1]
- 1-2 years [2]
- 3-4 years [3]
- More than 5 years [4]
- N/A [5]

Currently, what is your primary role? MARK (X) ONE

- Dean or Associate Dean
- Program Chair or Director
- Faculty, Full-time, Associate Professor
- Faculty, Full-time, Assistant Professor
- Clinical Faculty, Full-time
- Adjunct/Associate Faculty, Part-time
- Other:

Length of time in this role?

- Less than 1 year [1]
- 1-2 years [2]
- 3-4 years [3]
- More than 5 years [4]

Are you male or female? MARK (X) ONE

- Male [1]
- Female [2]

In what age range do you fall? MARK (X) ONE

- 25-35 years [1]
- 35-45 years [2]
- 45-55 years [3]
- 55-65 years [4]
<table>
<thead>
<tr>
<th>Section 1B: Information about You</th>
<th>Section 3: Information about Your Entry-Level Physical Therapy Program as it relates to practice management.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td>In what type of course(s) do you include practice management content? <strong>MARK (X) ONE</strong></td>
</tr>
<tr>
<td>Type of professional (entry-level) education program you have completed to become a PT (prior to taking licensure exam)?</td>
<td></td>
</tr>
<tr>
<td><strong>MARK (X) ONE</strong></td>
<td>Series of practice management courses over several semesters [2]</td>
</tr>
<tr>
<td>❑ Baccalaureate [1]</td>
<td>Dedicated course in practice management PLUS some practice management content included in Professional Issues course(s) [3]</td>
</tr>
<tr>
<td>❑ Postbaccalaureate Certificate [2]</td>
<td>No dedicated course in practice management; content only in Professional Issues course(s) [4]</td>
</tr>
<tr>
<td>❑ Entry-level Master’s [3]</td>
<td>Combination of classroom and clinical learning experiences [5]</td>
</tr>
<tr>
<td>❑ DPT [4]</td>
<td>Other [99]</td>
</tr>
<tr>
<td>❑ Other [99]</td>
<td>Total estimated number of credit hours dedicated to practice management content?</td>
</tr>
<tr>
<td>Highest earned degree (or degrees) held in any area of study <strong>MARK (X) ALL THAT APPLY</strong></td>
<td>❑ Less than 3 credit hours [1]</td>
</tr>
<tr>
<td>❑ Associate [1]</td>
<td>❑ 3 credit hours [2]</td>
</tr>
<tr>
<td>❑ Baccalaureate [2]</td>
<td>❑ 3-5 credit hours [3]</td>
</tr>
<tr>
<td>❑ DPT [4]</td>
<td>❑ Other [99]</td>
</tr>
<tr>
<td>❑ PhD (or equivalent, eg EdD or ScD) [5]</td>
<td><strong>In what type of institution is your entry-level program?</strong></td>
</tr>
<tr>
<td>❑ PhD (or equivalent) and DPT [7]</td>
<td>❑ Public [2]</td>
</tr>
<tr>
<td>❑ PhD (or equivalent) and tDPT [8]</td>
<td><strong>Section 4: Information about Your Teaching Methods for teaching practice management at entry-level.</strong></td>
</tr>
<tr>
<td>❑ Other [99]</td>
<td>In what ways do you teach practice management content? <strong>MARK (X) ALL THAT APPLY</strong></td>
</tr>
<tr>
<td>Do you have a business degree (eg MBA)? <strong>MARK (X) ONE</strong></td>
<td>❑ Lecture [1]</td>
</tr>
<tr>
<td>❑ No [0]</td>
<td>❑ Small group work [3]</td>
</tr>
<tr>
<td>Have you completed any professional development related to areas of practice management? <strong>MARK (X) ONE</strong></td>
<td>❑ Case-based [4]</td>
</tr>
<tr>
<td>❑ No [0]</td>
<td>❑ Experiential learning (applied experiences) [6]</td>
</tr>
<tr>
<td><strong>Section 1C: Information about You</strong></td>
<td>❑ Guest lectures [7]</td>
</tr>
<tr>
<td><strong>Work Experience</strong></td>
<td>❑ Journal review/discussion [8]</td>
</tr>
<tr>
<td>Have you held a ‘management, leadership, or supervisory’ role in physical therapy? <strong>MARK (X) ONE</strong></td>
<td>❑ Capstone project (eg Business plan) [9]</td>
</tr>
<tr>
<td>❑ Yes [1]</td>
<td>❑ Clinical experiences [10]</td>
</tr>
<tr>
<td>❑ No [0]</td>
<td></td>
</tr>
<tr>
<td>Length of management, leadership, supervisory experience?</td>
<td>❑ 1-2 years [2]</td>
</tr>
<tr>
<td>❑ Less than 1 year [1]</td>
<td>❑ 3-4 years [3]</td>
</tr>
<tr>
<td>❑ 1-2 years [2]</td>
<td></td>
</tr>
</tbody>
</table>
☐ More than 5 years [4]  ☐ Other [99]