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The February holiday honors US presidents. Here are some facts about one of them, Franklin D. Roosevelt (FDR), and the Roosevelt Warm Springs Institute for Rehabilitation in Georgia.

- FDR bought the Warm Springs resort in 1926, turning it into the first hospital devoted to polio treatment.
- He visited Warm Springs every year (except 1942) from 1924 until he died there in 1945. The Little White House, built in 1932, is a national historic landmark.
- While the site’s eponymous warm springs are closed to the public, they still feed the institute’s therapeutic pools.
- Other US presidents have visited Warm Springs. Both John F. Kennedy and Jimmy Carter spoke there during their presidential campaigns.

https://www.nps.gov/nr/travel/presidents/roosevelts_little_white_house.html

http://gvra.georgia.gov/warmssprings/
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**International Volunteering**

Having done volunteer work as a physical therapist (PT) for 11 years in Macedonia, 2 years in Africa, and recently in Haiti, I do not agree with many of the comments in “Making the Most of International Volunteer & Learning Opportunities” (November 2016).

Volunteering in other countries is important work. To consider it volunteerism certainly does not describe it. Volunteering and tourism should be separated. They are not the same.

PTs should carefully select which organization they choose, and certainly the sponsoring company should not enrich itself with money the students pay. It is all right, however, if one knows that part of the payment helps the cause of volunteer work.

I disagree with the comment that it is not efficient to use foreign-based volunteers in Kenya. I volunteered there and was able to teach physicians about physical therapy treatment possibilities. I taught PTs about different treatment options. I also worked with PTs treating their patients. They learned new skills that they could apply to treating other patients. I then was invited to teach PTs in the general hospital in Nairobi about women’s health, so, in 2 weeks, I reached a great number of PTs. In Macedonia, I do similar work. The PTs do not have many experienced therapists to offer their teaching expertise, so I was asked to teach classes in different subjects to both PTs and students studying to become PTs.

Thanks to the help of publishers and booksellers, I also was able to procure physical therapy textbooks that local PTs, with their low incomes, could not afford. Macedonia’s physical therapist association now has approximately 100 textbooks in its library, helping both teachers and students. Sometimes I stay 2 weeks and work with PTs and their patients. This year I worked with them to enhance treatment in intensive care.

I've also helped PTs find information on the Internet about early rehabilitation in intensive care. Many do not know what "ICU" means, nor would they recognize which research papers come from reputable sources. I can see how much the PTs are learning. Their interventions have changed from mostly passive range-of-motion to include patient participation and functional exercises. More-comprehensive evaluations are being conducted, resulting in better outcomes.

My Macedonia and Kenya volunteer work “fell into my lap” when I was asked to help, and it has continued to grow. The truth is that PTs in these countries cannot take expensive courses in English-speaking countries and pay for the transportation and lodging, given monthly salaries of approximately $250 to $300. That’s why experienced PTs need to go there and volunteer.

Last year I also volunteered in Haiti for 2 weeks as part of the group STAND—Sustainable Therapy And New Development—which was founded by 2 PTs from Oregon. Our group of PTs, nurses, orthotists, and prosthetists joined more than 30 volunteers. I understand that a Haitian PT needs to earn some money and cannot work for free. We worked in northeast Haiti, where the average pay is a dollar or 2 a day. We treated the poorest of the poor. The goal of STAND Haiti is to train Haitians so that they can help their own people. We saw patients who had walked for hours to reach us. Some had not eaten for 24 hours. They could not afford to buy food, pay a doctor, or buy medicine or shoes. They had all types of injuries, many of which have been unattended for years.

We did not charge patients for treatment. We gave them shoes, canes, crutches, braces, and medicine, if necessary. STAND paid for X-rays. Our group had 2 PT students, who learned a lot that they would not have in America. They were surrounded by a group of therapists with varying expertise who worked as a team, helping each other as needed. We all learned from one another.

The experience of working outside America transforms us. I would not call it sexy or thrilling. To the contrary, it makes us humble, and more grateful for what we have.

Beate Carrière, PT

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**PT in Motion welcomes your opinions. We will consider letters, email, and posts that relate to specific articles in the magazine and those of general interest to the physical therapy profession.**

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Compliance Matters

By Carmen Elliott

New CPT Evaluation Codes Are Here

What you need to know about the changes.

Effective January 1, 2017, Current Procedure Terminology (CPT; ©American Medical Association) code 97001 (physical therapy evaluation) was deleted from the AMA CPT code book and replaced with 3 new tiered codes designed to enable physical therapists (PTs) to better describe the complexity of patients’ and clients’ clinical presentation and other important contextual factors affecting their outcomes. Code 97002 (physical therapy reevaluation) also was deleted and replaced with a new reevaluation code.

Despite the recommendation of AMA’s Relative Value Scale Update Committee (AMA RUC), the Centers for Medicare and Medicaid Services (CMS), in the 2017 physician fee schedule, priced the new evaluation codes as a group—using the same value for all 3 codes—rather than stratifying them. CMS says it will collect and analyze utilization data on the new evaluation codes during 2017 to help determine possible future changes in payment policy. This means that even though the code values weren’t stratified for 2017, it’s critical for PTs to be thoughtful in choosing the most accurate code for each examination, as CMS potentially will use the data when and if it does decide to establish tiered payment.

Here are some key facts to help you start using the codes correctly.

The New Codes

Code 97161 (physical therapy evaluation, low complexity) denotes:

- A history of the present illness or problem, citing no personal factors and/or comorbidities that affect the plan of care;
- A limited examination of the affected body area or organ system, using standardized tests and measures addressing 1 or 2 of the following: body structures and functions, activity limitations, and/or participation restrictions;
- A clinical presentation featuring stable and/or uncomplicated characteristics; and
- Clinical decision making of low complexity, using a standardized patient...
assessment instrument and/or measurable assessment of functional outcome.

This level of evaluation typically will require 20 minutes face-to-face with the patient or client and/or family.

**Code 97162** (physical therapy evaluation, moderate complexity) denotes:

- A history of the present illness or problem that includes a review of the pertinent body system and cites 1 or 2 personal factors and/or comorbidities that affect the plan of care (potential factors include sex, age, coping style, social background, education, profession, past and current experience, overall behavior pattern, character, and other elements that may influence how disability is experienced by the individual);

- An examination of the affected body area or organ system and other symptomatic or related areas and systems, using standardized tests and measures to address a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;

- An evolving clinical presentation, featuring changing characteristics; and

- Clinical decision making of moderate complexity, using a standardized patient assessment instrument and/or measurable assessment of functional outcome.

This level of evaluation typically will require 30 minutes face-to-face with the client and/or family.

**Code 97163** (physical therapy evaluation, high complexity) denotes:

- A history of the chief problem (review extended to a limited number of additional body systems and to pertinent past, family, and/or social history) that includes 3 or more personal factors and/or comorbidities that affect the plan of care;

- An examination of the applicable body system or systems, using standardized tests and measures to address a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions;

- An evolving clinical presentation featuring unstable and unpredictable characteristics; and

- Clinical decision making of high complexity, using a standardized patient assessment instrument and/or measurable assessment of functional outcome.

This level of evaluation typically will require 45 minutes face-to-face with the patient or client and/or family.

**Code 97164** (physical therapy reevaluation) denotes:

- An examination including a review of history and use of standardized tests and measures; and

- A revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome.

The reevaluation typically will require 20 minutes face-to-face with the patient or client and/or family.

One thing to note is that the typical times listed for each code are for guidance only; these are not timed codes. The amount of time spent with the patient or client for an examination can vary greatly at any of the 3 levels of complexity.

**Frequently Asked Questions**

**Why did 3 new CPT codes replace the single evaluation code 97001?** The federal government and leading policy groups had been discussing needed reforms to therapy payments under federal programs. In June 2013, a report from the Medicare Payment Advisory Commission (MedPAC) included payment reform recommendations for physical therapy under Medicare. These recommendations included payment reductions, access limitations, and utilization controls.

In addition, increasing regulatory and legislative burdens on physical therapy providers spurred APTA to more aggressively pursue alternative payment and coding methods to help ease or prevent policies that negatively affected payment for physical therapist services.
APTA recognized that the health care system was in the process of transitioning from being based on the volume of services to being value-based. Revising the physical medicine and rehabilitation (PM&R) evaluation codes to a patient management coding system starts positioning physical therapy as an integral component of new, value-based health care. A first step was revising the evaluation codes within the PM&R code set.

(For more on how coding changes fit into the larger picture of health care reform, see “Coding Reform, to Payment Reform, to Health Care Reform” in the April 2016 issue of PT in Motion.)

To which providers, settings, and entities do these new codes apply? The new CPT codes apply to PTs and others providing therapy services in outpatient Part B settings that are billed to third-party payers using CPT codes. Beyond PTs, all entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), such as federal and commercial payers, must use the new codes. (Workers’ compensation programs and auto liability carriers are not required to acknowledge the new codes, as they are exempt from HIPAA.)

What changes must I make to my practice to implement the new CPT codes—for example, in such areas as staff training and electronic medical records (EMR)? Staff must be trained on the new coding system. Because the new system has 3 levels of evaluation, PTs must be able to distinguish among varying patient presentations in order to select the appropriate code level. EMR must be updated to incorporate the new codes, and outdated CPT evaluation and reevaluation codes must be removed from EMR systems.

Will documentation requirements change with these new CPT codes? Yes, most likely. Look to APTA’s website for updates on this. In the meantime, as with the old codes PTs should ensure that their documentation supports the services they are performing and the code they are billing. PTs also should document the clinical reasoning behind their choice of code level, including support for the selected code based on the patient’s presentation.

Of note, in response to APTA’s comments that PTs should not be unduly penalized by Medicare administrative contractors during medical reviews while becoming familiar with the new code set, CMS has delayed changes to the Medicare Benefits Policy Manual (MBPM) related to documentation instructions for physical therapy evaluations and reevaluations. CMS reminds PTs, however, that they are expected to comply with the existing MBPM instructions for evaluation and reevaluations that were in effect for the old evaluation codes.

How will value/outcomes be measured for my patients under this new system? Codes are 1 part of the system for reporting services for the purpose of payment. The new coding system does not measure outcomes on its own; it must be paired with outcomes measures. The coding language (refer back to the descriptions under each new code number earlier in this column) does incorporate use of standardized tests and measures to help the physical therapy profession begin to report standardized data elements. This enables outcomes, and ultimately the value of physical therapy, to be measured in a more uniform manner.

Can the new codes be billed on the same day as other therapeutic procedures? Neither the CPT Handbook nor the National Correct Coding Initiative (NCCI) restricts PTs from billing the new evaluation codes on the same day as other therapeutic procedures, and many third-party payers follow the same regulations. However, billing the new codes along with some existing codes may require modifier -59 to indicate that the procedures are separate and distinct services. APTA’s NCCI webpage (http://www.apta.org/Payment/Medicare/CodingBilling/CCI/) includes a link to the NCCI resource that lists the affected code pairs.

For reevaluations, CMS bundled the old reevaluation code (97002) with all of the 97000-series therapy codes. This means if PTs performed a reevaluation during the same visit as any therapeutic procedure, they could bill for both services using the -59 modifier. This edit likely will apply to the new reevaluation code, 97164, as well. The reevaluation must be medically necessary and distinctly separate from the therapeutic procedure, and the distinction must be clearly indicated in the documentation.

In addition, indications for a reevaluation are new clinical findings or the patient’s failure to respond to interventions, which could lead to a change in the plan of care. While patients are assessed at each visit, it is unusual to perform or bill for a complete reevaluation.

What is the payment rate for the new evaluation codes? All 3 new evaluation codes retain the same relative value unit that the old 97001 code held (1.20). The new 97164 reevaluation code was revalued at 0.75, up from the 0.60 value of the old 97002 code. CMS established these rates under the 2017 Medicare physician fee schedule, which took effect on January 1. Third-party payers generally published their new payment rates after the release of the fee schedule last November. PTs should contact these payers directly for their current fee schedules.

Who should I contact if I have problems being paid when I bill using the new codes? Start by getting in touch with the payer to ensure that it is aware of the
coding changes. For Medicare-related issues, get in touch with the Medicare administrative contractor in your area.

Should you continue to have problems, contact APTA’s advocacy team at advocacy@apta.org.

**Where can I find more information about the new codes?** APTA continually updates its payment reform webpage that specifically pertains to the new codes. Visit www.apta.org/PaymentReform/NewEvalReevalCPTCodes/. There also is a discussion forum within APTA’s online Payment Reform Hub community for members to share their insights and ask staff experts their questions on the new evaluation codes. It’s open to all APTA members and is accessible with APTA member login by going to the Hub (http://communities.apta.org/p/us/in/), then the Payment Reform community, then New Evaluation and Reevaluation Codes Discussion.

**resources**

**American Physical Therapy Association**

- New Evaluation and Reevaluation CPT Codes Webpage
  www.apta.org/PaymentReform/NewEvalReevalCPTCodes/

- APTA Payment Reform Hub Community and Discussion Forum
  http://communities.apta.org/p/us/in/ (member login required)

- Free Self-Paced Course
  http://learningcenter.apta.org/ (Search for course code LMS-794)

**Centers for Medicare & Medicaid Services**

- National Correct Coding Initiative
  www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/

- Medicare Administrative Contractors
  www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html

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Students preparing for a career as a physical therapist (PT) or physical therapist assistant rely on the expertise and mentorship of clinical instructors (CIs) to help them gain the hands-on knowledge and skills they’ll need for success in the profession of physical therapy. Both CIs and students must be careful, however, to ensure that the relationship does not become unduly personal and threaten the integrity of the educational role. Consider the following scenario.

Heavy Lifting

Jim, a PT at a large rehabilitation hospital, relishes the opportunity to serve as a CI to students enrolled in the doctor of physical therapy (DPT) program at nearby State University. Jim, a State graduate, feels that the CIs who mentored him during his clinical rotations were invaluable in preparing him for success as a PT. He sees serving as a CI as a way of giving back to the profession and helping to ensure that today’s students are as ready as they can be for the challenges that will await them as newly minted PTs. The learning curve at the hospital is steep: patient presentations often are complex, and learning the institution’s ins and outs is difficult. Jim has greatly enjoyed his role in navigating bright, energetic students through their clinical rotations.

This is the fourth year Jim has taken a DPT student from State under his wing. Tom is a third-year student, and this is his final clinical rotation. It’s clear from the start that he’s eager to learn, and quite personable. But Jim soon finds that Tom isn’t as well-prepared and confident in his decision-making as were his previous students. Tom clearly isn’t ready to take on Jim’s full neurological caseload.

Jim does what he can to provide extra help, asking Tom to come in early and stay late, as the 2 men work together to improve the student’s knowledge and abilities and build his confidence. Jim contacts the...
university, and the Physical Therapy Department’s director of clinical education comes to the hospital to observe Tom in action and discuss the situation. She sets up a learning contract that spells out what it will take for Tom to successfully complete the rotation.

As time goes on, Jim does see some incremental improvements in Tom’s performance. The progress is not sufficient, however, to assign him the full caseload he should be carrying. Jim is impressed, though, by Tom’s continued determination to learn and grow. On a personal level, furthermore, the 2 men are hitting it off. They have many common interests and very good rapport. They’ve gotten to know each other quite well during the course of the rotation, given the extra hours and the intensity of the mentor-student relationship—often discussing family and personal matters at the beginning and end of the work day. Jim has talked of toasting Tom’s first job with him at a local bar once he’s graduated, passed the licensing exam to become a PT, and secured his first job. Jim feels that even though Tom is struggling a bit now, he has a bright future in the profession.

One week, as the 2 men are getting ready to go home on a Friday afternoon, Jim mentions that he and his wife will be moving from a condo to a small house over the weekend. “It’s not a huge job, and the distance isn’t that far, so we didn’t hire a moving company,” he says. “We’ve enlisted some friends to help, with pizza and beer as inducements. But one of my brawnier buddies begged out this morning, so now I’m thinking this might go into overtime—like, maybe late into Sunday night.”

“I’ve been there,” Tom responds. “Not with my own house, because I don’t have one yet, but when I helped my older brother and his wife move into their house a couple of years ago. This one friend of my brother’s never showed up, and we didn’t finish until 2 o’clock Monday morning. I yawned all the way through my first class at 8 am.”

Tom’s account gives Jim an idea. “You know,” the CI says, “you are a pretty big guy, and, well, you should have your body mechanics down at this point, right? Do you have any major plans this weekend? If you do, that’s fine. But if you’d have some time to help me out, I’d even throw in dessert after the pizza both days. I mean, that big sofa in our den isn’t going to move itself.”

Tom actually does have plans, but Jim’s gone out of his way to try to help him through the clinical rotation,

Considerations and Ethical Decision-Making

Jim doesn’t seem to see any ethical implications in asking Tom to help him move. Nor, for that matter, does it appear that Tom does. Both men apparently see the assistance as a personal matter that’s apart from their CI-student relationship. Might their friend-like relationship, however, be blurring ethical lines and obscuring underlying motives?

Realm. The realm is individual—between CI and student.

Individual process. The situation requires moral sensitivity, as Jim doesn’t seem to appreciate the power differential in the relationship, and the position into which he has placed Tom. For his part, Tom seems not to recognize the likely tug of that power differential on his decision to agree to help Jim move.

Ethical situation. This is a problem for Jim, in that moral values related to the power differential are being challenged. For Tom, this is a temptation: There is a right action and a wrong action for the student, but the wrong action—agreeing to help his CI move—holds potential benefits, whether or not Tom is consciously aware of them at first.

Ethical principle. The following principle of the Code of Ethics for the Physical Therapist offers both Jim and Tom guidance in their decision-making process:

Principle 4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority (eg, patients/clients, students, supervisees, research participants, or employees).
and Tom is grateful. He agrees to help out, and ends up spending several hours on both weekend days moving furniture and other items into Jim’s new home. The work wraps up around dinnertime on Sunday.

Upon arrival at the hospital on Monday morning, Tom and 2 other students who also are there on clinical rotations compare notes about their weekends. Tom thinks nothing of telling them the way he spent most of Saturday and Sunday. He becomes surprised and upset, however, when the other students exchange knowing glances, and when 1 of them—Beth—remarks in parting, “I guess your rotation is taken care of!”

Standing alone in the hospital hallway, Tom second-guesses his decision to help his CI move. He now realizes it could be seen as a quid pro quo if and when Jim signs off on Tom’s successful completion of the rotation. Was Beth’s remark meant playfully, or do his fellow students somehow know that he’s struggling and in danger of less-than-successfully completing his rotation?

Tom now questions, too, the propriety of Jim having sought his help with moving in the first place. Did his relationship with Jim overstep a line somewhere along the way?

For Reflection
What if Tom was doing fine in his clinical rotation? If his successful completion of the rotation wasn’t in doubt, would Jim’s request for help with moving, and Tom’s decision to say yes, still beg ethical questions?

For Followup
I encourage you to share your thoughts about the issues raised in this scenario by emailing me at kirschna@sph.rutgers.edu.

If you are reading the print version of this column, go online to www.apta.org/PTinMotion/2017/2/EthicsinPractice/ for a selection of reader responses to the scenario, as well as my views on how the situation might be handled. If you are reading this column online, simply scroll down to the heading “Author Afternote.”

Be aware, however, that it generally takes a few weeks after initial publication for feedback to achieve sufficient volume to generate this online-only feature.

resources

At www.apta.org/EthicsProfessionalism/

▸ Core ethics documents (including the Code of Ethics for the Physical Therapist and Standards of Ethical Conduct for the Physical Therapist Assistant)

▸ Ethical decision-making tools (past Ethics in Practice columns, categorized by ethical principle or standard; the Realm-Individual Process-Situation [RIPS] Model of Ethical Decision-Making; and opinions of APTA’s Ethics and Judicial Committee)

At www.apta.org/PTinMotion/2006/2/EthicsinAction/

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PREPARING FOR Old(er) Age
While it’s never too late to help older adults enjoy healthy and active lives, it’s a lot easier if you start helping them prepare during their younger years.

By Chris Hayhurst

If you watched the Olympics last summer, you may have noticed something remarkable: not only the athleticism, which certainly was outstanding, but also the “advanced” age of many of those competing.

Most famously, there was Michael Phelps, who at 31 and in his fifth Olympic Games would take home 5 golds and 2 silvers. But there also were a number of lesser-known athletes, many of whom were in their 40s and beyond. Among them: US cyclist Kristin Armstrong, who won her third gold medal in as many Olympic appearances the day before she turned 43; 41-year-old Uzbekistani gymnast Oksana Chusovitina, who didn’t win a medal this year but did earn team gold back in 1992; and Australian equestrian Mary Hanna, who at age 61 is a grandmother.

“Age Is No Barrier” was a typical headline touting the achievements of the games’ “mature” competitors. A BBC story framed it another way: “Rio Olympics: Older athletes still at the top.”

“It’s fabulous and inspirational what these athletes are doing,” says Carole Lewis, PT, DPT, PhD, a board-certified clinical specialist in geriatric physical therapy in Washington, DC. While last year’s Olympians weren’t “old” by conventional measures, they were well beyond what is generally considered to be prime competitive age, she notes. “They really are showing us that anything is possible, that no matter who you are—world-class athlete or not—just because you’re getting older doesn’t mean you have to stop doing the things you love to do.”

Lewis recalls reading about an 83-year-old bodybuilder who only started lifting weights when she turned 70. And Lewis has seen numerous patients in her own private practice who continued to exercise into their 90s.

“As a society, we unfortunately have a lot of misconceptions and prejudices about the potential of people who are older,” Lewis says. “Olympians are one thing, but we shouldn’t be so surprised every time we see people do something that seems to defy their age. Maybe what they’re doing is perfectly normal.”

Mike Studer, PT, MHS—co-owner of Northwest Rehabilitation Associates, a healthy-aging and neurology outpatient clinic in Salem, Oregon—agrees. “A lot of myths need to be debunked about what normal aging really is,” he says. “And we as physical therapists—the ‘movement experts’—should be out there leading the way.”

The Case for Prevention

That “normal aging” is not what it seems may be a hard sell to the patient who is older and needs a wheelchair to get around, or to the septuagenarian who’s recovering from hip surgery. That’s why, Lewis and Studer say, physical therapists (PTs) should be making the case for prevention—working with patients across the lifespan to help them avoid aging’s most common pitfalls.

“We should be helping people age successfully,” Lewis says. “And part of that involves raising public awareness of what we have to offer,” whether it’s in pediatrics, geriatrics, or to patients and clients in general. “We should show people how we can help them before they break a bone, or before they hurt their shoulder. And we should point to the evidence when we do—the research that shows that if you are strong, if you are flexible, and if you practice balance exercises and work on your endurance, you can not only improve your function but also reduce the chances of injuring yourself.”

Research also shows that people who reach age 70 in good health are better positioned to stay healthier longer, while people who reach that age in poorer condition are likelier to face deteriorating health earlier and more quickly, notes Linda Fried, dean of public health at Columbia University’s Mailman School of Public Health. “We must attend to the health of our...
population, so that people arrive at age 70 healthy and stay healthy longer,” she wrote in *The Future of Aging: Realizing the Potential of Longevity.*

In her own practice, Lewis works exclusively with geriatric patients. While some already have experienced debilitating injuries, many others are in relatively good health. “They’re a great population to work with because they’re starting to see changes,” she says, and they’re thinking about their future. “They realize that when they walk down the grocery aisle, they can’t turn their head side to side. Or they’ve noticed that when they go to pick up something from the floor, their back is so tight that they have to hold onto something.”

Her pitch to them, Lewis says, is simple: “You’re still shopping, you’re still picking stuff up, and that’s great. But wouldn’t you like to do those things the best way possible, and learn how to prevent that tightness from getting worse?”

Younger patients, Lewis admits, are less likely to be interested in addressing issues that may not yet seem worth their worry. “Younger patients are working out, running miles every day, lifting weights. Everything seems perfect, except for the injury that’s brought them to physical therapy. So what we need to do,” Lewis says, “is give them a balance test or something similar. Because, unless they’re 20 and a dancer, or they’re really in top shape, they’re going to show deficits they didn’t know they had.”

From there, Lewis advises, it’s just a matter of supplying suggestions for patients to consider the next time they exercise. For example, “Advise patients, ‘When you run, try turning your head from side to side to stimulate your vestibular system.’”

Studer generally sees 2 types of individuals in his 2 clinics, he says: those with neurologic impairments such as stroke and Parkinson disease, and those recovering from sports injuries or orthopedic challenges. He also offers a service called “GeriAthletics” for competitive athletes older than 65. “These people actively train for events such as marathons and triathlons,” Studer says. “They’re in the clinic because they know they’re going to be pushed, but in a way that respects both their goals and their age.”

That respect, Studer adds, is rooted in science. “Research has shown that as people age, they need more recovery time, and high-intensity interval training at a very specific dosage may be more effective than just increasing volume.” He’s been working with a client who just completed his first marathon at age 69. He first came to see Studer several years ago for a

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These examples are taken from “Optimizing Bone Health Across the Lifespan,” presented at the APTA Combined Sections Meeting in 2015. They don’t encompass a complete program but are meant as representative steps that might be taken at various stages of an individual’s life.


<table>
<thead>
<tr>
<th>STAGE</th>
<th>PRENATAL</th>
<th>INFANCY</th>
<th>CHILDHOOD</th>
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<tr>
<td>Age</td>
<td>0-6 months</td>
<td>6-12 months</td>
<td>1-3 years</td>
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<td>Exercise</td>
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<td>Weight bearing and muscle contractions. Moderate to vigorous activity daily.</td>
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<td>Lifestyle</td>
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<td>Keep out of direct sunlight.</td>
<td>Physical activity and time spent outdoors is encouraged, but minimize sunlight exposure.</td>
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<td>Calcium (mg/day)</td>
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<td>Nutrition</td>
<td>Vitamin D supplement.</td>
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<td>Comments</td>
<td>Bone formation.</td>
<td>Bone growth.</td>
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<td>9-18 years</td>
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<td>Weight bearing.</td>
<td>Work antigravity muscles: sit to stand frequently.</td>
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<td>Posture and balance activities.</td>
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<td>PTs should ask about</td>
<td>Absence of physical activity stimulates bone resorption.</td>
<td>Lifestyle modification (smoking cessation, moderation of alcohol consumption).</td>
<td>Adolescent history screening as part of a geriatric assessment.</td>
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<td>past and present eating</td>
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<td>Vitamin D replacement</td>
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<td>Bone growth. Peak bone</td>
<td>Parity (# of births after 20 weeks) is protective; improves bone mass density in later years.</td>
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<td>Bone mass decreases.</td>
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<td>mass density by age 20</td>
<td>Transient osteoporosis possible.</td>
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hamstring he’d injured while training for a sprint (shorter distance) triathlon. “He recovered from that and was hungry for more. Now he’s talking about competing into his 80s. He wants to keep going as long as he can.”

As a PT, Studer believes he is in a unique position to take people who currently are well—and with no falls history—and help them maintain and improve their health, with an eye toward success in older age. “Even if they don’t think of themselves as ‘athletes,’ they’re very interested in anything they can do to stay active and remain well,” Studer notes. By working with these clients in a wellness capacity rather than on a needs-only basis, “we can make a difference in how they’ll do later on in life,” he says.

A “Cornerstone of Practice”

Studer and Lewis hardly are the only PTs encouraging patients and clients to plan for their future.

“An emphasis on successful aging should be a cornerstone of every physical therapy practice,” says Mindy Renfro, PT, PhD, clinical coordinator of the Missoula-based Montana Adaptive Equipment Program. She helps individuals with developmental disabilities get the tools they need to be functionally independent. At the heart of that process is enabling “aging in place”—something she feels all PTs should attempt to facilitate, regardless of their patient and client population.

“The classic example,” Renfro says, “is the 55-year-old couple whose youngest child just went off to college. Do they spend money on turning that bedroom into a Jacuzzi space, or do they attach a ramp to the front steps to ensure that the house is accessible in case one of them has an injury and requires the accommodation?” When a person goes into a nursing home because his or her own home wasn’t designed to accommodate age-related needs, “their long-term prospects for getting back to their residence dim very quickly,” Renfro notes. PTs should make their older patients aware of this, she says, and “have that conversation before it’s too late.” [For more about aging in place, see “Making a House an Accessible Home” in the September 2016 issue of PT in Motion.]

Likewise, says Renfro, who works with patients and clients of all ages, PTs should incorporate “primary prevention for aging” into every treatment plan. “It’s about stopping the ‘illness before it occurs,” she explains. “Children, 20 year olds, 50 year olds—everyone’s aging, There’s no way around it.” But PTs can do their part, Renfro says, to help prevent conditions that might develop in relative youth, such as obesity, muscle weakness, or poor balance or posture.

“We as physical therapists can set our patients up with home programs they can follow over the long term,” she says—with resources they can use even after an episode of care has concluded. Such resources might include age-appropriate classes at the local YMCA, or participation in other community programs that promote physical activity. “If your patient weighs 100 pounds more than is recommended, all the quad sets in the world aren’t going to cure his knee pain,” Renfro notes. “We need to focus on treating the whole person—and not just how the patient feels after leaving the clinic, but how that person is going to do for the rest of his or her life.”

There are, of course, significant challenges to such an approach. “For physical therapists, it begins with our educational foundation,” Renfro says. And that, in turn, is built around the existing health care system. “Students are not taught to think about public health, successful aging, or primary prevention,” she notes, “because PTs are paid based on illness and injury. We’re not paid to keep people fit.”

Some PTs, such as Lewis, overcome that financial hurdle by employing cash-based business models. “Many people are ready to pay for this,” Lewis says. But even when they aren’t ready or are unable to do so, “that doesn’t mean we can’t talk about aging when they come to see us.”

What needs to change? In Renfro’s view, “We have to move to a single-payer system in which providers are paid per-person for health outcomes. Once we do that,” she says, “we’ll get serious about prevention and promoting successful aging.”

Starting Young

One PT committed to the cause of healthy aging is Hadiya Guerrero, PT, DPT. Before she was hired by APTA last April as a senior practice specialist, she worked primarily with pediatric patients in the Harlem area of New York City, and at the Mayo Clinic in Minnesota. She recounts 1 of her first early-intervention cases as a PT, and how it framed her vision of what she could do to help her patients become healthy adults.

“The patients were twins who had been referred for physical therapy because they were obese,” Guerrero says. They were in home care, but Guerrero devoted much of her time to getting the twins out of the house. “The mother was only 15 years old, so their grandmother was there, too. I took the entire family out to the park, and we walked around the neighborhood and looked for ways that everyone could be more active.”
Guerrero talked to the mother and grandmother about eating well, and showed them where they could find healthful snacks. She explained, too, the importance of leading by example. “Modeling good behaviors is critical in pediatrics,” she notes. “Take the stairs instead of the elevator. Pick up grapes and bananas at the corner store for snacks, instead of just buying soda and cupcakes.”

That was nearly a decade ago, but Guerrero still keeps in touch with the family. The twins, now 12 years old and in seventh grade, no longer are obese, but they are overweight. Guerrero describes them as “works in progress.” Still, she adds, the fact that progress is being made gives her hope.

“A lot of PTs who work with children may not think about their aging process all that much,” Guerrero notes, unless the child is dealing with an issue that always will be a part of his or her life.

Instead, she says, there’s a tendency to focus on the immediate problem, such as inability to climb stairs or need to rehab an injury. “But that needs to change,” Guerrero says. “We should be looking at the big picture—the things we can do now to set children up for their future.”

She recently attended a 2-day workshop titled “Nutrition Across the Lifespan for Healthy Aging” at the National Academy of Sciences (NAS) in Washington, DC. Guerrero recalls a speaker making the point that one’s health outcomes as an adult are in large part predetermined in early childhood. That reinforced Guerrero’s point that “we must get involved [in promoting lifelong health] as early as possible, because that’s 1 place where we can really make an impact.” (See the timeline “Optimizing Bone Health” on pages 18-19 for an example of steps that can be taken to optimize bone health as people age.)

Yves Joanette, scientific director of the Institute of Aging at the Canadian Institutes of Health Research, made a similar point in The Future of Aging. “Our susceptibility to various metabolic diseases,” he wrote, “will influence our lifelong condition. Nothing can be done about those genes, but the booming science of epigenetics tells us that the nature of our very early exposures can have a major impact on the manner in which our genetic potential actualizes itself. The future of aging would be brighter if there were programs to inform the public about the early-life optimal conditions that favor the good
sides of our genes and diminish their dark sides.”

**Happiness and Healthy Aging**

Guerrero, who is working on an APTA report that will detail physical therapy’s role in primary care, notes that aging today is different from what it was just a few decades ago. “People now expect to remain healthy and active well into old age,” she says. “And we now know what they need to do to help make that possible—how nutrition and exercise factor in.”

At the NAS gathering, a discussion revolved around biomarkers of aging—how, for example, elevated interleukin-6 serum levels are associated with mobility disabilities in old age. “A biologist who was well into his 80s spoke,” Guerrero recalls, “and he said that his ‘marker’ for healthy aging is whether he’s happy and still can do the things he wants to do. That statement struck me as being so simple, yet so perfect. What else is there beyond being able to physically and/or mentally do the things you enjoy in life?”

Even more recently, Guerrero says, she was on her way to visit a home care patient and saw a man who was older walking up a steep hill. “He was hunched over, leaning forward, and he kept his hands behind his back.” When she was returning to her office after the appointment, the man was continuing on his way. “Slow and steady, getting his exercise,” she says. “It was so inspiring to see.”

Carole Lewis, for her part, has seen many patients over the years in late middle age who have transitioned successfully into becoming high-functioning, active senior citizens. Nevertheless, she says, her goal for this year is to redouble outreach efforts to let the wider world know the ways in which PTs can help people healthily age. She’s writing letters to the editors of medical journals and even approaching the physicians who send her patients to offer them free balance screenings and assessments. “When some of these physicians see that they already have a balance deficit even though they’re only in their 30s or 40s, they’ll be more likely to understand how I might help their patients in primary care,” she reasons.

Physicians, Lewis says, “are becoming more aware of the preventive piece” and the role that it plays in optimizing health. “But medicine really has no idea how to do this,” she adds. “That’s a job for which I think PTs are uniquely qualified. Of all the professionals working in health care, I believe that we’re in the best position to help people age.”

**Chris Hayhurst is a freelance writer.**

**REFERENCE**


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Mindfulness: How It Can Help Patients, PTs, and Students

Physical therapists increasingly are using mindfulness in their interventions. New research supports its benefits.
By Michele Wojciechowski

A woman recovering from a mild stroke had problems with her balance. But they weren’t solely physical. “When we started working on balance, I noticed she would freeze up and become extremely anxious,” says Karen Mueller, PT, DPT, PhD, a professor in the program in physical therapy at Northern Arizona University. Mueller talked with her patient to get at the root of the problem. The woman revealed a fear of falling that caused her to tense up, which made it more difficult to do what she physically needed to do to improve.

Mueller suggested that mindfulness meditation might help. “I explained that mindfulness would help her focus on her body and what is happening,” she says. They began spending 10 minutes before each session on mindfulness meditation. “She’d begin the mindfulness exercises before her balance interventions. Bringing that more relaxed framework into her balance allowed her to be more comfortable with herself,” says Mueller. “Her balance rapidly improved after that. Her fear of losing her balance had been locking her up.”

Carolyn McManus, PT, MSPT, MA, picks up on that thought. “Generally, stress is a contributing factor when patients don’t recover as expected,” she says. “I’ve seen people who’ve gone through physical therapy, but no one has taught them the missing piece of awareness. It breaks my heart.” McManus established the popular Mindfulness-Based Stress Reduction (MBSR) program at Swedish Medical Center in Seattle. She’ll present a session on “Improving Pain Treatment With Mindfulness” at APTA’s NEXT 2017 Conference in June.

Mindfulness Defined

The American Mindfulness Research Association describes mindfulness as “the state, process, and practice of remembering to observe moment-to-moment experiences with openness and without automatic patterns of previously conditioned thoughts, emotions, or behaviors.

“Mindfulness,” the organization continues, “can be cultivated through mind-body practices (such as focused attention and open-monitoring meditation, as well as other intrapsychic and sensory-based practices) that are founded on a discerning mode of awareness that recognizes wholesome and unwholesome states of being.”

The concept of mindfulness received an initial wave of attention when Jon Kabat-Zinn, PhD, established the Stress Reduction Clinic at the University of Massachusetts Medical School in 1979. (He also was the founding executive director of the school’s Center for Mindfulness in Medicine, Health Care, and Society, established in 1995, and remains a professor of medicine emeritus.)

Kabat-Zinn—who has a doctorate in molecular biology from the Massachusetts Institute of Technology and is internationally known for his work as a scientist, writer, and meditation teacher—has focused his work and research on the effects of MBSR, the relationship between the mind and the body, and the clinical applications of mindfulness meditation. His 1990 book Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress Pain and Illness first addressed how people could use MBSR to promote their own health and healing.

“MBSR took off because it was the missing link in the whole health care system,” says Matthew J. Taylor, PT, PhD, director of the Matthew J. Taylor Institute, which takes a biopsychosocial approach to rehabilitation.

MBSR is described as comprising 3 different techniques:

- **Body scan**, which involves gradually sweeping attention through the entire body from feet to head, focusing noncritically on any sensation or feeling and using periodic suggestions of breath awareness and relaxation.

- **Sitting meditation**, which involves mindful attention on breath or the rising and falling abdomen, as well as on other perceptions, and a state of nonjudgmental awareness of cognitions and the stream of thoughts and distractions that continuously flows through the mind.

- **Hatha yoga practice**, which includes breathing exercises, simple stretches, and posture, and is designed to strengthen and relax the musculoskeletal system.
What does a physical therapy session that incorporates mindfulness look like? McManus describes how she employs it: “The patient is sitting or lying down for breath instruction or the mindful body scan. As the PT, I offer guided awareness instruction. I might say, for example, ‘Bring your awareness now to your breath. Pay attention to the immediate sensory experience of the breath—how it actually feels in your body. As you breathe, pay attention with acceptance. Allow for your experience just as it is, without struggle or judgment. Observe your experience with self-kindness.’

“With people who are in pain, I tell them their experience of pain is a physical sensation combined with their reaction to that sensation. They can learn to calmly observe the sensation and separate out their physical reaction. Once they understand these different pieces that contribute to their experience, they can take control. They learn that pain is a physical sensation; it is not who they are,” McManus says.

One element of mindfulness is overcoming preconceived ideas. “I tell patients to let go of preconceived ideas and concepts about their body, and to listen as if for the first time,” McManus says. “I encourage them to appreciate that each breath is a new breath, each moment is a new moment.”

The Evidence

Why should physical therapists consider incorporating body scans, sitting meditation, and/or yoga into their practice? Because research shows that it can help patients with everything from lessening pain to increasing flexibility.

While those interviewed for this article agree that further research is needed, published studies are promising, they say. “We’re beginning to see mindfulness being used for chronic pain management,” Taylor notes. “With patients who have chronic pain, we’ve also discovered the importance of patients not fearing or ‘catastrophizing.’ They make things worse when they have these thoughts.”

A study published last year in JAMA investigated the effectiveness of MBSR versus cognitive behavioral therapy (CBT) or usual care. The results indicated that, compared with usual care, adults with chronic lower back pain who received MBSR or CBT experienced greater improvement in both their back pain and functional limitations. There were no significant differences in outcomes whether patients were treated with MBSR or CBT. The findings suggested that MBSR may be an effective option for treating patients who have chronic lower back pain.

In an ongoing study, David Morrisette, PT, PhD, and Steven George, PT, PhD, are researching interventions including mindfulness, CBT, and fear avoidance—collectively termed “psychologically informed physical therapy” or PIPT—to discover if its use can prevent acute episodes of low back pain from becoming chronic. Morrisette is director of the Division of Physical Therapy in the College of Health Professions at the Medical University of South Carolina. George is vice chair of clinical research in the Orthopedic Surgery Department at Duke University School of Medicine and director of musculoskeletal research for the Duke Clinical Research Institute.

“We’re trying to help patients become copers rather than averters—be more introspective, so that they can analyze their situations and make good decisions—and we’re giving them methods to reduce stress and relax so that they can be in a better place physically,” says Morrisette. “We’re not saying that the mind can cure cancer or, in this instance, can cure low back pain. We’re trying to help patients cope with this problem so that it doesn’t destroy their lives.”

“Physical therapists should use tools relevant to psychology and the thought processes of the patient,” Morrisette says. “When I was in PT school, we learned CBT. Physical therapists need to understand that while patients with pain may be working with psychologists, this may not be enough. These techniques may need to be integrated with patients’ physical therapy as well. Whether we recognize it or not, we make our decisions

“‘We’re beginning to see mindfulness being used for chronic pain management. We’ve also discovered the importance of patients not fearing or ‘catastrophizing.’ They make things worse when they have these thoughts.’”

– Matthew J. Taylor, PT, PhD
based on our belief system,” Morrisette notes. “Part of mindfulness is recognizing what your biases are, understanding how you look at things, and trying to be as objective as you can.”

“What makes physical therapists different from psychologists and others who do mindfulness approaches,” George adds, “is that we can touch our patients. I can’t tell you how many psychologists with whom I’ve worked think this combination is really powerful—the fact that we PTs can touch patients while using mindfulness techniques.”

Mary Lou Galantino, PT, PhD, distinguished professor of physical therapy and coordinator of the holistic health minor in the School of Health Sciences at Stockton University in New Jersey, led a study targeting joint pain in postmenopausal breast cancer survivors who are receiving aromatase inhibitors. It found that yoga may reduce pain and improve balance and flexibility in breast cancer survivors with AI-associated arthralgia.5

“We have results from other studies showing that mindfulness can help reduce cardiovascular risks and depression, and that it also helps patients with musculoskeletal issues and problems with asthma,” says Galantino.

If mindfulness can serve as a useful tool for PTs, the next question is, how can PTs implement mindfulness techniques with patients?

Use with Patients
Galantino incorporates mindfulness into every patient session. She does this because, she explains, while patients typically tell the stories of what’s going on with their bodies, they aren’t describing how they feel at that particular moment.

“Mindfulness can help reduce cardiovascular risks and depression, and that it also helps patients with musculoskeletal issues and problems with asthma.”

– Mary Lou Galantino, PT, PhD
“I say that I have the data, but in order to begin our therapeutic process, they need to tell me where they are at that moment in their bodies,” says Galantino. “What’s interesting is that sometimes they’re not even aware. They can tell me the story behind why they have chronic pain but can’t tell me how they feel in the moment. The first thing I do is a body scan. Then I ask them to breathe. Most of my patients are apical (upper chest) breathers, especially if they’ve experienced a devastating diagnosis like cancer or chronic pain.”

As her patients become aware of their breathing, Galantino notices a change. “Becoming aware of breath can start to shift their physiology,” she says. “The research shows that individuals in a hyper-aroused state typically are in sympathetic overdrive, and that’s why their breathing is shallow.”

Once Galantino is able to foster deeper breathing, she has her patients do the same with their thoughts. She encourages them to practice MBSR outside of treatment, as well, because, “I don’t want someone with a sympathetic overdrive coming in for a treatment that won’t be sustainable. If they go right back into the environment that’s stress-filled, that won’t help.”

McManus, for her part, has collected patient stories describing the effects of mindfulness. Here’s one from a woman with a 6-year history of undifferentiated connective tissue disease: “We were doing mindful movement, and after we had stretched 1 leg, you asked us to compare how it felt with the unstretched leg. I realized I liked the feeling of the stretched leg, which had sensation to it, rather than the unstretched leg, which I couldn’t feel much at all. I have spent so much energy running away from physical sensation that it was an epiphany that having it could feel good.”

If patients don’t acquire the skills of techniques such as MBSR, they won’t be able to self-navigate their chronic pain, Galantino says. “We are movement specialists, but if the internal autonomic nervous system is on overdrive and there’s little awareness of it to shift to the parasympathetic, then all the great manual therapy, all the modalities, and all the therapeutic exercises in the world won’t be sustainable for long-term management,” she advises.

This aligns with APTA’s vision statement: “Transforming society by optimizing movement to improve the human experience.” “If we’re trying to create value in the health care system, we need to be changing patients’ lives so they can participate in society fully,” Mueller says. “We’re creating value with our interventions.”

She has found that using mindfulness body scans with patients who have multiple sclerosis has been especially beneficial in the neuro rehab clinic. These patients often have problems with fatigue. She has instructed her students to build in mindfulness breaks with their treatments. “While these are anecdotal examples, 1 patient was able to come home after treatment without being wiped out. Another patient was using it successfully for sleep issues,” Mueller says.

“If we can teach patients to sense and feel the early signs of fatigue from that moment-to-moment awareness, then adjust their behavior so that they don’t burn out, they can have better outcomes from a physical therapy standpoint,” Taylor states. “Mindfulness is a powerful tool.”

Staffan Elgelid, PT, PhD, an associate professor in physical therapy at Nazareth College in Rochester, New York, agrees that there’s value in incorporating mindfulness into physical therapy. “We’re so stressed today that the sympathetic nervous system is firing all the time, and when that happens, we can’t heal at a deeper level,” he says. “When we get patients to breathe, they slow down and focus on what they’re doing.”

McManus suggests that something beyond ordinary stress is heightening the need for mindfulness practice. “In school, we are taught how to think rationally and clearly, but we are not taught how to pay attention. I find so many young people are trained in distraction because of electronics. They really need coaching in body awareness in the era of technology. PTs can help build body awareness. That’s where PTs really are finding the value of mindfulness.”

Words Matter

To encourage both patients and PTs to accept mindfulness, it’s important to use the proper terminology, George emphasizes. “I have been careful to call the...
“We’re so stressed today that the sympathetic nervous system is firing all the time, and when that happens, we can’t heal at a deeper level. When we get patients to breathe, they slow down and focus on what they’re doing.”

– Staffan Elgeld, PT, PhD

Resources

Where should a PT begin to learn more about mindfulness, and particularly how to incorporate it into practice or interventions?

Carolyn McManus, PT, MSPT, MA, gives this advice: PTs need personal experience practicing mindfulness before introducing it to patients or clients. For PTs who have little or no experience with it, a good talk on mindfulness by Jon Kabat-Zinn can be found on YouTube at www.youtube.com/watch?v=dd6ktroF18Q.

Participating in a mindfulness-based stress-reduction course will provide PTs with the experience of mindfulness and enable them to witness its affects, McManus adds. The University of Massachussetts Center for Mindfulness maintains a directory of certified mindfulness-based stress reduction instructors at http://www.umassmed.edu/cfm/stress-reduction/find-an-mbsr-program/.

Finally, McManus recommends these 3 books on the subject:

▶ *You are Not Your Pain: Using Mindfulness to Relieve Pain, Reduce Stress, and Restore Wellbeing* by Vidyamala Burch and Danny Penman

▶ *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* by Jon Kabat-Zinn

▶ *Real Happiness: The Power of Meditation: A 28-Day Program* by Sharon Salzberg

[Image: WARNING: Mindful Movement May Lead to Pain-Free Motion]
work I do either ‘behaviorally based’ or ‘psychologically informed’ physical therapy,” he says.

“If someone is averse to the term ‘meditation’ because of a religious precept, it may not be seen as being as effective as prayer,” says Galantino. She gives the example of recruiting female cancer survivors from churches in Atlantic City for an MBSR and yoga study to look at chemotherapy-induced cognitive decline. Even though she had endorsements from pastors, few women showed up. “We have to be conscious of the context in which we use the term ‘mindfulness,’” Galantino cautions.

“What gives mindfulness a bad rap is saying things like, ‘Is your body in tune with the universe?’ and ‘Are you in harmony with the planets?’” says Morrisette. “Mindfulness grows out of psychology. It’s no more than thinking about what’s going on. One term that’s used to describe it is ‘metacognition.’ You’re getting out of automatic mode.”

McManus agrees. “There’s nothing ‘New Age’ about the mind being in the present moment. It’s just a fact of life that we’re always facing change. We might like to be comfortable, but that isn’t the way the world works. We need to be able to handle the difficult things in life and still be happy.”

“We’ve got really bright people in our profession who may still think of mindfulness as fringe or complementary medicine,” Mueller concedes, “but there are solid neurophysiologic correlates that suggest mindfulness not only improves calm and relaxation, but it actually can improve cognition, executive function, and decision making.”

Mindfulness in School

“DPT students have anxiety,” Galantino says. “They’ve overwhelmed. The DPT curriculum is demanding, they have to meet a minimum GPA, and the costs of their education are high.” During class, she often tells her students to pause, take a breath, and be in the moment.

Research published in 2016 concluded that mindfulness meditation practiced over an 8-week period can help lower the blood pressure of physical therapy students and reduce their perception of stress.

Besides using mindfulness techniques themselves, DPT students should be taught how to use these techniques with patients, say the PTs interviewed for this article. “Mindfulness is being taught in medical schools, but not in all physical therapy programs, and that’s a shame,” says Elgelid. “We spend more time with our patients than physicians do, so we should use it.”

Mueller teaches mindfulness techniques in her clinical communications class. Her reasons are twofold: to help students relieve their own stress and to teach skills to use with patients. After a first-year student told Mueller that she was thinking of dropping out because of stress, Mueller asked her other students how they felt. Many admitted they were feeling overwhelmed. As a result, Mueller may create a pilot mindfulness course.

“One of our program’s strategic plan initiatives is developing lifestyle intervention,” says Mueller. She cites similar classes taught in medical schools and hopes to offer the class to DPT students as an elective.

Aligning With #ChoosePT

The goal of APTA’s #ChoosePT campaign is to educate consumers about the opioid epidemic and urge them to choose physical therapy to manage pain without the risks of opioids. Mindfulness aligns perfectly with the campaign, Galantino says. Some research already has shown, she notes, that mindfulness techniques can help alleviate pain, as well as how people perceive it. And research published in JAMA last year indicates that mindfulness meditation can offer pain relief.

“PTs need to have the skillset to teach MBSR along-side other professionals. We need to work as a team to help people addicted to pain medication opioids,” says Galantino. “With mindfulness, we can give these people an alternative to pharmacologic agents.”

McManus cites preliminary research indicating that “if people have been on opioids for a while, they don’t have the same response to external stimuli—such as a beautiful sunset. So,” she says, “there’s an application for people coming off opioids to focus on pleasant experiences, and how it feels in the moment.”

Ideally Suited for PTs

While other health care professions use mindfulness, McManus suggests that it and physical therapy are an ideal match.
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“PTs are recognizing that, in order to effectively treat pain, we need to have basic skills that support the whole person to heal. PTs work with whole people,” she says. “We all know that the mind is not separate from the body. Psychologically informed physical therapy and cognitive behavioral strategies are being introduced into physical therapy so that we can better address the needs of patients with complex pain disorders. I see mindfulness as another tool for our toolbox—as enhancing and improving our ability to help people respond to their illness or injury, move, and pace activity in a healthy way.”

Michele Wojciechowski is a freelance writer.

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Financial Literacy and the New DPT Grad

Few recent graduates were exposed to classes in financial literacy while they were in school. Most educators think they should have been.
When it comes to financial literacy, is today’s physical therapist (PT) student—to borrow the question posed by a popular television show—smarter than a fifth grader? Probably. But, are these doctoral students more financially savvy than a high school senior? All too often, the likely answer is no.

“Many students never have had to handle their own finances. Their parents took care of it for them at the undergraduate level, so those students are in unfamiliar territory,” says Kathy Anderson, director of financial aid at the MGH Institute of Health Professions in Boston. “In my opinion, parents do their children a disservice by keeping them out of financial discussions, because financial literacy isn’t something that students learn in K-12 education.”

That’s led to some alarming results:

- In 1 survey, 28% of first-year college students with federal debt reported that they did not have any federal debt—and 14% reported having no debt at all.1

- In another survey, 73% of undergraduate and graduate students thought Sallie Mae (the Student Loan Marketing Association) was a person, not a company.2

- More than half—54%—of student loan holders did not try to determine how much their future monthly payments would be before taking on their loans.3

- On a 5-question financial literacy quiz developed by the Financial Industry Regulatory Authority, Millennials exhibited “very low levels of financial literacy,” with only 24% answering at least 4 questions correctly, compared with 48% of Baby Boomers.4

Today’s physical therapist graduates on average leave school with more than $83,000 in student loan debt. Total average debt (adding, for example, credit cards and other loans) for recent graduates is more than $96,000.5 Total US student loan debt stood at $1.411 trillion on December 1, 2016, up from $240 billion at the start of 2003.6

Once the pomp and circumstance of graduation ends, reality sets in, and with it comes the stress and worry of how to pay those debts and handle finances going forward.

Mark A. Boland, PT, DPT, MBA, would like recent graduates to become more knowledgeable about financial literacy concepts so they can better reduce and manage that debt. He is clinical assistant professor in the Department of Physical Therapy at Saint Francis University in Loretto, Pennsylvania.

“Recent graduates need to have a general idea of the impact their debt will have on their personal budget and future borrowing power,” he says. “They also need to be confident in their ability to manage their debt, develop and adhere to a personal budget, and begin to save for retirement.” Boland was the primary investigator on 2 Saint Francis studies examining student loan debt and starting salaries.

Helping to soften the financial blow, these students are entering a profession that is predicted to grow by 34% from 2014 to 2024—“much faster” than the average rate for all career paths, according to the 2014-15 Occupational Outlook Handbook, published by the US Bureau of Labor Statistics. In addition, new graduates most likely will find work that pays well enough to help them manage and retire their debt.7

Student loan debt is a key contributor (though not the only one) to the postgraduation financial woes of many new PTs. But this seldom is addressed in PT education, Boland notes, even though it’s vital that new and recent graduates understand not only how to avoid debt, but also how to cope with debt-related issues.

Terence Brown, PT, DPT, president of APTA’s Private Practice Section and a PT at Frankfort Physical Therapy in Kentucky, says that before choosing a PT program, prospective students should consider the cost of attending the institution.

“We probably assume that students are doing this research before they enter school, but many are not,” says Brown.

**Influencing the Profession**

When Boland speaks to recent graduates, he hears that student loan debt is influencing their career choices. That pressure, he believes, has the potential to negatively affect the profession.

“Instead of choosing a job based on a favorable geographic location or a clinical setting about which they are passionate, many graduates are choosing jobs based solely on salary so that they are better able to manage their debt,” he notes. “While this may help them achieve short-term financial goals, it also could lead to decreased professional development and job satisfaction.”

Mary Ann Wharton, PT, curriculum coordinator of Saint Francis University’s physical therapy program, agrees—calling the evolution of job selection “a profound problem.”

“In the past, [graduates] would come out of school and make choices based on good clinical opportunities. They would get experience to enhance their skills,” she says. “Now, we are seeing a lot of graduates choosing clinics based on saving money, such as being close to home, and they’re maybe not getting the same depth of experience. They may not have mentors in these positions. A graduate may become a manager in a

**By Keith Loria**

The average PT student—"to borrow the question posed by a popular television show—smarter than a fifth grader? Probably. But, are these doctoral students more financially savvy than a high school senior? All too often, the likely answer is no.

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GETTING THE TIMING RIGHT

By the time a student graduates from a DPT program, much of any financial “damage” has been done. New graduates have some options for assistance, but they already have taken out loans as students and have incurred other indebtedness. PTs interviewed for this article—and academicians generally—emphasize the need to educate students before those decisions are made.

So, when should financial literacy education occur? During PT education is an approach some schools are taking.

Saint Francis has incorporated it into its DPT program in several ways—including development of a personal budget; discussion of student loan repayment options; and lectures by a financial planner who discusses general budgeting, investing, and debt-management to better prepare students for life after graduation. Financial literacy courses are required. The school also offers extensive online resources related to financial literacy, including videos and links to other sites.

However, some educators balk at adding such content to already stretched DPT curricula. While not specifically referring to financial literacy, Leslie Portney, PT, DPT, PhD, in her 2014 Pauline Cerasoli Lecture at APTA’s Combined Sections Meeting titled, “Choosing a Disruptive Path Toward Tomorrow,” said, “We are constantly faced with having to add material to a very crowded curriculum. We can’t just keep stuffing more into our courses and expect any true learning to occur.”

Instead, Portney proposed a provisional licensure model that would allow students to graduate at the completion of a shorter generalist curriculum, followed by a 1-year internship, then a residency.

Diane Jette, PT, DSc, suggests a similar process: DPT students would graduate in 2 years, then complete a third year as paid interns. “That structure could save graduates from paying for often heavily credited clinical education courses and allow them to earn money during mentored experiences,” she says. “Our speech and language pathology colleagues have a system that’s somewhat like this, and medical education requires that students pass parts of the medical board examinations at different points in their education, both before and after graduation.”

Jette, a Catherine Worthingham Fellow of the American Physical Therapy Association, is associate chair of, and a professor within, the Physical Therapy Department at MGH Institute of Health Professions.

If financial literacy education can’t be added to many graduate programs, can it be moved to the undergraduate level? The undergraduate curriculum is likelier to be flexible. And, armed earlier with financial literacy tools, students likely would benefit.

Indiana University (IU), while not proposing to shorten its 4-year undergraduate program, is promoting financial literacy by educating its students on the benefits of graduating within those 4 years, rather than in 5 or more. The efforts seem to be working.

In the past 5 years, the number of IU students seeking a bachelor’s degree who graduate in 4 years has risen from 38% to 42%. Considering that IU has 94,000 undergraduates and that even the in-state cost of attending the school is $21,412 annually, reducing the time it takes students to earn a bachelor’s degree can result in real savings.

The State University of New York (SUNY), meanwhile, created Smart Track, a program to provide students with standardized information about financial aid and the availability of financial literacy tools. SUNY observes that with the average net price across all 4-year, degree-granting institutions in the state of Indiana began requiring all 1-person clinic right off the bat, with no one to help him or her out with billing and insurance policies and procedures. Those choices and experiences will have a profound effect on [that practitioner’s] clinical expertise.”

Brown concurs. “Many decisions are market-driven,” he says. “Some PTs choose to work in public service jobs in order to use the Public Service Loan Forgiveness Program, which forgives the remaining balance of student loans after the PT has made 120 qualifying monthly payments. Or they’re heading to rural areas because of debt-forgiveness programs linked to working in underserved regions,” he says.

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colleges that accept state aid to send similar letters to their undergraduate students. Nebraska passed a law along these lines in 2016.

Montana State University in Bozeman uses a more targeted approach. Students with high debt—primarily students whose annual borrowing represents about double the amount of in-state tuition—receive letters alerting them to their obligation and encouraging them to seek financial counseling. Students receiving the letter borrow an average of one-third ($1,360) less the next semester, according to a 2015 analysis by Montana State and Federal Reserve researchers. Students receiving the letters also are slightly more likely to switch to a major associated with higher-paying jobs, researchers found.

One discovery made in several surveys was best summarized by the Indiana experience: “Students usually accept whatever aid colleges award them, without questioning whether they could live more cheaply—and borrow less. Before all the financial literacy work began,” says Phil Schuman, IU’s director of financial literacy, “I don’t think students actually knew they had the option to take less aid.”

Similarly, Tyler Pruett, director of financial aid at Samuel Merritt University in Oakland, California, reminds students to not just accept the first loan offer. “And they’ll be getting lots of offers. Health profession graduates are the most sought-after financial customers in the student loan world, because they tend to pay their loans back and generally have well-paying careers.”

Clearly, some college students veer off financial course before they can be reached. So, the next question is: Can financial literacy education be moved down to the high school level?

Saint Francis’ Boland notes that students who complete undergraduate coursework and enter PT school spend their academic careers focused on preparing for licensure as physical therapists. As a result, he would like to see financial topics explored not only in undergraduate curricula, but in high school.

“I would love to see financial literacy taught to younger kids, so that they would be comfortable budgeting and managing money,” he says. “It would become second nature. This would promote a better understanding of how borrowing decisions they make during their college careers will affect them later in life, he says. “Money shouldn’t be scary.”
In 2009, researchers at the University of Wisconsin-Madison published results of a national survey of K-12 teachers. Regarding instruction in financial literacy in high school or even lower grades, there's good news and bad news. The good news: Most thought it should be taught. The bad news: Most didn’t feel qualified to teach it.\(^3\)

Those results were based on more than 1,200 online responses from K-12 teachers, prospective teachers enrolled in teacher education programs, and teacher education faculty. Eighty-eight percent of the prospective teachers and the education faculty said financial education should be taught in grades 9-12, as did 92% of the K-12 teachers.

In fact, many states already do teach financial literacy in high school. In 2015, Champlain (Vermont) College’s Center for Financial Literacy rated states on their efforts to improve financial literacy in high schools. Five states received a grade of “A,” 20 states received “Bs,” 11 states received “Cs,” 3 states received “Ds,” and 12 states received “Fs.”\(^4\)

The top-scoring state was Utah, which merited an A+ because it requires all high school students to take a half-year course dedicated to personal finance topics. Students also are required to take an end-of-course assessment examination. States earning Cs required that substantive personal finance topics be taught in high school by including these topics in their instructional guidelines. However, those states left it to the local school board to determine how and where to do that integration. The states receiving Fs had few or no requirements for personal finance education in high school.

The University of Wisconsin-Madison study also found that 89% of teachers said students should be required either to take a financial education course or to pass a financial literacy test as a prerequisite for high school graduation.

Survey respondents could provide multiple answers, and many supported beginning even earlier than high school. Support for teaching financial education in grades 6-8 ranged from 59% for prospective teachers to 80% for education faculty.

Many felt that financial literacy education shouldn’t even wait until the sixth grade. Sixty percent of the education faculty and more than 33% of prospective and current teachers said financial education should be taught in grades 3-5.

**Minimizing Debt**

“Somehow, the student needs to realize before it happens that you can’t incur $160,000 in debt and [pay it off reasonably with] a $60,000 job,” Brown says. That’s why Terry Nordstrom, PT, EdD, an associate professor of physical therapy at Samuel Merritt, says a key element of financial responsibility is minimizing debt before going into a graduate program.

“Use community college. Use state-supported systems,” he advises. “Work, if you need to, to pay off your college debt or your college expenses. Live with your family. Do everything you can to minimize your undergraduate expenses, because then you have a lot more freedom in your graduate program.”

“We advise students to pay down consumer debt and check their credit at least 6 months before the DPT program begins,” Anderson says. “Students should be prepared to live frugally while in school.”

Brad Cooper, PT, MSPT, MBA, ATC, chief executive officer of Colorado-based US Corporate Wellness, agrees

APTA Resources

APTA’s House of Delegates in 2016 adopted RC 11-16, calling on the association to investigate the effect of student loan debt on the physical therapy profession and to develop, by June 2018, a plan with feasible options to address the issue.

“APTA is taking a very important first step by highlighting the matter and trying to learn as much as possible about this challenge,” says Mark Boland PT, DPT, MBA, a clinical assistant professor in the Department of Physical Therapy at Saint Francis University in Loretto, Pennsylvania. “One concern for the profession is: At what point will the cost of obtaining a physical therapy education, compared with the salary of a physical therapist, make entering the profession cost-prohibitive?”

While the association and profession investigate the issues both short and long term, APTA offers online resources for current students and recent graduates on debt management and financial education. Some of these can be found at www.apta.org/DebtManagement/. Among them are:

- Understand and Prepare Your Debt for Graduation and Beyond
- Budgeting Essentials for Students
- Federal Student Loan Forgiveness Opportunities
- Budgeting Essentials for PTs and PTAs
- Financial Management: Money Changes Everything
- The Secret to a Successful Financial Live
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with the others interviewed for this article that this conversation really should occur 6 years earlier, as it would be much easier to manage or avoid debt if PT students knew some of these concepts before entering college. Since time machines don’t exist, Cooper suggests that when students graduate with debt, that they pour all of their efforts into eliminating it.

“I knew someone who got a sign-on bonus—a nice one—when he took a job. But he used the money to buy a sports car. He could have paid off his loans and would never have had to think of them again,” he says. “Instead, he had a depreciating asset, and, years later, he still has all those loans to pay off.”

Cooper advises students to be as frugal as possible. Make meals in a crock pot instead of going out. Choose a smaller or less attractive apartment if the rent is cheaper. Walk or bike places rather than taking public transportation.

“The smartest thing to do is to work through high school and undergrad studies,” he says. “It’s a heck of a lot easier then to combine work with school than it is once you’re in a DPT program. If you’re able to enter grad school without outstanding undergraduate loans, your path will be easier. If you’re careful through grad school, you can then pay off those loans within a few years with hard work, by taking a second job, by working some overtime, living frugally, and so on.”

**Coping With Debt**

DPT students and recent graduates experiencing financial difficulties should not delay seeking help, those interviewed for this article agree. Early intervention is key.

Anderson’s advice is to seek out experts—especially the school’s financial aid office, because personnel there can point students and recent grads to helpful resources. Many financial aid offices offer tools to improve students’ financial literacy.

Recent graduates need to pay attention to the variety of repayment options and any loan forgiveness programs out there, Anderson adds.

“There never have been more options, which make paying back loans easier. But deciding which option to choose can be overwhelming, so trust the experts,” she advises. “We recognize that students are very busy while they are enrolled, but we encourage them to take time to come to a seminar we offer that details loan-repayment strategies. If that’s not possible before graduation, we also let students know that our services are available to them after graduation.”

In the long term, the hope is that the cost of education can somehow come down, to reduce the need for such high debt and subsequent financial wrangling in the first place. “Down the road, we need to make professional education less expensive,” Brown says. “Should it cost this much money to be a physical therapist? I don’t think that it should.”

But even if the cost of education can be controlled, the need for financial literacy education will remain, say those interviewed for this article.

Keith Loria is a freelance writer.

**REFERENCES**

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Health Care Employment
Rose 28,400 in November

Health care added 28,400 jobs in November, according to the US Bureau of Labor Statistics, for a total of 15,674,000 people nationwide employed in health care. Ambulatory services added 22,200 jobs, while home health care services added 2,200. Nursing and residential care facilities gained 700 jobs; that sector’s employment stood at 3,331,900 jobs. Over the past 12 months, health care added 407,000 jobs.

Also in November:

- The unemployment rate decreased by 0.3 percentage point to 4.6%, and the number of unemployed people declined by 387,000, to 7.4 million. Both measures had shown little movement from August 2015 through October 2016.
- Total nonfarm payroll employment rose by 178,000. Employment gains occurred in professional and business services as well as in health care. Employment in other major industries—including mining, manufacturing, wholesale trade, retail trade, transportation and warehousing, information, financial activities, leisure and hospitality, and government—changed little. Through November, employment growth in 2016 averaged 180,000 per month, compared with an average monthly increase of 229,000 in 2015.
- Among the major worker groups, the unemployment rate for adult men declined to 4.3%. Rates for adult women (4.2%), teenagers (15.2%), Whites (4.2%), Blacks (8.1%), Asians (3.0%), and Hispanics (5.7%) showed little or no change.
- The civilian labor force participation rate, at 62.7%, changed little. The employment-population ratio held at 59.7%.
- Average hourly earnings for all employees on private nonfarm payrolls declined by 3 cents to $25.89, following an 11-cent increase in October. Over the year, average hourly earnings had risen by 2.5%. Average hourly earnings of private-sector production and nonsupervisory employees edged up by 2 cents, to $21.73.
- The average workweek for all employees on private nonfarm payrolls was unchanged, at 34.4 hours. In manufacturing, the workweek declined by 0.2 hour to 40.6 hours, while overtime was unchanged at 3.3 hours. The average workweek for production and nonsupervisory employees on private nonfarm payrolls was unchanged at 33.6 hours.

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APTA, NIH Celebrate Rehab Research Plan

Has rehabilitation research reached a turning point? Very possibly, according to speakers who helped APTA celebrate the completion of the National Institutes of Health’s (NIH) rehabilitation research plan—a comprehensive reset of approaches and priorities that supporters believe will help power up investigations into restoring function.

The celebration came in the form of a congressional briefing held on Capitol Hill in December. Sponsored by APTA and other members of the Disability Rehabilitation Research Coalition, the event featured remarks from Rep Gregg Harper (R-MS), Rep Jim Langevin (D-RI), Allison Cernich, director of the National Center for Medical Rehabilitation Research (NCMRR) at NIH, and Rebecca Craik, PT, PhD, FAPTA, co-chair of the NIH blue ribbon panel that guided the creation of the 5-year plan. Craik is a former editor-in-chief of *Physical Therapy*, APTA’s scientific journal.

Craik described the factors that led to creation of the new plan, which included a 2011 review of the NCMRR research plan that hadn’t been updated since its creation in 1993. “NCMRR was functioning, but it certainly wasn’t thriving,” Craik said. “And we thought it had incredible opportunities to thrive.”

Cernich told attendees that recommendations of the blue ribbon panel related to an updated plan have led to the creation of a roadmap that not only will allow NCMRR to thrive, but also will set the stage for a new era of collaboration across NIH institutes and other centers.

The plan was unveiled in September and given a boost by the 21st Century Cures Act, signed into law on December 13 by President Obama. APTA was a strong supporter of both the plan and increased funding for rehabilitation research. At the time the plan was unveiled, APTA Chief Executive Officer Justin Moore, PT, DPT, said, “The rehabilitation research plan will be a major resource both for researchers and the agencies that provide funding. Rehabilitation science can help providers truly transform lives, and this new plan marks a long-awaited and significant step forward.”
Among topics covered within the priority areas: investigating new approaches to assistive technology in the home; increasing resources to recruit more researchers; ramping up efforts to analyze biological, chemical, and genetic components of recovery; and intensifying research on rehabilitation and disability across the lifespan.

Cosponsors of the briefing included the Brain Injury Association, the Association of Rehabilitation Nurses, the American Occupational Therapy Association, the American Speech Language Pathology Association, the American Academy of Physical Medicine and Rehabilitation, the United Spinal Association, the American Congress of Rehabilitation Medicine, the American Music Therapy Association, and the American Therapeutic Recreation Association.

http://www.apta.org/PTinMotion/News/2016/12/8/CuresAct/


http://www.apta.org/FederalIssues/PublicPolicyPriorities/

CoHSTAR Accepting Postdoctoral And Faculty Fellowship Applications

Physical therapists now have a chance to play a transformative role in physical therapy health services research.

The Center on Health Services Training and Research (CoHSTAR) is seeking candidates for fellowships at either a full-time postdoctoral level or a part-time faculty level. Fellowships are available at the 3 institutions participating in CoHSTAR: Brown University, Boston University, and the University of Pittsburgh. Applications are due February 15, 2017.

For the full-time fellowships, applications are being sought from PTs with a PhD, ScD, or DrPH, or from PTs with a DPT and research training, experience, and publication history. Part-time faculty fellow applicants must be licensed PTs and full-time faculty members with a doctoral degree or equivalent research experience. Faculty fellows must devote the bulk of their time to research activities, and must be able to participate in CoHSTAR activities and regularly visit the CoHSTAR site.

Application instructions are available at the CoHSTAR webpage.

CoHSTAR was created through a $2.5 million grant awarded by the Foundation for Physical Therapy through its “Center of Excellence” initiative. In addition to the fellowships, CoHSTAR sponsors visiting scientists and provides special summer training sessions.

http://www.bu.edu/cohstar/fellowships/
Energizing Your Team to Become Physical Therapy Pioneers

Lisa Corsa, PT, DPT

Pioneers are not just relegated to history. “Pioneering” is happening all around us, and it’s much needed in physical therapy. As business leaders, we need to look at fresh ways to advance our practices while opening the door to innovations and new “best practices” that give our employees the opportunity to become pioneers themselves.

Change your mindset to begin to think creatively and outside the box. Here are some ideas for fostering a spirit of continuous improvement at your facility.

- **Look for novel ways to increase revenue.** Most clinics are hamstrung (excuse the pun) because their patients’ insurance companies pay their bills. The problem lies in the way that carriers arbitrarily draw lines in the sand, only paying for certain interventions and timelines. That’s why I built my practice around the private-pay model. It was difficult and required a lot of dedication, but we discovered that plenty of people prefer having control over their health care and are willing to invest in a new type of compensation structure for their physical therapy.

- **Find underserved niches and fill them.** In my early years practicing, patient after patient told me his or her physicians weren’t communicating with each other. I vowed that my own facility would offer a concierge service to oversee all the patient’s medical treatment. Our model has been in place for several years now. Patients and clients tell me they are relieved that someone is staying on top of their medical diagnoses and situations. Another underserved niche has been the prehab market. Again, it isn’t covered by insurance, but it is much needed. Prehab gets a person’s body ready for surgery, and a robust prehab plan can lead to better postop rehab outcomes.

- **Consider investing in the latest technologies.** Owning the most advanced equipment in its category can require a daunting financial commitment. However, it can pay off when you are able to set yourself apart and provide clients with a comprehensive, world-class type of care. For us, having a state-of-the-art aquatic therapy pool with an underwater treadmill and resistance jets was an innovation that I knew would enable us to reach more patients. It allows us to help many patients, particularly those who cannot participate in land-based physical therapy.

- **Remember your dreams, and make them realities.** Speaking of the pool, when I was 10 years old I fell in love with the amazing feeling I got in the water. Eventually, I became a swim instructor and lifeguard. I saw the benefits when I was teaching kids—especially kids with neurological and orthopedic issues. Aquatic therapy built their strength, improved their range of motion, and made them feel alive. It became my dream to bring that kind of experience to others. The aquatic therapy pool we bought was a realization of my dream. I encourage everyone to reengage with the dream they had when they first ventured into physical therapy. Those dreams are the seeds of positive change for you and your business.

Lisa Corsa, PT, DPT, owns Premier Therapy Solutions in Boca Raton, Florida.
Make sure your school “Gets on The List” and donates by April 27, 2017

Thank you to all students for participating in the Foundation’s annual Marquette Challenge.

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Want to attract today’s health care customers? Use today’s marketing strategies.

APTA’s popular Business Skills in Physical Therapy: Strategic Marketing home-study course is in its second edition, with new ideas from author Peter R. Kovacek, PT, DPT, MSA, founder of PTManager.com, added to the tried-and-true guidance that made the first edition an APTA bestseller.

SEE WHAT’S INSIDE!

- The Physical Therapist Marketing Readiness Assessment Tool for you, your team, and your entire organization
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ACOs Beginning to Take Creative Steps to Address Nonmedical Needs

Some accountable care organizations (ACOs) are well aware of the ways that nonmedical needs of patients—for instance, housing, transportation, and food insecurity—can affect health outcomes, and are attempting to do something about it. But those sometimes-creative efforts to address the needs through ACOs are meeting significant challenges, a new study finds.

Researchers reported in *Health Affairs* on the results of interviews with 58 leaders from 32 ACOs, as well as the findings from 3-day site visits with 3 ACOs. They found that while 16 of the 32 ACOs surveyed were addressing patients’ nonmedical needs, the ways those needs were addressed varied in the way care was integrated and in the nature of the care itself.

Most ACOs, including those that did not address nonmedical needs, reported a general state of nonintegration, wherein both the services provided to patients and the organizations providing those services weren’t really working in a coordinated way. Of the ACOs that were addressing nonmedical needs, most were moving toward greater integration of services, albeit through use of outside organizations that were “fully independent and distinct.”

The authors found only 2 ACOs that were moving toward what they describe as a “fully integrated” model.

“In both of these cases, organizational integration did not involve a merger of organizations; instead, it involved representatives of nonmedical providers or agencies joining representatives of medical providers as voting members of the ACO’s board of directors,” the authors wrote. “In both cases, ACO formation served as a catalyst for the integration between medical and community services.”

The study also looked at how some ACOs were responding to nonmedical needs in transportation, housing, and food insecurity. Here are some of the findings:

**Transportation**

There was considerable variation among ACOs that provided transportation service. Examples include provision of monthly bus passes to all patients who had 4 or more medical visits per month, investment in a medical transportation company, and payment to a private for-profit transportation company.

**Housing**

ACOs that provided or coordinated housing services used similar strategies—mostly by serving as an administrative resource for patients—but a few added some creative twists. Among them: an ACO that negotiated with a housing program to alter its substance use requirements to allow the ACO’s patients to receive housing before they began addiction treatment. Another worked with a housing agency to establish beds specifically designated for the ACO’s patients, which in turn streamlined the ACO's discharge process.

**Food Insecurity**

The researchers described 1 ACO that partnered with a local food bank and farmers to purchase local produce and hold a market day for patients, offering reduced prices. Another sought to address the tendency of its patients to obtain processed and unhealthful foods from the local food bank by partnering with the food bank to prepare actual meals for patients with a qualifying illness.

While the work of some ACOs in these areas is encouraging, the authors said, even the most proactive organizations face a major hurdle: scalability. “ACO leaders described instances in which they observed a general need but were able to provide only individual solutions, not broader programs,” the authors wrote. “Even ACOs with formalized programs to meet patients’ nonmedical needs faced significant implementation barriers.”

Interested in learning more about ACOs and the role of the PT and PTA? Check out APTA’s ACO webpage. Also available: online learning from the APTA Learning Center on opportunities and challenges for PTs in ACOs, as well as ACOs as an innovative model of PT care delivery.

http://www.apta.org/ACO/

http://learningcenter.apta.org/student/MyCourse.aspx?id=0a083ddd-2f53-47c4-85b7-83d9497d97a&programid=dcca7f06-4cd9-4530-b9d3-4ef7d2717b5d
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Researchers Find ‘Unsettling’ Uptick in Stroke Rates in Adults Under 55

A recent study of strokes has found that while rates have declined in patients older than age 55, there has been an uptick among younger populations—and that the potential underlying factors are “unsettling.”

The study, published in the Journal of the American Heart Association, found that while the incidence of stroke has decreased in many countries over the past 20 years, that trend may now be reversing. Researchers applied an “age-period-cohort” analysis to data from the Myocardial Infarction Data Acquisition System in New Jersey in an attempt to “unravel the separate effects due to aging, secular changes, and life course experience” on incidence of ischemic stroke and ST-elevated myocardial infarction (STEMI). Time periods considered were 1995-1999 (period 1), 2000-2004 (period 2), 2005-2009 (period 3), and 2010-2014 (period 4).

The stroke rate for individuals ages 35 to 84 decreased from 314.1 strokes per 100,000 “person-years” (PY) in period 1 to 271 in period 4. The overall rate for STEMI decreased by 60% in the same timeframe.

However, the stroke rate among patients 35-39 more than doubled over that same 20-year period—from 9.5 to 23.6 per 100,000 PY. The rate also doubled for those in the age 40-44 cohort, from 22.9 to 46.0 strokes per 100,000 PY between periods 1 and 4. There also were smaller, yet still significant, increases for individuals ages 45-49 and 50-54. For groups older than 55, rates declined.

These findings echo results of similar studies in the United States, as well as from Taiwan, France, and Denmark, the authors noted. In their study, they wrote, “the downward trend in the oldest age groups, the flattening trend in the middle age groups, and the upward trend in the youngest groups suggest a birth cohort effect.” The authors suspect that higher prevalence of obesity and diabetes among younger cohorts, in addition to lack of treatment for high blood pressure and lower likelihood of having health insurance, may be contributing to this disturbing trend in the United States. The rise in obesity among younger populations also has led to an increase in atrial fibrillation—a risk factor for stroke.

http://jaha.ahajournals.org/content/5/12/e004245

ASSOCIATION RESOURCES

Free Learning Lab on Partnering With ACOs Recorded and Ready

Are you in a private practice or rehab agency and trying to figure out how to partner with physicians or hospitals in an accountable care organization (ACO)? Are you at a hospital and working on innovative approaches to improve patient access within your facility? Do you want to hear from your colleagues about their work in ACOs and learn from their experiences?

APTA’s Learning Labs series now offers the third of 4 opportunities for you to hear firsthand from the PT innovators who were selected to pursue new, creative models of care through APTA’s Innovation 2.0 program. This third online lab is available in the APTA Learning Center and focuses on how PTs can facilitate access and provide value as integral participants in ACOs. The free webinar includes the recorded session, the presenters’ slide deck, and a downloadable guide to replicating the program in other facilities.

The Innovation 2.0 series is designed to promote the participation of physical therapy in innovative models of care delivery by replicating successful models throughout the country. Free access to the course and materials is available through the APTA Learning Center.

Other Innovation 2.0 Learning Lab topics include pay for performance treating patients with low back pain (available now), adding value to a postacute care setting (available now), and a patient-centered medical home model that addresses childhood obesity (to come later this year).

http://www.apta.org/Innovation2/
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Timing is everything when it comes to a recently released joint guidance document on compliance created by APTA and 3 other organizations. The document arrives during a period of increased federal scrutiny of fraud associated with companies providing physical therapist services. That scrutiny resulted in settlements totaling more than $35 million.

The resource—created by APTA, the American Occupational Therapy Association, the American Speech-Language-Hearing Association, and the National Association for the Support of Long-Term Care—aims to help health care providers better understand compliance: what it is, the role of corporate compliance programs, and how best to report. The 2-page guide includes, as well, links to Department of Health and Human Services Office of Inspector General (OIG) compliance materials, and to OIG national compliance hotline information.

“Over the past few years, we’ve witnessed stepped-up efforts by the federal government to root out waste, abuse, and fraud—an effort very much supported by APTA,” said Roshunda Drummond-Dye, JD, APTA’s director of regulatory affairs. “We’re continuing to work to provide members with up-to-date compliance tools, and the joint guidance document we’ve created helps to bring some of the most relevant information together in one place.”

The compliance guide joins an array of other compliance resources available at APTA, most of which are featured on the website of the APTA Center for Integrity in Practice.

http://www.apta.org/Compliance/ReportingGuidelines/
https://oig.hhs.gov/oas/reports/region7/71401146.pdf
http://integrity.apta.org/home.aspx
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June 10-11, 2017 New York, NY  
September 30-1, 2017 Seattle, WA

#111 **Brian Hoke’s Advanced Level Biomechanics of the Foot and Ankle**  
**Brian Hoke, DPT SCS**  
July 22-23, 2017 Atlanta, GA  
Sept. 16-17, 2017 New York, NY

#114 **Donatelli’s Pathophysiology and Mechanics of the Shoulder with Lab**  
**Robert Donatelli, PhD, PT, OCS**  
May 12-13, 2017 Berlin, VT  
July 15-16, 2017 Tampa, FL  
July 29-30, 2017 Atlanta, GA  
Sept. 23-24, 2017 Brooklyn, NY

#147 **Evaluation and Management of the Lumbar/SJJ/Hip Complex**  
**Brian Swanson, PT CS, COMT, OMT, FAAMPT**  
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October 15-16, 2017 Rapid City, SD  
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#150 **Orthopedic Certification Specialist Exam Preparatory Course**  
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October 21-22, 2017 Scottsdale, AZ  
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#415 **Myofascial Release**  
**Theresa A. Schmidt, DPT, MS, OCS, LMT, CEAS**  
March 18-19, 2017 Raleigh, NC  
June 17-18, 2017 Alexandria, VA  
October 7-8, 2017 Phoenix, AZ  
November 11-12, 2017 St. Pete, FL

#179 **OSTEOPOROSIS: A Comprehensive Treatment Strategy Level 1**  
**Sara M. Meeks, P.T., M.S., G.C.S., K.Y.T.**  
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#216 **Vestibular, Oculomotor and Balance Rehabilitation**  
**Wendy Wood, DPT, GCS**  
June 17-18, 2017 Atlanta, GA  
August 5-6, 2017 San Anton, TX

#217 **Adult Neuro-Handling Techniques**  
**Michelle Mioduszewski, MS, OTR/L**  
February 25-26, 2017 Houston, TX  
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#329 **Pediatric NDT Intensive Handling Techniques**  
**Gail Ritchie, OTR, C/NDT**  
March 25-26, 2017 Austin, TX  
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July 14-15, 2017 Marlton, NJ  
August 25-26, 2017 Houston, TX  
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Jaimee Barber, PT, GTC

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Rehab of Persons with Common Medical Pathologies
Dr. Steven Tepper, PhD, PT

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- Greenville, SC .......... August 12-13, '17
- Lafayette, LA ............. September 16-17, '17
- St. Louis, MO ............ October 14-15, '17

Safe Steps: Measuring Gait and Balance to Show Treatment Works
Dr. James Wall, BSc, MSc, MD, PhD

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Dr. Wendy Aemaeat, PT, PhD, GCS, CWS, GTC, COS-C

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- New Rochelle, NY ....... November 4-5, '17

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- Charleston, SC .......... December 2-3, '17

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- West Orange, NJ .......... August 12-13, '17
- Columbus, OH .......... October 14-15, '17
- Dallas, TX ............... November 4-5, '17

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3. Effective February 25, 2014, the West Coast University Doctor of Physical Therapy program has been granted Candidate for Accreditation status by the Commission on Accreditation in Physical Therapy Education (1111 North Forsythe Street, Alexandria, VA, 22314; phone: 703-554-0796; email: accreditation@apta.org). Candidate for Accreditation is a pre-accreditation status of affiliation with the Commission on Accreditation in Physical Therapy Education that indicates that the program may replicate students in professional courses and that the program is progressing toward accreditation. Candidate for Accreditation is not an accreditation status nor does it ensure eventual accreditation. Graduates from a physical therapist education program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE), 1111 North Forsythe Street, Alexandria, VA 22314; phone: 703-554-0796; accreditation@apta.org are necessary for eligibility to sit for the Federation examination, which is required in all states.

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RockSauce contains 20% methyl salicylate, 10% menthol, and .002% capsaicin to deliver pain-alleviating warmth to muscles and joints, the manufacturer says. It can function as a stand-alone pain reliever or in conjunction with RockTape kinesiology tape. RockSauce’s reported success led to the development of RockSauce Chill, a cooling gel containing 6% menthol. RockSauce Chill’s active ingredient is said to work synergistically with inflammation-reducing ingredients such as arnica, green-tea, and aloe.

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PTinMOTIONmag.org / February 2017
When I was younger—much younger—I became interested in medicine after sustaining a few injuries while participating in sports. It seemed to me that working with the human body and being able to fix it was one of the coolest things anyone could learn to do.

At first, orthopedic surgery was my main interest. I was deeply involved in woodworking during high school, and I equated the 2 things. Both required great precision. But my mom, a nurse, had seen firsthand how stressful a surgeon’s life can be. She urged me to explore other opportunities to help people through a health care profession.

After I’d volunteered at a couple of clinics and had a few stints as a rehab patient, I was sold on orthopedic physical therapy as my career choice. Soon after graduating from college and becoming a physical therapist, however, I saw that I’d need to broaden my outlook. I realized that every patient or client—whatever his or her presentation, injury, or issue—might be dealing with an orthopedic condition, and that anyone with an orthopedic condition might face other issues, as well. So, it was back to the books for me, to learn more about neurologic physical therapy and developmental and acute rehabilitation. I needed to broaden my knowledge base in order to give my outpatient orthopedic patients the best care that I possibly could.

So, fast-forward a quarter-century. About 3 years ago a boxing gym opened next to 1 of my clinics—announced to the community with a burst of marketing. Intrigued, I introduced myself to the owner, Tricia Turton-Arcaro. We talked, and I signed up for classes at Arcaro Boxing. I immediately connected with the sport.

I loved the workouts. They simultaneously improved my coordination, agility, flexibility, and strength. Boxing ticked a lot of, well, boxes for me. But it was a personal hobby at first, with no ties to what I do as a PT. Until, that is, something quite unexpected happened. Tricia took me out for coffee to discuss a new program she was considering—noncontact boxing to help people with Parkinson disease (PD) manage their condition. She wanted to know if I was
interested in serving on her advisory team.

I’d been peripherally aware of the existence of noncontact boxing programs to help individuals with PD manage their symptoms. But when I looked into it, I found an impressive amount of evidence-based research on the benefits of boxing for this patient population, and I learned that PTs around the country and the world are right in middle of the ring, as it were. As the PT member of the advisory committee for the KO Parkinson’s program at Arcaro Boxing, I would, I learned, be volunteering my time to work alongside an occupational therapist and a speech-language pathologist, as well as with Tricia—herself a boxer—and another coach. It sounded like a great opportunity for all of us—the patients, my therapist colleagues, and me.

The program launched early in 2016. Our first participants were 2 individuals—physician-cleared and special needs-assessed—who presented different faces of the PD disease process. On the one hand, I had a certain comfort level with my role. I was, after all, in a familiar environment—the gym—and, being a veteran PT, I was a movement expert with the knowledge and skills to help people manage, and even overcome, a wide variety of physical limitations. On the flip side, though, I was new at helping people with PD. I felt much like I had on my first day on the job after graduating from PT school.

Those early jitters quickly faded, however, as our work with our highly motivated patients began yielding results. Carl, an ex-wrestler, began KO Parkinson’s with a pronounced tremor. But he has progressed tremendously over the course of the last year—from barely being able to jump rope at all, for instance, to performing “doubles” and “crossovers” better than I can. It’s exciting and inspiring. He’s told me that he thinks he’s in better shape now than he has been at any point in his life.

Peter has more-classic Parkinson symptoms, in that it’s difficult for him to pick up his feet. He shuffles quite a bit, is very stiff in the trunk, and has difficulty opening up his hips because he feels as if his feet are glued to the floor. Working with Peter challenges me to come up with ways to get him to “unglue” himself. But he, too, has made an amazing
amount of progress. He no longer struggles to nearly the extent that he did.

Both of these men are extremely dedicated to managing their condition. They come faithfully together to the 2 weekly classes—both of which consist of 17 3-minute rounds, with 30-second rests between each. Flexibility, balance, and agility are emphasized in the early warm-up rounds. Punch sequences ensue in subsequent rounds—centered on arm, trunk, and hip movements, with the intensity steadily increasing. By the time the final cooldown round ends, Carl and Peter are tired! They’re dripping with sweat. They’re moving with notably greater flexibility and motor control, though. That’s what we call a perfect hour!

When we conducted a 6-month survey to ask these 2 men how they felt they were doing and whether their needs were being met, Peter called us all crazy for spending so much time with them without getting paid a dime. He added that he was thrilled, however, with the 1-on-1 attention. He told us that we’d made a big difference in his life.

That was my moment of epiphany—when it came home to me just how right my mother had been. Thanks to her, my career has been all about helping people—without the stress I might have felt as a surgeon, had I pursued that, but with all the joys and satisfaction of service to others.

My mom has passed away. I wish I could thank her, again, for guiding me toward the profession I love. But every time I help people like Carl and Peter help themselves, I feel as if I’m paying tribute to her, and the huge role she played in making me the person and professional I am today.

I sometimes ask myself, if I wasn’t a PT, what else would I do? The answer always is the same: I have no idea! There’s nothing I’d rather do than help my patients fight—1 round at a time—the physical issues that limit their lives, so that they can emerge victorious.
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REFERENCE

379.3 MILLION

Annual ambulatory care visits to nonphysicians for musculoskeletal diseases during 2009-2011. Nonphysician providers include physical therapists, occupational therapists, chiropractors, social workers, physician assistants, nurse practitioners, and other related health care workers.

REFERENCE

$48.5B

Retail outlet sales of durable medical equipment in 2015. That’s a 3.9% increase from 2014 expenditures of $46.6 billion.

REFERENCE

28%

Portion of the US population that considers abuse of strong prescription painkillers an extremely serious problem. Another 38% deem it very serious.

REFERENCE

-0.9%

Decline in use of health care services for outpatient visits in 2014. That’s equal to a drop of 3 visits per 1,000 patients.

REFERENCE
ZeroG®-Lite
Robotic Body-Weight Support Treadmill System

Featuring Dual Arrest™ fall protection to safeguard your patients by preventing falls and simultaneously stopping the treadmill.

- Dynamic or Static Body-Weight Support
- Dual Arrest Fall Protection
- Anti-Skid Ramp and Landing
- Adjustable, Ergonomic Therapist Seating
- Wireless User-Interface Tablet

Now including training bouts!
The all new
Thermasonic® Gel Warmer
Warm and comfortable is now even better.
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